Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
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IN THE MATTER OF:

Brentwood Center for Health & Rehabilitation, LLC C/o Margaret Kirby, RN-BC [redacted]	))))	**FINAL DECISION**

This is the Department of Health and Human Services' Final Decision.

The Recommended Decision of Hearing Officer Strickland mailed July 8, 2022 and the responses and exceptions submitted on behalf of the Department have been reviewed.

I hereby adopt the findings of fact and I accept the Recommendation of the Hearing Officer that the August 3, 2021 Final Informal Review Decision is affirmed with an error rate of 38% and sanction of 5%.

DATED: 8-23-22 SIGNED: Jeanne M. Lambrew

JEANNE M. LAMBREW, Ph.D., COMMISSIONER
DEPARTMENT OF HEALTH & HUMAN SERVICES

YOU HAVE THE RIGHT TO JUDICIAL REVIEW UNDER THE MAINE RULES OF CIVIL PROCEDURE, RULE 80C. TO TAKE ADVANTAGE OF THIS RIGHT, A PETITION FOR REVIEW MUST BE FILED WITH THE APPROPRIATE SUPERIOR COURT WITHIN 30 DAYS OF THE RECEIPT OF THIS DECISION.

WITH SOME EXCEPTIONS, THE PARTY FILING AN APPEAL (80B OR 80C) OF A DECISION SHALL BE REQUIRED TO PAY THE COSTS TO THE DIVISION OF ADMINISTRATIVE HEARINGS FOR PROVIDING THE COURT WITH A CERTIFIED HEARING RECORD. THIS INCLUDES COSTS RELATED TO THE PROVISION OF A TRANSCRIPT OF THE HEARING RECORDING.

cc: Philip Burns, OMS

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

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Jeanne M. Lambrew, Ph.D., Commissioner
Department of Health and Human Services
11 SHS, 109 Capitol Street
Augusta, ME 04333

DATE OF MAILING: 7/8/22

Re: Brentwood Center for Health & Rehabilitation, LLC, NPI #1942540364-004
Final Informal Review Decision – MDS Assessment Review

ADMINISTRATIVE HEARING RECOMMENDATION

An administrative hearing in the above-referenced matter was convened telephonically on January 18, 2022, before Hearing Officer Jeffrey P. Strickland. The record was reopened through June 8, 2022, for additional evidence. The Hearing Officer's authority was conferred pursuant to 5 M.R.S. § 9062 by the Commissioner, Department of Health and Human Services.

CASE BACKGROUND AND ISSUE:

Brentwood Center for Health & Rehabilitation, LLC, appeals the Department's [redacted] Final Informal Review Decision concerning an MDS assessment or "case mix" review conducted on [redacted]. The Chief Administrative Hearing Officer's Order of Reference states the issue as,

> *(1) Was the Department correct in its Case Mix Review of Brentwood Center for Health & Rehabilitation, LLC as found in a Final Informal Review Decision dated* [redacted] *and Case Mix Review dated* [redacted]?

APPEARING FOR THE DEPARTMENT:

- Philip Burns, Esq., OMS Administrative Hearing Representative
- Suzanne Pinette, RN, RAC-CT, Case Mix Manager, State RAI Coordinator
- Emma Boucher, RN, RAC-CT, Health Services Consultant

APPEARING FOR APPELLANT:

- Margaret Kirby, RN, RAC-CT, Director of Clinical Reimbursement
- Rebecca Sinford, RN, RAC-CT, Regional Director of Clinical Reimbursement

ITEMS ADMITTED INTO EVIDENCE:

Hearing Officer Exhibits:

H-1: The following items, collectively:
- Hearing notice dated November 18, 2021.
- Order of Reference dated November 15, 2021.
- Hearing Report Form dated November 12, 2021.
- Acknowledgement letter dated November 12, 2021.

