

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

Number	Section/Topic	Question	Response	Forum Call Date
1.		<p>My question concerns finger punctures and the recording of glucometer readings to monitor blood sugar levels in diabetics. Our staff is doing this for some of our residents multiple times per day, but we can't get credit for their time and expertise on the MDS. I have asked this same question of our Case-Mix nurses for many years, but have never gotten an answer.</p> <p>How can this be addressed?</p>	<p>Payment items cannot be changed at this time. We will keep these requests on file in case the payment system is opened up for changes.</p>	6/7/12
2.		<p>One area that is time consuming for staff and is not a payment item is assisting residents with toileting due to incontinence of bowel and bladder. Ten years ago this was not an issue as most all our elderly residents were continent. Now that resident acuity is much higher by the time they come into residential care, this is much more of an issue that requires assistance and increased pericare, particularly in residents with some dementia.</p>	<p>Assistance with toileting due to incontinence can be captured at G1fa, Toileting, and assistance with peri-care can be captured at G1ga, Hygiene. The ADLs are an important part of the Case Mix and payment can be maximized by teaching staff what each ADL consists of and how to accurately code them.</p>	6/7/12
3.		<p>Does the facility have to complete an MDS/RCA for a respite resident (Medicaid) who will only be in the facility for 3 days? 1 week? 2weeks?</p>	<p>PNMI Regulations state that a "Resident shall be assessed within 30 days of admission. . ." If the Resident is discharged/deceased prior to completion of the RCA, maintain a paper copy of the Sections already completed with the resident's record and write a narrative note explaining that the resident was discharged/deceased prior to completion. At the very least, a Discharge Tracking form must be completed and submitted with the Basic Tracking Form</p>	6/7/12

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

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4.		If MaineCare is pending for a resident at the time of the admission assessment, mark the admission assessment as private pay.	If MaineCare is okayed back to admission, modify the admission assessment and correct the payment source to MaineCare.	6/7/12
5.		If a resident has different ADL values on different days	Can code the lower one but not the higher one unless the higher one happens 3 or more times.	6/7/12
6.		Is there a listing of RUG groups with case mix values?	There is a handout on the web site. We will send it with the minutes to this meeting.	6/7/12
7.		Residents don't get to see doctors very often. They don't have paperwork.	Can create problem list and have physician sign it. See section I1 in the manual. Code behaviors under E1. Send Maine Classification variables with minutes.	6/7/12
8.		If resident is not in the facility when an assessment is due how is this handled?	A note should be placed in the record as to why the assessment was not completed. Once the resident returns the assessment will need to be completed.	6/6/13
9.	A	If resident is in the Hospital at due date for assessment, when should the assessment be done?	An assessment cannot be completed on a resident who is not in the facility. A notation in the resident's record should be entered to describe why the assessment is late and the plan for completing the assessment upon return to the facility if return is expected. A minimum of 7 days is needed to capture ADL coding documentation. Example: Upon return, the facility may wish to evaluate the resident's status for up to 14 days in case the MDS/RCA should be a significant change.	6/7/12

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

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10.	A	What is considered as a “significant change in condition” and what would be a reason for a new assessment?	A6 of the Training Manual for MDS-RCA identifies a significant change in status assessment as: "A comprehensive reassessment prompted by a ‘major change’ that is not self-limiting, that impacts more than one area of the resident's clinical status, and requires review or revision of the service plan." Additionally, the manual states: "A Significant Change assessment is warranted if there is a consistent pattern of changes with two or more areas of decline or improvement (e.g., 2 areas of ADL improvement or decline). If the resident's condition requires review and change in the Service Plan, a Significant Change assessment is indicated. "	6/7/12
11.	A	Regarding dates of assessments. If a resident is admitted as a private pay resident and three months later becomes a Mainecare resident, does the semi-annual and annual date change to reflect the Mainecare date or remain as the admission date?	Change in payment is not an indication for a change in dates of assessments.	6/7/12
12.	A	Should the assessment reference date be the date of admission or 30 days after admission?	The admission assessment ARD can be chosen by the facility. I must be within the 30 day time frame.	6/7/12

