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AMERICAN ASSOCIATION
OF POST-ACUTE CARE NURSING

Webinar Additional Q&A and Clarification

Poll Question #3 Clarification

Poll: Mrs. Elderberry visited her sister's home during the 3-day section GG window. The family reported she used a stair lift while there to climb four stairs. The family assisted her into the chair and managed the controls both up and down the stairs.

Webinar Answer: Yes, the family's reports on stair use would be used to determine usual performance for section GG.

Clarification: While family reports are included in the *Steps for Assessment* for the determination of usual performance in section GG, this poll question example did not clarify that assistance can only be provided by a "helper," which does not include family members or others outside the facility's management and administration. While staff would need to consider family reports, it is important that assistance provided by the family is not considered while coding GG0130 and GG0170.

Q&A

Section C

1. I believe the *RAI User's Manual* states the only time you can code that the BIMS interview should not be conducted is with a 5-Day unplanned discharge. Please clarify?

   AAPACN Answer: This instruction guides staff to proceed to the staff interview when the resident unexpectedly discharges. On page C-2, the *RAI User's Manual* clarifies:

   > Because a PDPM cognitive level is utilized in the speech language pathology (SLP) payment component of PDPM, **only** in the case of PPS assessments, staff may complete the Staff Assessment for Mental Status for an interviewable resident when the resident is unexpectedly discharged from a Part A stay prior to the completion of the BIMS. In this case, the assessor should enter 0, No in C0100: Should Brief Interview for Mental Status Be Conducted? and proceed to the Staff Assessment for Mental Status.

   However, if the BIMS interview is not conducted when it should have been in any other case, the BIMS items, including the BIMS summary score, would all be dashed.

Section I

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1. With the clarification of coding sepsis at I2100 to meet the criteria of septicemia, if not meeting the criteria, I understand we are to code it in item I8000. However, does that preclude you from also coding the sepsis ICD-10 code in item I0020B?

   AAPACN Answer: If the sepsis diagnosis coded in I8000 best describes the primary reason for the Medicare Part A stay, then this diagnosis may be coded in I0020B.

2. If the resident was out at the hospital and admitted, came back with a diagnosis of septicemia, is that to be coded on the MDS?

   AAPACN Answer: If the diagnosis was identified by a physician/non-physician practitioner within the last 60 days and is active within the 7-day look-back period, the diagnosis of septicemia is coded at I2100. The updated coding guidance applies specifically to when a diagnosis of sepsis can be included at I2100.

3. Please clarify that urosepsis does not indicate septicemia unless additional documentation is available.

   AAPACN Answer: Urosepsis is not a true condition. The facility staff would need to query the physician to obtain an accurate diagnosis. For additional resources, see the AAPACN article, "Coding Diagnoses in MDS Section I: The Art of the Physician Query."

4. If the resident has sepsis related to a UTI and the new criteria of evidence of inflammation related to sepsis and the microbial process, would we code both sepsis and UTI on the MDS?

   AAPACN Answer: If the resident met the *RAI User's Manual* criteria for UTI, then code UTI in addition to sepsis.

5. If both criteria (inflammation or microbial process) are not met and the diagnosis is coded in I8000, would that still result in a PDPM nursing category of Special Care High?

   AAPACN Answer: No, it would not. The PDPM Nursing category specifically maps from I2100, Septicemia.

6. Does the resident need to be on antibiotics while at the SNF for the sepsis to be considered active in the 7-day look-back period?

   AAPACN Answer: Being on antibiotics is not a criterion for coding an active diagnosis of sepsis on the MDS. On page I-7, the *RAI User's Manual* states, "active diagnoses are diagnoses that have a **direct relationship** to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period." Additionally, the evidence of inflammation related to sepsis during the look-back period supports that the diagnosis is active.

