Eli's MDS ALERT

Your essential guide to mastering MDS as a tool for payment, risk management & quality of care

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MISSION STATEMENT

To help busy nursing and other professionals master the complexities of the Minimum Data Set as a payment, quality-of-care and quality-of-life, risk management and compliance tool. To bring readers clear, practical strategies and tools from the nation's experts on nursing assessment and coding. *MDS Alert* is an independent publication and does not accept advertising. Our only allegiance is to you, our reader.

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STRATEGIC PLANNING

Looking for a Smooth Transition to MDS 3.0? Move These Tasks to the Top of Your 'To Do' List

▶ ***Be prepared to transmit more quickly and deal with this new assessment.***

The countdown to MDS 3.0 implementation gets shorter by the day. And to be ready to roll on Oct. 1, consider tackling these tasks now.

1. Get your current MDS system in order. Make sure you're in compliance and on top of the MDS 2.0 process, advises **Pam Campbell, RN, C, CRNAC,** with LTC Solutions Inc., a software developer in Camdenton, Mo. "Facilities need to be on their 'A game' to make the transition" work well.

Proactive strategy: Get a handle on how well the current MDS staff members are getting assessments done and submitted on time. Then use that information to plan ahead and also to fine-tune your current system. For example, look at who's doing the MDSs, and the number of records a person does daily, weekly, and monthly, which will vary somewhat with a change in census, etc., advises Campbell. Also "look at multiple reports currently available on the MDS submission site, including missing assessment reports." Your facility's own software-generated reports can also help you evaluate compliance with the RAI process, she adds.

2. Develop systems to accommodate a faster transmission schedule. Facilities should begin the process of being able to support a 14-day timeframe for transmitting the MDS 3.0 versus the 31-day timeframe for the MDS 2.0 required now, urges Campbell. For example, set up tracking systems and contingency plans for handling the faster transmission cycle, advises **Victor Kintz, MBA, CHC, LNHA, RAC-CT, CCA,** managing director of operations for The Polaris Group based in Tampa, Fla.

3. Think through what tools will help you. Consider developing a standardized kit for the interview sections. The kit could include a list of interpreters' names and phone numbers for staff to use for the interview sections, advises **Elisa Bovee, MS, OT/LR,** a consultant with Harmony Healthcare International in Topsfield, Mass. By including laminated interview cards with verbatim MDS questions for residents and staff, you can help ensure greater inter-rater reliability, she points out. The toolkit could also include scoring sheets for the relevant MDS interview sections, she adds.

Rehab companies and therapists should look at their current documentation forms, systems, processes, etc., to see how they will track and report therapy minutes delivered in each mode — that is, individual, concurrent, or group, advises **Shehla Rooney,** a physical therapist and principal of Premier Therapy Solutions in Cookeville, Tenn. The MDS 3.0 requires you to break out the type of therapy modality when coding therapy minutes on the MDS.

Tip: "It might be helpful at least initially … to have a crib sheet that reminds you of changes to the look-back (assessment reference dates) for the various sections," says **Sue LaBelle, MSN, RN,** a consultant with PointRight Inc. in Lexington, Mass.

4. Be prepared for MDS discharge assessments and their QA implications. Unless CMS makes a change, your facility will be doing discharge assessments that make the current discharge-tracking requirement seem like a breeze.

The MDS 3.0 RAI manual requires doing the MDS assessments for residents being discharged regardless of whether they are expected to return, advises **Rena Shephard, MHA, RN, RAC-MT, C-NE,** founding chair and executive of the American Association of Nurse Assessment Coordinators and president and CEO of RRS Healthcare Consulting Services in San Diego.

"Requiring an MDS assessment at discharge adds a lot of extra work," observes Seattle-based MDS and clinical expert **Nathan Lake, RN, BSN, MSHA**, noting that the current discharge tracking form isn't an MDS assessment. Shephard says, however, that she is "hoping that [the time requirement] will balance out because the MDS 3.0 as it was tested took less time to do than the MDS 2.0."

