

RAI Panel Q&As for June, 2011

Chapter 1

1. **QUESTION:** A State LTC facility has the same Facility ID number, is owned by the same business entity, does their billing the way they have in the past, etc. The difference is that they have divided their residents into different units; VA unit, unit for the cognitively impaired, and skilled unit. They are also keeping QI/QM reports and meeting minutes separate for the different units. The facility asks if they have to do discharges and readmissions on all of these residents since they have been divided into different units. My thought is that this is just internal facility re-arrangement and that the residents would simply stay on the established OBRA/Medicare PPS MDS schedules. Is this correct?

ANSWER: The RAI Panel agrees with you. As long as a facility has only one Medicare/CMS certification number and only one Medicaid certification number, it is considered as only one facility and the residents in that facility are all considered the same for MDS 3.0 purposes as long as they are in a Medicare/Medicaid certified bed.

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Chapter 2

1. **QUESTION:** It has been acceptable in the past to treat multiple nights out, e.g., trial home visit, just as an LOA without any discharge or entry forms being required. On page 2-12 of the revised RAI Manual, CMS changed the LOA definition from Temporary home visit/therapeutic leave to Temporary **overnight** home visit/therapeutic leave. This, and the definition of Discharge on page 2-10 lead me to the conclusion that any "LOA" that lasts more than 24 hours should be handled as a discharge. Is this correct?

ANSWER: (Revised by CMS, August, 2011) The LOA definition has been revised by CMS. The following definition is included in the updated manual:

Leave of Absence (LOA), which does not require completion of either a discharge assessment or an entry tracking record, occurs when a resident has a:

- **Temporary home visit of at least one night; or**
- **Therapeutic leave of at least one night; or**
- **Hospital observation stay less than 24 hours and the hospital does not admit the patient.**

-Providers should refer to Chapter 6 and their State LOA policy for further information, if applicable.

-Upon return, providers should make appropriate documentation in the medical record regarding any changes in the resident

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Chapter 3

1. Section A0310E

QUESTION: The facility for the past 9 months has not correctly identified A0310E correctly; they coded all of their MDS's as this not being the first assessment even though it was, and along with that they thought that the Entry record was an assessment, so they have not asked the pertinent question in Q0300 as to if the resident would like to talk to someone about the possibility of returning to the community. Now they want to know what they need to do with all of the wrong MDS 3.0 assessments that have been done incorrectly. Do they go back and correct all the ones before present and do Section Q properly or do they just go forward and do all the future ones correct

ANSWER: The facility should complete the assessments correctly moving forward and not go back and correct all the ones before present. They should be made aware that, as for survey results, if the team finds it, they will likely cite it. CMS for the AHFSA RAI Panel – June, 2011

2. Section J1700 – Falls

Question - A resident was originally admitted 06/08/10 status post fall with fractured hip. Resident is now on Medicaid. Went to hospital on 04/09/11 sustained a fall with a fractured hip. Was a bed hold. Returned 05/03/11, significant change MDS done. Section J 1700 indicated on A,B and C a "yes" answer. J1800 was indicated as "No." MDS nurse states it has to be answered this way per instructions that the resident had the fall and fracture prior to admission. She did have one prior to admission but she also had one in the facility. She states it goes by the date of re-entry for MDS purposes. That doesn't seem right to me but I am not sure. Seems it is not indicating that she had fracture before entry and after entry. The MDS made it look like she just had the one before and was just admitted.

Answer - In J1700, the facility answers the "Fall History on Admission" if this is the Admission Assessment (A0310 01 Admission) or if it is the first OBRA, PPS or Discharge Assessment **since the most recent admission** (A0310E = YES or NO) You say that this is a SCSEA - Significant Change in Status and the first assessment since Entry to the facility since the last assessment was a Discharge.

