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MDS Alert

Reimbursement: Tip The Cognitive Performance Scale In Favor Of Fairer Payment

Undercoding Section B can cost you $50 a day in Medicare reimbursement.

Coding a resident's cognitive abilities accurately in Section B is a smart move if you want to keep your patient care coffers as full as they should be.

Know the score: A resident with a score of 3 or higher on the Cognitive Performance Scale (CPS) will receive a point in the Extensive Services count determination which can make a difference whether he goes into SE1, SE2 or SE3. And SE3 pays about $50 more a day than SE2.

The CPS impacts not only RUG placement within the Extensive Services categories (SE1, SE2, SE3) but also the Impaired Cognition category, adds **Marilyn Mines, RN, BC**, director of clinical services for **FR&R Healthcare Consulting** in Deerfield, IL.

"Medicaid programs that use the MDS and RUGs will pay for a resident who groups into Impaired Cognition just as it does other RUG classifications," adds **Peter Arbuthnot**, industry regulatory analyst with **American HealthTech Inc**. in Jackson, MS.

Nail down the basics: The CPS looks at the coding for short-term memory loss (B2a) and cognitive skills for decision making (B4). The scale also considers the resident's ability to be understood (C4), whether he's comatose--and how dependent he is on staff for eating, says Mines.

Know What B4 Is Looking For

Honing your skills for coding B4 (cognitive skills for daily decision-making) will pay off in spades, considering this item plays a big part in determining a resident's score on the CPS. For example, a resident coded as a "3" for severely impaired at B4 will automatically get a CPS score of 5 if he has a code of 0, 1, 2 or 3 for self-performance in eating.

Keep it simple: "B4 is really looking at very common and fairly simple decision-making tasks," says **Rena Shephard, RN, MHA, FACDONA,** president of **RRS Healthcare Consulting** in San Diego. For example, the manual says to look at whether the resident chooses clothing items and uses "environmental cues to organize and plan," such as clocks and calendars or posted listings of upcoming events--or in the absence of environmental cues, seeks information appropriately (e.g., not repetitively) from others to plan the day.

Other examples include:

• making the correct decision concerning how to get to the lunchroom;
• acknowledging need to use a walker, and using it faithfully.

Know the coding: If the resident "rarely or never" made decisions during the seven-day lookback--even though staff gave him opportunities and cues to do so--code B4 as "3" for "severely impaired." If the resident attempts to make decisions, although poorly, code "2" for moderately impaired. Code a "1" if the resident organized his daily routine and made "safe decisions" in familiar situations, but experienced some difficulty making decisions when faced with new tasks or situations.

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Beware new survey focus: Mines notes that the RAI manual's instructions assume that the resident has opportunities for making decisions. A recent **Centers for Medicare & Medicaid Services'** Webcast on the new Psychosocial Outcome Severity Guide also stressed that facilities should provide care that promotes residents' autonomy in making decisions.

Don't Stop Short in Assessing Short-Term Recall

Coding at B2a (short-term memory) also plays into the cognitive impairment equation for scores under 5 on the CPS. The coding options for B2a include a 0 for "memory OK" or a "1" for "memory problem."

To test short-term memory, the manual suggests asking the resident to describe his breakfast meal or an activity that he just completed. "Or ask the resident to remember three items (e.g., book, watch, table) for a few minutes. After you have stated all three items, ask the resident to repeat them (to verify that you were heard and understood). Then proceed to talk about something else. Don't be silent or leave the room. Wait five minutes and ask the resident to repeat the name of each item."

The RAI manual also suggests a facility could use a more structured test. "If you are going to test someone's short-term memory ... use a statistical, reliable instrument like the Mini-Folstein," advises **Jane Belt, MS, RN, CS, CLNC**, quality assurance coordinator for **Plante & Moran Clinical Group** in Columbus, OH.

Cover the bases: You can perform a cognitive measure more than once to "make sure ... it's a consistent and true finding," says **Barbara Resnick, PhD, CRNP**, associate professor at the **University of Maryland School of Nursing**. In fact, the RAI manual says to code the resident's "most representative level of functioning"--not the highest. In testing short-term memory, look for the "optimal moment for testing," Resnick suggests.

Ideally, the resident will be tested by "someone he knows and feels comfortable with at a good time of day for the resident--not when he's upset or agitated," adds Resnick.

One of the biggest mistakes facilities make, in fact, is doing the assessment "on the fly," adds **Diana Waugh, RN, BS**, of **Waugh Consulting in** Waterville, OH.

For example, the staff person asks the resident what day it is--not realizing that the person may have lost a day or two due to surgery, illness or medication where the memory loss is really transient, Waugh says.

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