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PASRR and the Transition to ICD-10

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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

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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

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What's different about ICD-10 and DSM-5?

ICD-10

- Last update was to ICD-9 in 1979
- 14,000 → 69,000 codes
- Right or Left laterality accounts for >40% of codes
- More digits per code allows for more specificity
- Greater parameters for severity
- Combination codes capture complexity

DSM-5

- 297 → 152 diagnoses
- More ratings of severity
- More specifiers
- No more NOS diagnoses
- No more Axes; No GAF
- Standardized assessments
- Condensed Diagnostic Categories
- Revised diagnostic criteria
- New diagnoses

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Two Paths to an ICD-10 Code: Coding vs. Mapping

CODING

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

MAPPING

Human-driven OR technology-driven process where a diagnosis code is determined by "translating" it from a previously accepted code.

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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	(F32.9) Unspecified Depressive Disorder
E.g. Recurrent Brief Depression, Short Duration Depressive Episode (4-13 days), Depressive Episode with insufficient symptoms.	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.

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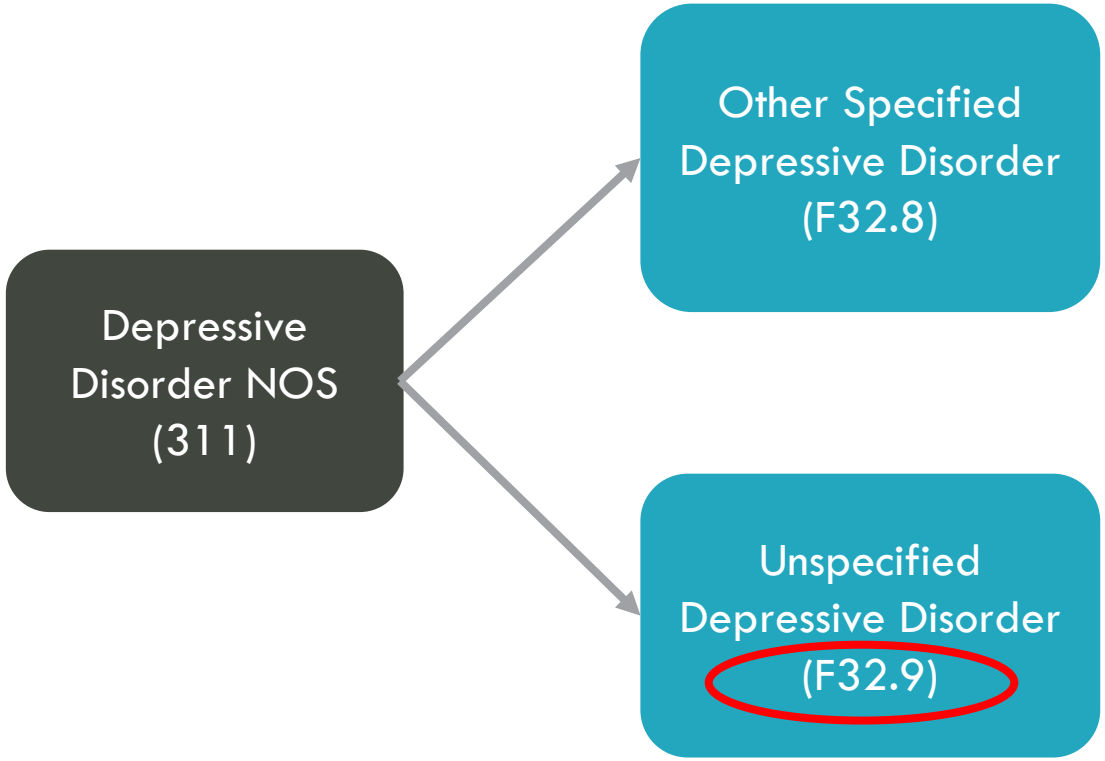
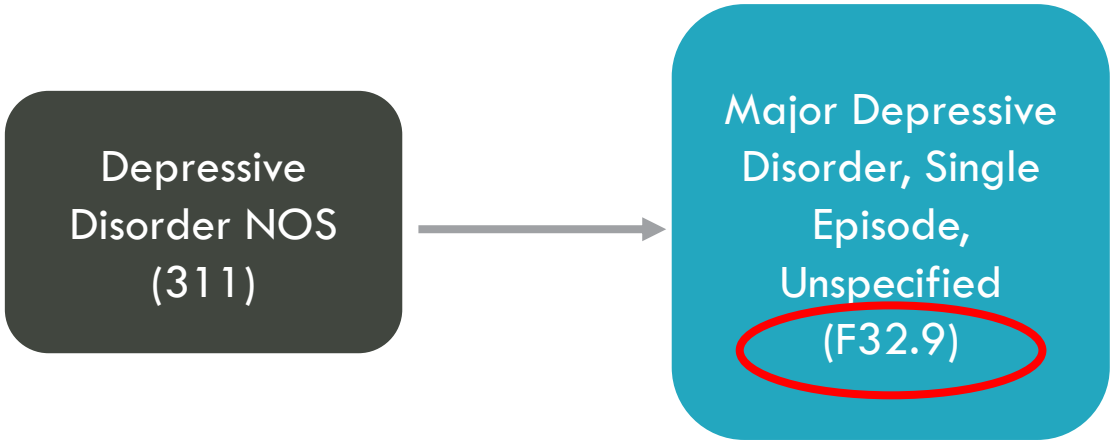
DSM Mapping

