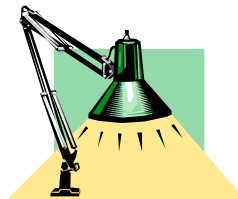


# RAI Spotlight



DEPARTMENT OF  
**HEALTH**

## RAI Manual Update



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On August 1, 2008, CMS released the latest RAI Manual Updates at [www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS20Update200807.pdf](http://www.cms.hhs.gov/NursingHomeQualityInits/Downloads/MDS20Update200807.pdf). These updates cover a variety of topics: clinical situations, Medicare PPS billing due to new regulation (see Billing the Default Category for Medicare PPS on page 2), technical issues and updates to contact personnel in the appendices. This article highlights some important changes, but all NACs needs to review the complete Manual Update documentation and assure that their copy of the RAI Manual is up-to-date so that the latest standards will be met.

whether or not the resident's condition requires a new assessment, CMS encourages facilities to complete an SCSA due to the importance of ensuring that a coordinated plan of care between the hospice and nursing facility is put into place." This seems to indicate that the shift in focus to recognize that the resident has six or fewer months to live, and will be receiving care from a specialized hospice service as well as the usual facility care, is probably enough to trigger a Significant Change assessment.

### Questions about the RAI?

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

#### Significant Change Assessments (page 2-11):

CMS deleted the second sentence of the second paragraph and inserted the following: "While the need to complete an SCSA will depend upon the resident's status at the time of election of hospice care, and



#### Activities of Daily Living: G1hA Eating Self-Performance (page 3-81):

For Eating, selecting the proper Self-Performance code for very dependant residents has always been challenging. The third bullet for this item has been shortened to say "To code Item G1hA = 8 [Activity Did Not Occur], consider if in the past 7 days



*(Continued on page 3)*

## Section P4 Restraints Teleconference

**Date:** October 9, 2008  
**Time:** 1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)  
**Topic:** P4 Devices and Restraints  
**Handouts:** Power Point slides will be available about October 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:** 59082670

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



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## MDS Submission Accuracy Q & A

On July 10, 2008, a training teleconference was provided on MDS Submission Accuracy. Only one question was received: Does Pennsylvania require that nursing facilities complete a Discharge Return not Anticipated (AA8a = 6) if the resident has been previously discharged Return Anticipated (AA8a = 7) and will not be returning?

This is a requirement only for Pennsylvania facilities who participate in the MA program. The following information is taken from the Resident Data Reporting Manual page 7-5: “Residents for whom a Discharge return anticipated (AA8a = 07) is the last record effective for the Picture Date will appear in the non-MA section of the CMI Report. However, the nursing facility may have knowledge that the resident will not be returning to the facility. For example, this situation could occur when the resident was discharged to the hospital with an anticipated return, but the resident dies or is admitted to another nursing facility from the hospital. Without further action by the facility, the resident will incorrectly appear in the non-MA section of the CMI Report.

Corrective activity: Electronically submit a Discharge Tracking form completed as follows:

AA8a = 06 (Discharge return not anticipated)  
 R3 Discharge Status = 9 (Other)  
 R4 Discharge Date = [Discharge date from the previous Discharge return anticipated Tracking form]

## Billing the Default Category for Medicare PPS

CMS released two regulations recently, one being the Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2009 Proposed Rule (May 7, 2008) and the Final Rule on August 8, 2008. Both are available at [www.gpoaccess.gov/fr/browse.html](http://www.gpoaccess.gov/fr/browse.html). They used this opportunity to clarify the situations in which a SNF may bill the Default category (AAA, BC1).

For SNF PPS, the provider is required to submit resident assessment data according to an assessment schedule. When the resident assessment is prepared timely, the provider should bill the RUG payment group that is assigned to the assessment. When the SNF fails to comply with the assessment schedule, it must file a late assessment in order to be paid. In this situation, CMS pays a “default rate,” a reduced payment rather than the full SNF PPS rate that would have been paid if there was a timely assessment.

There are a few limited circumstances in which the SNF may receive the default payment even though an assessment

After completing this “second” discharge record, submit the record to the CMS MDS 2.0 Data Collection System, and return at a later time to view and print your revised CMI Report.

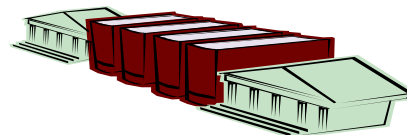
If the MDS software used by the NF will not allow the creation of a second discharge record for a resident without first submitting a Reentry record, complete a Reentry Tracking Form prior to completing the “second” discharge record.

Corrective activity: Electronically submit a Reentry Tracking form completed as follows:

AA8a = 09 (Reentry)  
 A4a Date of Reentry = [Discharge date from the previous Discharge return anticipated Tracking form]  
 A4b Admitted from (at reentry) = 8 (other)  
 A6 Medical Record No. = [Resident’s medical record number]

After completing this reentry record, submit the record to the CMS MDS 2.0 Data Collection System before, and in a separate batch from, the Discharge return not anticipated Tracking form.