More than a workload issue: Once facilities are doing the MDS discharge assessments, CMS could compare residents' status at admission to their status at discharge from the SNF, Shephard points out.

Tip: "A facility could compare its MDS 3.0 admission assessments to its discharge assessments in order to look for trends," says Campbell. She advises providers to work with their software vendor to set that up as an automated function. ■

We welcome your comments! Call Editor Karen Lusky at 615-708-8568.

HEALTHCARE REFORM

Get Up to Speed With These Key Provisions in the Healthcare Reform Legislation

▶ ***Beware: A tighter Medicare billing timeline is already in effect.***

The healthcare reform legislation includes several measures that affect nursing home payment and compliance. Here's what you need to ramp up for now and beware of in the future.

Top priority: "The reform legislation puts a 12-month limit on Medicare fee-for-service billing," says **Betsy Anderson,** VP at FR&R Healthcare Consulting in Deerfield, Ill.

Based on the new law, "claims for services furnished on or after Jan. 1, 2010, must be filed within one calendar year after the date of service," states CMS in a notice (www1.cms.gov/prospmedicarefeesvcpmtgen/downloads/Health_Reform_Timely_Filing_Provider_Notice.pdf). "Under the previous rules, a provider might have anywhere from 15 to 26 months to file a claim depending on the dates of services," says **Victor Kintz, MBA, CHC, LNHA, RAC-CT, CCA,** managing director of operations for The Polaris Group based in Tampa, Fla. The healthcare reform law, however, "mandates that claims for services furnished before Jan. 1, 2010, must be filed no later than Dec. 31, 2010," states CMS. This includes claims that extend back as far as October 2008.

To deal with the quicker billing timeline mandated by the new law, "SNFs are really going to have to tighten up their admissions process," Anderson urges.

Update Your Systems

To deal with the quicker billing timeline mandated by the new law, "SNFs are really going to have to tighten up their admissions process," Anderson urges. Staff will have to "get the right information and populate the system at admission with all the proper insurance payers." That includes identifying people who are on Medicare Advantage or where Medicare is their secondary payer, she adds.

Also: "SNFs used to look at their billing on an annual basis in the last quarter of the year to identify what hadn't been billed but still met the timely filing deadlines," Anderson notes. But now "they should look at this every month … Otherwise, they may [run out of time to get those claims billed]."

Keep an eye out: The reform bill states that "the [HHS] Secretary may specify exceptions to the one calendar year period," but there's no word yet as to what scenarios might qualify for exceptions.

Prepare for Expanded RACs, Mandatory Corporate Compliance Programs

The federal healthcare revamp also extends the RACs' authority to Medicare Part C and D and Medicaid (currently RACs only review Medicare fee-for-service Part A and Part B claims). The legislation "is going to give the RACs the ability to cross-over to dual eligibles (Medicare-Medicaid recipients) and look at coding errors that way," predicts Anderson. "The regulatory

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WHAT DO YOU THINK?

To Bill or Not to Bill Medicare Fee-For-Service for Medicare Advantage Patients

__Question:__ If a resident is receiving skilled care covered by his Medicare Advantage plan, does the SNF need to send bills to its FI or MAC?

__Answer:__ "If a SNF resident is receiving skilled care covered by the Medicare Advantage plan, the SNF is supposed to submit monthly bills to the MAC or FI with a condition code of 04 that indicates the claim is for information only," says consultant **Jennifer Wormington.** The MAC or FI then uses the claim to update the Common Working File. SNFs are required to submit the claims to Medicare because "Medicare and the MA plans don't have systems set up to communicate" that information, adds Wormington, with BKD LLP in Springfield, Mo. ■

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PAYMENT

Healthcare Reform Legislation Delays RUG-IV for a Year

▶ ***The delay includes a difficult twist.***

The healthcare reform bill delayed RUG-IV implementation until Oct. 1, 2011. And that means without congressional intervention or a regulatory remedy, RUG-III will remain in place until then but in a modified form. The new law requires CMS to implement two RUG-IV payment features this Oct. 1: the limitation on concurrent rehab therapy and elimination of the hospital lookback period for reimbursement purposes.