DSM-IV-TR → **DSM-5**



ICD Mapping

ICD-9-CM → **ICD-10-CM**



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The Problem

- On **October 15, 2015**, all heath 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.

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ICD-10-CM Field Testing Project

AHA Advancing Health in America

AHIMA American Health Information Management Association

"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)

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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.

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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.

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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?

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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.

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Resources

Centers for Medicare and Medicaid Services, (2015). What is different with ICD-10? *Roadto10*. Retrieved 2/7/16 from: http://www.roadto10.org/whats-different/.

American Psychiatric Association. *Guide to Using DSM-5 in the Transition to ICD-10*. Retrieved 2/7/16 from: http://www.dsm5.org/Documents/Guide%20to%20Using%20DSM-5%20in%20the%20Transition%20to%20ICD-10.pdf

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MDS 3.0: A Primer for Data Users

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.

Background - What is the MDS and the intended use?

- 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.

MDS version 3.0

- 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

PPS-related Assessments Cycle	OBRA Assessment Cycle
5 Days	Admission
14 Days	Quarterly
30 Days	Annual
60 Days	Significant Change in Status Assessment
90 Days	

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

Short Term Stay Measures	Long Term Stay Measures
New/Worse Pressure Ulcer	Hi-risk Pressure Ulcer
Antipsychotic Medication	Physical restraints
Mod/Severe Pain	Falls
	Falls with Major Injury
	Antipsychotic Medication
	Antianxiety/Hypnotic
	Behavioral symptoms affect Others
	Depression symptoms
	Urinary Tract Infection
	Catheter Insert/Left Bladder

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Reliability and Integrity of the Data

- For the MDS to be a useful research tool it must have high inter-rata 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*

How reliable is the MDS?

- 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

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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!

Questions and Answers

- 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.
  - http://pasrrassist.org/resources/mds/minimum-data-set-mds-primer-data-users-0

