

CMS Updates RAI User's Manual

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The Centers for Medicare & Medicaid Services (CMS) June 2 posted revisions to the *Long-Term Care Facility Resident Assessment Instrument User's Manual*. The following is a summary of the updates. Revisions for grammar, punctuation, or additional clarity are not addressed in this article; the revisions have not been placed in the full context of manual instructions. The revisions, including the table of the changes that were made to each affected portion of the manual, can be accessed through the Need to Know column on the AANAC home page. Assessors should take the time to study the manual sections for which they are responsible.

Chapter 2

- If a resident is enrolled with hospice on admission to the nursing home, then O0100K, Hospice Care, should be entered on the Admission assessment. A SCSA is not required (p. 2-21).
- "Unplanned discharge" is defined in the context of requirements for completion of a Discharge assessment.
 - For unplanned discharges, the facility should complete the Discharge assessment to the best of its abilities. The use of the dash, "-", is appropriate when the staff are unable to determine the response to an item, including the interview items.
 - An unplanned discharge includes, for example:
 - Acute-care transfer of the resident to a hospital or an emergency department in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation; or
 - Resident unexpectedly leaving the facility against medical advice; or
 - Resident unexpectedly deciding to go home or to another setting (e.g., due to the resident deciding to complete treatment in an alternate setting) (p. 2-34).

Chapter 3, Section D

- The definition of a completed PHQ-9-OV changed from 7 of 10 items to 8 of 10 items answered by staff members (p. D-15)

Chapter 3, Section G

G0110. ADL Assistance: Definition of "facility staff" for coding G0110:

- For the purposes of completing Section G, "facility staff" pertains to direct employees and facility-contracted employees (e.g. rehabilitation staff, nursing agency staff). Thus, does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration. Therefore, facility staff does not include, for example, hospice staff, nursing/CNA students, etc. Not including these individuals as facility staff supports the idea that the facility retains the primary responsibility for the care of the resident outside of the arranged services another agency may provide to facility residents (p. G-3).
- G0300D, Moving on and off Toilet. Added to the definition of code 2 (not steady, only able to stabilize with staff assistance): If lift device is used (p. G-26).

G0400. Functional Limitation in ROM: Instructions for coding when resident has an amputation:

- Do not look at limited ROM in isolation. You must determine if the limited ROM impacts functional ability or places the resident at risk for injury. For example, if the resident has an amputation it does not automatically mean that they are limited in function. He/she may not have a particular joint in which certain range of motion can be tested, however, it does not mean that the resident with an amputation has a limitation in completing activities of daily living, nor does it mean that the resident is automatically at risk of injury. There are many amputees who function extremely well and can complete all activities of daily living either with or without the use of prosthetics. If the resident with an amputation does indeed have difficulty completing ADLs and is at risk for injury, the facility should code this item as appropriate. This item is coded in terms of function and risk of injury, not by diagnosis or lack of a limb or digit (p. G-31).

Chapter 3, Section J

J1400. Prognosis: Several edits were included to clarify that documentation must be in the medical record by a physician stating that the resident's life expectancy may be less than 6 months. This requirement has been in the manual from the start (p. J-23), but the coding instructions did not seem to be consistent with that statement.

- The new edits indicate that if the resident is receiving hospice services, the expectation is that the documentation [that the resident has a life expectancy of less than 6 months] is in the medical record (p. J-24).
- It also provides a definition for "terminally ill": "...the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course" (p. J-24).
- With the above definitions in mind, the coding instructions now read:
 - Code 0, no: if the medical record does not contain physician documentation that the resident is terminally ill and the resident is not receiving hospice services.
 - Code 1, yes: if the medical record includes physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services (p. J-24).
- The bottom line is that, to code "yes," a physician must state in the medical record that the resident's life expectancy may be less than 6 months.

Chapter 3, Section K

K0500D. Therapeutic Diet

- A therapeutic diet is a diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium, potassium) (ADA, 2011) (p. K-9).
- Therapeutic diets are not defined by the content of what is provided or when it is served, but **why** the diet is required...(p. K-10).
- A nutritional supplement (house supplement or packaged) given as part of the treatment for a disease or clinical condition manifesting an altered nutrition status does not constitute a therapeutic diet but may be **part** of a therapeutic diet...(p. K-10).

Chapter 3, Section M

M0210. Unhealed Pressure Ulcer(s): Clarification regarding identification of a healed pressure ulcer:

- If a resident had a pressure ulcer on the last assessment and it is now healed, complete Healed Pressure Ulcers item (M0900) (p. M-5).
- If a pressure ulcer healed during the look-back period, and was not present on prior assessment, code 0, No, indicating the resident did not have one or more unhealed pressure ulcer(s) at Stage 1 or higher, and skip to M0900, Healed Pressure Ulcers (p. M-5).

