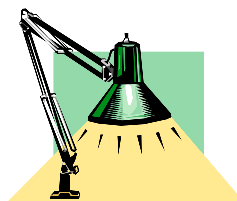
RAI Spotlight



DEPARTMENT OF HEALTH

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P1b/T1b-d Therapy Clarification

On May 7, 2008, CMS published the Proposed Rule for the Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2009. Though the Final Rule will not be published until approximately August 1, CMS used this opportunity to further clarify some MDS completion issues. While this is presented as standards that must be met in order to ensure Medicare payment, it also establishes a standard for MDS completion.

Supporting the RAI Manual instructions on pages 3-185 and 3-215, the proposed rule states:

"For Medicare to cover rehabilitation services in a SNF, the services must be directly and specifically related to an active written treatment plan that is developed before the start of rehabilitation services. The plan must be based upon an initial evaluation performed by a qualified therapist (after SNF admission and before the start of rehabilitation services in the SNF) and must be approved by the physician after any needed consultation with the qualified therapist. This means that the evaluation must have been performed for each discipline and the plan of treatment developed in order to include minutes for each discipline under Section P ("Special Treatments and Procedures") of the Resident Assessment Instrument, and also to project minutes under Section T ("Therapy Supplement for Medicare PPS") of the Resident Assessment Instrument….In those cases where a beneficiary is discharged during the SNF stay and later readmitted, an initial evaluation must be performed upon re-admission to the SNF, prior to the start of rehabilitation services in the SNF."

Time for the initial evaluation, whether on Admission or Readmission, cannot be reported on the MDS.

Questions about the RAI?

Please submit them to

qa-mds@state.pa.us

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MDS Submission Teleconference

Date: July 10, 2008
Time: 1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)
Topic: MDS Submission Accuracy
Handouts: Power Point slides will be available about July 1 on the DOH Message Board at
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: 45507899

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: qa-mds@state.pa.us

Restorative Nursing

On April 10, 2008, a training teleconference was provided on Restorative Nursing. The following questions were received

Q. Often, residents who have been discharged from the Restorative Care program will continue to attend the group. Can this still be counted as a Restorative Care program for those residents who are scheduled to participate?

A. *The fifth criteria listed for a Rehabilitation/Restorative Care program on page 3-192 states "This category does not include groups with more than four residents per supervising helper or caregiver." If Residents #5 and #6 join the group, this group is no longer meeting the criteria for a Rehabilitation/Restorative Care program for the four scheduled residents. You will need alternative plans for the other two residents, e.g., another activity, another staff member to maintain the 4:1 ratio, a closed door, etc.*

Q. Is clamping a catheter part of Bladder Retraining?

A. *Page 3-124 says H3b Bladder Retraining Program is "A retraining program where the resident is taught to consciously delay urinating (voiding) or resist the urgency to void. Residents are encouraged to void on a schedule rather than according to their urge to void." It seems that this would be a program after the catheter was removed when the resident is again controlling the voiding process. Clamping might be used to try to increase bladder size after a long period of catheter use, but it does not seem to be part of "bladder retraining" as it is defined for the MDS .*

Q. On page 3-192 of the RAI Manual, it states that various Nursing Rehabilitation/Restorative Care activities may be "...provided by any staff member or volunteer under the supervision of a licensed nurse." What are the legal requirements for volunteers if they are not family members?

A. *The RAI Coordinators Panel responded to this question as follows:*

- *"This is a nursing delegation function and the volunteers would need to be trained.*
- *The delegation would come under the license of the nurse providing supervision,.*
- *The nurse would need to document that the volunteer is competent to complete the delegated function.*
- *Nursing would still be responsible to set it up, monitor, and evaluate to assure the program is appropriate for the resident, and ensure it is implemented in the correct and safe manner.*
- *Due to privacy issues, the facility would need to be very careful regarding the type of information about each resident that would be shared with the volunteer.*
- *Certain restorative programs like exercise groups and make-up application lend themselves well to volunteer participation, but clearly these must be specific to the needs of the resident(s) involved.*
- *This has some state specific implications in that you must check your own state rules and regulations governing the use of volunteers in nursing homes."*

  a. 42 CFR § 483.13(b) ***Abuse****: The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.* ***Intent:*** *Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or* ***volunteers****, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. (F223)*

  b. In addition, if the volunteer is in the facility on a routine basis such as every day, the volunteer should have the prerequisites of a staff person, e.g., criminal background check, TB testing, etc.

  (PA Departmentt of Health)

QI/QM Update

Since the QI/QM teleconference was presented in January, CMS has announced a change in the use of Admission assessments in the calculations. For the Prevalence QIs (one time events, e.g., QI/QM 1.2 Prevalence of Falls), an Admission assessment is never used as the Target assessment, and this has not changed. Events such as pressure ulcers or use of 9+ medications that are present on Admission are not a measure of the NF's quality of care.