National Association of PASRR Professionals
NAPP

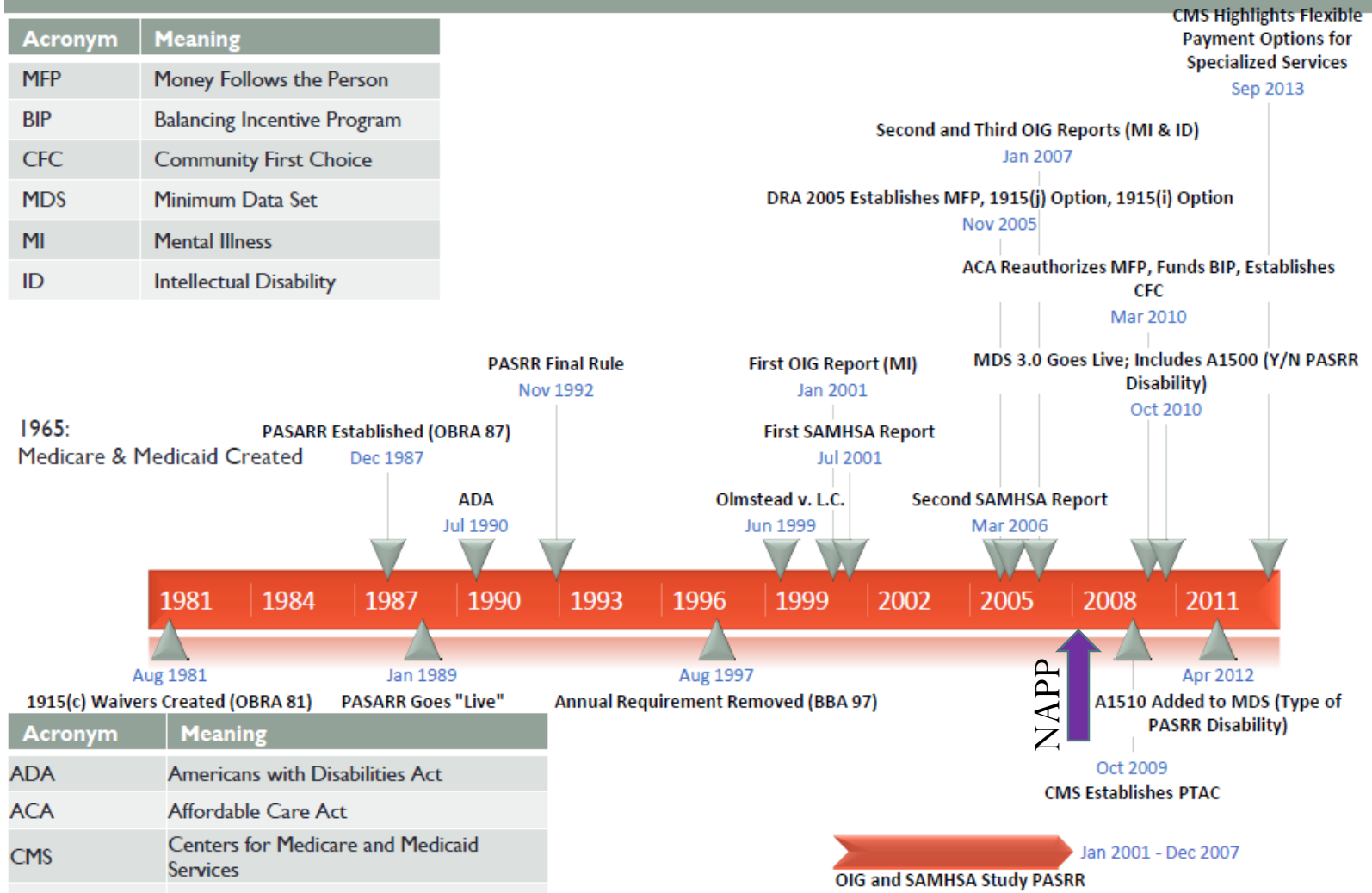
Advocating for Innovation

National Association of PASRR Professionals

Brandon S. Sturgill

NAPP Establishment

Acronym	Meaning
MFP	Money Follows the Person
BIP	Balancing Incentive Program
CFC	Community First Choice
MDS	Minimum Data Set
MI	Mental Illness
ID	Intellectual Disability



Acronym	Meaning
ADA	Americans with Disabilities Act
ACA	Affordable Care Act
CMS	Centers for Medicare and Medicaid Services
DRA	Deficit Reduction Act
OBRA	Omnibus Budget Reconciliation Act
SAMHSA	Substance Abuse and Mental Health Services Administration

