PASRR and the Transition to ICD-10

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ASCEND MANAGEMENT INNOVATIONS
PTAC WEBINAR SERIES: FEBRUARY 9, 2016
Objectives

- Define ICD-10 and DSM-5
- Describe the changes to depressive disorder diagnoses in ICD-10-CM and DSM-5
- Discuss the implications of these changes for PASRR
- Identify strategies that can be used to manage these changes
Introduction

What is ICD-10?
- International Classification of Diseases, Tenth Edition
- World Health Organization
- Content: Mortality, Clinical Modification (CM), and Procedure Coding System (PCS)

What is DSM-5?
- Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition)
- American Psychiatric Association
- Content: Diagnostic Classification, Diagnostic Criteria Sets, Descriptive Text
# What’s different about ICD-10 and DSM-5?

<table>
<thead>
<tr>
<th><strong>ICD-10</strong></th>
<th><strong>DSM-5</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Last update was to ICD-9 in 1979</td>
<td>- 297 → 152 diagnoses</td>
</tr>
<tr>
<td>- 14,000 → 69,000 codes</td>
<td>- More ratings of severity</td>
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<tr>
<td>- Right or Left laterality accounts for &gt;40% of codes</td>
<td>- More specifiers</td>
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<tr>
<td>- More digits per code allows for more specificity</td>
<td>- No more NOS diagnoses</td>
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<tr>
<td>- Greater parameters for severity</td>
<td>- No more Axes; No GAF</td>
</tr>
<tr>
<td>- Combination codes capture complexity</td>
<td>- Standardized assessments</td>
</tr>
<tr>
<td>- Condensed Diagnostic Categories</td>
<td>- Revised diagnostic criteria</td>
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<tr>
<td>- Revised diagnostic criteria</td>
<td>- New diagnoses</td>
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</table>
Two Paths to an ICD-10 Code: Coding vs. Mapping

C O D I N G

Human-driven process where one arrives at a psychiatric diagnosis guided by the DSM-5 and then assigns the code that matches the diagnosis.

M A P P I N G

Human-driven OR technology-driven process where a diagnosis code is determined by “translating” it from a previously accepted code.
Focus: Depressive Disorder NOS (311)

- Commonly associated with a “mild or situational” depression
- Does not exist in DSM-5
- Where there was one diagnosis, now there are two:

### (F32.8) Other Specified Depressive Disorder

E.g. Recurrent Brief Depression, Short Duration Depressive Episode (4-13 days), Depressive Episode with insufficient symptoms.

### (F32.9) Unspecified Depressive Disorder

No more specific diagnosis was able to be determined.

The clinician has concluded that a depressive disorder is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced.
The Problem

- On **October 15, 2015**, all health information systems automatically translated all ICD-9 diagnoses to ICD-10.

- Anything previously coded as “Depressive Disorder NOS (311) on September 30, 2015 was found as “Major Depressive Disorder, Single Episode, Unspecified (F32.9) on October 1, 2015.”
“Lack of a clear ‘default’ code when sufficient information was not available to determine a specific code or uncertainty as to whether “default” code was appropriate.

Examples: …‘depression,’ with no further information, defaults to code F32.9, but the code description is “major depressive disorder, single episode, unspecified,” which seems more specific than the documented diagnosis.” (p. 26)
ICD-10 essentials for busy physicians who would rather be doing something else – depression and anxiety

May 09, 2012 | Rhonda Butler - ICD-10, 3M

Major Depression No Laughing Matter: Serious Diagnosis Requires New Documentation, Coding and Privacy Focus

Written by Kimberly Janet Carr, RHIT, CCS, CDIP, CCDS, AHIMA Approved ICD-10-CM/PCS Trainer | Monday, 08 September 2014

CODING DEPRESSION for PASRR, ICD-10-CM and MDS

Please note that ICD-10-CM is a new code set with new terminology (language). There are 3 code sets with the name ICD-10 AND they are not the same. There is ICD-10 used by the rest of the world; ICD-10-CM the new US modified version; and ICD-10- PCS for physician and hospital use as procedure codes.

In ICD-10-CM, the diagnoses of “Depression” and “Depressive Disorder” code to “Major Depression”, F32.9; and there is no way around it for billing and MDS purposes. The RAI Manual, Coding Clinic, HIPAA, AHIMA and the Official Coding Guidelines all direct use of the ICD-10-CM code as printed by DHHS with their terminology - in this case, “Major Depression”.