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

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13.	AB	<p>Section AB 9-Mental health Hx Are Dx of Depression or Anxiety considered as Mental Illness?</p>	<p>AB-9 (Not AB8)</p> <p>The intent is to code a "...primary or secondary diagnosis of psychiatric illness..." Depression and anxiety usually do not rise to the level of a psychiatric diagnosis.</p> <p>The definition of mental illness in the manual states: "schizophrenic, mood or paranoid, panic or other severe anxiety disorder; somatoform disorder, personality disorder; other psychotic disorder; or another mental disorder that may lead to chronic disability."</p> <p>The diagnosis must be supported by physician documentation</p> <p>The physician must clearly define the level of disease.</p> <p>See intent and process under AB9 in the manual.</p>	6/7/12

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

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14.	ADLs	To code 4 on ADL's it must be coded 4 all across the 7 days. If there is even one 3 then it cannot be coded 4 anymore. The question is as on the flowsheet how do you code if there are some 8's. The activity did not occur on a couple of shifts but every time it did it was a total assist. How would this be coded particularly in regards to transfers and locomotion.	If there are no shifts lacking documentation (i.e. "blank spots"), you should code it as total assist (4), because even though it did not occur at least 3 times, "4" is the level that was needed the times that it DID occur. If there is even one "blank spot," you should talk with the staff member that worked that shift to find out what level of assist was needed, and write a clarification note. You would then have to code the RCA based on the clarification (i.e. if the clarification is also "4," then code "4" on the RCA. Code to the highest according to the clarification. If clarification is independent, supervised, or limited, code RVA for that level. If clarification is extensive, code extensive (2-"4" and 1-"3" is 3X of weight bearing). If you do not obtain clarification from the staff member, then you must code the RCA "0" (independent), because you will not have documentation to support a higher level of need. You can only code "8" if "8" is documented as occurring every shift on the flowsheet.	3/7/13
15.	Admission and quarterly assessments	Assessments are due every 180 days. Can we do the assessments earlier than 180 days?	They can be done early but not late. A couple of weeks early is perfectly acceptable. It is not acceptable to complete MDS-RCA assessments early solely to obtain higher payment.	9/12/13
16.	B	If a resident is checked as severely impaired-what type of documentation is needed, by whom, and where does it need to be documented?	Documentation needs to be within the ARD time e (7 days) or the facility needs to explain what they mean by severely impaired. It is always best to use the language of the MDS-RCA. Check off flow sheets within the seven day lookback would be acceptable.	12/6/12

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

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17.	Coding	<p>My question is in regards to a private pay resident who recently came to us. The resident started paying for the unit on 4/6/21/13 and was expected to be admitted and move in on that date. The resident was hospitalized in the early morning hours of 4/6/2013 and went to rehab several days later. The resident was discharged from rehab and admitted to us on 4/30/2013. On 5/8/2013, 8 days later, the resident was sent back to rehab because the resident had declined and needed more rehab. 5/23/13 the resident was again discharged from rehab and returned.</p> <p>Regulations require the MDS/RCA to be completed within 30 days of admission. Would the MDS/RCA need to be completed by 5/30/2013 even though the resident has only been in the facility 15 days?</p>	<p>If the resident was discharged unable to complete the admission on the 8th. Then an admission assessment could have been completed with the date of 5/30/13 otherwise yes you will need to complete an admission assessment by 5/30/13.</p>	6/6/13
18.	Corrections	How do facilities fix corrections	<p>Manual page 101 discusses the correction procedure if the facility finds an error. If a correction is made then the QA Nurse must look at the corrected MDS while doing the review.</p> <p>The facility needs to include a correction request form to make any correction. If a Casemix RN finds an error then must do a full reassessment with a new assessment reference date.</p>	9/6/12