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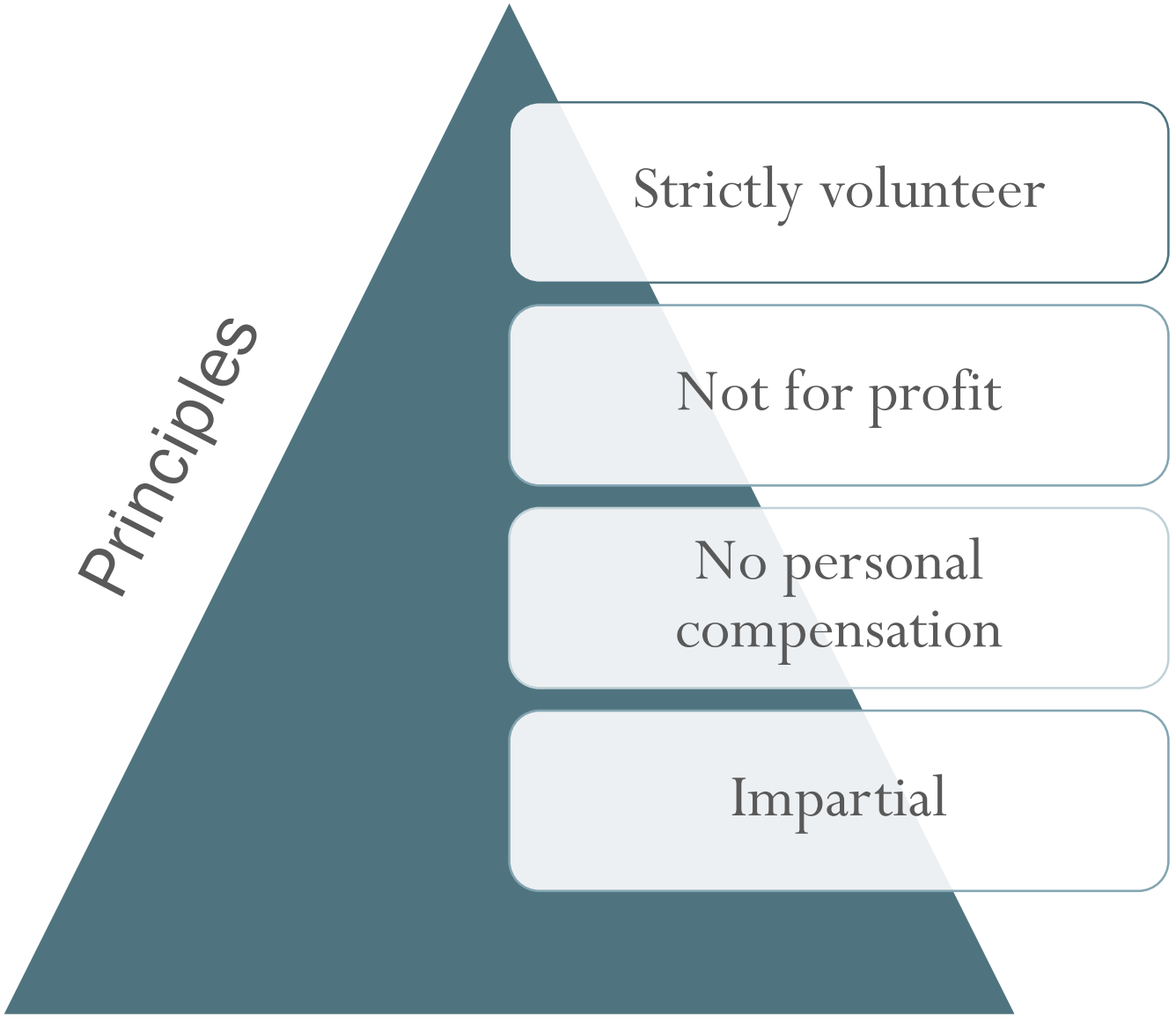
