MDS Alert

What Do You Think?

Question 1: I am confused about inactivation vs. modification. Can you explain the differences?

Answer 1: The May 2013 RAI updates changed the requirements. Basically, you can make a modification when there is an error in the target date, (entry and discharge dates, and ARD), reason for assessment, and clinical items. However, there are certain requirements that you also must meet in order to do a modification.

For example, you can modify the ARD only if the reason is due to a data entry or typographical error. If the look-back period would need to change, a modification is not appropriate.

Another example is in the case of the reason for assessment. If an error was made in the reason(s) for assessment, and the same item set would be utilized, a modification is acceptable. However, if you would need a more stringent item set, a modification is not appropriate.

Modification of an assessment is not permitted if the error is related to the type of provider, or the submission requirement needs to be changed. In the former situation an inactivation is required; for the latter, a manual correction/deletion is required. In addition, if a different item set would be required or the look-back period would change, inactivation rather than modification is necessary.

Please refer to chapter 5 in the RAI manual for specifics related to this question.

Question 2: My treatment nurse and I disagree on the following. Can you be the referee? The resident had two stage 2 pressure ulcers on her left buttock. They merged into one, and became a stage 3. Do we code a worsening stage 2 or 3 worsening pressure ulcer in M0800?

Answer 2: You would code this as a worsening stage 3 pressure ulcer. If the pressure ulcers had only merged and did not go up to a stage 3, you would not code it as worsening. See the examples in Chapter 3 M-27 of the RAI manual.

Question 3: Once a pressure ulcer is surgically debrided, is it considered a pressure ulcer or a surgical wound?

Answer 3: It continues to be a pressure ulcer until it is healed (RAI manual Chapter 3-M34).

Question 4: Is the look-back period for Section M seven days?

Answer 4: The look-back period for Section M is seven days, for the most part. However, to properly code some of the items, you must look back to the previous assessment and determine if the pressure ulcer was indicated on the prior assessment and what stage it was. For example, you cannot code a healed pressure ulcer in M0900 if no pressure ulcer was indicated on the previous assessment, even if the resident developed one that healed during the quarter. As indicated in question 3, for Section M0800 and M0900, the look-back period is the ARD of the prior assessment, if one was completed.

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