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MDS Alert

MDS, Compliance & Clinical News To Use: Don't Miss These New COT, EOT, and EOT-R OMRA Clarifications

A Nov. 29 CMS clarification document has a "Clarification regarding the relationship between the End of Therapy OMRA and the Day of Discharge" as follows: "In cases where a resident classified into a Rehabilitation or Rehabilitation plus Extensive Services RUG category and does not receive any therapy services for three or more consecutive calendar days and the resident is discharged from the facility on the third day of missed therapy services, then no EOT OMRA is required. More precisely, in cases where the date coded for Item A2000 is the third consecutive day of missed therapy services, then no EOT OMRA is required. Facilities may choose to combine the EOT OMRA with the discharge assessment under the rules outlined for such combination in Chapter 2 of the MDS RAI manual," states the follow-up document.

More: "In cases where the last day of the Medicare Part A benefit, that is the date used to code A2400C on the MDS, is prior to the third consecutive day of missed therapy services, then no EOT OMRA is required. If the date listed in A2400C is on or after the third consecutive day of missed therapy services, then an EOT OMRA would be required. Finally, in cases where the date used to code A2400C is equal to the date used to code A2000, that is cases where the discharge from Medicare Part A is the same day as the discharge from the facility, and this date is on or prior to third consecutive day of missed therapy services, then no EOT OMRA is required. Facilities may choose to combine the EOT OMRA with the discharge assessment under the rules outlined for such combination in Chapter 2 of the MDS RAI manual."

N**ow for the C**OTO**MR**A**:** "In cases where the resident is discharged from the facility on or prior to Day 7 of the COT observation period, then no COT OMRA is required," CMS states. "More precisely, in cases where the date coded for Item A2000 is on or prior to Day 7 of the COT observation period, then no COT OMRA is required. Facilities may choose to combine the COT OMRA with the discharge assessment under the rules outlined for such combination in Chapter 2 of the MDS RAI manual."

"In cases where the last day of the Medicare Part A benefit, that is the date used to code A2400C on the MDS, is prior to Day 7 of the COT observation period, then no COT OMRA is required. If the date listed in A2400C is on or after Day 7 of the COT observation period, then a COT OMRA would be required if all other conditions are met. Finally, in cases where the date used to code A2400C is equal to the date used to code A2000, that is cases where the 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, then no COT OMRA is required. Facilities may choose to combine the COT OMRA with the discharge assessment under the rules outlined for such combination in Chapter 2 of the MDS RAI manual."

CMS also clarified when you can do the EOT-Resumption OMRA: "To be considered an appropriate resumption of therapy, two qualifications must be met. First, the resident must resume therapy at the same RUG-IV therapy level as was in effect prior to the break in therapy... Second, the resident's previous therapy plan must still be in effect. For example, if the resident qualified for Very-High rehabilitation on the basis of receiving Physical and Occupational therapies, then these disciplines must resume at the same intensity as prior to the break in therapy. If, for a given resident, one or both of these two conditions are not met, then an EOT-R may not be completed for that resident," CMS states in the clarification document.

"For example, if the resident would resume at Very-High rehabilitation, but instead of receiving Physical and Occupational therapies the resident is expected to receive Occupational and Speech-Language therapies, then this would not constitute a legitimate resumption and an EOT-R could not be completed."

Editor's note: The document, which has additional clarifications, can be downloaded at https://www.cms.gov/SNFPPS/Downloads/NPC_Nov3_Clarification_FINAL.pdf. For additional coverage on the clarifications, see the next MDS Alert.

Sweating that your 5010 standard won't be in place by the Jan. 1 deadline? CMS has an early holiday gift, with its Nov. 17 announcement that it will not initiate enforcement action regarding 5010 until March 31, 2012.

Not a deadline shift: CMS stresses in its statement that the 5010 compliance date remains Jan. 1, 2012. However, the agency will not penalize practices that aren't using 5010 until after the new 90-day "discretionary enforcement period" ends in March, as long as practices can demonstrate that they are working toward 5010 use.

"If requested, covered entities that are the subject of complaints must produce evidence of either compliance or a good faith effort to become compliant with the new HIPAA standards during the 90-day period," CMS says in its statement.

To read the complete CMS announcement, visit www.cms.gov/ICD10/Downloads/CMSStatement5010EnforcementDiscretion111711.pdf.

"CMS decided to adopt the addendum version of the 5010 transactions as of April," says **Peter Arbuthnot,** regulatory analyst with American HealthTech in Jackson, Miss. "This moved actual testing for most trading partners from January 2011 to April or later in 2011," he adds. "Testing has gone fairly smooth for larger clearinghouses and Medicare payers but Medicaid payers, as well as the smaller providers, have been slower to begin testing. Hopefully, the CMS delay in enforcement will allow providers who are not ready by January 1 to get with their payers and work out the details for compliance without delays in payment," adds Arbuthnot.