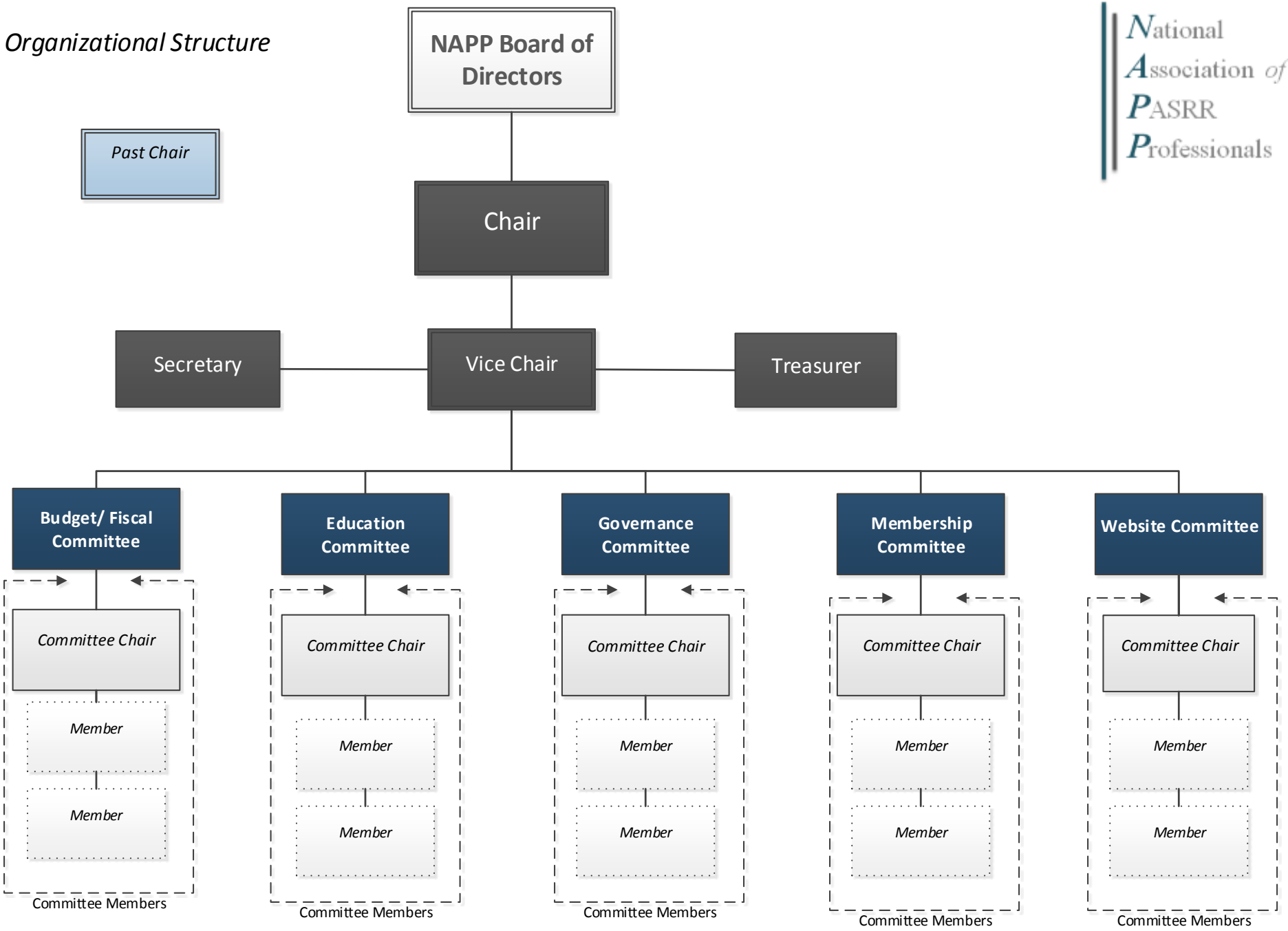
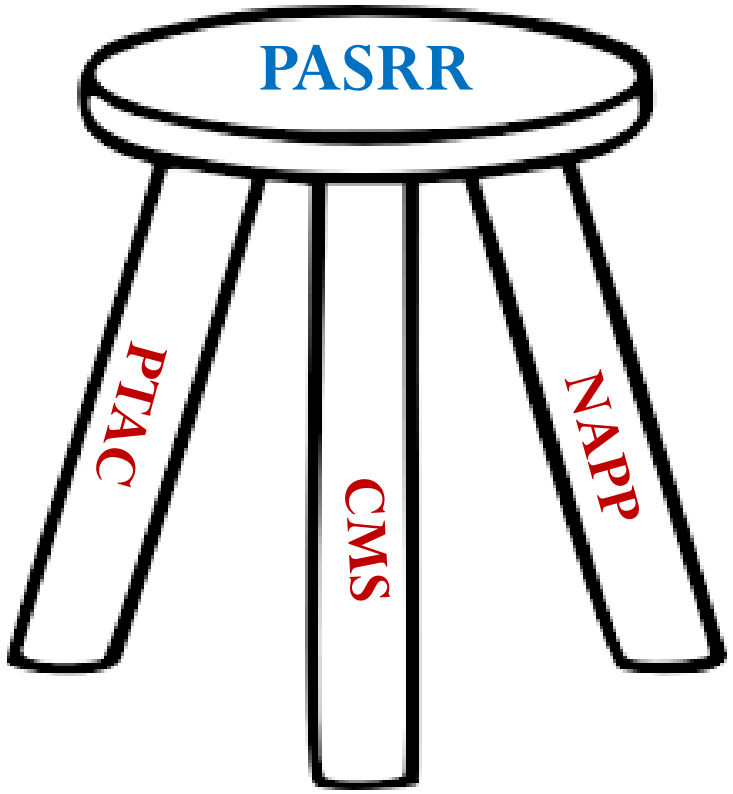


