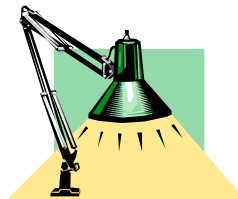


RAI Spotlight



DEPARTMENT OF
HEALTH

Susan Williamson
RAI Coordinator
1-717-787-1816
suswilliam@state.pa.us

RAI Manual Updates



On February 10, 2007, CMS posted the March 2007 RAI Manual Updates at <http://www.cms.hhs.gov/NursingHomeQualityInits/downloads/MDS20Update200703.pdf>. A few changes were made to Chapter 3 Item-By-Item Guide to the MDS that will affect how you complete some items:

- The definition of H3a Any Scheduled Toileting Plan was expanded: “A plan for **bowel and/or bladder elimination** whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a urinal, or remind the resident to go to the toilet. Includes **bowel** habit training and/or prompted voiding.”
- A phrase was removed from the definition of P1ac IV medications: “Includes any drug or **biological** (e.g., **contrast material**) given by intravenous push or drip through a central or peripheral port.” This

aligns this definition with the earlier instruction in this section that you “Do not code services that were provided solely in conjunction with a surgical or diagnostic procedure and the immediate post-operative or post-procedure recovery period.” Contrast materials are generally used only as part of a procedure, e.g., IVP.

- W2b requires that you state the reason that Influenza vaccine was not given to your resident. W3b requires the same explanation about the resident’s PPV status. The updates add the following instruction on pages 3-243 and 3-246: “**If none of the above reasons apply, enter a dash (-).**” CMS has directed the use of the dash in situations where the resident has requested that the vaccine be given, but the facility has not yet received their supply or reached the scheduled date for

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Section P1 Teleconference

Date: April 12, 2007
Time: 1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)
Topic: MDS Training Section P1 — Special Care/Therapies
Handouts: Power Point slides will be available about April 2 on the DOH Message Board at

<http://app2.health.state.pa.us/commonpoc/content/facilityweb/login.asp>

Call in number: 1-888-321-3075 or 1-973-582-2855

Conference ID Number: 8471845

Company Name: Myers and Stauffer Moderator: Cathy Petko
A recording of this conference will be available; directions for accessing this will be posted on the DOH Message Board.

Additional questions: suswilliam@state.pa.us

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Questions about the RAI?

Please submit them to
qa-mds@state.pa.us

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ADL Questions and Answers

On January 11, 2007, a training teleconference was provided dealing with MDS Sections G1 ADL Self-Performance/Support and G2 Bathing Self-Performance/Support. The following questions were raised in the Q & A portion of the conference and the following responses developed.

Q1. A resident is transferred from the bed to the shower chair. She travels in that chair to the shower room and into the shower stall for her bathing. Still sitting in that chair, she is returned to her room and transferred back into bed. Is this coded under Transfer or is it included in the Bathing activity coding at G2?



A. Since only one transfer occurred to provide the resident with a shower, this would be included with the Bathing activity. If, instead, the resident had been transferred to a wheelchair, pushed down the hall to the shower room, and then assisted from the wheelchair into the shower, only the last transfer would be incorporated with Bathing. The transfer from bed to wheelchair would be coded under Transfer; the travel to the shower room would be coded under Locomotion.

Q2. If a resident is placed on the bedpan/commode/toilet and does not produce any urine or BM, is it coded under Toilet Use?

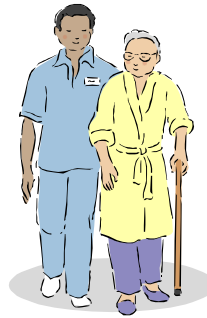
A. There was an expectation that elimination would occur when the resident was assisted to the bedpan/commode/toilet. Presumably, other such events during the 7-day look back period were more successful. Evaluate the level of Self-Performance and Support needed as usual, including this non-productive effort.

Q3. If IV fluids are used to dilute antibiotics, can this be counted as being for hydration purposes? Could it be coded at K5a Parenteral/IV (as well as P1ac IV Medication) and influence G1h Eating coding?

A. IV fluids used to reconstitute medications for IV administration can be counted as Parenteral/Intravenous (IV) at K5a only when they are administered for nutrition or hydration (RAI Manual p. 3-153). There would need to be some documentation that this fluid was being given for nutrition or hydration as well as being a vehicle for medication administration in order to code it at K5a and make it a factor in coding G1h Eating (RAI Manual p. 3-81).