H-2: Email chain dated November 22, 2019, through January 16, 2020.
H-3: Maine MDS RUG III Codes Model Version 5.20 ME for MDS 3.0.
H-4: MDS 3.0 Documentation Requirements August 2020.
H-5: Reopen notice dated March 4, 2022.
H-6: Long-Term Care Facility RAI User's Manual (10/1/19).
H-7: The following items, collectively:
- Amy Harvey, PA, Discharge Summary Notes dated [redacted]
- Michael Davis, NP, Progress Notes dated [redacted]
- Amy Harvey, PA, Progress Notes dated [redacted].
- Administration Record Report dated [redacted], through [redacted]
- MD: History and Physical Admission and Readmission dated [redacted]
- Centers for Disease Control and Prevention Tabular List of Diseases: A41.51.
- Progress Notes – View All dated [redacted] through [redacted].
- MINIMUM DATA SET (MDS) – Version 3.0 dated April 20, 2021.

H-8: Reopen notice dated May 25, 2022.
H-9: Department's response dated June 8, 2022.

Department Exhibits:

D-1: Hearing request dated September 20, 2021.
D-2: Final Informal Review Decision dated [redacted]
D-3: Informal review request dated [redacted]
D-4: Exit Conference dated [redacted]

Appellant Exhibits:

None.

FACTS OFFICIALLY NOTICED:

1. ICD-9-CM Tabular List of Diseases (FY12) identifies ICD diagnosis code 038.42 as "Septicemia due to Escherichia coli [E. coli]."

2. ICD-9-CM Official Guidelines for Coding and Reporting (FY12) includes guidelines for "Septicemia, Systemic Inflammatory Response Syndrome, Sepsis, Severe Sepsis, and Septic Shock."

3. ICD-10-CM Tabular List of Diseases (FY21) identifies ICD diagnosis code A41.51 as "Sepsis due to Escherichia coli [E. coli]."

4. ICD-10-CM Tabular List of Diseases (FY21) identifies ICD diagnosis code A41.9 as "Septicemia NOS" and "Sepsis, unspecified organism."

5. ICD-10-CM Tabular List of Diseases (FY21) does not identify ICD diagnosis codes for "Septicemia due to Escherichia coli [E. coli]" or other specified organism.

6. ICD-10-CM Official Guidelines for Coding and Reporting (FY21) includes guidelines for "Sepsis, Severe Sepsis, and Septic Shock."

7. ICD-10-CM Official Guidelines for Coding and Reporting (FY21) does not include guidelines for "Septicemia."

RECOMMENDED FINDINGS:

1. Appellant is a licensed Nursing Facility in Maine. On [redacted] the Department conducted an MDS assessment review of Appellant that resulted in a 46% error rate and 10% sanction based on six "unverified case mix group records" from the drawn sample of 13. The records at issue concerned Residents #3, #6, #7, #8, #9, and #11.

2. Appellant requested an informal review of the MDS assessment review findings concerning Residents #6, #7, and #8. The Department's August 3, 2021, Final Informal Review Decision upheld the review findings as to all three records. Appellant disputes the FIRD findings concerning Resident #7 only.

3. Appellant assessed Resident #7, a [redacted] using the CMS Minimum Data Set (MDS) with an assessment reference date (ARD) of April 20, 2021.

4. Appellant coded Resident #7 as having an active diagnosis of septicemia in the last seven days (MDS item I2100) and receiving intravenous medications in the last 14 days (MDS item O0100H) resulting in his classification into RUG-III case mix group SE2 with a case mix weight of 2.057.

5. Resident #7 received intravenous medication during the 14-day look-back period and has an ADL score of 14. Resident #7 had a documented diagnosis of septicemia in the last 60 days that had a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

RECOMMENDED CONCLUSIONS:

1. The Department was correct when it determined that Appellant's MDS assessments of Residents #3, #6, #8, #9, and #11 inaccurately represented the residents' conditions and therefore resulted in the residents' inaccurate classification into case mix groups that increased the case mix weights assigned to the residents.

2. The Department was not correct when it determined that Appellant's MDS assessment of Resident #7 inaccurately represented the resident's condition and therefore resulted in an inaccurate classification to a case mix group that increased the case mix weight assigned to the resident. In fact, Appellant's assessment of Resident #7 accurately represented the resident's condition and therefore did not result in the resident's inaccurate classification into a case mix group that increased the case mix weight assigned to the resident.