2016 Organizational Structure

National Association of PASRR Professionals



The National PASRR Arena



CMS
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Stay tuned for the February Networking with NAPP webinar!!

NAPP Annual Meeting is January 28th: Register Here.

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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

- National Conference Partnership: "Wellness: Building Capacity for Tomorrow's Older Adults in Tulsa, Oklahoma on September 24-25, 2015
- 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

National Association of PASRR Professionals

NAPP Future

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

- **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*

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NAPP Can Talk About Difficult Issues

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- 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

National Association of PASRR Professionals

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

National Association of PASRR Professionals

2015 Webinar

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

Your Input

Would You Participate in a NAPP Sponsored Workgroup?

- **93%** YES

Would You Attend a National PASRR Conference?

- **94%** YES

Challenge to NAPP in 2016

National Association of PASRR Professionals

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**

NAPPfrontdesk@pasrr.org

www.pasrr.org

National Association of PASRR Professionals

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.

PTAC

PASRR Technical Assistance Center

Question and Answer Transcript
"A Trio of Talks about PASRR: ICD-10, MDS, and NAPP"
Presented by Alice Bernet, Dustin Dodson, and Brandon Sturgill

Question 1: How will the increased amount of major depression diagnosis on the MDS affect data presented about the kinds of patients Skilled Nursing Facilities are taking care of? The work around Colorado has come up with is to make a note in the patient record about the new diagnosis not being a major depression, but the diagnosis on the MDS will show Major Depression.

Answer: If you maintain a diagnosis in the MDS that does not reflect the true clinical condition for that resident, I can only imagine the myriad problems and risks that you would encounter by doing this.

I am not an expert on SNF reimbursement, but in general you may be giving the appearance of fraudulent "upcoding" if you maintain a diagnosis of MDD for an individual who truly does not have MDD. In reimbursement structures that adjust for severity of case mix, such as Medicare Advantage, this can be very problematic. Essentially you would be portraying, by maintaining the diagnosis of MDD, that your patient population is more clinically complex and as such, eligible for higher rates of reimbursement. If it is discovered that these diagnoses of MDD are not clinically substantiated, this may pose a financial risk for the institution.

If the MDS data were being used for research, the practice of maintaining the MDD diagnosis would distort the data: it would appear that there are more residents with a serious mental illness than there actually are. As we learned in a recent PTAC webinar, an analysis of MDS data suggested that we are *under*-identifying serious mental illness through PASRR; depression diagnoses were especially under-represented. By keeping MDD diagnoses in the MDS, when it is not the true diagnosis for that resident, the MDS might give researchers a false sense of security that more people are being identified as having a serious mental illness and may attribute this to the success of PASRR programs, when in fact it is because a MDD diagnosis has been falsely attributed to the individual.

There may be risk that the facility may be classified as an IMD, due to the proportion of residents who now carry a more severe psychiatric diagnosis. Again, I'm not an expert, but this would be something to consider.