Q4. Page 3-101 of the RAI Manual states “If a facility has a policy that all residents are supervised when bathing (i. e., they are never left alone while in the bathroom for a bath or shower, regardless of resident capability), it is appropriate to code the Staff Support [G2B] as supervision even if the supervision is precautionary.” In the teleconference, you said this was correct, but that we could not count a “stand-by” person, e.g., someone pushing a wheelchair behind a resident who is being assisted to walk by an aide. This is an important safety measure for some residents and it seems we should be able to count two people when coding Support.



A. Walk in Corridor (G1d) is defined as “How the resident walks in corridor on unit.” She is able to walk with the assistance of only one aide. If she was able to walk independently but was followed by an aide with the wheelchair, this could be coded as Supervision in the Support column. We understand the questioner’s concern, but the Bathing codes in G2 have always worked differently than the codes for the ADL items in G1. This was presented to the RAI Coordinators Workgroup, who also felt this interpretation was correct.

Calculating the RUG ADL Score

The RUG ADL Score is calculated in the same way in both the Medicare and PA Medical Assistance systems. Using the Self-Performance and Support codes for G1a Bed Mobility, G1b Transfer and G1i Toilet Use, identify the ADL Score for each:

If Self-Perf =	AND Support =	ADL Score =
‘-’, 0 or 1	Any number	1
2	Any number	3
3 or 4	2	4
3, 4 or 8	3 or 8	5

To identify the Eating ADL Score, review K5a Parenteral/IV and K5b Feeding tube. If either is checked, the Eating ADL Score is 3. If neither is checked, identify the Eating ADL Score by comparing the Self-Performance (G1hA) code to this table:

If G1hA =	ADL Score =
‘-’, 0 or 1	1
2	2
3, 4 or 8	3

Add the four ADL Scores together to identify the RUG ADL Score that is used in classification. The range is 4 to 18.



National Provider Identifier (NPI)

In a final rule published January 23, 2004, the federal Department of Health and Human Services established the NPI as a unique health identifier for health care providers for use in the health care system. Nursing facilities are "health care providers" and **MUST** obtain and begin using this number in electronic transactions beginning May 23, 2007. Billing, especially for Medicare, and MDS submission along with other standard transactions will be affected by this requirement. Extensive information, as well as an application form, can be found at http://www.cms.hhs.gov/NationalProvIdentStand/01_Overview.asp.

MA providers must register their NPI number with the Department of Public Welfare (DPW). MA Bulletin 99-06-14 effective 12/18/06 (<http://www.dpw.state.pa.us/General/Bulletins/003673169.aspx?BulletinDetailID=1536>) provides instructions for this

registration. Failure to register the number with DPW could result in non-payment for Medical Assistance services. For additional information, refer to <http://www.dpw.state.pa.us/Business/NPIinfo/>.

Until May 23rd, the use of this NPI on the MDS is optional; for assessments dated on or after May 23, the number must be used and rejection is expected to occur if it is not present. This number must appear in two places in your MDS electronic submission file: in the Header record in fields 577-586 and in W1 in fields 1626-1635. The two numbers must match; if not, it is a Fatal Error and the record will be rejected.

Investigate whether your facility has applied for and obtained an NPI. Consult with your vendor to assure that your software has been upgraded for this number. You may begin using it for MDS submissions as soon as it is obtained. Addressing the issue now will avoid problems on May 23rd!!!

Do You Know....



Where to find the instructions to complete a Correction Request Form?

Finding the form itself and the completion instructions are not easy tasks! The form may be found in the RAI Manual on page 5-12. More specific information may be found in the CMS Manual [Provider Instructions for Making Automated Corrections Using the MDS Correction Request Form](https://www.qtso.com/download/mds/PrMn1002.pdf) available at <https://www.qtso.com/download/mds/PrMn1002.pdf> and http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHOIMDS20.asp. The form may be found on page 1-20 of this manual with instructions for completion included on pages 3-1 through 3-11. A hard copy of the completed Correction Request form must be kept with the corrected paper copy of the MDS record in the clinical file; a hard copy should also be kept with an inactivated record.

Where to find information about how the Department of Health conducts a survey, and the details of the F-tags that may be cited?

A wealth of information is available about the survey process and resident care in this material used by surveyors. It is not light reading, but it is a useful resource for your facility.

