

Table Comparing CMS Final Guidance on Pain Management to AHCA Comments on Draft Guidance

Section	Draft Guidance	Final Guidance
Interpretive Guidelines § 483.25.	Interpretive Guidelines – Overall Quality of Care § 483.25.	<p>Interpretive Guidelines § 483.25.</p> <p>*CMS removed the word “overall,” which was one of AHCA’s suggestions.</p> <p>*CMS did not adopt AHCA’s recommendation to add the following sentence: “Physician’s progress notes provide good information related to situations when the resident’s failure to reach the highest practicable level of well-being is unavoidable.”</p>
Procedures § 483.25.	General Quality of Care Procedures § 483.25.	<p>Procedures § 483.25.</p> <p>*CMS removed the word “general,” which was one of AHCA’s suggestions.</p> <p>*CMS added several new sections, including a “General Investigative Protocol for F309, Quality of Care,” as well as various sections describing some specific issues or care needs that are not otherwise covered in the remaining tags of 483.25. These include “review of a resident with non pressure-related skin ulcer/wound,” “review of a resident receiving hospice services,” “review of a resident receiving dialysis services,” and “review of a resident who has pain symptoms, is being treated for pain, or who has the potential for pain symptoms related to conditions or treatments.” We discuss this latter section in more detail below.</p>

Recognition and Management of Pain	This section states that in “order to help a resident attain or maintain his or her highest practicable level of well-being and to prevent or manage pain, to the extent possible,” the facility should take certain steps.	CMS did not adopt AHCA’s addition of the phrase “in accordance with the comprehensive assessment and plan of care” at the end of this sentence.
Overview of Pain Recognition and Management	Contains a sentence stating that it “is important to consider treating the underlying cause [of pain], where possible.”	CMS did not adopt AHCA’s suggestion to phrase the sentence: “Where possible, it is important for the physician to determine and consider treating the underlying cause” of pain.
Overview of Pain Recognition and Management	The last two paragraphs of this section address (1) possible misconceptions about pain, and (2) barriers to the evaluation and management of pain.	<p>AHCA suggested that these two paragraphs did not make sense and were contradictory.</p> <p>CMS revised them by creating three paragraphs: the first addresses certain factors that may affect the recognition, assessment, and management of pain; the second addresses pain management in individuals who have cognitive impairment or communication difficulties; and the third discusses that those who cannot report pain may present with nonspecific signs.</p>
Care Process for Pain Management	<p>This section discusses the processes for the prevention and management of pain.</p> <p>Such processes include: “Using non-pharmacological interventions, to the extent possible.”</p>	<p>AHCA wanted to add “and when consistent with the resident’s desires and goals” to this sentence.</p> <p>Instead, CMS changed it to read “Considering non-pharmacological and CAM interventions.”</p>

<p>Pain Recognition</p>	<p>This section begins “Because pain can significantly affect a person’s well-being, it is important that the facility recognize and address pain promptly.”</p> <p>The section goes on to discuss expressions of pain, which may be verbal or non-verbal.</p>	<p>AHCA recommended removal of the word “promptly,” but CMS kept it in.</p> <p>AHCA wanted more emphasis on viewing these indicators in the entire clinical context. However, CMS did not change the language significantly from the draft guidance.</p>
<p>Assessment</p>	<p>This section notes that other than the RAI, “an assessment or an evaluation of pain based on clinical standards of practice may necessitate the following,” and lists nine bullet points.</p>	<p>AHCA wanted to change this to read “an assessment or an evaluation...may suggest a need for gathering the following information, to the extent possible,” followed by the bullets.</p> <p>Instead, CMS changed this sentence only slightly from the draft, to read “an assessment or an evaluation of pain...may necessitate gathering the following information, as applicable to the resident,” followed by the same nine bullets.</p> <p>CMS removed from the draft a sentence at the end of this section, which read: “This assessment becomes even more important if the resident does not or cannot report on pain.”</p>
<p>Management of Pain</p>	<p>The first paragraph of this section begins, “Based on an appropriate evaluation,” the various entities and individuals develop, implement, monitor, and revise interventions to prevent or manage each resident’s pain, beginning at admission.</p>	<p>AHCA recommended that CMS remove the word “appropriate,” which it did.</p> <p>AHCA wanted to add to the end of this sentence, “consistent with the resident’s desired level of pain relief, if ascertainable.” However, CMS chose not to add this language.</p>

		<p>AHCA asked how this coincided with the required timelines for RAI/MDS assessment, but CMS did not address this in the final guidance.</p> <p>AHCA recommended that CMS remove the paragraph discussing what happens if a resident elects the Medicare hospice benefit, noting this would be more appropriate in a separate guidance on end-of-life. However, CMS retained this paragraph in the final guidance.</p> <p>Finally, CMS adopted AHCA’s suggestion, in the last paragraph, to specify that staff should be educated and guided regarding the proper evaluation and management of pain <i>as reflected in or consistent with the protocols, policies, and procedures employed by the facility.</i></p>
Pharmacological Interventions	This section begins with the sentence, “A pain management regimen (including medications) is specific to each resident.”	<p>AHCA expressed concern about the inadequate recognition of the physician/prescriber’s role in the development of the pain management regimen. To address this, CMS changed the sentence at the left to read: “The interdisciplinary team (nurses, practitioner, pharmacists, etc.) is responsible for developing a pain management regimen that is specific to each resident who has pain or who has the potential for pain, such as during a treatment.”</p> <p>Later in this section, AHCA again recommends specific mention of the physician/prescriber role, in a paragraph about the factors influencing doses of medication. However, CMS chose not</p>

