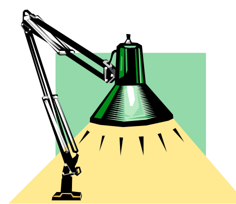
RAI Spotlight



DePArtment of HEALTH

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Hot Topics

Continuing Education Requirements

On June 29, 2006, Act 58 (P.L.275, No. 58) was signed which requires professional nurses to complete 30 hours of continuing education for biennial license renewal. The State Board of Nursing has issued Proposed Rulemaking for implementation of this requirement in the Pennsylvania Bulletin of April 28, 2007 (www.pabulletin.com/secure/data/vol37/37-17/743.html). Assuming that these regulations become final before the end of 2007, the first group to be affected would be those whose license renewal would occur in 2010. Failure to comply with the continuing education requirement could lead to civil penalties which also appear in the Pennsylvania Bulletin (www.pabulletin.com/secure/data/vol37/37-17/744.html). Comments on these proposed rules will be accepted for 30 days after publication.

ADL Coding Discussion

In 2004 during a CMS sponsored training program on MDS Section G1 Activities of Daily Living, it was stated that if an activity occurred less than three times during the observation period, correct coding for G1A Self-Performance was 0 Independent. This followed the coding flowsheet on page 3-90 of the RAI Manual, and was applicable even if the resident was totally dependant when the activity occurred only one or two times.

This continues to be the correct coding practice for Pennsylvania nursing facilities. However, the issue is again being reviewed by the RAI Coordinators' Group and CMS. Any new information will be shared through the DOH Message Board.

Questions about the RAI?

Please submit them to

qa-mds@state.pa.us

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RAPs and Care Planning Teleconference

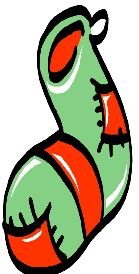
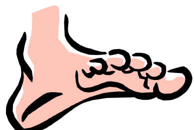
Date: July 12, 2007
Time: 1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)
Topic: RAPs and Care Planning
Handouts: Power Point slides will be available about July 2 on the DOH Message Board at
http://app2.health.state.pa.us/commonpoc/content/facilityweb/login.asp
Call in number: 1-888-321-3075 or 1-973-582-2855
Conference ID Number: 8764097

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

Teleconference Questions and Answers

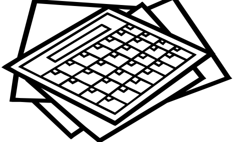
Questions have been received by DOH that relate to the recent MDS training teleconferences. The following responses have been developed:

Section G1 ADLs	
Is there any place on the MDS to take credit for TED hose? 	Stockings are included as "items of clothing." G1b Dressing is defined as "How the resident puts on, fastens, and takes off all items of clothing, including donning/removing a prosthesis. Dressing includes putting on and changing pajamas and housedresses." Extensive assistance coding in Self-Performance (3) includes "Full staff performance of activity (3 or more times) during part (but not all) of the last seven days." Page 3-98 of the RAI Manual illustrates this in the second scenario under Dressing: "Resident is totally independent in dressing herself except for donning and removing TED stockings. Nurse assistant applied the TED stockings each AM and removed them at bedtime." Correct coding is identified as G1gA = 3; G1gB = 2.
Section M Skin Condition	
How do you code diabetic foot ulcers? 	Diabetes itself is not a factor in coding ulcers in Section M Skin Condition. If the ulcer develops because of circulatory problems (venous or arterial) or pressure, it should be recorded in M1 Ulcers. If it is due to pressure or venous insufficiency, it would also be coded in M2 Type of Ulcer. If the ulcer did not qualify for these sections, it could be reported at M4c Open Lesions/sores which includes "…skin ulcers that developed as a result of diseases…" In addition, it would also be coded at M6c Open lesions on the foot.
Can skin prep be counted as a preventative measure?	Skin prep can be counted both at M5i Other preventative or protective skin care (other than to feet) and M6e Received preventative or protective foot care, depending on the location of the skin area being protected.
Section P1 Special Treatments and Procedures	
Does Ostomy care include PEG tube sites and suprapubic sites?	Yes. The definition for this item (RAI Manual p. 3-183) states "Includes both ostomies used for intake and excretion." An "ostomy" – a surgically formed artificial opening – must be created before a PEG tube or suprapubic catheter can be inserted. Only tracheostomies are excluded from P1af.
How do you code incentive spirometers on the MDS?	Pennsylvania regulation includes incentive spirometry within the definition of Respiratory Therapy. The RAI Manual states that P1bd Respiratory Therapy includes coughing, deep breathing, and assessing breath sounds. The time the qualified professional spends with the resident working with the incentive spirometer and assessing the results could be counted.

