MDS Alert

RAI Manual Update: Nail Down The Latest Coding Changes For Restorative, IVs And Wounds

Heads up:Some changes affect payment or provide helpful clarifications.

As an MDS coordinator, you're only as good as your mastery of the latest coding instructions, and if you haven't implemented the April 2004 update, you're already behind theeight ball with payment and regulatory compliance.

Posted on the **Centers for Medicare & Medicaid Services'** Web site, the manual revisions contain the following clarifications that could impact RUGs placement, experts note. These include:

Don't code fluids used solely as flushes at K5a (parenteral/IV). "That appears to refer to flushes used to keep a line open, as CMS doesn't want facilities to be able to code a heparin lock as an IV," says **Sue Rogers, RNAC**, an MDS nurse with**Omnicare Health Network** in Columbus, OH.

Dentures are not a prosthetic device for purposes of coding Section P3 (restorative nursing). This clarification may have been driven by facilities that were pushing the envelope by trying to get credit for restorative nursing for helping residents with denture care, says **Holly Sox, RN,** MDS manager for **J. F. Hawkins Nursing Home** in Newberry, SC, and clinical editor for careplans.com.

A trained nurse may perform respiratory assessments (Section P- respiratory therapy). Nurses have always been able to provide respiratory treatments in nursing homes if they are trained, says **Diane Brown, CEO**, **Brown LTCConsultants** in Needham, MA. "But the RAI manual instructions giving [nurses] the ability to do evaluations for the purpose of the facility providing and coding respiratory therapy treatments is new,"she says. "And there have been concerns raised about what training a nurse must or should have to do the evaluations.

"**Potential solution:** The training requirement is still nebulously defined, agrees **Patricia Boyer, MSM, NHA**, a consultant with**BDO/Heritage Healthcare Group** in Milwaukee, WI. She advises facilities provide some initial training for nurses on how to perform whatever respiratory treatment will be administered and coded on the MDS in Section P, such as nebulizer treatments. "Then the facility can have an RT or nurse educator provide an annual inservice updating staff on the RT treatments performed in the facility and counted toward RUG payment."

Or a facility could use a competency checklist to validate a nurse has the respiratory therapy skills if the nurse, for example, has recent experience in a respiratory unit in an inpatient facility, Boyer suggests.

Take the High Road When Coding IVs

No, the most recent update didn't include new instructions for excluding IVs and IV meds related to surgical procedures. But be careful what you code in that regard, as it affects RUG payment -- and CMS is definitely keeping an eye on the issue.

In a previous manual update, "CMS said that facilities could not count on the MDS (and toward RUG payment) an immediate pre- or post-op IVmed or IV,"notes Boyer. Examples would include a resident who received a prophylactic antibiotic for hip surgery or had an IVhanging during a procedure, she adds.

Providers had expected more changes expanding what counts as a pre- or post-op IV or IV med, based on hotly contested information presented by CMS representatives at the April 2004 **American Association of Nurse Assessment Coordinators** conference in Atlantic City. While the clarification didn't materialize, providers remain wary

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of coding IVs and IV meds associated with a surgical procedure.

Try this solution: Don't code an IV that's hung before or during a surgical procedure and allowed to run in and then discontinued -- or even if the recovery room staff hangs a second bag that runs in before the IV is discontinued, advises Boyer.

"But if the IV or IV med continues and becomes part of the treatment plan for that resident after the procedure, then the facility should count [the IV or IV med], as it will require skilled nursing monitoring and care," Boyer maintains.

Section M Changes Didn't Materialize

CMS has acknowledged that Section M (skin condition) needs some work, so providers were disappointed to see so few clarifications in the update, says **Jane Belt, MSN, RN**, with **Plante & Moran Swartz Group** in Dublin, OH.

The update does advise providers to code at Section M4c any open lesions/sores not coded elsewhere in Section M -- but don't code skin tears or cuts at M4c.

Beyond that, providers are left winging it on various skin coding issues. Assessing and coding skin lesions isn't easy, in Belt's view, "but CMS needs to think through all the skin conditions that occur in long-term care and give more definitive directions. For example, we can all argue that an ulcer covered by necrotic eschar should be labeled unstageable, but at least the MDS directions now say to code it as a Stage 4," Belt says.

"That's what we need: Code this, don't code that," she adds. "We don't have to agree with the directions necessarily, but at least everyone will be coding wounds the same on the MDS."

Review all of the RAI manual changes at www.cms.hhs.gov/medicaid/mds20/rai0404upd.pdf.

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