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

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19.	Diagnosis	If a resident has a diagnosis at time of admission does the physician have to sign off on the diagnosis prior to every assessment.	<p>No, however the physician should be consulted at least annually regarding any diagnosis and should indicate if it is still current.</p> <p>Page 64 of the manual states: To document diagnoses that have a relationship to the resident’s current ADL status, cognitive status, mood or behavior status, medical treatments, monitoring, or risk of death. In general, these are conditions that drive the current service plan. Do not include conditions that have been resolved or no longer affect the resident’s functioning or service plan.</p>	9/6/12
20.	Discharges	When is a Discharge Tracking Form completed? Examples included with the question were: After the Goold Assessment, after the 30 days of bed hold, or after the therapy ends in the SNF?	Complete and submit a Discharge Tracking Form when a resident is discharged with no anticipation of return to your facility. Code the appropriate status of either “discharged” or “discharged prior to completing the assessment” if the assessment was unable to be finished. Complete within 7 days of the discharge date and submit within 30 days of the completion date.	9/12/13
21.	Discharges	It a resident is on SNF and the 30 days of LOA has expired do we have to submit a discharge tracking Form>	No. It is the facility’s decision to determine when the resident is not coming back. Many facilities hold a room for more than 30 days. It is the facility’s decision.	9/12/13
22.	E	Is actual repetitive complaints of pain coded at E1h? (repetitive health complaints) Cause is known and it is valid pain.	Yes repetitive complaints of pain would be considered as repetitive health complaints. The RCA manual states code regardless of what you believe the cause to be.	3/7/13

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

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23.	E	E7: Does the resident have to have a physician documented mental health diagnosis to code “yes” or “no” about the resident’s “insight about his/her mental problem” or should it be answered for any resident coded for mood/behavior items in Section E?	<p>No physician diagnosis of mental illness is needed to code “yes” or “no” to this question.</p> <p>The RCA manual states, “Intent: To assess the extent of the resident’s understanding of their condition and ability to assimilate information regarding that condition.” The RCA form states, “Resident has insight about his/her mental problem?”</p>	12/5/13

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

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24.	E1a-i	<p>I am emailing for some clarification on your requirements for documentation for section Ea-i. What we are confused about is when using nurses notes during the 30 days- are you still requiring statements in quotations during those 30 days? Or can we have nurses notes during those 30 days from other staff that don't write in specific statements in quotations and then we write the specific statements in quotations in the MDS note.</p> <p>For example a staff may write during the 30 days : Jane asked the same question all shift long. – But the staff didn't write what Jane said specifically. Even though we know what she asked, can we just write in the MDS note- Up to five days a week, Jane asked repetitive questions of "What am I doing?"</p>	<p>The manual states on pages 34-36 for coding E1a-r the following:</p> <p>“For each indicator apply one of the following codes based on interactions with and observations of the resident in the last 30 days. Remember; code regardless of what you believe the cause to be.</p> <ul style="list-style-type: none"> 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week (a minimum of 4 times per month). 2. Indicator of this type exhibited daily or almost daily (6 or 7 days each week).” <p>We will look for documentation to support the occurrence <u>and</u> the frequency of the indicators during the 30 day look back period for the MDS/RCA ARD. When narrative statements are intended to support this requirement (rather than flow sheets), they must be specific and site the source of the information or how the writer came to these conclusions. Remember that the payment is not higher for coding “2.”</p>	9/6/12

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

Number	Section/Topic	Question	Response	Forum Call Date
25.	F	Section F3 – Life Events History: Events in the past 2 years – it seems to me that placement in a facility should be placed at the top of the list. This is a major life event and stressor that has significant impact on the resident and family.	The form cannot be changed at this time. We will keep this request on file for future changes.	6/7/12
26.	G	In my 7 day window for ADL's, I have all 8's for the overnight shift, (3) 4's, a 2 and a 1 for the day shift and all 4's for the evening shift. I do not know what to code this as.....it is for locomotion....(Resident performance)	<p>The manual states the following:</p> <p>ADL SELF-PERFORMANCE Measures what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last 7 days according to a performance-based scale.</p> <p>Extensive Assistance – While the resident performed part of activity over last seven days, help of following type(s) was provided three or more times:</p> <ul style="list-style-type: none"> • Weight-bearing support provided three or more times. • Full staff performance of activity (three or more times) during part (but not all) of last seven days. <p>Total Dependence – Full staff performance of the activity during entire seven-day period. Complete non-participation by the resident in all aspects of the ADL definition.</p> <p>The code would be “3” Please see pages 48-52 of the MDS/RCA Manual</p>	9/6/12