In other words, "we'd have the worst part of RUG-IV without any of the benefits," concludes **Peter Arbuthnot,** a regulatory analyst for American HealthTech, a long-term care software developer in Jackson, Miss.

"The delay and changes to the RUG-III system provide a lot of challenges," says American Health Care Association spokeswoman **Susan Feeney,** "which is why we want RUG-IV and MDS 3.0 to be implemented at the same time."

Congressional leaders had hoped to repeal the RUG-IV delay as part of the reconciliation process, Feeney tells *MDS Alert.* However, "strict procedural rules for reconciliation didn't allow them to do so."

The American Association of Homes & Services for the Aging is telling its member facilities to continue to assume that RUG-IV will be fully implemented as planned on Oct. 1, advises **Barbara Manard, PhD,** VP for long-term care health strategies for the organization. "Efforts are underway to devise an appropriate solution and return to the full implementation as originally planned for October 1, 2010," Manard said in a March 25 e-mailed statement.

CMS' **Sheila Lambowitz** reported in the April 22 SNF/LTC Open Door Forum that CMS is briefing its leadership and looking at all possible options for how to best make the RUG-IV-related changes mandated by the healthcare reform legislation. So stay tuned. ■

CARE PLANNING

Beat These Parkinson's Disease-Related Problems

▶ ***Experts share inside tips for combating dysphagia, pain, falls, and more.***

Parkinson's disease can be a difficult foe, but the right combo of strategies can improve clinical outcomes and quality of life for people with the condition.

Case in point: Swallowing problems are a big issue in Parkinson's, relayed **Ron Benner, BSN, RN, MBHA, LNHA,** director of nursing at the Lieberman Geriatric Center in Skokie, Ill., in a presentation at the March 2010 American Medical Directors Association annual meeting. One solution is to time administration of Parkinson's drugs so the person is "on" rather than in an "off" period when he eats, Benner said.

> ***To ease patients' walking problems, a full-time music therapist at Lieberman works with a physical therapist to help patients with Parkinson's disease walk to the beat of music.***

"If you give the medication about 30 minutes before meals, it will kick in so the person can swallow better as he's eating," instructs **Brian J. Gates, PharmD,** at Washington State University.

There's another reason to give the Parkinson's med before the meal: "Protein can affect absorption of levodopa," Gates tells *MDS Alert.* Separating medication administration from meals is "most critical in the later stages of Parkinson's."

To reduce saliva secretions that accumulate because the person can't swallow them well, clinicians sometimes order anticholinergics, Gates notes. Yet elderly patients can develop a lot of side effects from these drugs, which are known to cause confusion and worsen dementia. The anticholinergic glycopyrrolate (Robinul) doesn't cause confusion as often as some of the other medications do, he adds.

"Some people will administer atropine eye drops to patients orally — just drop them in the mouth — to

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dry up the mouth," says Gates. "That way, the patient doesn't develop as many systemic effects from the [anti-cholinergic effect]."

Another option: Administering botulinum toxin to paralyze the person's salivary glands can also help but is usually reserved for the more extreme cases, adds Gates.

The SNF team at Lieberman also focuses on Parkinson's disease-related effects on a resident's voice, Benner noted. (For tips on how speech therapists and nursing facility caregivers can help residents with this problem, see the sidebar on page 54.)

Focus on PD-Related Pain

Pain seen in people with Parkinson's disease can be due to dyskinesia, Parkinson's medication-related "on and off periods," and comorbid conditions, Benner noted. "Pain in the Parkinson's disease patient usually occurs in the legs or in the large muscles of the arms and legs."

"People with PD can generally take most of the common pain medications, such as opioids for severe pain," says Gates. "Muscle relaxants can sometimes help contracted muscles, although sometimes not."

You also should evaluate whether the Parkinson's medications are working properly or if the clinician needs to make an adjustment, he stresses.