Having identified that the term “Major Depression” is one of the triggers for a Level II PASRR, significant efforts have been made to determine PASRR, MDS and UB-04 requirements.
Ascend’s Guidance for Providers

- Determine whether change to MDD was due to ICD-10 changeover
- Ask provider to have their clinician verify the diagnosis
- Use the verified diagnosis to proceed with decision to refer to Level II
- Advise provider to proactively identify any other resident that may have experienced this diagnosis change (i.e. new dx of F32.9) and have clinician verify the diagnosis.
- Do not suggest an alternative diagnosis.
Implications for PASRR

- If the diagnosis changed due to the ICD-10 transition, is that a significant change in status?
- Could this lead to increased PASRR Level II referrals?
- Moving forward, what is the role of screening tools for understanding impact of depressive symptoms?
Summary

- Coding from DSM-5 will result in a more accurate diagnosis code vs. mapping from ICD-9 to ICD-10

- The lack of a default diagnosis for depression in ICD-10 has implications for PASRR professionals

- Underscores need to use a variety of measures to understand an individual’s disability from mental illness.
Resources


Dustin Dodson, NHA, MBA
- PTAC Consultant, bring the provider perspective to topics of discussion
- 20+ years of experience in acute and post acute health care operations
- Active in the State of Colorado Community Living Advisory Group - Olmstead Act implementation
- A balanced approached as an advocate for outcomes that are good for payers, regulators, policy makers, operators and consumers
Limitations of MDS 3.0

- Primary goal of this presentation is how to, and more specifically how *not* to use the MDS 3.0 as a data source when conducting research.
- We will walk through the background of the MDS 3.0 and its strengths and weaknesses, discover how erroneous data may present itself if not used with caution, and illuminate the limitations of the MDS 3.0 through specific examples.
The Minimum Data Set is a document that every licensed nursing home and swing bed provider must complete by the interdisciplinary team of professionals and is managed by the MDS Coordinator, typically a Registered Nurse.

Through 20 domains the MDS captures information such as functional and medical information, 17 quality measures, resident acuity, and new to MDS 3.0 sections that take into account the words of the resident, including Section Q.
CMS introduced MDS version 3.0 in October 2010 with the aim of improving accuracy and reliability, increased efficiency, more valid items, and the direct inclusion of resident input.

This expanded version has resulted in an increased burden to the provider resulting in the tool taking more time and in many cases additional high level staff members being employed.
Is the MDS really the Treasure Trove?

- When the MDS is used as a data warehouse there are some potential pitfalls to be aware of that may lead to false conclusions.
  - Data Continuity
  - Determining total and average length of stay
  - Measures of quality
  - Reliability and integrity of the data
Data Continuity and the MDS Cycles

- Data continuity and the numerous MDS cycles can be problematic to data analysis as not every question is asked within every MDS cycle
  - There are potentially 13+ MDS cycles per year for every resident
  - This is important as not all questions are asked at each of the 13+ times an MDS is updated.
  - Individual MDS records are not coordinated within the NF population, meaning that a ‘facility snapshot’ on a particular day may not be possible for certain data analysis
## MDS 3.0 Assessment Cycles

<table>
<thead>
<tr>
<th>PPS-related Assessments Cycle</th>
<th>OBRA Assessment Cycle</th>
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<tbody>
<tr>
<td>5 Days</td>
<td>Admission</td>
</tr>
<tr>
<td>14 Days</td>
<td>Quarterly</td>
</tr>
<tr>
<td>30 Days</td>
<td>Annual</td>
</tr>
<tr>
<td>60 Days</td>
<td>Significant Change in Status Assessment</td>
</tr>
<tr>
<td>90 Days</td>
<td></td>
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</tbody>
</table>
Determining Total and Average Length of Stay

- State agencies, payers such as Medicaid, Medicare, commercial insurance plans, Value Based Purchasing stakeholders and others utilize total and average length of stay information for critical analysis.
- Such data is used for reimbursement rate setting, cost containment comparison, demographic studies and more.
Events that cause a new ‘date of admission’

- Discharge, Return not Anticipated
- Return Anticipated, up to 30-Day Absences
- Change of Ownership
- Resident Transfers
- Disasters
- Hospitalizations
A possible solution.