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

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27.	G	<p>When a resident is getting into the facility car with Transporter to go to an appointment can we count the assist needed by the resident for the transfers and locomotion ?</p> <p>Does assist need to be in building or on the facility grounds or when resident is in the care of a staff member?</p> <p>Also can we count the assist the Activity Director gives out side of the facility at activities such as out to eat-out for ice cream?</p>	<p>The amount of assistance needed to get to the vehicle (locomotion) can be documented in the record for that one time. The same is true for the amount of assistance needed to transfer from a wheelchair to the vehicle can be documented in the record for that one time. Please see pages 47-48 in the Manual.</p>	9/6/12
28.	G	<p>We have several residents with hearing aids and staff put them in a.m. and takes them out in p.m. and way to capture that?</p>	<p>Dressing – “How the resident puts on, fastens, and takes off all items of <i>street clothing</i>, including donning/removing a prosthesis.” A hearing aide is a prosthesis. Please see page 44 in the Manual.</p>	9/6/12
29.	G	<p>I have a question about coding for dressing. I know that we can include hearing aides and ted stockings. But can we also include the leg strap that hold a cath bag in place?</p>	<p>Not for dressing. Would be coded as part of how the resident manages the catheter. Code under ADLs for toilet use and under section G (G1Fa) .</p>	12/6/12

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

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30.	G	According to the 7 day ADL flow sheet an activity was coded with an 8 and there were some blank boxes. How to code?	When staff have documented incorrectly on the ADL sheets, an interview with the staff within a reasonable time can be used to correct the erroneous documentation. The correction to documentation must be in the record with a statement how the correct information was confirmed. Correction of erroneous documentation must also be followed with staff training. The documentation must be very specific referring back to the dates that were in error or at the least the 7 day look back period. This note must be completed prior to submission of the MDS. This should be the exception to the rule and not be a pattern of repeated behavior. See Page 48 of the manual.	12/6/12
31.	G	I have a question about coding for dressing. I know that we can include hearing aides and ted stockings, but can we also include the leg strap that holds a catheter bag in place.	Not for dressing. Would be coded as part of how the resident manages the catheter. Code under ADLs for toilet use and under section G (G1Fa)	12/6/12
32.	G	A resident wore underwear in the past and now due to incontinence uses briefs. The resident does not remember that she uses briefs and staff has to check with her to see if she is wearing her briefs because when she does not see her underwear she wears nothing. How would that be tracked-supervision with dressing?	You would code Supervision for either dressing or toileting (or both), depending on <u>when</u> the assistance is being provided. You would also capture this at Item H3g (pads/brief used) and H4-#3 (Resident incontinent and receives assistance with managing supplies). Section H is a 14-day look-back period.	9/12/13

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

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33.	G	Please clarify-when a resident sits in a chair-say in the dinner room-needs to have chair pulled out for resident and then needs staff to bear weight to push resident in to table-is it assist with transfer or locomotion-if staff physically guides resident in to chair such as holding and guiding arm- is that transfer?	This does not qualify as locomotion or transfer. Page 44 of manual lists the definition of locomotion or transfer. Guiding a resident into a chair is limited transfer.	3/7/13
34.	G	G1da: If we are spoon feeding meds to someone because either they have been crushed and added to applesauce or something or if the resident's cognitive level is severe and they don't understand one step direction of swallowingcan the resident be coded a "4" for eating?	Medication administration is not considered eating. The resident must require full staff performance for eating for the WHOLE SHIFT to code a "4." In order to code a "4" on the MDS, the resident must require full staff performance for all shifts and every time the resident eats. Please review Section G or the Training Manual.	12/5/13

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

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35.	G	<p>If in a resident's Care Plan, under ADLs, under eating, there is a problem-potential for choking--goal- will not choke-approach-supervise at meal time-does that documentation qualify supervision for eating? Or does the resident have to have a specific diagnosis from a doctor in order to supervise at meal time?</p>	<p>Most facilities have an internal policy of "supervise dining room during meals." The RCA cannot be coded for supervision just because of a facility policy (i.e. it is an assessment of the resident not the facility). Per the RCA Manual, "Individualized service plans can be successfully developed only when the resident's self-performance has been accurately assessed. . ."</p> <p>There does not need to be a physician diagnosis, however there must be a reason for the supervision, such as history of choking, the resident doesn't remember to keep eating without cueing, due to dementia, etc.</p> <p>Documentation to support the resident's need for supervision is often found (appropriately) in the service plan, however, a physician's progress note, nurses' note or direct care staff note, OT or SLP evaluation, etc., may be used to support RCA coding.</p>	12/5/13
36.	G	<p>If a male resident has a catheter and staff-empties drainage bag, changes to leg bag for daytime and back in evening. Is this total with toileting as resident is not assisting at all?</p>	<p>No. All aspects of toileting must be considered when coding the RCA, so you must include the resident's self-performance level regarding bowel hygiene as well. Transfers on and off the toilet, commode or bedpan, peri-care and adjusting clothing, are all part of the toileting activity and should be included when staff are deciding what level of resident self-performance to document.</p>	12/5/13