Tip: "When you get into the narcotic utilization with this population, depending on the age group, constipation becomes a severe problem," as does maintaining "strong hydration to counter the constipation," Benner said.

Incorporate this: The Lieberman team has found that non-pharmacological remedies, such as music and biofeedback therapy, work quite well in treating pain in people with PD. Use of active and passive range-of-motion is very effective in controlling pain in the large muscles of the arms and legs, Benner noted.

Head Off Falls

To help prevent falls, the team at Lieberman assesses the patient for stiffness and weakness, as well as freezing and balance problems.

To ease patients' walking problems, a full-time music therapist at Lieberman works with a physical therapist to help patients with PD walk to the beat of music. "God Bless America" appears to be a favorite. There's "something about the beat of that song that helps [the patients] move well," Benner relayed. The music therapist plays the guitar while the patient sings aloud with the physical therapist by his side as he walks down the hall. "Sometimes we repeat the song depending on how long the hallway is."

The right walker can also help residents stay on their feet. Options include a U-step walker, which is a lot heavier than the standard walker and turns very smoothly, said Benner. The walker also has a "laser light component" to help the person see the entry points of doorways. The devices run about $450, which Medicare Part B doesn't cover, although Medicaid in some states "will contribute a percentage and the rest can be applied to a person's spend down or yearly allowance." (For more information on the walker, go to www.ustep.com/walker.htm.)

As for unique exercise programs: Lieberman offers yoga for people in wheelchairs. The team hasn't figured out how to do wheelchair Pilates yet. But Benner predicted that someone in his group will come up with a way to pull that off. (For more information on Pilates, go to www.pilates.com.) ■

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pieces will have to be put in place — it remains to be seen as to how it's going to be implemented."

The reform bill also requires SNFs to implement a corporate compliance program, which has always been voluntary, says Anderson. "Once CMS puts out the regulation for that, SNFs will have a three-year timeframe to put their compliance plan together," she adds.

"Most facilities that have already implemented [compliance] programs will simply have to review the statute and the forthcoming regulations to make sure their programs fit the requirements," says attorney **Ari Markenson,** with Benesch Friedlander Coplan & Aronoff LLP in White Plains, N.Y.

Also: "CMS has the option to make the fraud and abuse 'guidance' issued to long term care facilities mandatory," adds attorney **Wayne J. Miller,** with The Compliance Group in Los Angeles, Calif. ■

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REHAB THERAPY

Ease Parkinson's Disease-Related Voice Changes With This Simple Strategy

▶ ***Nursing staff can help the resident maintain this skill after therapy ends.***

If a resident with Parkinson's has voice and speech difficulties, reminders to "speak up" may be just the ticket for improving the person's speech overall.

The clinical problem: Parkinson's disease can lead to "a soft, weak voice, a fast rate, imprecise articulation — and a monotonous tone," says **Nancy Swigert, MA, CCC-SLP, BRS-S,** a speech language pathologist in Lexington, Ky.

The solution: The speech therapy technique that seems to work best and has the evidence to support its use is the Lee Silverman Voice Treatment (LSVT) method, says Swigert. "The essence of the approach is that you have the patient focus on being loud. Doing so not only helps the person speak more loudly — it also improves his articulation and breath support when speaking," she notes. "The approach seems to reorganize the whole speech system rather than just one part of it."

Swigert notes that therapists used to focus on helping a patient with PD-related voice/speech changes to improve each component (loudness, articulation, and taking deeper breaths) when speaking. "But it's easier to just focus on the loudness aspects," she says. "It's a simpler direction and yields better results than working on the individual components."

Applying the LSVT technique, "the therapist works intensively with the person daily for several weeks to encourage the person to concentrate on making his/her voice loud," Swigert explains. "The therapy should be covered under Part B and Part A, as it's considered a skilled service. The nursing staff can help the person maintain the ability by reminding them to talk more loudly." ■

SURVEY MANAGEMENT TIP

Fine-Tune Risk Management With This Shift in Mindset

▶ ***Are you including these issues in your risk-management meetings?***

Perspective can be everything when it comes to identifying resident's risks for negative outcomes. And sometimes you may have to think outside the usual risk parameters — or focus more intensely on the usual ones — to keep problems from falling through the cracks.