		<p>to add anything further on this subject.</p> <p>AHCA also recommended that CMS add “age” to the factors influencing doses of medication, but CMS chose not to adopt this suggestion.</p>
Monitoring and Reassessment		<p>AHCA sought to reword a sentence stating that the ongoing evaluation of the status of a resident’s pain is <i>vital</i>, but CMS declined to adopt AHCA’s suggested revision.</p>
Investigative Protocol for Pain Management		
Quality of Care Related to the Recognition and Management of Pain	<p>The “Observations” subsection notes that surveyors should observe the resident during various activities and use these observations to determine several things, including whether “staff respond to a report from the resident, family, or staff that the resident is experiencing pain.”</p>	<p>AHCA noted that this needs clarification, and that a response could be merely saying “ok,” which is clearly unacceptable. AHCA asked CMS to include what would be an acceptable response. However, CMS declined to do so.</p>
	<p>The “Resident/Representative Interviews” subsection notes that surveyors should interview the resident or representative, and if the resident is presently or periodically experiencing pain, determine several things, such as characteristics of the pain; factors that may precipitate or alleviate the pain.</p>	<p>AHCA wanted to add a bullet point stating that surveyors should also determine “If, in the resident’s/representative’s opinion, the facility is responding to the resident’s need for comfort in a manner that is satisfactory.” However, CMS chose not to add this bullet point.</p> <p>AHCA recommended deletion of a bullet point stating surveyors should determine “How the resident typically has expressed pain and responded to various interventions in the past.”</p>

		However, CMS chose not to remove this bullet.
	The “Nurse Aide(s) Interview” subsection notes that surveyors should interview staff to determine (1) if they are aware of a resident’s pain complaints or of symptoms or behavior that could indicate the presence of pain; (2) To whom they report the resident’s complaints or symptoms; and (3) If they are aware of and implement interventions for pain/discomfort management for the resident.	AHCA recommended the change that surveyors should interview staff who provide <i>direct care</i> to the resident; CMS adopted this change. AHCA recommended that for (1) and (2), CMS include non-verbal behavior, but CMS declined to add this. AHCA recommended that for (3), CMS add at the end of the sentence, “as identified in the resident’s plan of care.” CMS adopted similar language (“consistent with the resident’s plan of care”).
	The “Interviews with Other Health Care Professionals” subsection notes that surveyors should interview one or more health care professionals as necessary. Depending on the issue, surveyors should ask about several things, including how direction is provided to medication administration staff to guide decisions about selecting the most appropriate intervention(s) for the specific type or intensity of the resident’s pain, including choices regarding the dosing, type and frequency of PRN analgesics and how supervision and oversight are provided.	AHCA found the use of “medication administration staff” to be confusing and recommended revision of this entire bullet point. CMS condensed the bullet point and edited it to read “how they [health care professionals] guide and oversee the selection of pain management interventions.”
	The “Record Review, Assessment” subsection says surveyors should review	AHCA states that as written, all four bullet points exceed the RAI/MDS. However, CMS

	<p>various types of records to determine whether the information accurately and comprehensively reflects the resident's condition. The subsection gives four examples of information the records could contain, such as "identifies the pain indicators and the characteristics, causes, and contributing factors related to pain."</p>	<p>kept them all in the final guidance.</p> <p>CMS also added in a note that reads: "Although Federal requirements dictate the completion of RAI assessments according to certain time frames, standards of good clinical practice dictate that the assessment process is more fluid and should be going. (Federal Register Vol. 62, No. 246, 12/23/97, page 671983).</p>
	<p>The "Record Review, Care Plan" subsection contains a paragraph stating that if a resident has elected a hospice benefit, all providers must coordinate their care of the resident.</p>	<p>AHCA questioned the necessity of this paragraph, noting that hospice would be addressed in other tags or in an end of life care guidance or the guidance related to hospice contracts with nursing facilities. However, CMS kept this paragraph in the final guidance.</p>
<p>Concerns with Independent but Associated Structure, Process, and/or Outcome Requirements for a Resident with Pain or the Potential for Pain</p>	<p>The surveyor may identify concerns with related requirements for a resident with pain or the potential for pain; the surveyor must investigate the identified concern. The guidance lists several examples of related requirements, one of which is "physician supervision."</p>	<p>AHCA notes that as written in the draft guidance, the "physician supervision" section is inconsistent with and exceeds the regulation at 42 CFR 483.40(a). AHCA recommended either that CMS delete this section or revise the language. CMS revised the language slightly to better reflect the regulation.</p>
<p>Deficiency Categorization for a Resident with Pain or Potential for Pain</p>	<p>The survey team must evaluate the harm or potential for harm based upon four levels of severity. However, "Severity Level 1" does not apply for this regulatory requirement.</p>	<p>Regarding Severity Level 1, AHCA noted this guidance has eliminated the ability of the surveyor to allow for substantial compliance. AHCA said it would work with others on the TEP and CMS to develop examples of noncompliance related to pain management. It does not appear CMS made any changes in response to AHCA's comments.</p>

