
Pages detailing all changes were posted, as well as changed pages that can be inserted into the current manual. Websites were updated. A great number of the changes were grammatical – capitalization, bolding, removing extra spaces, etc. This article contains a few of the more significant changes; you will need to review all the material and update your manual.

As discussed in the previous issue of the RAI Spotlight, the most significant change is the ability to modify Target Dates and Reasons for Assessments, if the ISC does not change, beginning on May 19. Inactivation and resubmission are still required to correct A0200 Type of Provider. Chapter 5 has been extensively rewritten to support this change with clarifications and examples.

MDS assessments required when a resident changes Medicare pay sources have been clarified on page 2-45 under Medicare-required 5-day Scheduled Assessment: “If a resident goes from Medicare Advantage to Medicare Part A, the Medicare PPS schedule must start over with a 5-day PPS assessment as the resident is now beginning a Medicare Part A stay.”

For A0800 Gender, a dash (--) is no longer an acceptable response. However, if a modification or inactivation must be done, a dash may be entered at X0300 if this was the response used on the assessment accepted into the CMS database.

Coding for C0100 Should Brief Interview for Mental Status be Conducted? has been expanded to state “Code 0, (Continued on page 3)

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**Section M Teleconference**

**Date:** July 18, 2013

**Time:** 1:30 – 2:30 pm EDT  (Dial-in 10 minutes earlier)

**Topic:** Section M Skin Conditions

**Handouts:** Power Point slides will be available about July 15 on the DOH Message Board at [http://app2.health.state.pa.us/commonpoc/content/facilityweb/login.asp](http://app2.health.state.pa.us/commonpoc/content/facilityweb/login.asp)

**Call in number:** 1-888-694-4728 or 1-973-582-2745

**Conference ID Number:** 75226891

Company Name: Myers and Stauffer  Moderator: Cathy Petko

A recording of this conference will be available; directions for requesting this will be posted on the DOH Message Board.

**Additional questions:** qa-mds@pa.gov
Section N Medications Q & As

On April 18, 2013, a training teleconference was provided on Section N Medications. The following questions were received.

Q. A new sliding scale for insulin counts as a new order. What do you mean about not counting it if you “use the sliding scale?”

A. If the sliding scale order is in place and you administer a dose of insulin selected from that scale based on laboratory findings, you have simply “used the sliding scale.” It is not a new order.

Q. To what pharmacologic category does Klonopin belong?

A. It is a benzodiazepine and is considered to be an anti-anxiety medication. It is also used in the treatment of seizure disorders.

Q. If I apply an antibiotic ointment with a wound dressing, can this be counted as an antibiotic in N0410F?

A. Yes. On page N-6 of the RAI Manual under Coding Tips and Special Populations, the second bullet states “Include any of these medications given to the resident by any route (e.g., PO, IM, or IV) in any setting (e.g., at the nursing home, in a hospital emergency room) while a resident of the nursing home.”

Quality Measures Manual Update

MDS 3.0 Quality Measures (QM) User’s Manual (v8.0) was posted on April 12, 2013 at www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment- Instruments/NursingHomeQualityIniti/NAHQIQualityMeasures.html. An additional file, “Quality Measure Identification Number by CMS Reporting Module Table v1.2,” has also been posted to assist in identifying which QM is used in each of the various CMS reporting modules that include QMs. There is also a file documenting the changes made between versions. Some of the significant changes are detailed below; however, an updated manual is needed to fully understand these measures.

An age exclusion to the Short-Stay vaccination QMs was added:
- Influenza vaccine QMs: "Resident's age on target date of selected target assessment is 179 days or less."
- Pneumococcal vaccine QMs: "Resident's age on target date of selected target assessment is less than 5 years (i.e., resident has not yet reached 5th birthday on target date)."

ICD-9 codes no longer appear as qualifiers for inclusion in the Numerator in Measure N015.01 Percentage of long-stay, high-risk residents with Stage II – IV pressure ulcers. The presence of these ulcers will only be identified from M0300B1, C1 and D1.