- J1700A documents whether the resident had any falls during the month prior to the resident's entry date. **This would be coded as a YES**
- 1. J1700B documents whether the resident had any falls during the 2 - 6 months prior to the resident's entry date. **This would be coded as a NO**
- J1700C documents whether the resident experienced a fracture due to fall in the 6 months prior to the entry date. - **This would be coded as a NO**
- J1800 documents any falls since Admission or Prior Assessment (OBRA or PPS) whichever is more recent. This would be coded as **NO**

Since the MDS collects falls information back to the 6 months prior to the entry date, and the Entry Date is 5/3/11, the answers to B & C would be NO because the fall only occurred within the month prior to 5/3/11 on 4/9/11. The fall that occurred a year ago is not being collected with this assessment.

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3. Chapter 3 - O0100 K. Hospice Care

QUESTION: This question is about the therapy section and hospice provided therapy. If a resident is on hospice, family wishes for the resident to get stronger so that they can do things easier as family wants to take them home ie: transfer, and the hospice agency is providing this therapy.... Can I code this on the MDS? The resident meets the qualifications of having the physician order based on the therapist's assessment and treatment plan, is documented in the chart, and which is care planned..... We are having issues over what to use to determine what constitutes "medical necessity" per page O-19 under non-skilled services.

ANSWER: The facility will have to do a Significant Change in Assessment if one has not been completed when the resident chose Hospice. The facility can code the MDS for hospice, but for those services that hospice is performing, you will not code since your facility is not providing the care. You will need to ascertain what the Hospice Care Plan is - are they considering revoking the resident from hospice? If so, then why would the Hospice be providing skilled care which is what therapy would be. The requirements for skilled care under Medicare Part A PPS services are covered both in Chapters 2 and 6 of the MDS 3.0 manual and the Medicare manuals that are referred to in those chapters and that pertain to the facility therapy staff. The hospice must be a Medicare Certified Hospice. For information regarding Hospice services, please follow these guidelines:

Medicare Claims Processing Manual <http://www.cms.gov/manuals/downloads/clm104c11.pdf>

Chapter 11 - Processing Hospice Claims 10 - Overview (Rev. 304, Issued: 09-24-04, Effective: 12-08-03, Implementation: 06-28-04)

"To be covered, hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. The individual must elect hospice care and a certification that the individual is terminally ill must be completed by the patient's attending physician (if there is one), and the Medical Director (or the physician member of the Interdisciplinary Group (IDG)). Nurse practitioners serving as the attending physician may not certify or re-certify the terminal illness. A plan of care must be established before services are provided. To be covered, services must be consistent with the plan of care. Certification of terminal illness is based on the physician's or medical director's clinical judgment regarding the normal course of an individual's illness. It should be noted that predicting life expectancy is not always exact".

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4. Section O - O0100M - Isolation

Question: If a MD orders the resident to go to the pain clinic or the wound clinic, when pain care or wound care is available in the facility but the characteristics of the pain or the wound are such that the MD orders these services to be received at these clinics, can the facility still code isolation and quarantine if all the requirements of the RAI are

met AND the resident is provided with appropriate infection control measures while being transported to and from and while at these clinics?

Answer: Follow the instructions in the manual on page O-4, O-5 posted on June 2, 2011 that say [If a facility transports a resident who meets the criteria for strict isolation to another healthcare setting to receive medically needed services (e.g. dialysis, chemotherapy, blood transfusions, etc.) which the facility **does not or cannot provide**, they should follow CDC guidelines for transport of patients with communicable disease, and may still code O0100M for strict isolation since it is still being maintained while the resident is in the facility.] This question can't be answered further and the facility needs to consider more than just that a physician ordered these services to be received outside of the facility. The facility also needs to have justification to support that they do not have the ability or cannot provide the services to meet the resident's pain or wound needs.