3. The Department was not correct when it determined a 46% error rate and 10% sanction. The Department's MDS assessment review and FIRD support a 38% error rate and 5% sanction.

RECOMMENDED DECISION:

The Hearing Officer recommends that the Commissioner AFFIRM the Department's [redacted]2021, Final Informal Review Decision with a 38% error rate and 5% sanction.

RATIONALE:

Per the applicable rule, "Nursing care facilities will be reimbursed for services provided to members based on a rate which the Department establishes on a prospective basis and determines is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated facility in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards." 10-144 C.M.R. Ch. 101, Chapter III, §67.14.1.

Allowable costs under the prospective system of reimbursement are categorized based on the nature of the expense as either: 1) direct care costs (salaries, wages, and benefits for registered nurses, licensed practical nurses, nurse aides, patient activities personnel, and ward clerks), 2) routine costs, or 3) fixed costs. §§67.15 and 67.16. Of the three, "The basis for reimbursement within the direct care cost component is a resident classification system that groups residents into classes according to their assessed conditions and the resources required to care for them," or "case mix reimbursement system." §§67.15 and 67.22.3. The case mix reimbursement system "takes into account the fact that some residents are more costly to care for than others" by "(a) the assessment of residents on the Department's approved form – [Minimum Data Set] as specified in Principle 16.2; (b) the classification of residents into groups which are similar in resource utilization by use of the case mix resident classification groups as defined in Principle 22.3.2; [and] (c) a weighting system which quantifies the relative costliness of caring for different classes of residents by direct care staff to determine a facility's case mix index." §67.22.3.1.

Broadly, the Department determines the direct care cost component of a nursing facility's "prospective per diem rate" for a fiscal year based on the "case mix weight" for each of the facility's MaineCare residents. §67.22.3. There are "a total of forty-five (45) case mix resident classification groups [alternatively, "resource utilization groups" or "RUG's"] including one (1) resident classification group used when residents cannot be classified into one (1) of the forty-four (44) clinical classification groups" with associated case mix weights ranging from 0.749 to 2.484. §67.22.3.2. According to the rule, "The Minimum Data Set (MDS) currently specified for use by Centers for Medicare and Medicaid [Services] (CMS) . . . provides the basis for resident classification into one (1) of [the] forty-four (44) [clinical] case mix classification groups. The unclassified group is assigned when assessment data are determined to be incomplete or in error." §67.16.2. CMS guidelines require that MDS assessments be submitted electronically for each resident within 14 days of admission and quarterly, annually, and "whenever the resident experiences a significant change in status, and whenever the facility identifies a significant error in a prior assessment" thereafter. §§67.16.2.1, 67.16.2.2, and 67.1.4.

The Department conducts MDS assessment reviews "to ensure that assessments accurately reflect the resident's clinical condition." Depending on a facility's "assessment review error rate," the latter being defined as, "the percentage of unverified Case Mix Group Record[s] in the drawn sample," the Department will impose a sanction equivalent to a specified percentage of MaineCare resident days billed by the facility for a three-month period following the review. An "Unverified Case Mix Group Record" is in turn defined as being "one which, for reimbursement purposes, the Department has determined does not accurately represent the resident's condition, and therefore results in the resident's inaccurate classification into a case mix group that increases the case mix weight assigned to the resident." The Department is required to "hold an exit conference" and "share written findings for reviewed records" with facility representatives following the on-site portion of the review. The facility must correct any MDS assessment information determined to be inaccurate using the "MDS correction form" specified by CMS for that purpose. "Failure to complete MDS corrections by the nursing facility staff within fourteen (14) days of a written request by staff of the Office of MaineCare Services may result in the imposition of the deficiency per diem" rate, equivalent to 90% of the facility's per diem rate, "until the deficiencies have been corrected, as verified by representatives of the Department, following written notification by the provider that the deficiencies no longer exist." §§67.16.2.3 and 67.37.