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

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37.	M	Section M3-Foot problems Do services have to be performed by a Podiatrist or can it be coded if a staff member is observing resident's feet for issues on a regular basis?	Exams can be done by staff or by a podiatrist.	6/7/12
38.	M	Could you clarify the definition for a Stage one ulcer.	<p>The intent is to record the presence of ulcers of any state, on any part of the body, in the last 7 days. The definition of an ulcer is any lesion caused by pressure or decreased blood flow resulting in damage to underlying tissues.</p> <p>A Stage I ulcer is defined in the manual as "A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved." Please see page 78 in the Manual.</p> <p>A physician, physician extender or an RN are qualified to stage pressure ulcers. The qualified person must document the assessed cause that lead to the stage of the ulcer.</p>	9/6/12

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

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39.	M	Please comment on the following statement “you can basically code almost any wound as an ulcer, due to the wording on the MDS-RCA form and Manual, which state “regardless of cause.””	<p>In the RCA manual on pages 78 defines an ulcer as “ Any lesion caused by pressure or decreased blood flow resulting in damage to underlying tissues.”</p> <p>A referral will be made to licensing and regulatory services if there is a lack of documentation of assessment, notification of the physician, inclusion in the treatment plan and documentation of wound progression either improvement or decline.</p> <p>Section 7030.4 Penalty for falsification: The provider may be sanctioned whenever an individual willfully and knowingly certifies(or causes another individual to certify) a material and false statement in a resident assessment....</p>	3/7/13
40.	Modifications	When we submit an MDSRCA, with “+”(which means MaineCare pending) coded on AA line 7 and A line 4, and we then receive a retroactive MaineCare approval do we complete a modification when the target date is now a MaineCare covered stay	An assessment submitted in this manner would not be included in the calculation of your rate. Therefore, you must submit a modification to allow the assessment to properly contribute to your case mix calculation.	6/6/13
41.	O	Section O – Medications – I would like to see medications to treat dementia, other than Aricept, listed as I feel not taking Aricept, but perhaps Namenda or Exelon, etc., should also be considered due to the significance of the condition being treated.	The form cannot be changed at this time. We will keep this request on file for future changes.	6/7/12

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

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42.	P	<p>We have several residents attending the Elderworks program on a regular basis. What is the correct way of coding? Should this be coded as group therapy, sheltered workshop, day treatment program or something else?</p>	<p>Elderworks is a day support program that provides group therapy services to older adults with chronic mental illness. In order to code the attendance, review the purpose of the program for the resident. There may be more than one item to check, depending on the planned program for the day. Example: day treatment (P1ak) and also involves a group therapy session (P2b). The treatment plan/service plan needs to address P2b.</p> <p>There needs to be documentation of attendance.</p> <p>See manual for section P1 and P2.</p>	6/7/12
43.	P	<p>We have a Counselor from Specialized Health Management visiting our facility who sees several residents who have DX of Depression, Anxiety, Bi-polar, Schizophrenia, etc. Her visits are on a weekly and bi-weekly basis and she documents each visit in resident's records. Can this be coded in Sec. P 2 a or b? (visits are a part of service plan as an approach to a problem with mood, behavior issues)</p> <p>Added: What qualifications does that person need to have</p>	<p>P2b seems to fit the description provided. P2a is an interdisciplinary evaluation with the purpose of developing an intervention plan (service plan).</p> <p>Depending on the qualifications of the "counselor," this could also be captured at Item P2c.</p> <p>See manual page 88 which lists the types of licensing needed.</p>	6/7/12