- Appendix P of the State Operations Manual (http://www.cms.hhs.gov/manuals/Downloads/som107ap_p_ltcf.pdf) provides details about the survey process, including the new Quality Indicators Survey (QIS).
- Appendix PP (http://www.cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf) provides the regulatory basis, definitions, interpretive guidelines and procedures for each F-tag. The latest revisions, e.g., F329 Unnecessary Drugs, are included.

AA8b = 1 or 5?

Medicare (MC) Part A coverage rules and qualifications are intricate. One issue that seems to cause unnecessary concern is whether a MC PPS assessment should be designated AA8b = 1 Medicare 5-day assessment or AA8b = 5 Medicare readmission/return assessment.

The confusion arises when a resident of your facility must be hospitalized (D/07 Return anticipated or D/08 Discharge before completion of initial assessment), and returns to you after a short stay. Either due to this event or an earlier three day stay, she has met this technical eligibility requirement and will be requiring daily skilled care. What is the first



MC PPS assessment that should be completed for this MC Part A stay?

The decision is made based on the resident's pay source prior to this hospitalization. If her care was paid by Medical Assistance or private pay sources, select AA8b = 1 Medicare 5 day assessment; she is beginning a MC PPS stay. If her care was paid by MC Part A prior to the hospitalization, select AA8b = 5 Medicare readmission/return assessment; the hospitalization was merely an interruption to an established MC Part A NF stay.



(RAI Manual Update—Continued from page 1)

planned administration. None of the numbered responses are appropriate in these circumstances; use of the dash (-) is now directed in writing. Note: Residents who have a dash response in W2a, W2b, W3a or W3b are included in the calculation of the QM/QIs; they are not excluded.

Most of the remaining updates are administrative material:

- Changing all references from “nursing facilities” to “nursing homes” in Chapter 6;
- Updating Appendix B State Agency Contacts so that all data is current; and
- Adding the link for the [Provider Instructions for Making Automated Corrections Using the New MDS Correction Request Form](#) manual to the RAI Manual site at

http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp.
(See associated article on page 3)

The following note was removed from page 6-8 dealing with Physician Certifications and Recertifications for Medicare SNF PPS: **“NOTE: These certification statements have no correlation to requirements specifically related to the plan of treatment for therapy that is required for purposes of coverage.”**

In the introductory paragraph concerning RUG classification into the Rehabilitation categories on page 6-14, “physical, occupational or speech therapy” was changed to “physical **therapy**, occupational **therapy**, or speech **language pathology**.” More exact terminology reflects the meaning of this section.

New Submission Requirement



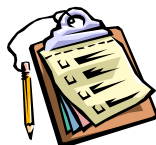
Federal regulation requires that MDS assessments and tracking forms be submitted within 31 days of the completion date. However, if the state has a more stringent requirement, the state’s requirements must be met.

Beginning on October 1, 2006, Title 55 PA Code Chapter 1187.22(18) requires that for facilities participating in the MA program, a newly admitted resident’s initial MDS record must be submitted within 7 calendar days of the date the record is completed. This information is important for the Nursing Home Transition initiatives that are being implemented throughout the state.

Initial MDS records and applicable dates are detailed in the following table. Whichever record is completed first for a newly-admitted resident must be submitted by the Latest Allowable Submission Date.

MDS Record	AA8a	AA8b	Completion Date	Latest Allowable Submission Date
Discharge	08	Blank	R4	R4 + 7 days
MC PPS	00	1	R2b	R2b + 7 days
Admission	01	Blank, 1	VB4	VB4 + 7 days

Retention of Validation Reports



Questions are frequently asked about the length of time Initial and Final Validation Reports must be kept at the facility. Unfortunately, there is no specific guidance available regarding the retention of these reports; it is a facility decision.

Validation Reports are the only proof the facility has that an MDS assessment or tracking form was submitted and accepted into the state database. Since these reports are deleted from the state database after three months, the facility must be certain to access them in a timely fashion. They can be saved in hard copy or electronic files.

Regulations applicable in PA relate to clinical record retention requirements; there is some variation:

- Title 28 Health and Safety Part IV Chapter 211.5(c) states that "Records shall be retained for a minimum of 7 years following a resident's discharge or death."
- Title 55 PA Code Chapter 1187.33(a)(3) states "The nursing facility shall maintain the records pertaining to each resident assessment data submission for at least 4 years following the date the nursing facility submits the assessment data to the Department."
- F515 (§483.75(1)(2)) states "Clinical records must be retained for the period of time required by State law or for a minor, three years after a resident reaches legal age under state law."