Appellant, a Maine-licensed Nursing Facility, disputes a Final Informal Review Decision dated [redacted] 2021, concerning the findings of an MDS assessment review conducted on [redacted] 2021. The FIRD determined a 46% error rate and 10% sanction based on coding errors identified in six of the 13 records reviewed, of which Appellant disputes only that pertaining to "Resident 7." The FIRD states,

Resident #7 (bulleted information submitted by the facility) had an ARD of 4/20/21

- *MDS ARD [redacted]21, Quarterly – MDS Item I2100 Septicemia. Audit identified as coding and payment error.*
- *Resident was admitted to Brentwood Nursing and Rehabilitation on [redacted] with a principle diagnosis of Sepsis on the discharge summary (Exhibit 7A)*
    - *UTI is source of sepsis confirmed by culture (Exhibit 7B)*
- *Michael Davis, NP's [redacted] progress note identifies the chief complaint upon readmission as Sepsis (ICD10 A41.51) due to Escherichia Coli. (Exhibit 7C)*
    - *Assessment also identified Sepsis secondary to UTI (Exhibit 7D)*
    - *IV Ceftriaxone at OSH (spell out hospital) transition to Cefpodoxime 200 MG BID x 8 days at Brentwood Nursing and Rehab. See attached MAR (Exhibit 7E)*
- *Dr. Raker included Sepsis and Cystitis in his H&P on [redacted] (Exhibit 7F)*
- *Per the ICD-10 tabular list of Diseases A41.51 designates the main diagnosis of Other Sepsis in Chapter 1: Certain Infectious and parasitic disease (Exhibit 7G)*
- *Both Dr. Raker and Michael Davis NP were queried on [redacted]21 by Sherry Nelson, LPN and they both stated sepsis was reported from the hospital and the resident was treated per sepsis protocol and stand behind their notes for this diagnosis (Exhibit 7H).*
- *This resident was monitored daily per McGreer Infection Nurse's Note and Skilled PDPM notes during the 7 day look back.*
- *MDS item I2100, Septicemia was coded accurately with sufficient documentation to support this diagnosis.*
- *The MDS is accurately coded and therefore no payment change.*
- *MDS was modified to remove sepsis as a result of the audit. (Exhibit 7I)*
- *The modification of MDS should be inactivated returning the MDS to original accurate capture of Sepsis.*

The Facility submitted documentation that confirmed a diagnosis of sepsis. Sepsis and septicemia are not the same condition. Sepsis is an illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. A bacterial infection anywhere in the body may set off the response that leads to sepsis. If the assessor is not sure of the diagnosis, he or she should consult with the physician. So long as there is a documented diagnosis in the last 60 days and it has a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period, either or both of these diagnoses can be captured on the MDS in Active Diagnoses in the Last 7 days. (AHFSA RAI Panel May 2020 and agreed to by CMS).

There was documentation to support a diagnosis of sepsis, but no documentation to support coding of a diagnosis of septicemia. The original MDS with ARD of [redacted] Had a case mix group of SE2 with a case mix index of 2.057. The assessment will need to be modified to reflect IV medications were not received while a resident;[1] the recalculated case mix group is SE1 with a case mix index of 1.190.[2]

The Facility's documentation does not support the facility's coding for Resident #7.

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[1] Typographical error – the coding error re MDS item O0100H2 (IV medications "While a Resident") concerned a different resident; Resident #7 was coded as O0100H1 (IV medications "While NOT a Resident"). Exh. H-7; Exh. D-2; Exh. D-4; Test. Suzanne Pinette.
[2] Typographical error – case mix weight for RUG III code "SE1" is 1.910. Exh. D-6. 10-144 C.M.R. Ch. 101, Chapter II, §67.22.3.2.

The informal review at issue was conducted by Case Mix Manager and State RAI Coordinator Suzanne Pinette, RN, RAC-CT. Ms. Pinette testified concerning her finding, per the FIRD, that "[t]he Facility's documentation does not support the facility's coding [of MDS item I2100] for Resident #7."

In pertinent part, Ms. Pinette testified that she had previously requested clarification from CMS relative to coding MDS item I2100, as it was not clearly explained in the RAI 3.0 User's Guide, and that she had based her finding on CMS's response, as cited in the FIRD, that "Sepsis and septicemia are not the same condition. . . . If the assessor is not sure of the diagnoses, he or she should consult with the physician. So long as there is a documented diagnosis in the last 60 days and it has a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period, either or both of these diagnoses can be captured on the MDS in Active Diagnoses in the Last 7 days."