7. Do you have to have a blood culture to prove the microbial process to code sepsis?

AAPACN Answer: CMS did not specify a positive blood culture is needed to prove the microbial process, but this is one method the physician would likely use to diagnose a resident with sepsis. The microbial process may also be evidenced by an active infection, such as a wound infection, pneumonia, or UTI with the physician's diagnosis of sepsis. For more guidance on assessment and documentation needs when a resident is diagnosed with sepsis, please see the AAPACN free member tool*: Sepsis: Nurse Documentation Training Aide*.

8. Can we capture an "active" diagnosis that may be active in the hospital but no longer active when the resident comes to the SNF?

   AAPACN Answer: Resolved diagnoses should not be coded on the MDS. Page I-7 of the *RAI User's Manual* clarifies: "Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses."

9. Does the physician have to specifically call the diagnosis "septicemia" to code it at I2100, Septicemia?

   AAPACN Answer: The physician would need to document the diagnosis of septicemia in the last 60 days and the diagnosis must have evidence of being active per the *RAI User's Manual* definition (see Question 6 above in this document) in the last 7 days.

10. Will the new ICD-10 code for "aftercare for sepsis" map to a PDPM category?

    AAPACN Answer: No, this is a "return to provider" code for I0020B determination of the clinical category for PDPM. For more details, see the AAPACN article, "Updates to ICD-10-CM Coding Guidelines: Key Revisions and Their Implications."

Section K

1. If the feeding tube is being used only for medications, but has flushes to keep patent, do you code the tube?

   AAPACN Answer: No, on page K-12 of the *RAI User's Manual*, CMS clarifies that "only feeding tubes that are used to deliver nutritive substances and/or hydration during the assessment period are coded in K0520B."

2. My understanding is that once a resident has a feeding tube the resident will never achieve a 60-day wellness period and will never earn a new 100-day benefit period for Medicare. Since the feeding tube cannot be coded if only used for medication, does that change the Medicare guidelines for the 60-day wellness period?

AAPACN Answer: A resident with a feeding tube can achieve a 60-day wellness period and earn a new benefit period. The presence of a feeding tube itself is not a skilled level of care. The resident must receive 26% of calories and 501cc of fluids or more per day in order to be at a skilled level of care. If they are receiving less than that amount, they are not skilled and may qualify for the 60-day wellness period to establish a new benefit period. The new coding instruction that removed medication administration would not impact the Medicare guidelines for when a feeding tube meets a skilled level of care.

Section N

1. When coding N0415 related to medications with two drug classes, how do we code? Examples: hydroxyzine used for itching but per drug classes it is an antihistamine and an anxiolytic and gabapentin which is classified as an anticonvulsant, mood stabilizer, and analgesic.

   AAPACN Answer: From Page N-9 of the *RAI User's Manual*:

   > Medications that have more than one therapeutic category and/or pharmacological classification should be coded in all categories/classifications assigned to the medication, regardless of how it is being used. For example, prochlorperazine is dually classified as an antipsychotic and an antiemetic. Therefore, in this section, it would be coded as an antipsychotic, regardless of how it is used.

2. Does the indication of use for anticonvulsants need to be the actual usage for the mode of action? If gabapentin is used for the control of pain, is that acceptable?

   AAPACN Answer: No, the indication for use is based on physician documentation, but the medication is coded by pharmacological classification regardless of the indication of use. Page N-8 of the *RAI User's Manual* states, "Code medications in Item N0415 according to the medication's therapeutic category and/or pharmacological classification, not how it is used."

   In this example, gabapentin with an indication of use for pain would be coded as an anticonvulsant, and the indication would be checked as the physician indicated its use. Indication and drug class do not have to match.

3. Gabapentin is often being used as a pain medication. How will this impact QMs?

   AAPACN Answer: At this time, the coding of anticonvulsants will not impact any Quality Measures.

4. Would you code magnesium sulfate as an anticonvulsant? Some pharmacies say yes.

   AAPACN Answer: RxList.com has the pharmacological classification of magnesium sulfate as "Antidysrhythmic." Based on this resource, it would not be coded as an anticonvulsant.