Key: Look at how you define high-risk when reviewing residents at routine risk-management meetings. For example, do you include residents who can't communicate their needs? asks **Joy Jordan, RN, MSN, RAC-CT**, a consultant with Boyer & Associates Inc. in Brookfield, Wis. Surveyors will want to make sure that staff members are anticipating those residents' needs, she cautions.

In addition, review anyone on thickened liquids, and monitor whether the resident has thickened liquid at the bedside and how long it sits there, Jordan adds. "Does everyone involved in the resident's care know how to mix the thickened liquids?"

Target this before surveyors do: Look for residents who have an episode of choking documented in the medical record who haven't received a speech therapy evaluation, advises **Cheryl Boldt, RN,** a consultant in Omaha, Neb.

Also use the risk management meeting to review patients on psychotropics who have behavioral symptoms, even though you're also taking a look at those folks during behavioral and/or pharmacy reviews, advises Jordan. "What else is the facility doing or should it be doing if the person on the medication still has behaviors?"

"The same is true of weight loss and pressure ulcers," advises Jordan. Those "issues are often reviewed in separate meetings, but they are also high-risk issues."

Also identify residents with a stage 1 pressure ulcer as high risk because the wound will progress if the team doesn't do anything about it, advises Jordan. ■

We welcome your comments! Call Editor Karen Lusky at 615-708-8568.

TOOL

Score Residents' Fall Risk Using This Tool

▶ ***Make sure you're capturing these key risk factors.***

Hendrich II Fall Risk Model™

Confusion Disorientation Impulsivity		4	
Symptomatic Depression		2	
Altered Elimination		1	
Dizziness Vertigo		1	
Male Gender		1	
Any Administered Antiepileptics		2	
Any Administered Benzodiazepines		1	
Get Up & Go Test			
Ability to rise in a single movement- No Loss of Balance with Steps		0	
Pushes up, successful in one attempt		1	
Multiple attempts, but successful		3	
Unable to rise without assistance during test (OR if a medical order states the same and/or complete bed rest is ordered) * If unable to assess, document this on the patient chart with the date and time		4	
A Score of 5 or Greater = High Risk		**Total Score**	

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What Do You Think?

Check Out These Q&As From the March CMS MDS 3.0 Training

▶ ***CMS sheds some light on common coding quandaries.***

Will ADL Data Collection Forms Meet This Requirement?

Question: **"**Regarding MDS 3.0 G0110 (Activities of Daily Living (ADL) Assistance) 'talk with direct care staff from each shift that has cared for the resident,' many facilities utilize a data collection form for staff from all shifts to utilize during the observation period. Can this take the place of the staff interviews?"

Answer: **"**The expectation is a direct conversation with a staff member. Providers should develop their own processes to ensure that this expectation is met," according to a Q&A from the CMS training sessions for state representatives in March (www.cms.gov/NursingHomeQualityInits/Downloads/MDS30QandA.pdf).

When Will Your Facility Stop Submitting the MDS 2.0?

Question: "Will there be a cutoff date when a facility will no longer be able to submit an MDS assessment or correction?"

Answer: "Assessments with ARD of 09/30/2010 must be an MDS 2.0. Assessments with an ARD of 10/01/2010 must be an MDS 3.0. CMS has not determined the cut-off date for when an MDS 2.0 record may not be modified or inactivated." (Ibid)

Does Failure to Code Restorative Automatically Mean the MDS Assessment Is Inaccurate?

Question: **"**If the MDS is blank for restorative nursing yet the facility says that the resident receives ROM or is on the floor ambulation program, should the MDS coding be assessed as inaccurate?"

Answer: **"**In order for restorative nursing care to be coded on the MDS, the requirements under 'Steps for Assessment' on page O-23 must be met. If the requirements for restorative nursing care on page O-23 are not met, then the MDS would not be coded." (Ibid)

Would You Code This as Tracheostomy Care (O0100E)?