Ms. Pinette further testified regarding evidence submitted with Appellant's hearing request amounting to the written opinions of two industry consultants that the terms "sepsis" and "septicemia" are interchangeable for purposes of item I2100.[3] Ms. Pinette testified that, as the State RAI Coordinator, she was obliged to follow guidance provided by CMS to the exclusion of conflicting guidance provided by private industry consultants.

Finally, Ms. Pinette testified that she understood CMS's statement that "either or both of these diagnoses can be captured on the MDS in Active Diagnoses in the Last 7 days" as meaning that only septicemia could be coded as MDS item I2100 ("Septicemia"), while sepsis could only be coded as MDS item I8000 ("Additional active diagnoses"). The Department argues in closing, "Reading this phrase closely, one can see that the only way that "either or both" of Sepsis and Septicemia can be captured in the MDS in Active Diagnoses is if there is a documented diagnosis in the last 60 days and that diagnosis has a direct relationship to the resident's functional condition. Here, although there was a documented diagnosis of Sepsis in the resident's clinical record, there was no documented diagnosis of Septicemia. Without that diagnosis of Septicemia in the clinical record, the only diagnosis that can be captured in the MDS in Active Diagnoses is Sepsis. The two diagnoses are not interchangeable."

Appellant's witnesses Ms. Kirby and Ms. Sinford testified that Resident #7's physician was queried in connection with the MDS assessment and had confirmed the diagnosis of sepsis and that the diagnosis included septicemia. Appellant's witnesses testified that they understood CMS's statement to mean either or both diagnoses could properly be coded as MDS item I2100. Appellant argues in closing, "Ms. Pinette's email dated Friday, November 22, 2019 at 4:11pm specifically questions the coding of MDS item I2100 Septicemia. It also clarifies that sepsis is a serious complication of septicemia. Even though Ms. Pinette's email also states that sepsis and septicemia are not the same,[4] we cannot have sepsis without having septicemia since sepsis is a serious complication of septicemia."

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[3] The materials in question include: 1) statements posted on AAPACN Connect MDS General Discussion Community – "If the physician documented the diagnosis within the last 60 days and it was active in the last 7 days Yes" (re 'can you code sepsis of septicemia in I2100,' Carol Maher, February 3, 2021); "Sepsis and septicemia are interchangeable for MDS coding" (re 'if it says Sepsis, can I code Septicemia,' Carol Maher, October 9, 2019); and 2) an email from rorth@relias.com to mgreen@nathealthcare.com – "The ICD-10 manual codes both situations under A41.9 for this reason I code both Sepsis and Septicemia under Septicemia on the MDS" (re 'does CMS consider [sepsis and septicemia] the same,' Ronald Orth, March 14, 2018). Exh. D-1.

[4] Ms. Pinette's email reads in pertinent part as follows: "**www.healthline.com:** Septicemia is a serious bloodstream infection. . . . Septicemia and sepsis aren't the same. Sepsis is a serious complication of septicemia. . . ." Exh. H-2.

Following the hearing, the Hearing Officer reopened the record to admit additional evidence, including: 1) RAI User's Manual, and 2) Appellant's informal review submissions, referenced in the FIRD as "bulleted information submitted by the facility." Of the latter materials, Michael Davis, NP's, [redacted] Progress Note documented "038.42 / A41.51: Sepsis due to Escherichia coli, . . . under the heading "DIAGNOSIS AND ASSESSMENT . . . ICD Codes." Exh. H-7, 2/55. In that ICD-9-CM Tabular List of Diseases identifies 038.42 as "Septicemia due to Escherichia coli," the Hearing Officer again reopened the record to take notice of that and certain other facts related to the coding of septicemia and sepsis in ICD-9-CM and ICD-10-CM according to the CMS and NCHS Tabular List of Diseases and Official Guidelines for Coding and Reporting. Exh. H-8.