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

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44.	P	Can “Need for Monitoring” be a topic of discussion?	<p>P3 is coded for (a) an acute condition or a new treatment or medication. The need must be documented by a physician or an RN.</p> <p>(b) If the resident has been placed on a new medication that requires special monitoring for serious untoward effects or has been placed on a new treatment that must be assessed for effectiveness over a period of time then code this area (again- as determined by RN or physician and documented)</p> <p>There must be documentation within the timeframe to show that the required monitoring had been carried out.</p> <p>There must be more than one note of monitoring and at least one of those notes must be in the 7 day look back.</p>	6/7/12
45.	P	We are working on an admission RCA for one of our residents who was evaluated by Laura Cote at the facility where he lived previously. The evaluation occurred in the week before he came to our facility and Laura forwarded the report to us. We have included Laura’s suggestions/interventions in his care plan and have used them within the last 7 days. Can we capture either P2C or P2J for him? Does this count as being evaluated by a licensed mental health specialist within the last 90 days or J (other) – evaluation by Laura Cote at previous facility? Eval 6/12/12. Admission to new facility asking the question on 6/19/12	<p>Manual Pages 88—89. Laura Cote’s primary role is one of State Agency consultation to Staff of the facility. This is not able to be coded at P2C or P2 J as the MDS/RCA is speaking about resident care and services.</p> <p>Did the facility consider other intervention programs such as B, F, or G? Without more specific information other guidance is not possible. Please call your Casemix Nurse directly.</p>	9/6/12

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

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46.	P	Can a lab order be included as part of the physician order count in section P/10	<p>You are coding days with order changes if this is an order for a <u>new</u> lab order - yes. The Manual states as follows:</p> <p>P10. <u>Physician Orders</u></p> <p>Intent: To record the number of days, in the last 14 days, that the physician has changed the resident's orders.</p> <p>Physician Orders - Includes written, telephone, fax or consultation orders for new or altered treatment. Does NOT include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. Orders written on the day of admission as a result of an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.</p> <p>Do not count visits or orders prior to the date of admission or reentry. Do not count return admission orders or renewal orders without changes. And do not count orders written by a pharmacist. The prohibition against counting standard admission or readmission orders applies regardless of whether the orders are given at one time or are received at different times on the date of admission or readmission.</p> <p>Please see page 92 of the MDS/RCA Manual</p>	9/6/12

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

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47.	P	<p>What type of documentation is needed, by whom, and where does it need to be located for P1bdA-Respiratory Therapy – Does this therapy need to be written in the Service Plan?</p> <p>Who is a qualified professional?</p>	<p>P1bdA - “Respiratory therapy – Included are coughing, deep breathing, nebulizers, aerosol treatments, and mechanical ventilation, etc., which must be provided by a qualified professional. Does not include hand-held medication dispensers (e.g., inhalers). Count only the time that the qualified professional spends with the resident.” There must be 15 minutes of direct contact with the resident during a 24 hour period.</p> <p>There must be a reason for the respiratory therapy, so there must be a physician’s order for the specific elements of the therapy and it must be included in the service plan.</p> <p>A qualified professional is a licensed nurse, registered nurse, or a respiratory therapist who is trained in these techniques of respiratory therapy.</p>	3/7/13
48.	P	P2J: Can this be coded for the use of Wander guard	It can be coded in Section P2, but it should actually be coded at Item P2e (“Resident-specific deliberate changes in the environment. . .”), because not <u>all</u> residents wear one & the door only locks or alarms for those that are wearing one.	12/5/13

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

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49.	P	<p>P2 a-j: The Manual states that “The service plan should document the evaluation for and provision of these services and the outcomes of treatment.”</p> <p>“Check all programs that have been used in the last seven days.”</p> <p>If any of this is missing can this be coded?</p>	<p>No. Each item coded in this Section must be included on the Service Plan, documented as used within the 7 days & have documented periodic evaluations (“outcomes of treatment”).</p>	12/5/13

