Codify
BY AAPC

MDS Alert

What Do You Think?

Question 1: What happens if a staff member documents in her ADL charting that a resident is Independent with transfers, but I know this is incorrect? Do I record this incorrect information?

Answer 1: No, you should not record the incorrect information for the resident's Activities of Daily Living (ADL), according to a recent Q&A by **Shelly Nanney, RN, RAC-CT**, MDS Clinical Coordinator for the **Texas Department of Aging and Disability Services**. "If you are reviewing documentation to complete the MDS and you find that the information entered by another staff member is incorrect, it is your obligation to ensure that the correct information is entered into the MDS."

When you find information on an MDS that is inaccurate, you should enter the correct data into the MDS and then document how you made that decision, Nanney said

Example: Make a note stating: "Upon staff interview, it was determined that the information entered for 4/1/16 on Mrs. J was incorrect for amount of staff assistance provided for transfers. The information entered was 1/1 when in fact the staff performed 100% of the task and the resident didn't participate in that instance, so 4/2 is the correct response."

You should never knowingly enter incorrect data into the MDS, because doing so is fraudulent, Nanney warned. "Correcting data before the MDS is locked is the appropriate process," even if you didn't find the incorrect information until after the Assessment Reference Date (ARD).

Question 2: In what types of situations must I complete a COT OMRA?

Answer 2: You must complete a Change of Therapy (COT) Other Medicare Required Assessment (OMRA) when the resident receives sufficient level of rehabilitation therapy to qualify for Ultra High, Very High, High, Medium, or Low Rehabilitation category, according to the **California Department of Public Health** (CDPH).

A COT OMRA is required "when the intensity of the therapy changes to such a degree that no longer reflects the RUG-IV classification and payment assigned, based on the most recent assessment used for Medicare payment," CDPH explains.

But according to CDPH, you do not need to complete a COT OMRA when:

- A resident is discharged from your facility on or prior to Day 7 of the COT observation period (in cases where the date you code for Item A2000 Discharge Date is on or prior to Day 7 of the COT observation period). If you choose to complete the COT OMRA in this situation, you may combine the COT OMRA with the Discharge assessment.
- The last day of the Medicare Part A benefit (the date you used to code A2400C End date of most recent Medicare stay) is prior to Day 7 of the COT observation period. But keep in mind that a COT OMRA would be required if the date listed on A2400C is on or after Day 7 of the COT observation period and all other conditions are met.
- The date you used to code A2400C is equal to the date you coded for A2000 (cases in which discharge from Medicare Part A is the same day as the discharge from the facility), and this date is on or prior to Day 7 of the COT observation period. You may choose to combine the COT OMRA with the Discharge assessment in this case.

Question 3: Can you please explain the sequencing of ICD-10 codes for long-term care facilities?

Answer 3: Sequencing in ICD-10 codes captures a resident's medical condition and will therefore drive reimbursement,

said **Nicky Martin, BS, LNHA**, Leadership Coach with the **Quality Improvement Program for Missouri's Long-Term Care Facilities** (QIPMO) in a recent educational offering. But long-term care (LTC) facilities' coding may not be as clear cut as it is for other providers.

"In LTC, when Medicare Part A is the primary pay source, the 'first listed' or 'primary diagnosis' will be the reason for a resident receiving the skilled services," Martin explained. "For instance, the chief complaint (reason for admission-primary diagnosis) for the hospital inpatient admission and the reason a resident is receiving skilled services in your home may differ."

"Coders will want to capture and list first the reason for the skilled services," Martin instructed. "The staff responsible for the task of coding will need to be proficient in Medicare guidelines and the resident's medical condition."

For LTC-focused ICD-10 information, Martin suggests checking out the specialty-specific guidance from "Road to 10" at www.roadto10.org/specialty-references and the **American Health Information Management Association**'s "ICD-10-CM Coding Guidance for Long-Term Care Facilities" at http://library.ahima.org/doc?oid=107574#.VxQiQXn2apo.

Question 4: We have a resident who was discharged return anticipated and returned within 30 days, but we didn't complete an OBRA Admission assessment. How should we code A1700?

Answer 4: In this case, you would code A1700 □ Type of Entry as 2 □ Reentry, according to the **Polaris Group**. The **Centers for Medicare & Medicaid Services** (CMS) recently clarified this in the RAI Manual, which states:

Reentry refers to the situation when all three of the following occurred prior to this entry:

1. The resident was previously in this facility; AND
2. The resident was discharged return anticipated; AND
3. The resident returned to the facility within 30 days of discharge.

In addition to coding A1700 as reentry, you must also complete an Entry tracking record upon the resident's return to the facility, the Polaris Group instructed.