In response to the Hearing Officer taking official notice, the Department argues, "According to Suzanne Pinette, Case Mix Manager for the Office of MaineCare Services and Maine's State Resident Assessment Instrument (RAI) coordinator, the Minimum Data Set (MDS) is not coded based on ICD-10 codes. Rather, ICD coding is used for payment purposes . . . In contrast to the ICD-10 codes, the MDS is a functional assessment tool used to collect data about individuals who reside in nursing facilities. One function of the MDS is to create a classification group that identifies the reimbursement group for each resident. Classification groups include Patient-Driven Payment Model (PDPM) for skilled nursing reimbursement and Resource Utilization Groups (RUG) for long term care facilities in the State of Maine. . . . The Active Diagnoses section is intended to 'code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. . . . If a disease is not specifically listed, one can enter the diagnosis and ICD code in [MDS] item I8000, which provides space to list additional active diagnoses. Item I8000 is the only item in Section I that includes ICD codes as these are additional active diagnoses that are not coded in the section above."

The Department argues that the informal review submissions support its findings concerning Resident #7. Among others, the Department cites Amy Harvey, PA's, [redacted] Progress Note, which states, "Patient with likely sepsis on admission though not officially meeting SIRS criteria. He was febrile earlier in the day and borderline tachycardic on arrival with left shift on his CBC. Source is urinary, confirmed by culture. Blood cultures negative. Much improved and back to baseline." Exh. H-7, 3/55. Per the Department, "This information indicates the infection was not in the blood as blood cultures were negative."

The Department further asserts, based on Ms. Pinette's email to CMS, "In contrast, septicemia is a serious bloodstream infection that is also known as blood poisoning." The Department notes that "I2100 is not checked and I8000 does not include sepsis" in the redacted MDS enclosed with the Hearing Officer's second reopen notice.[5] The Department asserts in conclusion, "The Department continues to determine that Brentwood Center for Health & Rehabilitation, LLC did not have sufficient documentation to code Septicemia at I2100. Physician documentation confirmed a diagnosis of Sepsis, which is a different diagnosis and cannot be coded at I2100." Exh. H-9.

The evidence does not support the interpretation of CMS's email urged by the Department, or that Appellant's coding of MDS item I2100 did not accurately represent the resident's condition and therefore resulted in the resident's inaccurate classification into a case mix group that increased the case mix weight

[5] Relative to this assertion, the evidence shows: 1) the Department required Appellant to modify coding for item I2100 as a "correction," based on the MDS assessment review, and 2) Appellant did not code sepsis in item I8000 based on its correct understanding that this diagnosis had been properly coded as item I2100. Exh. D-2; Exh. D-3; Exh. D-4; Test. Margaret Kirby.

assigned to the resident. In fact, the evidence shows: 1) MDS item I2100 may be coded based on either ICD-9-CM code 038.42 (Septicemia due to E. coli) or ICD-10-CM code A41.51 (Sepsis due to E. coli), and 2) Appellant's coding of MDS item I2100 accurately represented that "Physician-documented diagnoses in the last 60 days that ha[d] a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period" included septicemia due to E. coli.

To begin with, RAI Version 3.0 User's Manual does not contain coding instructions specific to MDS item I2100; general coding instructions for Section I: Active Diagnoses in the last 7 Days include: 1) "Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period," 2) "Check off each active disease. Check all that apply," and 3) "If a disease or condition is **not** specifically listed, enter the diagnosis and ICD code in item I8000, Additional active diagnoses." Exh. H-6, page I-8.

CMS's January 8, 2020, email is likewise uninformative regarding this issue. The email states, "Sepsis and septicemia are not the same condition," and that "either or both of these diagnoses can be captured on the MDS in Active Diagnoses in the Last 7 days," but does not specify as to which MDS item (I2100 or I8000) "either or both" should be coded. Assuming the email to be responsive to the question posed, it must be taken to mean that MDS item I2100 can be coded based on either diagnosis, given that Ms. Pinette's November 22, 2019, email specifically asked about coding "I2100 Septicemia" and whether the terms "sepsis" and "septicemia" were interchangeable for purposes of same.[6, 7] As written, however, CMS's January 16, 2020, email cannot be understood as exclusively intending to express either of the two proposed meanings, notwithstanding the logical assumption that it can only mean one or the other.