Measure N031.01, Percentage of long-stay residents who are receiving psychoactive drugs but do not have evidence of psychotic or related conditions in the target period, does not appear in the manual. This Surveyor QM had multiple exclusions including psychotic disorder, manic depression, hallucinations and delusions. Measure N031.02, Long-Stay residents who are receiving antipsychotic drugs in the target period, is the only remaining long-stay QM dealing with this issue. There are only three exclusions used in the calculation: I5250 Huntington's disease, I5350 Tourette's syndrome, and I6000 Schizophrenia.

Appendix F, Specifications for Facility Characteristics Report, has been added to the manual, providing detail as to how these calculations are performed.
- Gender (A0800)
- Age (A0900 Birth Date and A2300 Assessment Reference Date)
- Diagnostic Characteristics including Psychiatric Diagnosis (I5700-I6100, I5250, I5350), Intellectual Disability or Developmental Disability (A1550), and Hospice (O0100K2)
- Prognosis (J1400)
- Discharge Plan (Q0400A)
- Referral (Q0600)
- Type of Entry (A1700)

Non-valid Assessments on CMI Reports

Four times a year for MA-certified facilities, CMI Reports are generated reflecting residents identified as being in the nursing facility (NF) on the Picture Date (PD). It is the facility’s responsibility to review these reports, make necessary corrections by submitting further assessments or tracking forms, and then mail the signed certification page by the established deadline. This information will be used in setting the Medical Assistance per diem rate.

Residents are categorized into three groups on the CMI

(Continued on page 4)
RAI Manual Updates (cont’d)

(Continued from page 1)

No, if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not present.” In addition, the Coding Tips state that this “Includes residents who use American Sign Language (ASL).”

In Section G, ADLs, the algorithm on page G-6 was updated. Further clarification of ADL coding is anticipated in the fall.

In Section M, Skin Conditions, any wording describing wounds as being “deeper” or “worsened” has been changed to “increased in numerical stage.” Other additions include:

M0300 Current Number of Unhealed Pressure Ulcers: “If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the patient’s overall clinical condition should be reassessed.” (p. M-9)

M0300 Current Number of Unhealed Pressure Ulcers: “Cartilage serves the same anatomical function as bone. Therefore, pressure ulcers that have exposed cartilage should be classified as Stage 4.” (p. M-15)

M0700 Most Severe Tissue Type: “Granulation tissue, slough, or eschar are not present in Stage 2 pressure ulcers. Therefore, Stage 2 pressure ulcers should not be coded as having granulation, slough, or eschar tissue and should be coded as 1 [Epithelial tissue] for this item.” (p. M-24)

M0800 Worsening Pressure Ulcers: “The interdisciplinary care plan should be reevaluated to ensure that appropriate preventative measures and pressure ulcer management principles are being adhered to when new pressure ulcers develop or when pressure ulcers worsen.” (p. M-25)

M0800 Worsening Pressure Ulcers: “If two pressure ulcers merge, do not code as worsened. Although two merged pressure ulcers might increase the overall surface area of the ulcer, there would need to be an increase in numerical stage in order for it to be considered as worsened.” (p. M-26)

M1040H Moisture Associated Skin Damage: “Moisture associated skin damage (MASD) is a result of skin damage caused by moisture rather than pressure. It is caused by sustained exposure to moisture which can be caused, for example, by incontinence, wound exudate and perspiration. It is characterized by inflammation of the skin, and occurs with or without skin erosion and/or infection. MASD is also referred to as incontinence-associated dermatitis and can cause other conditions such as intertriginous dermatitis, periwound moisture-associated dermatitis, and peritomoral moisture-associated dermatitis. Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown.” (p. M-35)

Section P Restraints: Wherever the word “device” is used in reference to a restraint, the words “manual method or physical or mechanical device, material or equipment” have been substituted.

Jimmo Versus Sibelius Settlement

In the case of Jimmo v. Sebelius, it was alleged that Medicare claims involving skilled care were being inappropriately denied based on a rule-of-thumb “Improvement Standard” under which a claim would be summarily denied due to a beneficiary’s lack of restorative potential, even though the beneficiary did in fact require a covered level of skilled care in order to prevent or slow further deterioration. CMS has released a fact sheet concerning the settlement of this case at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Spotlight.html.

