



An Informational Bulletin Brought To You By Polaris Group

CMS has published parts of the RAI Manual for MDS 3.0

What is Published and What is Not:

- Chapter One: RAI overview is published.
- Chapter Two: **Instructions and Schedule for when to complete mandated and Medicare assessments is NOT published yet.**
- Chapter Three: Item by Item coding directions is published.
- Chapter Four: **Related to Care Area Triggers (CATS) and CAAs (Care Area Assessment) (RAPs) is NOT published yet.**
- Chapter Five: Submission and Correction procedures is published.
- Chapter Six: **Medicare Skilled Nursing Home PPS is NOT published yet.**
- Appendix A: Glossary of terms is published.
- Appendix B: State agency and regional office contacts is published.
- Appendix C: CAA is **NOT published.**
- Appendix D: Interviewing techniques is published. Nothing surprising but should be helpful.
- Appendix E: Cognitive Performance scale is published.
- Appendix F: Draft Matrix is published.
- Appendix G: References is published.
- Appendix H: Forms are published.

Here are some interesting issues: some are a change and some are clarifying areas of confusion.

ARD Clarifications/changes:

- When the resident dies or is discharged prior to the end of the look-back period for a required assessment, the ARD must be adjusted to equal the discharge date, even though this may result in a less than full 7-day look-back period. Generally, facilities are required to complete these assessments after the resident's discharge in order to bill for Medicare or Medicaid payment. Facilities must change the ARD to the date of discharge and cannot consider the care or services received prior to nursing home admission.
- The look-back period may not be extended simply because a resident was out of the nursing home during part of the look-back period (e.g., a home visit or therapeutic leave). For example, if the ARD is set at day 13 and there is a 2-day temporary leave during the look-back period, the 2 leave days are still considered part of the look-back period. When collecting assessment information, you may use data from the time period of the leave of absence as long as the particular MDS item permits.

- If the resident is admitted to the hospital prior to completion of the admission assessment and returns to the nursing home, the nursing home staff may choose to complete the original Admission assessment or start a new assessment. If the staff chooses to complete the original assessment, then the original ARD must be retained and staff must properly identify those MDS items that can be coded only when provided or observed during the nursing home stay. This is OBRA MDS not Medicare.
- It is CMS' intent to have a significant change in status assessment completed EVERY time the hospice benefit has been elected, even if a recent MDS was done and the only change is the election of the hospice benefit.
- **Interview:** Code interview responses based on first response; the reason to try two more times is to determine whether to continue the interview. This is clarifying. These are an entire addendum on best practices for Interviews.
- **Trial of a Toileting Program and response:** The look-back period for this item is to the most recent admission/readmission assessment, the most recent prior assessment, or when incontinence was first noted. But the Current Toileting Plan uses the usual 7 day observation period.
- **Code diseases** that have a documented diagnosis in the last 30 days and have a relationship to the resident's functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. They outline this as a 2 step process.
- **Weights and Heights** are now both supposed to use mathematical rounding instead of always rounding up.
- **Medications** is much shorter only asking about injections; Insulin number of days an injection was received and days with insulin order changes; Medications received by type - four psychoactive mrfd, diuretics, anticoagulant, and antibiotics.
- Clarified that concurrent minutes are resident minutes, and since limited to two residents, the grouper will divide the minutes in half to calculate RUG level.



- RAI manual now clearly states - Record only the actual minutes of therapy. The conversion of units to minutes or minutes to units is not appropriate. Do not round to the nearest 5th minute.
- A Discharge item is "death in facility"
- The Discharge Tracking form is now several pages long and most of the Section A questions. Question: Would a Discharge Tracking MDS be combined with an End of therapy MDS. Unsure which would be needed if happen if therapy ends, and resident is discharged the next day and the next day is not billed to Medicare but if stay two days passed end of therapy, the End of therapy MDS could also be the Discharge MDS. Both codings are allowed. More to come on when to complete what MDS.
- Regarding skin assessments: Check formal assessment has been completed. An example of an established pressure ulcer risk tool is the Braden Scale for Predicting Pressure Sore Risk. Check Clinical Assessment if resident's risk for pressure ulcer development is based on clinical assessment. A clinical assessment could include a head-to-toe physical examination of the skin and/or observation or medical record review of pressure ulcer risk factors.
- If a resident had a pressure ulcer that healed before the look-back period, code 0. Still not clear, but implies if any pressure ulcer during observation period even if healed by end of observation period it must be coded.
- Current number of unhealed ulcers at each stage - Ulcer staging should be based on the ulcer's deepest visible anatomical level. Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a deeper stage than what is observed now, it should continue to be classified at the deeper stage. Nursing homes that carefully document and track ulcers will be able to code this better.
- Oxygen therapy: Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item.
- BiPAP/CPAP Code any type of CPAP or BiPAP respiratory support devices that prevent the airways from closing by delivering slightly pressurized air through a mask continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask enables the individual to support his or her own respiration by providing enough pressure when the individual inhales to

keep his or her airways open, unlike ventilators that "breathe" for the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here.