Relative to the role of ICD codes in the assessment process, RAI User's Manual contains coding instructions specific to MDS items I0020, Indicate the resident's primary medical condition category, and I8000, Additional active diagnoses, based on "ICD Code," and also provides the URL for ICD-10-CM Index to Diseases and Injuries for coding guidance relative to the latter. Although RAI User's Manual requires that those MDS items be coded based on ICD codes, it does not proscribe or limit any other consideration of ICD codes in the assessment process in the manner suggested by the Department.

The evidence shows Resident #7 had a "Physician-documented diagnosis in the last 60 days" of "Septicemia due to Escherichia coli" based on the ICD-9-CM code 038.41 having been documented by Michael Davis, NP, in his progress note dated [redacted].[8, 9] Exh. H-7, 2/55. Apart from the latter,

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[6] Ms. Pinette's email states, "**#1: I2100 Septicemia** RAI Manual, page I-8: Coding Instructions," and cites the above-noted instructions for "I: Active Diagnoses in the last 7 Days." Exh. H-2.

[7] Notably, and as pointed out in Ms. Pinette's email to CMS, RAI User's Manual Appendix C states that "[d]iagnoses and conditions that present complications or increase risk for pressure ulcer/injury" include "*Sepsis (I2100)* [emphasis added]." Exh. H-2; Exh. H-6, page C-67.

[8] The Department argues that "the [E. coli] infection was not in the blood as blood cultures were negative." Exh. H-9. Apart from the absence of reliable evidence supporting this assertion, the record includes documentation of Appellant's [redacted] query wherein "The writer talked to Dr. Raker and Michael Davis NP on Sepsis diagnosis in their progress notes [redacted] and [redacted] They both stated [that] sepsis [was] reported from hospital and resident was treated for Sepsis protocol before cultures were done. [R]esident did improve with [IV ceftriaxone] treatment. They both stand behind their notes for Sepsis Diagnosis." Exh. H-7, 7/55. Per ICD-10-CM Official Guidelines for Coding and Reporting, "Negative or inconclusive blood cultures do not preclude a diagnosis of sepsis in patients with clinical evidence of the condition; however, the provider should be queried."

[9] As noted in the Exit Conference dated [redacted]2021, MDS 3.0 Documentation Requirements relative to MDS item I2100 include "Documentation of positive blood cultures." Exh. H-4; Exh. D-4. Again, however, the evidence shows that Resident #7 "was treated for Sepsis protocol before culture[s] were done." Exh. H-7, 7/55. And, in any event, the Department's Final Informal Review Decision dated [redacted]021, does not reference the requirement in question. Exh. D-2.

"Sepsis due to Escherichia coli" is in fact interchangeable with "Septicemia" for purposes of coding MDS item I2100. As seen in the facts officially noticed, ICD-10-CM unlike ICD-9-CM does not allow "Septicemia due to Escherichia coli" to be coded as a separate diagnosis, but instead accounts for the "Septicemia" or "underlying systemic infection" due to Escherichia coli in ICD-10-CM code A41.51, "Sepsis due to Escherichia coli."

According to ICD-9-CM Official Guidelines, "The terms septicemia and sepsis are often used interchangeably by providers, however they are not considered synonymous terms. . . . Septicemia generally refers to a systemic disease associated with the presence of pathological microorganisms or toxins in the blood, which can include bacteria, viruses, fungi or other organisms. . . . Sepsis and severe sepsis require a code for the systemic infection (038.xx, 112.5, etc.) and either code 995.91, Sepsis, or 995.92, Severe sepsis. If the causal organism is not documented, assign code 038.9, Unspecified septicemia." Per ICD-10-CM Official Guidelines, "For a diagnosis of sepsis, assign the appropriate code for the underlying systemic infection. If the type of infection or causal organism is not further specified, assign code A41.9, Sepsis, unspecified organism." ICD-10-CM Tabular List of Diseases in turn identifies A41.9 both as "Sepsis, unspecified organism" and as "Septicemia NOS," and does not identify codes for septicemia due to any specified organism. In sum, regardless of whether septicemia and sepsis are "considered synonymous terms" for other purposes, they are "interchangeable" for purposes of coding MDS item I2100.