The NF may still bill for the days of bedhold even though, in this limited Picture Date situation, the resident appears to have been permanently discharged before bedhold days expired.”



was not done:

- When the stay is less than 8 days within the spell of illness;
- When the SNF is notified on an untimely basis or is unaware of a Medicare Secondary Payer denial;
- When the SNF is notified on an untimely basis of the revocation of a payment ban;
- When the beneficiary requests a demand bill; or
- When the SNF is notified on an untimely basis or is unaware of a beneficiary’s disenrollment from a Medicare Advantage plan.

In circumstances other than these, no payment is available to the SNF when the SNF fails to assess the resident. Assessments cannot be completed retroactively: “SNFs are not permitted to backdate any portion of the medical record, including the resident assessment.” Further discussion can be found on pages 46432—46434 of the Final Regulation.

## RAI Manual Update



(Continued from page 1)

the resident truly did not receive any nourishment.” This probably should be coded rarely, and then only for a resident who may be near death.

Under the last bullet, the following has been added: “To code a resident as a “4” (Total Dependence) in G1hA, the resident would have to be totally dependent in eating, drinking and be non-participatory in the TPN, IV or tube feeding administration. If the resident participated in the act of drinking and/or eating and was totally dependent in the TPN, IV or tube feeding, the facility must evaluate all of the methods that food and fluids are being provided to the resident to determine the resident’s level of self-performance.” A resident who was able to feed herself at least part of her meals but was totally dependant for tube feeding administration may not be coded a “4”; the proper coding would be a “3” since she participated but required “Full staff performance during part (but not all) of the last 7 days.”

### R2b Signature of RN Assessment Coordinator (page 3-212):

CMS continues to be concerned that assessments not be created retroactively. Under Clarifications, a bullet was added stating “The term “backdating” means to give or assign a date to a document that is earlier than the actual date.” The recent regulations state very specifically that “SNFs are not permitted to backdate any portion of the medical record, including the resident assessment.” ( MC PPS Final Rule 8/8/08 [www.access.gpo.gov/su\\_docs/fedreg/a080808c.html](http://www.access.gpo.gov/su_docs/fedreg/a080808c.html) page 46432)

Under the Coding section, three sentences were deleted and new wordage inserted so it reads as follows: “Federal regulation requires the RN Assessment Coordinator to sign and thereby certify that the assessment is complete. Use the actual date that the MDS was completed, reviewed and signed as complete by the RN Assessment Coordinator. This date will generally be later than the date(s) at AA9 which documents when portions of the assessment information were completed by assessment team members.”

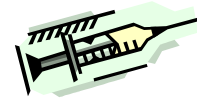
### T1b Ordered Therapies (page 3-216):

In the RAI Spotlight of May 2008, the lead article discussed the regulatory clarification concerning the need for physician orders and therapy evaluation before days/minutes could be entered at P1b and T1b-d. Under Process in the RAI Manual, the last sentence of the first paragraph was deleted and the following inserted: “Skip to Item T3 if the therapy evaluation is not completed, or the evaluation is completed but no treatment is scheduled.”



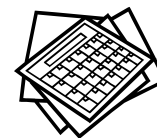
### W2 Influenza Vaccine (pages 3-240 and 3-241):

The first sentence under Process was deleted and replaced with the following: “Review the resident’s medical record and interview the resident or responsible party/legal guardian to determine Influenza vaccination status during this year’s flu season. The current influenza (flu) season begins when this season’s flu vaccine is made available to the public.” This allows the facility to record vaccinations given in September when the MDS documentation period begins on October 1.



### RAI Manual Section 2.5 The SNF Medicare Prospective Payment System Assessment Schedule and Section 2.6 Types of MDS Medicare Assessments for SNFs (pages 2-27 through 2-31):

Several small changes were made to clarify that MC PPS assessments authorize payment for variable periods **only** “as long as the resident remains eligible for Part A SNF-level services.” For example, the 14-day assessment may authorize payment for days 15 through 30 of the stay, but if the resident no longer is eligible for services as of Day 21, no payment will be made.



### RAI Manual Section 2.9 Factors Impacting the SNF Medicare Assessment Schedule (pages 2-37 through 2-40):

Several extensive deletions and insertions have been made in an effort to clarify the use of the default payment code. In summary, if the resident is in a MC PPS stay but is in the facility less than eight days total, the facility may either complete an assessment as completely as possible or bill the default code. “However, if the covered stay upon admission/readmission exceeds 8 days within the same benefit period the SNF shall not bill the default rate code but shall complete a Medicare assessment to be paid. In these situations, if no Medicare assessment is completed, no payment will be made.”



The facility may still complete a late assessment and receive partial payment, e.g., complete a 5-day assessment with an ARD of Day 10 to cover days 1 – 14 of the stay. “If the ARD on the late assessment is set prior to the end of the payment period for the Medicare-required assessment that was missed, the SNF will bill all covered days up to the ARD at the default rate and on and after the ARD at the HIPPS rate code established by the late assessment.”