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CMS Releases Final MDS 3.0 RAI Manual Updates

On August 31, 2017, the Centers for Medicare and Medicaid Services (CMS) released the final revisions to the MDS 3.0 RAI Manual v1.15 effective October 1, 2017.

Summary of Key Revisions:

Chapter 2

CMS added the word "major" to improvement or decline, in the definition of Significant Change in Status. (p. 2-22).

New criteria listed for Significant Change in Status MDS

- "Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment" (p. 2-25)
- Not only the emergence of a new pressure ulcer at Stage 2 or higher, but also "a new unstageable pressure ulcer/injury, a new deep tissue injury" (p. 2 -26)

Chapter 3

Section A:

- The incorrect examples for A2400 (#3 and #5) were corrected to indicate that A0310H should be coded 1 (Yes—a SNF Part A PPS Discharge assessment) on the OBRA Discharge assessment. Further explanation was added to both examples:
- Even though only an OBRA Discharge was required, when the Date of the End of the Medicare Stay is on the day of or one day before the Date of Discharge, MDS specifications require that A0310H be coded as 1.

Section G:

- G0110-the ADL Self-Performance Rule of 3 Algorithm on page G-8 has been updated. Note that nothing has changed with the definitions of levels of assistance; the algorithm is simply clearer.

Additional clarification on Pages G-9 and G-10: For residents transferred with a full-body mechanical lift, holding onto a bar or strap should not be considered resident participation in the activity.

- Transfers via lifts that require the resident to bear weight (stand lifts) should be coded extensive assistance.
- Turning side to side for incontinence care is a component of bed mobility.
- If the resident transferred out of bed or chair for incontinence care or to use the bedpan or urinal, the transfer is coded in G0110B. How the resident uses the bedpan or urinal is coded in G0110I Toilet use.
- Item G0600 Mobility Devices: Instructions for G0600C, Wheelchair (manual or electric), have added: "Do not include Geri-chairs, reclining chairs with wheels, positioning chairs, scooters, and other types of specialty chairs."

Section GG:

- Coding on admission should reflect the person's baseline admission functional status, and is based on a clinical assessment that occurs soon after the resident's admission.
- The admission functional assessment, when possible, should be conducted prior to the person benefiting from treatment interventions in order to determine a true baseline functional status on admission. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment. (p. GG-3)
- When coding the resident's usual performance on page GG-5, "effort" refers to the type and amount of assistance the helper provides in order for the activity to be completed. The 6-point rating scale definitions include the following types of assistance: setup/ cleanup, touching assistance, verbal cueing, and lifting assistance.
- CMS has also clarified on this page that the Discharge functional assessment "must be completed within the last three calendar days of the resident's Medicare Part A stay, which includes the day of discharge from Medicare Part A and the two days prior to the day of discharge from Medicare Part A."

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- **In the self-care items, the description of eating on page GG-6** now includes this: Clinicians may code the eating item using the appropriate response codes if the resident eats using his/her hands rather than using utensils (e.g., can feed himself/herself using finger foods). If the resident eats finger foods with his/her hands independently, for example, the resident would be coded as 06, Independent.
- **In reference to the three-day assessment period on page GG-3**, CMS added the statement: "A provider may need to use the entire 3-day assessment period to obtain the resident's usual performance."
- **In regards to discharge goals, additional wording was added to page GG-14** to help with goal planning and to involve the resident and family concerning the goals and anticipated length of stay.
- **Pages GG-38 and GG-39 contain very helpful information for the coding of wheelchair** items; numerous examples have been added throughout the section to help clarify accurate coding.

Section H:

- In H0100, Appliances, CMS removed the word "sterile" from the definition of intermittent catheterization, and added this coding tip: "Self-catheterizations that are performed by the resident in the facility should be coded as intermittent catheterization (H0100D). This includes self-catheterizations using clean technique."

Section I:

- Under coding tips for I2300, Urinary Tract Infection (UTI) (Last 30 Days), the criteria for coding UTI have been reduced to two indicators.

Code only if both of the following criteria are met in the last 30 days:

1. It was determined that the resident had a UTI using evidence-based criteria such as McGeer, NHSN, or Loeb in the last 30 days,

AND

2. A physician documented UTI diagnosis (or by nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days. (p. I-8)

RAI Manual (page I-9) makes clear that providers must use a tool that is linked to their Infection Prevention and Control Program.

Section J:

- In J1700, Fall History on Admission/Entry or Reentry, CMS has clarified that an intentional therapeutic intervention challenging a resident's balance and training the resident to recover from loss of balance is not considered an intercepted fall.

Section L:

Coding guidance has been added:

> The dental status for a resident who has some, but not all, of his/her natural teeth that do not appear damaged (e.g., are not broken, loose, with obvious or likely cavity) and who does not have any other conditions in L0200A–G, should be coded in L0200Z, none of the above. (p. L-3)

Section M:

- CMS has clarified that mucosal ulcers should not be coded in M0210
- Further clarification of examples of "present on admission/entry or reentry" are noted on page M-14.
- Guidance is provided in M0800 for coding worsening of pressure ulcers (p. M-28).
- For M1040D, Open lesion(s) other than ulcers, rashes, cuts, the example given has changed from cancer lesion to bullous pemphigoid.