M0300. Current number of Unhealed Pressure Ulcers at Each Stage

- Added definition of “on admission” for identification of pressure ulcers that were present on admission or reentry: “On admission is defined as: as close to the actual time of admission as possible” (p. M-6).

M0700. Most Severe Tissue Type for Any Pressure Ulcer

- Code this item with a dash in the following situations:
 - Stage 1 pressure ulcer
 - Stage 2 pressure ulcer with intact blister
 - Unstageable pressure ulcer related to non-removable dressing/device
 - Unstageable pressure ulcer related to suspected deep tissue injury

The dash is being used in these instances because the wound bed cannot be visualized and therefore cannot be assessed (M-23).

M0800. Worsening in Pressure Ulcer Status since Prior Assessment

- Added coding tip: If a previously staged pressure ulcer becomes unstageable due to slough or eschar, do not code as worsened (p. M-24).

Chapter 3, Section O

O0100. Special Treatments, Procedures, and Programs

- Language was added to the general instructions for this section stating that facilities may code these items even when the resident performed the activity independently or after set-up by facility staff (p. O-1 and O-2). The instructions also state:
 - Residents who perform any of the treatments, programs, and/or procedures below should be educated by the facility on the proper performance of these tasks, safety and use of any equipment needed, and be monitored for appropriate use and continued ability to perform these tasks (p. O-2).
- Instructions specific to the following items were added indicating that the item may be coded if the resident performs the task him- or herself:
 - O0100C, oxygen therapy
 - O0100D, suctioning
 - O0100E, tracheostomy care
 - O0100G, BIPAP/CPAP
 - O0100J, dialysis

O0100M. Isolation or quarantine for active infectious disease: Revised instructions:

- Code only when the resident requires transmission-based precautions and strict isolation alone in a separate room because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. Do not code this item if the

resident only has a history of infectious disease (e.g., s/p MRSA or s/p C-Diff - no active symptoms). Do not code this item if the precautions are standard precautions, because these types of precautions apply to everyone. Standard precautions include hand hygiene compliance, glove use, and additionally may include masks, eye protection, and gowns. Examples of when the isolation criterion would not apply include urinary tract infections, encapsulated pneumonia, and wound infections (p. O-4).

- Code for “strict isolation” only when all of the following conditions are met:
 1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
 2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
 3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.
 4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.) (p. O-4 and O-5).
- If a facility transports a resident who meets the criteria for strict isolation to another healthcare setting to receive medically needed services (e.g. dialysis, chemotherapy, blood transfusions, etc.) which the facility does not or cannot provide, they should follow CDC guidelines for transport of patients with communicable disease, and may still code O0100M for strict isolation since it is still being maintained while the resident is in the facility.

Finally, when coding for isolation, the facility should review the resident’s status and determine if the criteria for a Significant Change of Status Assessment (SCSA) is met based on the effect the infection has on the resident’s function and plan of care. The definition and criteria of “significant change of status” is found in Chapter 2, page 20. Regardless of whether the resident meets the criteria for an SCSA, a modification of the resident’s plan of care will likely need to be completed (p. O-5).

O0400E. Psychological Therapy

- Psychological Therapy is provided by any licensed mental health professional, such as psychiatrists, psychologists, clinical social workers, and clinical nurse specialists in mental health as allowable under applicable state laws. Psychiatric technicians are not considered to be licensed mental health professionals and their services may not be counted in this item (p. O-17).

O0600. Physician Examinations

- Telehealth visits are included as long as physician/practitioner type and other requirements are met. See page O-36 of the *Long-Term Care Facility Resident Assessment Instrument User’s Manual*, chapter 15 of the *Medicare Benefit Policy Manual*, and chapter 12 of the *Medicare Claims Processing Manual* at www.cms.gov/manuals.

Chapter 3, Section Q

The instructions for this section have been edited significantly, although the methods for assessment and essence of the items have not changed. See the manual for the details.