Relative to case mix group classification and case mix weight, RUG-III Extensive Services category "qualifiers" include IV medications in the last 14 days and an ADL score of seven or more. Extensive Services comprises a total of three RUG-III codes with case mix weights of 1.910, 2.057, and 2.484 based on the total "count" of qualifiers in all categories. Exh. H-3. It is undisputed that Resident #7 received IV medications in the last 14 days and has an ADL score of seven or more. Given that active diagnoses in the last seven days included septicemia, Appellant accurately classified the resident into RUG-III case mix group SE2 with a case mix weight of 2.057.

As noted previously, the Department's MDS assessment review determined a 46% error rate and 10% sanction based on six "unverified case mix group records" (Residents #3, #6, #7, #8, #9, and #11) out of 13 records in the sample. Of the six, Appellant requested an informal review concerning three (Residents #6, #7, and #8). The FIRD upheld the MDS assessment review as to all three resident records. Of the three, Appellant requested an administrative hearing concerning one (Resident #7). The MDS assessment review and FIRD findings were incorrect relative to the record in question.

The evidence supports a 38% error rate based on five "unverified case mix group records" (Residents #3, #6, #8, #9, and #11) out of 13 records in the sample. The rule specifies a 5% sanction, or "decrease in the total allowable inflated direct care rate per day after the application of the wage index and upper limit," where an MDS assessment review results in an error rate of between 37% and 41%. §67.16.2.3.4.

In light of the above, the Department's [redacted] 2021, MDS assessment review and [redacted] 2021, Final Informal Review Decision were not correct in determining a 46% error rate and 10% sanction. Based on the evidence presented, the Hearing Officer recommends the Commissioner modify the Department's determination in this case to a 38% error rate and 5% sanction.

RIGHT TO FILE EXCEPTIONS AND RESPONSES:

THIS IS A RECOMMENDED DECISION OF THE DIVISION OF ADMINISTRATIVE HEARINGS; THE COMMISSIONER WILL MAKE THE FINAL DECISION IN THIS MATTER. PARTIES TO THIS RECOMMENDED DECISION MAY SUBMIT WRITTEN EXCEPTIONS AND RESPONSES TO THE DIVISION OF ADMINISTRATIVE HEARINGS PRIOR TO THE FINAL DECISION. EXCEPTIONS AND RESPONSES SHALL INCLUDE A CLEAR STATEMENT OF THE PARTY'S POSITION AND THE REASONS FOR IT, ANY ERRORS OR OMISSIONS MADE BY THE HEARING OFFICER, AND ANY LEGAL ARGUMENT THAT THE PARTY WISHES TO MAKE. FACTUAL INFORMATION NOT PRESENTED AT HEARING NEED NOT BE CONSIDERED BY THE FINAL DECISION MAKER. EXCEPTIONS AND RESPONSES MUST BE RECEIVED BY THE DIVISION OF ADMINISTRATIVE HEARINGS BY MAIL, FAX, OR EMAIL WITHIN TWENTY (20) CALENDAR DAYS FOLLOWING THE DATE OF MAILING INDICATED IN THE UPPER RIGHT CORNER OF THE FIRST PAGE OF THIS RECOMMENDED DECISION. ANY PARTY SUBMITTING EXCEPTIONS AND RESPONSES MUST PROVIDE COPIES TO ALL OTHER PARTIES. A REASONABLE EXTENSION OF THE TIME LIMIT FOR SUBMITTING EXCEPTIONS AND RESPONSES MAY BE GRANTED BY THE CHIEF ADMINISTRATIVE HEARING OFFICER IF THE PARTIES ARE IN AGREEMENT TO THE EXTENSION OR FOR GOOD CAUSE SHOWN. 10-144 C.M.R. CH. 1, § VII(B)(5).

DATED: July 8, 2022

SIGNED: */S/ Jeffrey P. Strickland*
Jeffrey P. Strickland, Esq.
Hearing Officer

cc: Philip Burns, Esq.
Margaret Kirby, RN