- New SECTION X: CORRECTION REQUEST is included with each type of MDS. The first item in this section indicates whether an MDS record is a new record to be added to the MDS National Repository (repository) or a request to modify or inactivate a record already present in the repository. If this is a new record, then all items except the first item are skipped.
- **Isolation:** Code only when the resident requires strict isolation or quarantine in a separate room because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with a communicable disease, in an attempt to prevent spread of illness. Do not code this item if the resident only has a **history** of infectious disease (e.g., MRSA or C-Diff with no active symptoms), but facility policy requires cohorting of similar infectious disease conditions. Do not code this item if the "isolation" primarily consists of body/fluid precautions, because these types of precautions apply to everyone. Transmission-Based Precautions must also be considered regarding the type and clinical presentation related to the specific communicable disease. The three types of transmission-based precautions are contact, droplet, and airborne. More information related to the types of transmission-based precautions can be found in the **2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings**

For additional information, please visit our website at:
<http://www.polaris-group.com/news.asp>

CMS Delays Implementation of PECOS Enrollment Policy

PECOS in an Internet-based Medicare provider enrollment process, known as Internet-based Provider Enrollment, Chain and Ownership System (PECOS).

Internet-based PECOS is available to physicians, non-physician practitioners, provider and supplier organizations in all States and the District of Columbia. Internet-based PECOS will allow physicians, non-physician practitioners, provider and supplier organizations the opportunity of enrolling, making a change in their Medicare enrollment information, viewing Medicare enrollment information, or tracking the status of their Medicare enrollment applications.

CMS announced on Nov. 23 that it would delay implementation of new rules that give Medicare the authority



POLARIS GROUP™
Strategic solutions for health care



POLARIS PULSE

to reject claims for services or supplies when the ordering physician or health care professional is not enrolled in the [Medicare Provider Enrollment, Chain and Ownership System](#), or PECOS. The agency is delaying implementation of the new policy until April 5, 2010. In contacting one of the MAC's, we verified that this does apply to Medicare Certified SNF's.

The policy was first made public on October 5 and was designed to be phased in gradually. The original grace period was scheduled to end on January 4, but according to CMS, an extension of the implementation date will give physicians and other health care provider's sufficient time to enroll or, if necessary, re-enroll in Medicare.

Even though a provider or supplier organization may be enrolled in Medicare, its enrollment record might not be in PECOS. If the provider or supplier organization enrolled in Medicare more than 5 years ago and has not reported any changes or updates to its enrollment record in the past 5 years, the provider or supplier organization probably does not have an enrollment record in PECOS. A provider or supplier organization that does not have an enrollment record in PECOS will have to submit an initial Medicare enrollment application, either via Internet-based PECOS or by using the paper application process.

For additional information, please visit our website at:
<http://www.polaris-group.com/news.asp>

Q & A

"Where No Question Goes Unanswered!"

- Q. A Part A resident was discharged home with Hospice. She stayed at home for 70 days then returned to the hospital and has a new qualifying stay. Would receiving Hospice at home interfere with the 60 day break in spell of wellness?
- A. Hospice services provided at home would not affect the spell of wellness.



**WISHING YOU A HAPPY HOLIDAY
SEASON AND A HAPPY NEW YEAR!**

TELECONFERENCE TRAININGS

Polaris Group is pleased to offer the following
CEU approved live teleconferences

Topic	Date
Medicare Part A Basics	12/8
Sections I, J, O, & W—Right Coding for Revenue	12/9
RAC Audit—Do's and Don'ts	12/9
MDS 3.0—Now and Future	12/10
Medicare Documentation & Skilling Criteria	12/15
Implement an Effective QA Program	12/15
Get Ready for RUG IV	12/17
Denial Letters & Generic Notices for All Occasions	12/22
Using Your QM/QI Reports	12/22

Please join us!
*For further information, please contact the
Seminar Department
at: 800-275-6252 ext. 233
or register online at: www.polaris-group.com*

Risk Management solutions at your fingertips

- * **Immediate analysis for improving MDS**
- * **Survey outcomes & clinical support applications**
- * **Regulatory research library and manuals**

Apollo RM (risk management web application)

Demo date: January 8th at 11:00 AM

Learn more and register for demo online:

www.polaris-group.com

.....
POLARIS PULSE is an informational newsletter distributed to POLARIS GROUP clients. For further information regarding services or information contained in this publication, please contact POLARIS GROUP corporate headquarters at 800-275-6252.

Contributors:

Debora Philips, RN, AAS
Victor Kintz, MBA, CHC, LNHA, RAC-CT, CCA
Marty Pachciarz, RN, RAC-CT
Deborah Moss, RN, MHS, RAC-CT
Susan Dickson, RN, RAC-CT

Editor:

Chuck Cave, BS, CHC

Production Manager:

Cindy Hernandez