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

Number	Section/Topic	Question	Response	Forum Call Date
50.	P	P3b: Is conjunctivitis an acute condition?	<p>Item P3 (Need for ongoing monitoring) has several documentation requirements: 1. A condition must be “acute” as defined in the RCA Manual (unstable, fluctuating, medically complex. . .rapid onset, severe symptoms and a short course). <u>Documentation in the resident’s record should support this definition.</u> 2. Medications must be <u>new</u> and “requires <u>special</u> monitoring for <u>serious</u> untoward effects.” 3. Treatments must be <u>new</u> and “assessed for <u>effectiveness</u>. . .” 4. “The need for on-going monitoring. . .must be determined by the physician or RN” (documented). 5. On-going monitoring by the “staff” members responsible, as coded at Item P3 (on-going implies more than one note of monitoring, and <u>at least one note must be written within the 7-day look-back period.</u></p> <p>Item P3b is “new treatment/medication.” The eye drops/ointments ordered to treat conjunctivitis typically do <u>not</u> “require special monitoring for serious untoward effects. . .” and therefore would <u>not qualify</u> to code at Item P3b.</p> <p>Item P3a references “acute condition”—Occasionally conjunctivitis might be severe enough to meet the definition of “acute” (as above). The physician or RN must make this determination and document their concerns and directions for monitoring.</p>	12/5/13

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Number	Section/Topic	Question	Response	Forum Call Date
51.	P	P2g: If we are providing only redirection and not validation of feelings, can we code P2g?	Item P2g is "Validation/redirection" and while the description in the RCA Manual describes "Validation <u>Therapy</u> " which utilizes both aspects, if only one aspect meets all the documentation requirements for this Section (P2), it <u>should be</u> coded on the RCA (Documentation requirements as for prior P2 question).	12/5/13

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

Number	Section/Topic	Question	Response	Forum Call Date
52.	P	P1d: What documentation do you need to get credit for administering a nebulizer treatment under the respiratory therapy part of section P of the MDS-RCA	<p>P1 d. “Respiratory therapy – Included are coughing, deep breathing, nebulizers, aerosol treatments, and mechanical ventilation, etc., which must be provided by a qualified professional. Does not include hand-held medication dispensers (e.g., inhalers). <u>Count only the time that the qualified professional spends with the resident.</u>”</p> <p>The following criteria are required and must be documented in the resident’s record:</p> <ol style="list-style-type: none"> 1. This must be ordered by the resident’s physician 2. Performed by a qualified specialist who, for example, meets state credentialing requirements (e.g. respiratory therapist, licensed nurse). Treatments can be either inside or outside the facility. 3. Must be based on a therapist’s treatment plan or the current service plan. 4. Documentation in the record, is required, of the time the therapist spends on the treatment <u>in direct contact with the resident.</u> 5. Documentation must state whether the time spent was in the facility or outside of the facility. 6. There must also be periodic documentation of evaluation of the plan. <p>For Case Mix payment, the therapy must be administered as above, for at least 15 minutes per day, 5 or more days in the 7-day look-back. Period.</p>	12/5/13

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

Number	Section/Topic	Question	Response	Forum Call Date
53.	P & U	<p>1) In section U, Why are there only 18 spots to list medications? Some of our resident take over 30. What is the correct way of choosing which medications get excluded or added to the list?</p> <p>2) In section P, Number 2. On F & G Do we get in trouble for tagging these if only one apply. If you notice in F it is redirecting/cueing. What if the resident was only redirected or only cueing was done? In G it lists validation / redirection: same question what if only one was done?</p>	<p>Electronically submit the most important ones up to the maximum number allowed by your software. Keep a record of all others in the patient’s chart.</p> <p>P – F is reorientation/cueing and G is validation/redirection. When either or both (F and /or G) are prescribed in the service plan and then documented as used as a technique to address individual resident issues, then you may code. Most usually both (F and /or G) are prescribed in the service plan and when only one is used, only that one is documented as provided.</p>	12/6/12
54.	P&U	<p>1) In Section U, why are there only 18 spots to list medications? Some of our residents take over 30 medications. What is the correct way of choosing which medications get excluded or added to the list?</p> <p>2) In Section P, number 2F and 2G; do we get in trouble for tagging these if only one applies. In 2F, it is redirecting/cueing. What if the resident was only redirected or only cueing was done? In 2G, it lists validation/redirection. Same question, what if only one was done?</p>	<p>1) Electronically submit the most important ones up to the maximum allowed by your software. Keep a record of all other in the resident’s chart.</p> <p>2) 2F is reorientation/cueing and 2G is validation/redirection. When either or both F and/or G) are prescribed in the service plan and then documented as used as a technique to address individual resident issues, then you may code. Most usually, both F and G, are prescribed in the service plan and when only one is used, only that one is documented as provided.</p>	12/6/12
55.	P10	I was wondering if a crush order for medications can count as a physician order?	<p>No. This is considered a clarification of the same order (the order for the medication). “Does NOT include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. “ See the manual on Page 100.</p>	6/6/13