For the Incidence (comparison) QI/QMs, the Admission assessment may be used as the Prior assessment to evaluate the resident's progress in the facility, e.g., the Quarterly may be the Target assessment and the Admission assessment designated as the Prior assessment to identify resident changes that occur while she is in the NF's care. The fact that she had no pressure ulcer on Admission but now has an ulcer reported on the Quarterly is a potential indicator of the NF's quality of care.

Buried in lines of programming code was a situation where the Admission assessment could be the Target assessment if the resident had been in the NF in the previous six months. New events reported in the Admission assessment that were

(Continued on page 4)

Restorative Nursing and RUG Classification

In both the MA and Medicare RUG classification systems used in Pennsylvania, only two Restorative Care activities are required to place the resident in a higher category, but the systems differ significantly in the way these are identified. An 'X' in the table below indicates that the item may be counted individually. In some situations, only one of a pair of items may be counted. In the MA system, possible countable items for the final end split vary with the assigned RUG. "Other" refers to classification into the Impaired Cognition, Behavior Problems and Reduced Physical Function categories.

<table>
<tr><th colspan="2"></th><th colspan="3">Medicare PPS RUG v. 5.20</th><th colspan="3">Medical Assistance RUG v. 5.01</th></tr>
<tr><th colspan="2">MDS Item</th><th>Code</th><th>RLA/RLB</th><th>Other</th><th>Code</th><th>RLA/RLB</th><th>Other</th></tr>
<tr><td>H3a</td><td>Scheduled toileting plan</td><td>√</td><td colspan="2" rowspan="2">Only one may be counted</td><td>√</td><td>Not used</td><td>X</td></tr>
<tr><td>H3b</td><td>Bladder retraining</td><td>√</td><td colspan="3">Never used in v. 5.01</td></tr>
<tr><td>P1a</td><td>ROM (P)</td><td>6</td><td colspan="2" rowspan="2">Only one may be counted</td><td>5</td><td>X</td><td>X</td></tr>
<tr><td>P1b</td><td>ROM (A)</td><td>6</td><td>5</td><td>X</td><td>X</td></tr>
<tr><td>P1c</td><td>Splint/brace assistance</td><td>6</td><td>X</td><td>X</td><td>5</td><td>X</td><td>X</td></tr>
<tr><td>P1d</td><td>Bed mobility</td><td>6</td><td colspan="2" rowspan="2">Only one may be counted</td><td>5</td><td colspan="2" rowspan="2">Only one may be counted</td></tr>
<tr><td>P1f</td><td>Walking</td><td>6</td><td>5</td></tr>
<tr><td>P1e</td><td>Transfer</td><td>6</td><td>X</td><td>X</td><td>5</td><td>X</td><td>X</td></tr>
<tr><td>P1g</td><td>Dressing/ grooming</td><td>6</td><td>X</td><td>X</td><td>5</td><td>X</td><td>X</td></tr>
<tr><td>P1h</td><td>Eating/ swallowing</td><td>6</td><td>X</td><td>X</td><td>5</td><td>X</td><td>X</td></tr>
<tr><td>P1i</td><td>Amputation/ prosthesis care</td><td>6</td><td>X</td><td>X</td><td>5</td><td>X</td><td>X</td></tr>
<tr><td>P1j</td><td>Communication</td><td>6</td><td>X</td><td>X</td><td colspan="3">Never used in v. 5.01</td></tr>
</table>

In the Medicare system, there are several situations where only one of a pair of items may be counted. For example, if H3a and H3b were checked and six days were reported for ROM (P), ROM (A), Bed Mobility and Walking, only three Restorative Nursing activities would be counted for any classification group despite the fact that six items seem to qualify.

In the Medical Assistance system, with H3a and H3b checked and five days reported for each of the four P3 items mentioned above:

- For RLA/RLB classification, the count would be three activities: ROM(A), ROM (P), and one counted from the Bed Mobility/Walking pair.
- For classification in the Other groups, the count would be four activities: H3a Any scheduled toileting plan, ROM (A), ROM(P), and one counted from the Bed Mobility/Walking pair.

The full explanation of the Medicare PPS RUG classification may be found in Chapter 6 of the RAI Manual (www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp). For the Medical Assistance RUG classification, refer to Chapter 6 of the Resident Data Reporting Manual (www.dpw.state.pa.us/omap/provinf/ltc/case_mix_manual_LTC.pdf).

New Manual

A revised version of the Resident Data Reporting Manual was released March 1, 2008 at www.dpw.state.pa.us/omap/provinf/ltc/case_mix_manual_LTC.pdf . The Documentation Guidelines in Chapter 10 were updated to include the January 2008 RAI Manual changes, as well as a web site change.