However, while it is not classified as an anticonvulsant, one of its indications for use is to prevent seizures during pregnancy.

5. For anticonvulsants, is the indication for use strictly for seizures or for any diagnosis indicated by the physician?

   AAPACN Answer: Item N0415K, column 1, is checked if the resident received a medication that has a pharmacological classification of an anticonvulsant. N0415K, column 2, is checked if there is an indication for use for this medication. This indication does not specifically have to be for seizures. Indication is defined as "the identified, documented clinical rationale for administering a medication that is based upon a physician's (or prescriber's) assessment of the resident's condition and therapeutic goals." (*RAI User's Manual,* page N-6)

Section O

1. Do we need actual documentation from the family/MD office/Walgreens etc. that COVID-19 vaccination was given? Or is it enough to have a written documentation in the progress notes that the family provided us the information?

   AAPACN Answer: The facility staff will need to document how the information regarding COVID-19 vaccination was obtained, but they do not have to have proof from the physician or pharmacy. The Steps for Assessment in section O of the *RAI User's Manual*, page O-20, clarify that assessors can use information from any source:

   > Vaccination status may be determined based on information from any available source. Review the resident's medical record or documentation of COVID-19 vaccination and/or interview the resident, family or other caregivers or healthcare providers to determine whether the resident is up to date with their COVID-19 vaccine.

2. Can you code pneumococcal vaccine from "any available source" (like COVID), or do you need proof?

   AAPACN Answer: Assessors can also obtain pneumococcal vaccine history from the resident or their family. Per page O-16 of the *RAI User's Manual*, the Steps for Assessment in section O state:

   > 1. Review the resident's medical record to determine whether any pneumococcal vaccines have been received. If vaccination status is unknown, proceed to the next step.
   >
   > 2. Ask the resident if they received any pneumococcal vaccines outside of the facility. If vaccination status is still unknown, proceed to the next step.

3. If the resident is unable to answer, ask the same question of the responsible party/legal guardian and/or primary care physician. If vaccination status is still unknown, proceed to the next step.

4. If pneumococcal vaccination status cannot be determined, administer the recommended vaccine(s) to the resident, according to the standards of clinical practice.

3. The National Healthcare Safety Network (NHSN) only changes the definition of up to date every quarter. Are we going by CDC recommendations or NHSN definitions?

   AAPACN Answer: For MDS coding, use only the CDC's "Staying Up to Date with COVID-19 Vaccines" webpage, not NHSN guidance.

4. How do we code the COVID-19 vaccine if our facility doesn't offer it? We only do clinics on occasion. Would we code "not offered?"

   AAPACN Answer: MDS item O0350 is asking if the resident's COVID-19 vaccination status is up to date, regardless of where the vaccine was administered. This is a yes or no question. If the resident's vaccination status is not up to date, the instructions are to offer the vaccine if the facility has it available. If the facility currently does not have the vaccine available to offer prior to the ARD, then the resident would be coded as 0, No, not up to date. "Not offered" is not a response option for item O0350.

5. Will this new COVID-19 question affect SNF QRP?

   AAPACN Answer: Yes, this item will be used in the new SNF QRP measure: *COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date,* which starts data collection Oct. 1, 2024. For more information on this measure, please see the AAPACN SNF QRP Quick Facts tools.

Section GG

1. Where do we find GG function score?

   AAPACN Answer: For the PT/OT function score calculation, please see the *RAI User's Manual* pages 6-16 – 6-18. For the nursing function score calculation, please see pages 6-33 – 6-34. For a quick reference tool, please also see the AAPACN PDPM At-a-Glance tool.

Section X/Chapter 5

1. When an assessment is rejected on the validation report due to coding in A0410, are you saying centers must do the manual deletion?

AAPACN Answer: Since this assessment was rejected, it is not in iQIES. Only assessments that have been accepted into iQIES and meet one of the required events will need a manual deletion.