Question: **"**The manual says to code cleansing of the trach and/or cannula — what if the resident does this care themselves?"

Answer: **"**Yes, you can code tracheostomy care in item O0100E if the resident performs this care for themselves." (Ibid) ■

We welcome your comments! Call Editor Karen Lusky at 615-708-8568.

MDS 3.0 TIP

Be Ready to Incorporate Resident Voice in Care Planning When MDS 3.0 Goes Live

▶ ***Surveyors may target this omission.***

Translating the MDS 3.0 resident interviews into a person-centered care plan will require some effort — one that surveyors may be reviewing with 20/20 hindsight.

The MDS 3.0 "is really going to be a survey trigger in terms of what facilities do with resident voice," predicts consultant **Jane Belt, MS, RN, RAC-MT.** "That's especially true for the customary routine and preferences interview," says Belt, with Plante & Moran PLLC in Columbus, Ohio. For example, as part of that interview, suppose the resident says something is "somewhat important" to him. "Do you care plan that?"

Belt thinks the team will need to have further discussions with the resident/family "to get to the bottom line of what the person feels and really wants" as part of his care and life in the facility. ■

> ***The MDS 3.0 "is really going to be a survey trigger in terms of what facilities do with resident voice," predicts consultant Jane Belt, MS, RN, RAC-MT.***

DIAGNOSIS CODING

ICD-10 Implementation Poses a Good News, Bad News Scenario

▶ ***CMS, AHIMA reps combat myths about the expanded diagnosis system.***

ICD-10 implementation is looming ahead, and if you aren't ready to use the new system when it goes into effect on Oct. 1, 2013, don't count on having any wiggle room. That's the "cup half empty" view of implementation. The upside is that ICD-10 isn't really as daunting as it may seem initially. Those were two key messages from a Centers for Medicare & Medicaid Services-sponsored March Open Door Forum explaining the new diagnosis coding system.

A hard line: "I must stress quite strongly that Oct. 1, 2013, will be the date that everyone will begin to use ICD-10," said **Pat Brooks**, senior technical advisor with CMS, during the call. "There will be no grace period," she said. "In other words, we will not be slipping the date beyond Oct. 1, 2013, for ICD-10 codes, and this will be a compulsory implementation of this system," Brooks stressed.

CMS will not accept ICD-9 codes for any dates of service on or after Oct. 1, 2013, but will continue to process claims for services prior to that date "for a period of time," Brooks said.

Speaker Dispels ICD-10 Myths

To reduce confusion and concerns about the new coding system, **Sue Bowman** with the American Health Information Management Association addressed some misunderstanding shrouding the ICD-10 system, as follows:

• **There won't be any hard copy ICD-10 coding books.** Not true, said Bowman. "ICD-10-CM code books are actually already available from some publishers and are of a normal, manageable size," she said.

• **Payers will require much more detailed documentation to support coding.** Bowman also debunked that idea, noting that "much of the detail contained in ICD-10-CM is already in the medi-

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> ***"Just as the size of a dictionary doesn't make the dictionary more difficult to use, a higher number of codes doesn't necessarily increase the complexity of the coding," said Sue Bowman. In fact, she noted, greater specificity and clinical accuracy should actually make ICD-10 easier to use.***

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MDS 3.0

Beware: The MDS 3.0 Requires You to Answer Whether Residents Are Receiving This Mandated Evaluation

▶ ***Here's what you need to know and code about the PASRR.***

The MDS 2.0 doesn't alert you to the fact that your facility isn't in step with Preadmission Screening and Resident Review (PASRR) evaluation requirements. But "there's a question on the MDS 3.0 asking about that (A1500)," notes **Marilyn Mines, RN, RAC-CT, BC,** manager of clinical services for FR&R Healthcare Consulting in Deerfield, Ill.

MDS item A1500, which is completed only on an admission assessment, asks the question: "Has the resident been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition?" (see the MDS item on this page).