- ‘Section S’, the MDS 3.0 has left this area unscripted to allow for state specific needs.
- Section S could be used to total the days that an individual has received nursing home care and services from that provider or for their lifetime utilization.
- Would require significant infrastructure enhancements but is possible.
Measures Of Quality

- Value Based Purchasing is now the standard for all health care providers, including clinics, acute care, emergency departments, and now post acute providers.
- MDS generated Quality Measures and CMS Five Star Rating
- How can *quality* be measured?
Measures of Quality

- Can the MDS 3.0 be used as a tool in determining the level of quality that is being provided?
- To a degree, yes... however there are limitations.
  - minimal risk adjusting
  - does not honor self determination/person centered care
  - This creates a ‘filter’ for admitting new admissions- presenting an access to care unintended consequence
### 17 Quality Measures reported from the MDS

<table>
<thead>
<tr>
<th>Short Term Stay Measures</th>
<th>Long Term Stay Measures</th>
</tr>
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<tbody>
<tr>
<td>New/Worse Pressure Ulcer</td>
<td>Hi-risk Pressure Ulcer</td>
</tr>
<tr>
<td>Antipsychotic Medication</td>
<td>Physical restraints</td>
</tr>
<tr>
<td>Mod/Severe Pain</td>
<td>Falls</td>
</tr>
<tr>
<td></td>
<td>Falls with Major Injury</td>
</tr>
<tr>
<td></td>
<td>Antipsychotic Medication</td>
</tr>
<tr>
<td></td>
<td>Antianxiety/Hypnotic</td>
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<tr>
<td></td>
<td>Behavioral symptoms affect Others</td>
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<tr>
<td></td>
<td>Depression symptoms</td>
</tr>
<tr>
<td></td>
<td>Urinary Tract Infection</td>
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<tr>
<td></td>
<td>Catheter Insert/Left Bladder</td>
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</table>
Reliability and Integrity of the Data

- For the MDS to be a useful research tool it must have high inter-rater reliability.
- 42 CFR 483.20 (g), Nursing regulation F278 states
  - The MDS must accurately reflect the resident’s status as of the Assessment Reference Date in order to
    - Develop an appropriate plan of care
    - Produce Quality Measures that adequately reflect the resident care
    - Generate appropriate reimbursement
    - Avoid the appearance of fraud or abuse
In 2003 Mor et al published a study that found adequate to good levels of inter-rater reliability. However, there were four domains that consistently had self reported to audited findings significant gaps.

- Severity of Injury
- Associated with Falls
- Pressure Ulcer Status
- Use of Restraints
- Late Loss Activities of
  Daily Living (ADL) Status
What are the causes of low data reliability?

- Impacts to quality data input include:
  - Staff turnover
  - Knowledge of how to correctly complete an MDS
  - Technology implementation learning curve
Increased Regulatory Oversight

- Due to the weight that the MDS carries CMS has started a nationwide validation process to ensure that MDS’s are being completed accurately.
- In 2015 ‘MDS Focus Surveys’ were initiated and continue into this year.
Conclusions

- The MDS 3.0 improves on earlier versions and provides a powerful tool for measuring and improving quality, research, and so on.
- Limitations still exist and more are expected as the gap widens with the advancement of honoring personal preferences and other initiatives such as value based purchasing.
- Human error is possible, particularly with high employee turnover
- Be careful, but don’t discount the value of the MDS 3.0!
Thank you for your time and consideration of the key points that were discussed.

The New Minimum Data Set (MDS): A Primer for Data Users

- A timely, accessible review of the issues that must be kept in mind when using MDS for data-analytic purposes.
- An excellent resource for anyone who was worked with MDS (or thinks they might like to do so in the future), as well as anyone who would like to be able to interpret MDS findings they read about.
National Association of PASRR Professionals
NAPP

Advocating for Innovation

Brandon S. Sturgill
NAPP Establishment

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>MFP</td>
<td>Money Follows the Person</td>
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<tr>
<td>BIP</td>
<td>Balancing Incentive Program</td>
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<td>CFC</td>
<td>Community First Choice</td>
</tr>
<tr>
<td>MDS</td>
<td>Minimum Data Set</td>
</tr>
<tr>
<td>MI</td>
<td>Mental Illness</td>
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<tr>
<td>ID</td>
<td>Intellectual Disability</td>
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May 12, 2015