P4 Restraints

Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movements or normal access to one's body. This is a two phase definition: the resident can't easily remove it; and, it prevents her from doing something she wants to do and is able to do. If she could not perform the activity, e.g., get up and out of any chair, use of a recliner is not a restraint.

Questions were received about the use of bolsters, enablers (very short sections of rail usually placed in the middle of the side of the bed) and siderails themselves. The RAI Manual on page 3-198 states that the intent is to record the frequency with which the resident was restrained by any of the devices. If a bolster prevents the resident from doing what she wants to do, e.g., get out of bed, it is a restraint and it should be coded at P4b. If she can remove them or go over them, they are not a restraint. If the resident can get out of bed around the enabler, it is not a restraint and would only be coded at G6b. If the resident likes using the siderails for positioning, but must call for help to lower them so she can get out of bed, they are a restraint and would be coded at P4a/b, as appropriate, and G6b.



Scheduling Assessments

As an RNAC, you have the responsibility to complete MDS assessments following two very complex schedules. In addition, you are expected to do this efficiently and with an eye to enabling your facility to receive the highest reimbursement that is legitimately possible. An Admission assessment, as required by the OBRA regulations, must be completed by Day 14 (R2b/VB2). Medicare (MC) PPS assessments must be done with the Assessment Reference Date (ARD) set within a defined window. Setting the ARD outside of the assessment window will result in a period of default payment. Grace days may be used to maximize a RUG or for the convenience of the assessor in scheduling, but should not be used consistently, e.g., all 5-day assessments have an ARD of Day 8. (RAI Manual p.2-28)

If you are in a window for both a Medicare and an OBRA assessment, one assessment can meet both requirements. However, you must complete the MDS form that meets the most stringent requirement. An Admission, Annual or Significant Change OBRA assessment requires the full assessment with Triggers and RAPs; a Medicare PPS assessment requires the 3½-page MPAF form; a Quarterly OBRA assessment requires the 3-page RUG-III 1997 Update form.

When the resident first comes to your facility, usually the Admission assessment is completed with either the 5-day or 14-day Medicare assessment. Combining it with the 5-day may capture more events that happened prior to admission, e.g., IVs and IV medications. Combining with the 14-day assessment may capture more therapy days and minutes. The Medicare RUG system is detailed in Chapter 6 of the RAI Manual; the Medicaid RUG system is detailed in Chapter 6 of the Resident Data Reporting Manual.

The following tables indicate the windows that are available for Medicare PPS assessments with grace days designated with a 'G'. If you select a date that meets the requirement for both OBRA and MC PPS, only one assessment needs to be done. However, if it best meets facility and resident needs, they might all be done separately, e.g., MC 5-day ARD = Day 4; Admission ARD = Day 13; MC 14-day ARD = Day 19.

Day	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
MC	5 day					G	G	G			14 day			
OBRA	Adm.													VB2

Day	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**
MC	G	G	G	G	G		30 day							
OBRA														

Day	**29**	**30**	**31**	**32**	**33**	**34**	**35**	**36**	**37**	**38**	**39**	**40**	**41**	**42**
MC		G	G	G	G	G								
OBRA														

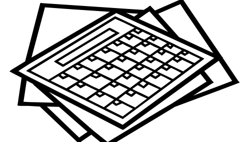
Day	**50**	**51**	**52**	**53**	**54**	**55**	**56**	**57**	**58**	**59**	**60**	**61**	**62**	**63**	**64**
MC	60 day										G	G	G	G	G
OBRA															

A quarterly assessment must be completed within 92 days of the R2b of the last OBRA assessment If the R2b of the OBRA Admission assessment was Day 14, Day 106 would be the latest date for the Quarterly R2b (14 + 92). There is no requirement to do it any sooner, but if a 90-day assessment is required (AA8b = 4), it could be combined with a quarterly (AA8a = 5) to decrease the work load. An MPAF form is the more stringent requirement when compared to the RUG-III quarterly, so that set of data would need to be completed.