The nuts and bolts: Anyone who applies for admission to a Medicaid-certified nursing facility needs a Level 1 identification screen to identify whether he might have statutorily defined mental illness or mental retardation (MI or MR), according to a CMS Webcast, "Mental Illness in Nursing Homes" (http://surveyortraining.cms.hhs.gov/pubs/VideoInformation.aspx?cid=1066). A person identified by the Level 1 screen as having potential serious MI or MR requires a state-performed PASRR Level II evaluation to determine whether nursing home placement is needed — and, if so, what specialized services the state is responsible to provide or arrange for the person to receive.

Also: If you complete a significant change assessment on a resident on a Level II PASRR, the nursing home must notify the "state mental health authority, mental retardation or developmental disability authority," states the MDS 3.0 RAI User's Manual.

Steps for Assessment and Coding

The manual instructs you to:

"1. Complete if A0310A = 01 (Admission Assessment).

2. Review the Level I PASRR form to determine whether a Level II PASRR was required.

3. Review the PASRR report provided by the State if Level II screening was required."

"• **Code 0, no:** if any of the following apply:

PASRR Level I screening did not result in a referral for Level II screening, or

Level II screening determined that the resident does not have a serious mental illness and/or mental retardation-related condition, or

PASRR screening is not required because the resident was admitted from a hospital after requiring acute inpatient care, is receiving services for the condition for which he or she received care in the hospital, and the attending physician has certified before admission that the resident is likely to require less than 30 days of nursing home care, or

PASRR was not performed as required. If subsequent PASRR Level II concludes that serious mental illness and/or mental retardation-related condition is present, change response to **1, yes.**

• **Code 1, yes:** if PASRR Level II screening determined that the resident has a serious mental illness and/or mental retardation-related condition.

• **Code 9, not a Medicaid-certified unit:** if the bed is not in a Medicaid-certified nursing home. The PASRR process does not apply to nursing home units that are not certified by Medicaid (unless a State requires otherwise) and therefore the question is not applicable.

Note that the requirement is based on the certification of the part of the nursing home the resident will occupy, not the source of payment. In a nursing home in which some parts are Medicaid certified and some are not, this question applies when a resident is admitted, or transferred to, a Medicaid certified part of the building."

Editor's note: The above instructions are included in the MDS 3.0 RAI manual as of press time, although CMS could update the instructions. If that occurs, MDS Alert *will notify readers in an upcoming issue.* ■

A1500. Preadmission Screening and Resident Review (PASRR) Complete only if A0310A = 01	
Enter Code ☐	**Has the resident been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition?** 0. **No** 1. **Yes** 9. **Not a Medicaid certified unit**

We welcome your comments! Call Editor Karen Lusky at 615-708-8568.

Diagnosis Coding, continued from page 57

cal record documentation, but it's just not being utilized because it's not needed for ICD-9 coding," she counseled.

• **ICD-10 won't be user-friendly.** One of the bigger myths regarding ICD-10 is that the increased number of codes will make ICD-10 impossible to use. Not so, Bowman said. "Just as the size of a dictionary doesn't make the dictionary more difficult to use, a higher number of codes doesn't necessarily increase the complexity of the coding," Bowman said. In fact, she noted, greater specificity and clinical accuracy should actually make ICD-10 easier to use.

Start Your ICD-10 Engines

Although you shouldn't start your intensive, in-depth ICD-10 training until six to nine months before implementation, you can prepare in other ways now, Bowman said.

To get ready for ICD-10, you should start identifying medical record documentation improvement opportunities, Bowman advised. ICD-10 won't require you to improve your documentation, but the higher quality your documentation is, the easier it will be to avoid using unspecified codes and the faster you'll find the accurate ICD-10 code. In addition, you can start learning the basic structure, organization, and unique features of ICD-10, and refresh your knowledge of biomedical concepts so you won't be tripped up by more enhanced code definitions and descriptions.

Resource: Brooks alerted callers to a new ICD-10-CM Quick Reference Information sheet, which can help you prepare for the change. The guide is available at www.cms.gov/icd10. Click "CMS sponsored calls" on the left, followed by the "2010 ICD-10 Conference Calls" download.

