

# North Carolina



Current Information on North Carolina Case Mix Reimbursement

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The North Carolina News is a publication produced under contract with The North Carolina Division of Medical Assistance by Myers and Stauffer LC 9265 Counselors Row, Ste. 200 Indianapolis, IN 46240

The North Carolina News is published to keep all interested parties current on North Carolina Case Mix Reimbursement. Its goal is to provide information on major issues, work groups, and upcoming activities. The articles presented here are only a synopsis of the topics and are not intended to present a complete analysis of the issues.



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## Medical Correction Policy - Revised

The Division of Medical Assistance adopted a new policy 01-01-08 for medical record corrections related to acceptance of supporting documentation for MDS validation reviews. This policy allows for minor changes or corrections to previously recorded documentation in the resident's status in accordance with standards of clinical practice and documentation.

- a) If an error is discovered on or after but within 7 days of the Assessment Reference Date (A3a) of an MDS and before submission to the State MDS database, the response may be corrected using standard editing procedures on the hard copy (cross out, enter correct response, initial, and date) and correction of the MDS record in the facility database. The resident's care plan should also be reviewed for any needed changes.
- b) Any corrections made including but not limited to, the Activities of Daily Living (ADL) grid must have an associated note of explanation per **correction**.
- c) If a **major** error is discovered in a record in the State MDS database, modification or inactivation procedures must be implemented by the facility to assure that the database information is corrected.
- d) Clinical **documentation** corrections must also be made as necessary to assure that the resident is accurately assessed, the care plan is accurate, and the resident is receiving the care needed.
- e) A quarterly or summary note will not substitute for an occurrence correction.

## Ulcers/Pressure Ulcers - M1a-d and M2 (RAI Manual pages 3-159 to 3-164)

Per the current Supportive Documentation Guidelines, documentation of ulcers must include staging of skin ulcer(s) in terms of what is seen (i.e., visible tissue) within the observation period (commonly referred to as reverse staging).

While measurements are not currently required to support ulcers, measurements may be used by the reviewer to assist in the determination of reverse staging.

It is anticipated that with the next version of SDGs, measurements of ulcers will be required for the MDS validation review.

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# Dear Patty...

The "Dear Patty..." column is a regular feature in each issue of *The North Carolina News*. Patty Padula, Myers and Stauffer's RN consultant, will discuss questions that are frequently answered by our staff. We welcome your questions for future issues.



## Dear Patty:

*Q. Will a printout of an electronic hospital MAR suffice as documentation of IV medication administration?*

*A.* The MDS validation reviewer must see evidence of the administration of an IV medication. The Supportive Documentation Guidelines (page 27) state that "Supportive documentation entries must be dated with a complete date and their authors identified by an initial and corresponding signature." A computer generated report that indicates "given on 4/8/08 at 0800" with no nurse initials or code will not be sufficient for the review. A facility has several options available in order to provide supporting documentation. (1) Ask the hospital for a key or legend that correlates with the medication administration system. (2) Ask the hospital for a blank computer generated MAR that includes the key or legend. (3) Write a policy that includes how the MAR is interpreted. (4) Review hospital nurses notes as another source of IV med documentation.

## Common Reasons Why Nursing Restorative Programs are Unsupported for the MDS Validation Review

There are several common reasons why nursing restorative programs are unsupported for the MDS validation review.

- ✓ *There is no care plan of the program.*
- ✓ *Care plan does not state the problem, need or strength. Why does the resident need the program?*
- ✓ *The program goal is "maintain" with no measurable goal. How do you determine if the resident has "maintained"? What was the resident's previous level of functioning compared to the current level of functioning? What do you use to measure the goal? How do you measure the goal?*
- ✓ *Evaluation of the program lacks the resident's response. Does the resident walk the distance specified? Does the resident complain of pain during PROM exercises? Is the resident unable to raise his/her arm to shoulder level but could last month?*
- ✓ *Approaches/interventions are not specific. What is AROM to UE and LE? How does the CNA or RNA know what exercises to do, how many repetitions? Does the facility have a policy stating what an AROM program consists of? Does the resident need verbal or physical cueing – if so, what kind and how much? Does the resident need task segmentation? If so, what tasks and how are those tasks segmented?*
- ✓ *Splint programs are lacking documentation of daily assessment by a licensed nurse that includes an evaluation of the resident's skin and circulation under the device. Is the skin under the splint intact? Is the skin red? Are there open areas under the splint? Is the skin warm and dry? Is the skin cool to touch?*
- ✓ *A communication program that does not meet RAI definition. For example, problem is at risk for decline, requires group involvement; goal is to maintain communication abilities and improve as able. Why is the resident at risk for decline? What is the resident at risk for decline in? Why does the resident require group involvement? What does maintain communication abilities mean? What is the resident's current communication ability? What is improve as able? How is "improve as able" measured?*

Reminder: A care plan should include: 1) a resident problem, need or strength, 2) a measurable goal and 3) specific interventions/approaches.

*Refer to the RAI manual, pages 3-191 through 3-195 and the Supportive Documentation Guidelines for additional information.*



# FAQ's About Follow Up Reviews



Q: What is a follow-up review?

A: *A follow-up review is a review conducted at the discretion of the State. It would be in addition to an annual review.*

Q: When is a follow-up review scheduled?

A: *Anytime after 120 days following the previous review.*

Q: Why was this facility selected for a follow-up review?

A: *Facilities selected are determined by the State.*

Q: What is different about the follow-up review than the normal review?

A: *The review will be conducted in a similar manner as the regularly scheduled review.*

Q: What are the criteria for a follow-up review?

A: *Criteria are determined by the State and may vary on a case-by-case basis.*

Q: What is the unsupported threshold for a follow-up review?

A: *The unsupported threshold is the same as the current State unsupported threshold.*

Q: What happens if I go over the unsupported threshold?

A: *All unsupported assessments will be reRUGged and a new CMI calculated. A retrospective rate adjustment will be made if applicable.*

Q: Who should be present for a follow-up review?

A: *Recommend facility Administrator, MDS coordinator and any other staff of facility choice.*

Q: Will facility be notified if review is considered a follow-up review?

A: *Yes.*

Q: How many follow-up reviews can be done?

A: *A follow-up review may be done as frequently as determined by the State, but no earlier than 120 days from previous review.*

Q: Will a facility have the right to request a reconsideration of the review results?

A: *Yes. The Post Review Summary letter will contain the information for a reconsideration request.*

Q: What records are selected for a follow-up review?

A: *The records for review will be selected randomly by computer. However, the reviewers may ask for additional information above and beyond the standard review.*

## Electrical Stimulation of Wounds (Licensed Therapy)

There have recently been questions raised regarding the coding of minutes for electrical stimulation of wounds on the MDS and supporting those minutes for the MDS Validation Review.

Cindy DePorter, the State RAI Coordinator, presented these questions to the National RAI Panel. The panel was in agreement that there must be documentation in the medical record that the licensed therapist was directly providing or supervising the treatment. The medical record must also indicate that the wound being treated is a Stage III or higher in order to code these minutes on the MDS.

This information has been posted on the MDS transmission website. This is effective immediately.