Section N: (New Coding Items)

- **A new coding option** has been added to N0410 Medications Received-N0410H, Opioid-to indicate the number of days the resident received an opioid medication at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- Coding Clarification; Anticoagulants such as Target Specific Oral Anticoagulants, which may or may not require laboratory monitoring, should be coded in N0410E, Anticoagulant.

New Item: Antipsychotic Medication Review N0450.

- If the resident received an antipsychotic medication since admission/entry or reentry or the prior OBRA assessment, the data is recorded in N0450A. If the resident received an antipsychotic medication, the assessor must determine whether a gradual dose reduction (GDR) has been attempted and note the date in N0450B and N0450C. If the dose reduction was not attempted, the assessor is to determine whether there is physician documentation that the GDR is clinically contraindicated and code Yes or No in N0450D and the date in N0450E.

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Section O:

- "Up to date" in item O0300A, Pneumococcal Vaccine, means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations.
- Under O0400, this clarification was added for O0400D, Respiratory therapy: Only minutes that the respiratory therapist or respiratory nurse spends with the resident shall be recorded on the MDS.
- Items O0600, Physician Examinations, and O0700, Physician Orders, are not required to be completed by CMS, but the individual states continue to require their completion, so assessors must know their state's requirements. If the state does not require completion of the items, use the standard "no information" code (a dash, "-").

This clarification for physician orders was added:

- Includes orders written by medical doctors, doctors of osteopathy, podiatrists, dentists, and physician assistants, nurse practitioners, clinical nurse specialists, qualified dietitians, clinically qualified nutrition professionals or qualified therapists, working in collaboration with the physician as allowable by state law. (p. O-45)

Section P: (New Coding Item)

CMS states it is not prohibiting restraints but saying that residents should be free of physical restraint unless it is deemed necessary and appropriate as permitted by regulation

Addition of personal alarms in a new item, P0200 Alarms: Coding an Alarm in this new section does not mean the alarm is restrictive. If the alarm is restrictive, it should also be coded in as a restraint in bed/or chair/out of bed.

- CMS provides this definition of an alarm: Any physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected, and may include bed, chair and floor sensor pads, cords that clip to the resident's clothing, motion sensors, door alarms, or elopement/wandering devices.
- It is noted that alarms have not been proven an effective intervention to prevent falls and as such must not be the primary or sole intervention in the care plan (p. P-8). "The use of an alarm as part of the resident's plan of care does not eliminate the need for adequate supervision, nor does it replace individualized, person-centered care planning."
- The use of an alarm as a safety intervention must be based on the assessment and on monitoring its effectiveness as well as unintended consequences. CMS indicates that at times the use of an alarm may meet the definition of a restraint.

Section Q:

- The emphasis in the wording updates makes it clear that responses must be driven by the resident rather than the nursing home staff.
- On page Q-5, regarding coding of Q0300 (Resident's Overall Expectations), the following is noted: This item is individualized and resident-driven rather than what the nursing home staff judge to be in the best interest of the resident. Coding other than the resident's stated expectation is a violation of the resident's civil rights.
- In Q0500, Return to Community, instructions for Q0500B indicate that a response code of 1, Yes, means that the resident is requesting to learn about home- and community-based services, not making a request for discharge.

Chapter 4

On pages 4-10 and 4-11 there is a revised list of how the overall care plan should be oriented. The first three items are new:

1. Assisting the resident in achieving his/her goals.
2. Individualized interventions that honor the resident's preferences.
3. Addressing ways to try to preserve and build upon resident strengths.

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Emergency Preparedness Training Online Course

The CMS Survey & Certification Group (SCG) developed the Emergency Preparedness Basic Surveyor Training online course to help health and safety and Life Safety Code (LSC) surveyors and reviewers gain proficiency in surveying all affected participating providers and certified suppliers for compliance with their individual emergency preparedness requirements. Because the individual regulations for each provider and supplier type share a majority of standard requirements, this training provides guidance and survey procedures for all provider and supplier types in a single course.

Memo Summary:

- **Emergency Preparedness Training:** The Centers for Medicare & Medicaid Services (CMS) has developed the new Emergency Preparedness Training which is available on-demand and learners may access it at their convenience: 24 hours a day, 7 days a week.
- **The Emergency Preparedness Basic Surveyor Training Course is a required course for all State Survey Agency (SA) and Regional Office (RO)** surveyors and reviewers who conduct or review health and safety or LSC surveys for emergency preparedness requirements. Non-survey professionals and other SA or RO support staff responsible for ensuring compliance with regulations are also encouraged to take the course.
- **Surveying for requirements begins November 15, 2017.**

Link to Emergency Preparedness Training: https://surveyortraining.cms.hhs.gov/pubs/CourseMenu.aspx?cid=0CMSEmPrep_ONL

To read complete CMS S&C Memo: http://polaris-group.com/news_releases.asp

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