Day	**80**	**81**	**82**	**83**	**84**	**85**	**86**	**87**	**88**	**89**	**90**	**91**	**92**	**93**	**94**
MC	90 day										G	G	G	G	G
OBRA	Qtly														

This review assumes that all progresses neatly for the resident. Some situations may intervene which require additional or different assessments.

(Continued on page 4)



Scheduling Assessments (continued)

(Continued from page 3)

- A long term resident of your facility is hospitalized and returns in a MC Part A stay. Unless the resident has undergone a Significant Change or a regularly scheduled OBRA assessment is due, only MC PPS assessments are required. No Admission assessment should be done unless the resident had been discharged Return not anticipated (AA8a = 6). If an OBRA assessment was due while the resident was in the hospital, the facility has up to 14 days after the resident's readmission to complete the assessment.
- The resident in a MC Part A stay must return to the hospital. On her return, a Readmission/Return assessment (AA8b = 5) is required followed by a 14-day, 30-day, etc. using the same intervals/grace days but counting from the day of readmission.
- The resident undergoes a Significant Change in condition. You have 14 days after the significant change is identified to complete (VB2) the assessment; hopefully the ARD can be set to coincide with a MC PPS assessment window. This assessment would reset the clock for completion of the quarterly.
- All skilled therapies end but the resident continues in a Medicare Part A stay due to skilled nursing needs. An OMRA assessment (AA8b = 8) must be performed within 8 – 10 days of the last day of skilled therapy; the first day with no therapy = Day 1 for scheduling purposes. If this ARD falls within the window for a MC PPS assessment, it will replace it; otherwise, the regular schedule must be followed.

P8 Physician Orders

The MDS item Physician Orders is an ongoing source of confusion. The definition states "To record the number of days during the last 14-day period (or since admission, if less than 14 days ago) in which a physician has changed the resident's orders. In some cases the frequency of physician's order changes is indicative of clinical complexity." The RAI Manual lists several types of orders that cannot be counted. In addition, there may be services provided to the resident that are initiated based on nursing assessment and standards of practice that do not require a physician order, e.g., Nursing restorative activities.

Recently, the question was asked "Do you count orders for skin prep, sween, iodines, betadines and other protocol items?" UMR teams had also been asking for clarification on items such as siderails, "enablers", wanderguards, bed and chair alarms, mats to the floor, certain skin care, such as house lotion, Eucerin cream, I and O, daily weights, "check q 15 minutes", etc. Were orders for such items to be counted as a day of order change? Must there be a physician order to use these items, or could they be initiated by the nursing staff?

These issues were submitted to the State RAI Coordinators workgroup. They responded, "When a physician or physician extender, as identified in the RAI manual, writes an order for a new medication or treatment, or changes an order for a medication or treatment for whatever condition, they can be counted on the MDS under physician order changes." It's possible that the facility also might initiate the same treatment without a physician order, but the facility should have policies and procedures approved by the medical director in place for this care, and it must be within the limitations of the state Nurse Practice Act.

7-Day Submission Requirement

For facilities participating in the MA program, it is very important to submit the first assessment completed for a resident within 7 days of completion (See RAI Spotlight Volume 1 Issue 3). The **only** assessments identified as "first assessments" are:

- an Admission/MC 5 day (AA8a = 1, AA8b = 1);
- MC 5-day (AA8a = 0, AA8b = 1); and
- a Discharge prior to completion of the initial assessment (AA8a = 8).

All other assessments fall under the federal requirement to be submitted within 31 days of completion.