M5c Turning/Repositioning Program

A new DAVE 2 MDS Tip Sheet on M5c Turning/Repositioning Program has been released. It is incorporated with the other four Tip Sheets into a single .zip file which may be found at www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp. The sheet includes the following information, as well as Coding Examples:

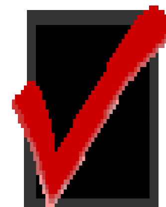
Definition	Item M5c asks you to indicate whether there has been a continuous, consistent program for changing the resident's position and realigning the body during the 7-day look back period.
Clarifications	Program – means a specific approach that is *organized, planned, documented, monitored and evaluated.*
Coding Tips	Simply using a standard turning schedule whereby residents are turned every two hours does not constitute a turning/repositioning program that would allow you to code Item M5c. Consider the following when evaluating whether a turning/repositioning program may be coded at M5c: • The turning/repositioning plan/program is specific as to the approaches for changing the resident's position and realigning the body. This plan/program is organized and planned. • Progress notes, assessments, or other documentation (as dictated by facility policy) supports that the turning/repositioning plan/program is monitored and evaluated over time to determine the effectiveness of this intervention. The frequency with which position changes are performed must be based on the individualized assessment of the resident.

On May 22, a new Tip Sheet dealing with H3a Any Scheduled Toileting Plan was released. This can be accessed at www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS20ToiletingTipSheet.pdf.

MA for MA Case-Mix

The present data specifications for MA for MA Case-Mix require that if S1a MA Number is filled out, AA5a SSN must not be blank. There are residents in nursing facilities who have received a PA/FS 162 and have an MA number but because of alien status, cannot obtain SSNs. Software will not allow submission of records indicating they are MA for MA Case-Mix.

After consultation with the Office of Income Maintenance policy staff, the Bureau of Provider Support, Office of Long Term Living, has stated that any resident who has obtained an MA number but is unable to obtain an SSN shall be considered non-MA for purposes of constructing the CMI Report. These residents should appear on the non-MA section of the report.



QI/QM Update

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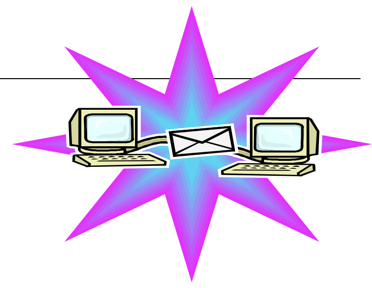
not present on the MDS from the previous stay would then appear on the QI/QM report and count as part of the NF's percentages/flags. The most common situation occurred when a resident had been discharged in the past six months but then returned for care after suffering a hip fracture. She would be included in the counts for QI/QM 1.1 Incidence of New Fractures. The NF certainly was not responsible in any way for this fracture!

The programming has been rewritten so that for the Chronic Care Incidence QI/QMs, an Admission assessment can never be the Target assessment; this new fracture will never be included in the NF's percentages/flags. Historical data was also updated, so numbers might change if an old QI/QM Report is rerun. Other QI/QMs affected by this programming change are 2.1 Residents who have become more depressed or anxious; 4.1 Incidence of cognitive impairment; 9.1 Residents whose need for help with daily activities has increased; 9.3 Residents whose ability to move in and around their room got worse; 9.4 Incidence of decline in ROM.

The QI/QM Manual, which can be found at www.qtso.com/mdsdownload.html, has been updated to reflect this change in programming.



Broadband Connectivity Reminder

ARE YOU READY?
CMS has determined that transmission of MDS and OASIS records to the state data base can occur securely over broadband lines through an IP-Sec connection into CMS' Medicare Data Communication Network (MDCN). This new process not only ensures that beneficiary information remains safe and secure, but also reduces the connectivity costs. In July 2007, Pennsylvania providers began migrating to this new process with a deadline set for January, 2008. This deadline has been extended, but in the near future this extension will end and submissions via the old process will no longer be allowed.

HAVE YOU DONE THIS?
Each provider is being required to obtain connectivity to the MDCN via an Internet Service Provider (ISP). AT&T's Global Network Client, version 7.2.1 must be downloaded and installed to make it possible for providers to connect, submit assessments and retrieve reports. This software and much additional information is available at www.qtso.com/mdcn.html .

HOW DO I KNOW?
If you are unsure whether you are using this new process, go to the front screen of the AT&T Global Network Client; this screen contains the Connect button. Below the button, there is a line labeled Connection Sequence. Expand that section by clicking on the down arrow on the right side of the line to identify the Connection Type. If the Connection Type is Broadband, the new connection process has already been completed by someone in your facility. If the Type is something other than Broadband, you must migrate to the new process.

WHEN IS THE BROADBAND CONNECTION DEADLINE?
There have been technical issues that prevented some providers from implementing this new process by the original January 2008 deadline. CMS is working with AT&T to identify solutions. Once this is done, the MDCN direct dial-up (non-ISP) connection termination date will be set and providers will be required to use the broadband connection after that date. It is not known how much warning CMS will give before this termination date. Waivers will only be issued where there is no ISP available to the provider. Make the transition now, and avoid the upset of being unable to submit assessments until you can get the proper software installed and working! Contact the MDCN Help Desk at 1-800-905-2069 if you have problems.

Initial Record Submission

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