Editor's note: The above news item (excluding the comments by Peter Arbuthnot) originally appeared in the Coding Institute's Part B Insider. For information on how to subscribe, call 1-800-508-2582.

Medicare RA**Cs can now request more records for complex reviews.** "Under the previous formula, providers such as SNFs with a lower volume of claims would only be required to submit one or two claims per a 45 day period," says **Janice Potter, CPA,** a healthcare research specialist with FR&R Healthcare Consulting Inc. in Deerfield, Ill., which covered this topic in a September client bulletin. "This would not make for a valid sample for the RACs to review. Using the new rules, the minimum number of records to be requested is 35 claims," Potter tells Eli. FR&R believes "the change was specifically made to enable RACs to look at SNFs and other small providers," she adds.

Keep pain on your radar screen. Diane Atchinson, RN**-BC, M**SN**,** AN**P, R**A**C-C**T**,** says that she's conducted mock surveys and identified where "during the reference period for an MDS, the staff has coded that the resident had moderate to severe pain. Then you look to see if the nursing staff did an in-depth review of the pain issue, including pain medication in use and recommendations to the physician regarding adjusting the program -- and the answer is no."

Also: "Facility staff often assess for pain, add a routine or PRN pain medication, but then don't reassess until the next MDS is completed," adds Atchinson, president of DPA Associates Inc. in Springfield, Mo. "Facilities can obtain best practice data regarding pain management from their state QIO organization," Atchinson advises.

Atchinson says she's also "finding instances where people are on opioids and there's no bowel program -- or they were getting PCA pain medication in the hospital and came in for rehab with nothing ordered but PRN Tylenol. And then staff wonder why the resident does not want to go to therapy or is having behavioral issues," she adds.

Do your residents need these vitamin and mineral supplements? One is vitamin D. People's "vitamin D [levels] go down with aging," said **John Morley, MD,** in a presentation on OTC supplementation and medical foods at the March 2011 American Medical Directors Association annual meeting. And "if you can find one person in your nursing home who is not 'vitamin D deficient,' certainly if you use 30 ng [per ml as a cutoff] -- that is a miracle." He also noted that "vitamin D deficiency is related to hip fracture and sarcopenia."

Remedy: "Someone can go in the sun one half hour day without sunblock and get enough vitamin D3 -- or you can supplement," says Morley, director of the division of geriatric medicine at St. Louis University School of Medicine in St. Louis, Mo. "We give everyone 1,000 units a day. Studies show that somewhere between 400 units and 650 actually works. And there's no such thing as a 650-unit dose, so you can give 800" units instead, Morley tells Eli.

What about calcium? "We know that calcium improves bone mineral density," said Morley in his talk. If a person requires calcium supplementation, he advises giving the calcium tablets at night. That's because "while people sleep, calcium

comes off their bone when they are lying flat," Morley tells Eli.

Also: "If you give the calcium [supplements] with medications, the medications won't be absorbed. That's one reason you see study data associating calcium supplements with myocardial infarction. It blocks all the meds that prevent acute MI," says Morley, who also discussed that problem in his AMDA conference presentation.

Morley observes that "vitamin B-12 deficiency is extraordinarily common in older patients," requiring high dosing to correct if it occurs. "B-12 [deficiency] can cause tingling in the fingers, poor balance, or mild cognitive impairment without anemia."

Also: "Magnesium deficit can occur in some people -- most commonly in those with diabetes or on diuretics," warns Morley. "You need to pay attention to that and test for it. Weakness is probably the [major] symptom you will see, and the person won't feel good. Constipation is another one. Anytime you see constipation, you should test for magnesium" levels, adds Morley**.**

Researchers recently discovered that "high blood pressure and other known risk factors for stroke also increase the risk of developing cognitive problems, even among people who have never had a stroke," states a press release from the National Institutes of Health, which funded the study.

"Our results emphasize the importance of early intervention to treat high blood pressure and preserve cognitive health prior to a stroke or other cerebral event," said first author **Frederick Unverzagt, PhD**, in the release.

Unverzagt further points out that "the people who experienced cognitive decline may have had silent strokes or other subclinical changes affecting the brain's blood supply." The release goes on to say that the "study does not rule out other possible causes, such as Alzheimer's disease, but Dr. Unverzagt notes there is growing recognition of an overlap between the pathology of stroke and Alzheimer's. The two conditions share several risk factors -- including high blood pressure."

You can read the full release at http://www.nih.gov/news/health/nov2011/ninds-07.htm.