The document states that “A beneficiary’s lack of restorative potential cannot, in itself, serve as the basis for denying coverage, without regard to an individualized assessment of the beneficiary’s medical condition and the reasonableness and necessity of the treatment, care, or services in question.” Coverage depends not on the beneficiary’s restorative potential, but on whether skilled care is required.

The settlement agreement also includes language specifying that “Nothing in this Settlement Agreement modifies, contracts, or expands the existing eligibility requirements for receiving Medicare coverage.” Upcoming manual revisions will clarify that coverage of therapy “…does not turn on the presence or absence of a beneficiary’s potential for improvement from the therapy, but rather on the beneficiary’s need for skilled care.”

For a resident in your facility, “…restoration potential is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a resident may need skilled services to prevent further deterioration or preserve current capabilities.” Conversely, coverage in this context would not be available in a situation where the beneficiary’s care needs can be addressed safely and effectively through the use of unskilled personnel.

Resident Data Reporting Manual (RDRM)

A revision to the RDRM was posted on May 24. It can be found on the DPW web site at www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/manual/d_006851.pdf and in the CMS MDS Welcome Page Bulletins section.
Physician Delegation of Tasks

On March 8, 2013, CMS released a memorandum concerning Physician Delegation of Tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs).

The key to accurate application of the regulation is to identify:

- In which setting, SNF or NF, the physician services are being provided. The “setting” is determined by whether the visit to a patient in a certified bed is to a resident whose care is paid for by Medicare Part A in a SNF or under Medicaid in a NF.
- Whether the task must be performed personally by the physician, and
- Whether or not the non-physician practitioner (NPP) is employed by the facility.

The following chart summarizes these requirements.

<table>
<thead>
<tr>
<th>Setting</th>
<th>Initial Comprehensive Visit /Orders</th>
<th>Other Required Visits*</th>
<th>Other Medically Necessary Visits &amp; Orders+</th>
<th>Certification / Recertification</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNFs</td>
<td>PA, NP &amp; CNS employed by the facility</td>
<td>May not perform/ May not sign</td>
<td>May perform alternate visits</td>
<td>May perform and sign</td>
</tr>
<tr>
<td>PA, NP &amp; CNS not a facility employee</td>
<td>May not perform/ May not sign</td>
<td>May perform alternate visits</td>
<td>May perform and sign</td>
<td></td>
</tr>
<tr>
<td>NFs</td>
<td>PA, NP, &amp; CNS employed by the facility</td>
<td>May not perform/ May not sign</td>
<td>May not perform</td>
<td>May sign subject to State Requirements</td>
</tr>
<tr>
<td>PA, NP, &amp; CNS not a facility employee</td>
<td>May perform/ May sign</td>
<td>May perform</td>
<td>May perform and sign</td>
<td></td>
</tr>
</tbody>
</table>

*This reflects clinical practice guidelines
+Other required visits are the required monthly visits.
++Medically necessary visits may be performed prior to the initial comprehensive visit.
+=This requirement relates specifically to coverage of a Part A Medicare stay, which can take place only in a Medicare-certified SNF.

There is a penalty for inclusion of non-valid assessments. Rather than using the CMI that is determined by the RUG classification, non-valid assessments for a resident with the status of MA for MA Case-Mix are assigned the lowest CMI for the MA CMI (currently 0.48) and the highest CMI for the Total Facility CMI (currently 1.75). Non-valid assessments for a non-MA resident are assigned the highest CMI for the Total Facility CMI. Incorporation of these penalty CMIs may have a negative impact on the NF’s MA rate.

Non-valid Assessments on CMI Reports (cont’d)

Report: Medical Assistance Residents, Non-Medical Assistance Residents and Non-valid Assessments. In general, NFs are careful to assure that the proper MA for MA Case-Mix status is reported. However, the presence of non-valid assessments may inadvertently be overlooked.

Of the residents that the NIS determines are in the NF on the Picture Date, the NIS picks the most recent valid, classifiable assessment for that resident to place on the CMI Report. “Validity” is based on the age of the assessment compared to the PD. An assessment is considered valid if the Assessment Reference Date (A2300; ARD) is within four months of the Picture Date, e.g., for May 1, 2013, the ARD must be January 1, 2013, or later. If no valid assessment is present, the most recent non-valid assessment is placed on the CMI Report.