Chapter 5

- Do not submit MDS records except to meet OBRA and SNF PPS requirements:
Required MDS records are those assessments and tracking records that are mandated under OBRA and SNF PPS. Assessments that are completed for purposes other than OBRA and SNF PPS reasons are not to be submitted, e.g., private insurance, including but not limited to Medicare Advantage plans (p. 5-1).
- MDS Correction Policy update:

A Modification Request should be used when an MDS record (assessment, Entry tracking record or Death in Facility tracking record) is in the QIES ASAP system, but the information in the record contains clinical or demographic errors. The Modification Request is used to modify most MDS items. The exceptions are:

- An Inactivation of the existing record followed by submission of a new corrected record is required to correct:
 - Type of Provider (Item A0200),
 - Type of Assessment (A0310),
 - Entry Date (Item A1600) on an Entry tracking record (A0310F = 1),
 - Discharge Date (Item A2000) on a Discharge/Death in Facility record (A0310F = 10, 11, 12),
 - Assessment Reference Date (Item A2300) on an OBRA or PPS assessment.
- An MDS 3.0 Manual Assessment Correction/Deletion Request is required to correct:
 - Submission Requirement (Item A0410),
 - State-assigned facility submission ID (FAC_ID),
 - Production/test code (PRODN_TEST_CD) (p. 5-10 and 5-11).

See Section 5.8 for details on the MDS 3.0 Manual Assessment Correction/Deletion Request.

Chapter 6

CMS included four examples of situations involving End of Therapy (EOT) Other Medicare Required Assessments (OMRAs) to illustrate when the RUG from various assessment types begins payment. They are copied and pasted below from page 6-9 and 6-10.

When all rehabilitation therapy ends, an End of Therapy OMRA must be performed within 1 to 3 days after the end of therapy, in order to establish a Medicare Non-Therapy RUG (Z0150A) for billing beginning with the day after therapy ended until the end of the current payment period. After the End of Therapy OMRA, a Medicare RUG in the Rehabilitation Plus Extensive or Rehabilitation groups should not be billed unless rehabilitation therapy starts again. Example 1 presents the most common situation.

EXAMPLE 1. Rehabilitation therapy ends on Day 20 of a Medicare stay. An End of Therapy OMRA is performed with ARD on Day 22 and the Medicare Non-Therapy RUG (Z0150A) is billed from Day 21 (day after therapy end) to the end of the current payment period of Day 30.

Consider Example 2 where a scheduled PPS assessment has set the payment rate for the next payment period and then an End of Therapy OMRA is conducted before the beginning of the next payment period.

EXAMPLE 2. The PPS 30-day assessment is performed with ARD on Day 25 to establish a Medicare RUG (Z0100A) for the Day 31 to Day 60 payment period. Rehabilitation therapy ends on Day 26 and an End of Therapy OMRA is performed with ARD on Day 27. The Medicare Non-Therapy RUG (Z0150A) from the End of Therapy OMRA is billed for the remainder of the current payment period, Day 27 through Day 30. The Medicare **Non-Therapy** RUG from the 30-day assessment is then billed for the next payment period. The Non-Therapy RUG from the 30-day assessment is used since all therapy has previously ended.

Consider Example 3 where an End of Therapy OMRA is performed and followed within a few days by a scheduled PPS assessment.

EXAMPLE 3. The End of Therapy OMRA assessment is performed with ARD on Day 25 since therapy ended on Day 24. The PPS 30-day assessment is then performed with ARD on Day 26 to establish a Medicare RUG for the Day 31 to Day 60 payment period. The Medicare Non-Therapy RUG (Z0150A) from the End of Therapy OMRA is billed for the remainder of the current payment period, Day 26 through Day 30. The Medicare **Non-Therapy** RUG (Z150A) from the 30-day assessment is then billed for the next payment period, Day 31 through Day 60. The Non-Therapy RUG from the 30-day assessment is used since all therapy has previously ended. The normal Medicare RUG (Z0100A) should not be used since it may contain a Rehabilitation Plus Extensive or Rehabilitation group RUG, because the 7-day reference period extends back before therapy had ended.

Consider Example 4 where an End of Therapy OMRA is performed and followed within a few days by a scheduled PPS assessment during the scheduled assessment grace days.

EXAMPLE 4. The End of Therapy OMRA assessment is performed with ARD on Day 32 since therapy ended on Day 31. The PPS 30-day assessment is then performed with ARD on Day 34 (during the grace days) to establish a Medicare RUG for the Day 31 to Day 60 payment period. The normal Medicare RUG (Z0100A) from the 30-day assessment establishes the payment rate for the Day 31 to Day 60 payment period. However that RUG which may be in a Rehabilitation Plus Extensive or Rehabilitation group is only billed for Day 31, since the End of Therapy OMRA will reset payment to a Non-Therapy RUG (Z0150A) beginning on Day 32 (the day after therapy ended) through the remainder of the current payment period ending with Day 60.

Combining assessments would seem to be an option for examples 2 and 3. There are no changes to the manual instructions that indicate that anything has changed with regard to combining assessments – it is still an option according to the manual.

Appendix A. Glossary and Common Acronyms

- Respiratory Therapy

A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws (p. A-19).