Editor's note: The original version of the above article ran in Part B Insider. *For subscription information, call 1-800-508-2582.* ■

MDS & CLINICAL NEWS TO USE

CMS has completed its MDS 3.0 train-the-trainer sessions. In March, the agency conducted training for state representatives, including state RAI coordinators. The agency has posted Q&As from those sessions on its Web site at www.cms.gov/NursingHomeQualityInits/Downloads/MDS30QandA.pdf. For a sampling of the Q&As, see the "What Do You Think" feature in this issue.

In April, CMS conducted intensive sessions for stakeholders, including industry association representatives and providers. The training was a "well-received success," said CMS' **Mary Pratt** in the April 22 SNF/LTC Open Door Forum. MDS nurse **Nemcy Cavite Duran, CRNAC**, who attended the April training, found the discussion to be "comprehensive" and the speakers "energetic." She also found the training materials provided to be excellent.

Be on the lookout: Audiovisual taping of the April training will be available on the CMS Web site once editing has been finished, Pratt relayed. In addition, CMS is working hard to update the RAI User's Manual by the end of May and will be posting revised sections of Chapter 3 as they become available. A number of training tools, such as interview videos for the pertinent sections of the MDS, will also be posted.

You can receive notice of the training materials and RAI manual update through the SNF/LTC Open Door Forum list serve. To sign up, if you haven't already, go to https://subscriptions.cms.hhs.gov/service/subscribe.html?code=USCMS_515.

Research on the breast cancer front includes surprising news about an old drug and the advent of an innovative clinical trial. Researchers have found that beta blockers appear to have a positive impact on breast cancer outcomes. A study at Nottingham's Breast Institute showed that the drugs, which many people take for hypertension, could help prevent breast cancer metastasis, reported one of the study's researchers at the recent seventh European Breast Cancer Conference in Barcelona.

The research study, which included 466 cancer patients, found that the patients on beta blockers showed a 71 percent reduced risk of death from breast cancer during the study compared to those who were not in the drug, according to a HealthDay news article posted on Medline Plus (www.nlm.nih.gov/medlineplus/news/fullstory_96905.html). The study also revealed a 57 percent reduction in risk of getting a secondary cancer.

Researchers surmise the drugs prevent cancer-cell stimulation by stress hormones, according to the article. "Beta-blocker drugs compete

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MDS & CLINICAL NEWS TO USE (Cont.)

with stress hormones and bind to the same target receptors [on a cellular level], but unlike stress hormones, do not activate cancer cells," said one of the researchers, **Dr. Des Powe,** in the article. Powe is a senior healthcare research scientist at Queen's Medical Centre, Nottingham University Hospital NHS Trust, in Nottingham, England.

Meantime, patients with aggressive breast cancer may have some new treatment options in the not-so-distant future. The Biomarkers Consortium, a collaboration between federal health agencies and large pharmaceutical companies, recently announced the launch of a clinical trial aimed at testing targeted therapies for fast-growing breast cancers. "The I-SPY 2 trial will employ a groundbreaking clinical trial model that uses genetic or biological markers (biomarkers) from individual patients' tumors to screen promising new treatments," states a release on the trial (for more information, go to ispy2.org/).

If you're looking for a baseline standard-of-care exercise program for your post breast-cancer lymphedema patients, you're in luck. A new study could provide just that for the estimated 20 percent of patients with breast cancer who develop breast cancer-related lymphedema (BCRL), according to a press release from the American Occupational Therapy Association. The research, conducted by University of Pittsburgh, revealed that the Breast Cancer Recovery Program© (BCRP) could work as a model exercise program in treating BCRL. In a study of 32 women with BCRL, researchers found that the BCRP significantly reduced swelling caused by arm lymphedema, increased arm and shoulder movement, promoted weight loss, and improved both mood and quality of life. (For more information, go to www.breastcancerrelatedlymphedema.org/). ■

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