Finally, there is the risk to the resident, who now carries a diagnosis of a serious mental illness. Major Depressive Disorder, by nature, is a chronic condition, therefore, once this diagnosis is made, it is very hard to say that someone "no longer has Major Depression". It may go into remission, but there is a lingering risk for recurrence of a depressive episode. As a result, the resident may be exposed to unnecessary treatment and intervention with the goal of mitigating any risk for future depressive episodes, which may not even be applicable to the resident if they do not truly have Major Depressive Disorder.

Question 2: It seems to me that there needs to be a way to bill a separate screen for this issue because it is not a real status change/depression diversion screen. It is creating a load for nursing homes and OBRA Coordinators in our state of Colorado. What are your suggestions on how to manage this issue?
Answer: I agree that it is important to get the state PASRR Program Manager or other state officer stakeholders involved in finding a solution to this issue.

I can share with you that when making the decision to refer for a Level II Evaluation, through a "Level 1.5" process, we consider the recent change from a diagnosis of a "mild or situational" depressive disorder to a diagnosis of Major Depressive Disorder to be a significant enough change to warrant *suspicion* of a serious mental illness. The purpose of the Level II process is to confirm or refute that suspicion. I believe it would be risky to state that there was "no status change" when the accompanying PAS reveals that there was a major diagnostic change to a more severe diagnosis.

In creating a process to give providers a "pass" on these types of status changes, we would only be band-aiding the larger problems associated with keeping a diagnosis of MDD on the record, when there is no clinical evidence to support the diagnosis. (See my response to Question 1). I believe that the most effective solution, which will address the root cause of this problem, is to partner with the physicians and practitioners in your facility to verify the correct diagnosis for the resident.

Question 3: Since there is a clinical difference between Depressive Disorder NOS and Major Depression, for Level I screening purposes, would it be permissible to list the specific diagnosis that the psychiatrist/doctor diagnosed on the Level I Screening Tool and simply notate in the clinical record that Major Depression is a translation from ICD-9 to ICD-10, not an actual physician diagnosed diagnosis?
Answer: You are very correct that there is a significant clinical difference between "Depressive Disorder NOS" and "Major Depressive Disorder". Those diagnosed with MDD represent a higher severity of illness and likely require more resources in the nursing facility compared to residents with the NOS diagnosis. This is why it is imperative to correctly distinguish between these two groups by ensuring the accuracy of the depressive disorder diagnosis.

If I am understanding this question correctly, it appears you are trying to find a way to maintain the diagnosis of MDD in the clinical record, even though you acknowledge that it was not generated by a physician? I anticipate you would be creating a lot of risk and confusion by doing this. If MDD is not the true diagnosis for the resident, what would be the benefit of keeping it in the resident's record? I imagine the risks associated with keeping the incorrect diagnosis (see response to Question 1) would far outweigh the benefit. I would not endorse the creation of a process which preserves a Major Depression diagnosis that does not accurately describe the clinical presentation of the resident.

Question 4: What happens when resident or patient does not have additional family members to answer questions in Section Q?
Answer: Good question, thank you. Although this scenario does occur it is very rare as one of the requirements is that every resident has a 'legal entity' if they are not able to speak for themselves. If this extremely rare exception presents itself there is a mechanism within MDS 3.0 Section Q that states "Unknown, or Uncertain" that can be populated.

Question 5: Can you speak to the primary implications of the MDS presentation for PASRR?
Answer: The MDS version 3.0 had a significant change from prior versions related to PASRR. Of particular interest are sections A1500 and A1510 which specifically identifies if the individual has a serious mental illness (MI), or an intellectual disability (ID) or related condition (RC). Question A1510 asks the coder to identify which disability the individual has. The introduction of A1510 allows data users to track rates at which individuals with MI, ID, or RC are 'detected' by state PASRR programs, and to compare those rates with other diagnostic items within the MDS 3.0, or a state to state comparison for example.

Question 6: Does NAPP have a listserv where members can ask questions about how different states manage various aspects of PASRR? If not, is this a consideration for the future?
Answer: The short answer is no- but this is a good idea and we can definitely assemble one. NAPP does have a directory that is accessible by our members that will permit access to all NAPP members contact information. We also have a forum where you can pose questions to the entire member-base… or submit questions to NAPP anonymously. If you have further questions, please feel free to send to our general mailbox and a board member will return your inquiry : nappfrontdesk@pasrr.org