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

Number	Section/Topic	Question	Response	Forum Call Date
56.	P1a	What documentation is required to support coding treatments and programs listed under P1a?	<p>Code any of these items that occurred in the 14 day look back period. There must be documentation in the record of any treatment received by a resident either at the facility or on an outpatient or in-patient basis. P1aa requires a cancer diagnosis. Treatments in the facility must be ordered by a physician or legally accepted physician extender.</p> <p>Programs must be documented in the record as having been received in the 14 day look back period. The service plan needs to address these treatments – frequency, goals, etc.</p>	9/12/13

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

Number	Section/Topic	Question	Response	Forum Call Date
57.	P3	A resident has terminal cancer and is due for an MDS-RCA soon. The resident is receiving Hospice Services for terminal care. I was told to code this under P3 as need for ongoing monitoring. Is this correct?	<p>No. Supportive terminal care does not qualify as an <u>acute condition</u>. Coding P3 is intended for the on-going monitoring of an <u>acute condition</u>(unstable, fluctuating, medically complex) or new treatment/medication. The need for monitoring of an <u>acute condition</u> must be determined and documented as needed by the physician or a Registered Nurse. This could include monitoring an acute <u>(illness having rapid onset, severe symptoms, and a short course)</u> or a chronic condition that has exacerbated into an acute episode, i.e., Diabetes with unstable glucose levels, Angina requiring increased medication as a result of recurring episodes. Other examples of acute conditions are: Gall Bladder Attack (Cholecystitis), Bronchial Pneumonias, as well as decompensating psychiatric conditions, e.g., Schizophrenia, Bipolar Disorder.</p> <p>If the resident has been placed on a new medication that requires special monitoring for serious untoward effects or has been placed on a new treatment that must be assessed for effectiveness over a period of time then code this area.</p> <p>The terminal cancer can be captured at I1ww and under P1f as long as the documentation is present in the record from the physician</p>	9/12/13
58.	S2B	What is the penalty for completing MDS-RCA later than required?	Section 7060.1 of the regulations state "The Department will sanction providers for failure to complete assessments, accurately and on a timely basis."	3/7/13

Residential Care Level IV Forum Calls 6/7/12 through 12/5/13

Number	Section/Topic	Question	Response	Forum Call Date
59.	Submissions	What is the penalty for submitting MDS-RCA later than required?	Failure to make timely submissions may affect reimbursement rate and if it results in payment errors there may be penalties.	3/7/13
60.	Submissions	Once the admission MDS has been completed and 3 months later a significant change MDS has been completed it is not coming up on the 180 days for the next MDS is that MDS the semi-annual even though it has been all most 9 months since the admission MDS?	No because a significant change assessment is a comprehensive assessment and resets the clock. This would make the next scheduled assessment a semiannual (180 days from the significant change).	3/7/13
61.	U	Regarding medications on the assessment. If a resident administers her/his own medications do we list those on the assessment?	The purpose of listing medications in Section U is to identify all medications the resident is receiving whether self-administered or administered by staff.	6/7/12
62.	U	If a person is on PRN meds and don't receive any during that period	Only include those medications given during last 7 days (do not include PRNs not included).	6/7/12

The first line of information is the training manual for the MDS Resident Care Assessment Tool. If there is a specific case that you are unsure of coding, call your case mix nurse for more guidance.

The web site to obtain copies of the Training Manual, the training power point and handouts, etc is:

http://www.maine.gov/dhhs/oms/provider/case_mix_manuals.html

Remember to be sure that when they complete any new assessment or discharge tracking form that the assessment is transmitted to the SMS system and you receive a validation report indicating the assessment was accepted.

When you add a missing assessment or discharge to your draft roster report, please remember to submit that assessment or discharge to the SMS system. If an assessment or discharge does is not reflected on the roster, Muskie does not have that assessment and cannot include it in your payment calculation.

The email account to send MDS-RCA questions is: MDS3.0.DHHS@maine.gov