PTAC: Past, Present, and Future

<table>
<thead>
<tr>
<th>Event Description</th>
<th>Date</th>
</tr>
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<tbody>
<tr>
<td>OIG Reports</td>
<td>Jan 2009</td>
</tr>
<tr>
<td>OIG Reports</td>
<td>Oct 2010</td>
</tr>
<tr>
<td>OIG Reports</td>
<td>Mar 2011</td>
</tr>
<tr>
<td>OIG Reports</td>
<td>Jul 2011</td>
</tr>
<tr>
<td>OIG Reports</td>
<td>Apr 2012</td>
</tr>
<tr>
<td>OIG Reports</td>
<td>Oct 2009</td>
</tr>
<tr>
<td>CMS Establishes PTAC</td>
<td>Jan 2001 – Dec 2007</td>
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1965: Medicare & Medicaid Created

1981: 1915(c) Waivers Created (OBRA 81)  
PASRR Goes "Live"  
Annual Requirement Removed (BBA 97)


National Association of PASRR Professionals
Strictly volunteer
Not for profit
No personal compensation
Impartial
The National PASRR Arena
Stay tuned for the February Networking with NAPP webinar!!

NAPP Annual Meeting is January 28th: Register Here.
A Forum for PASRR Professionals!

Want to Ask Anonymously... Click Here

Or... Ask the community a question below

Create topic

✓ Subscribed (Unsubscribe)
NAPP is Involved


NAPP Comments to CMS LTC Regulation Reform

NAPP Comments to SAMHSA Strategic Plan 2015-2018

Public Event Subscription and outreach to enhance NAPP community services

Piloted strategies in NAPP Forum development

Participation in Regional CMS PASRR calls

Participation in NASMHPD monthly calls
NAPP Future

- **1)** NAPP as a platform for state’s to compare available options
  - PASRR in a digital and contractor-based environment
- **2)** NAPP as a national leader in delivering PASRR subject-matter
  - Comprehensive library of PASRR content
- **3)** NAPP as a creator of tools to be made available to the state’s
  - Best practices, RFP creation, Level I, Level II

Ally To The State’s
In Promoting
PASRR
Innovation
Through
Transparency, Education, and Tools.

www.pasrr.org
NAPP Can Talk About Difficult Issues

• How much are you paying for a Level II... & what do you get for your money?
• Who do you use as a PASRR contractor... & what are they good at / bad at?
• What is the most effective way to implement PASRR... & how do we get there?
• What type of data management system works best... & how do we gain access to it?
• What issues do we need to be aware of when we have a contract change?
• Who are the current contractors... & what can they offer my state?
• Is an RFP the right way to procure a PASRR contractor?
• What are your approval/denial rates?
• Are your determinations effective... & how do you know?

Questions
2016 NAPP Platforms

Education

Innovation/Technology

Membership
Delaware, Maryland, New York, Pennsylvania, Ohio, Florida, Missouri, Idaho, New Mexico, Arizona, Colorado, Washington, Maine, Kansas, New Jersey, Kentucky, Oklahoma, North Dakota, Georgia, California, South Carolina
Your Input

How Can NAPP Best Meet Your Needs?
- 50% Promoting State-Specific Best Practices
- 36% Advocating for Your PASRR Program & Addressing Concerns Anonymously

Length of Experience in PASRR?
- 65% Less Than 5 Years (36% 0-2 Years)

Which Issues Would You Like to See NAPP Address?
- 40% Level I.5 System
<table>
<thead>
<tr>
<th>Question</th>
<th>Input</th>
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</thead>
<tbody>
<tr>
<td>Would You Participate in a NAPP Sponsored Workgroup?</td>
<td>93% YES</td>
</tr>
<tr>
<td>Would You Attend a National PASRR Conference?</td>
<td>94% YES</td>
</tr>
</tbody>
</table>
## Challenge to NAPP in 2016

### Education
- Sponsor a National PASRR Conference
- Create 2 Usable Tools for the States
- Post 1 New PASRR-related Article per Week on pasrr.org
- Develop & Present PASRR 101 Trainings Throughout the Year

### Innovation/Technology
- Provide an Unbiased, Transparent, Open Stage for any PASRR Contractor to Showcase Services They can Provide to States
- Assemble a RFP Committee to Ensure States Using Contractors are Informed

### Membership
- Grow the Existing Member-base from ~70 to 500

[www.pasrr.org](http://www.pasrr.org)
NAPPfrontdesk@pasrr.org
www.pasrr.org
Networking with NAPP
(National Association of PASRR Professionals)
http://www.pasrr.org/about.aspx

• Networking with NAPP is a follow up discussion on the webinar.
• The next Networking with NAPP session is:

  Tuesday, February 23rd, 2016
  1 PM EST

To register for the session, please contact nappfrontdesk@pasrr.org
A reminder invite will be sent to all webinar participants.