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5. Chapter 3 -Section O0250A - Influenza Season

QUESTION : We received a question from a provider regarding the dates of the current flu season; the provider voiced frustration over being referred to the CDC website by the MDS Manual and then not being able to find the dates. We understand their frustration after several attempts trying to find the dates for the 2010-2011 flu season. Is October 3, 2010-May 21, 2011 considered the current flu season for 2010-2011 by CMS?

ANSWER: The question should be thought of as " did the resident receive the influenza vaccine in this facility for this year's influenza season or the **"or most recent influenza season"**. That will help answer the question easier. CMS does not give definite dates for the Influenza Season and instead has stated in the MDS 3.0 manual on page O-7 that the CDC should be referenced. The CDC advises that the season starts when the Influenza vaccine becomes available in the community and continues while the influenza is still prevalent in the local community. The vaccine became available beginning Sept.1, 2010 and continued through May 31, of 2011 in most regions. Each facility can determine the dates of the current season by conferring with their local Health Department. This helpful website is from the CDC:

<http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-flu.pdf>

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6. Section O0250A - Influenza Season

Question: we have a facility that has asked if they can dash fill the Influenza Vaccine question because it isn't the flu season. The only place we can find in the manual in this section where dash fill is discussed is related to the coding instructions for the date the vaccine was received; "If the date is unknown or the information is not available, a single dash needs to be entered in the first box".

How would the facility answer O0250A and C with an ARD of July 1, 2011?

If the ARD was during the current flu season and they answered "No" because their facility ran out of vaccine (not due to a declared shortage) how would they code O0250C?

ANSWER: It is not appropriate to use a dash when the question can be answered by asking the person if they received the influenza vaccine in this facility for this year's influenza season, or the most recent influenza season. This wording has been approved by CMS and will make this question much easier to code.

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Chapter 4

1. CAAs QUESTION: Since we have never really received training/education on the **Care Area Assessment** process using the tools in Appendix C, I am looking for someone who could provide our State agency staff and our LTC providers with this training. Are you aware of anyone who does training on this topic? I would like the training to include examples of CAA documentation. Are you aware if CMS has any plans to provide training on this topic in the near future (i.e. webinar, webcast, etc.)?

ANSWER: Many RAI Coordinators have included this type of training as a more advanced training in MDS 2.0 and they will most likely be doing the same for MDS 3.0 in the future. This does take some in-depth research and development on the part of the RAI Coordinator. CMS provided the initial training on CAAs at the MDS 3.0 RAI Conference in March of 2010 and additional training at the RAI Conference in April, 2011. Appendix C is only a resource for the facility to use or not use as it is not mandatory for the MDS 3.0 completion. Chapter 4 is the basis for preparing for the Care Area Assessments and the care plan and is the basis for any training that you do. The RAI Manual, page 4-3 states under Care Area Assessment. "The CAA process does not mandate any specific tool for completing the further assessment of the triggered areas, nor does it provide any specific guidance on how to understand or interpret the triggered areas. Instead, facilities are instructed to identify and use tools that are current and grounded in current clinical standards of practice, such as evidence-based or expert-endorsed research, clinical practice guidelines, and

resources. When applying these evidence-based resources to practice, the use of sound clinical problem solving and decision making (often called "critical thinking") skills is imperative."

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Chapter 5

- 1 **QUESTION: Inactivation** - A facility inadvertently keys in Reason for Assessment as a 14-day PPS which in reality it should have been a 30-day PPS assessment. Everything on the assessment is accurate except the Reason for Assessment. Can the facility inactivate the erroneous 14-day assessment and recreate a new assessment using the exact same data, except the Reason For Assessment which would be corrected to show 30-day Medicare PPS? If so, what dates should be used on the new assessment at Z0500? If Z0500 has to be dated the actual date it is signed, what happens to the facility's payment if the date at Z0500 is past the required PPS completion date?

ANSWER: The facility will copy and or save the original assessment and then inactivate the one with the wrong reason for assessment. They will then submit a new assessment using the information from the original one and resubmit using the correct reason for assessment. The reason for assessment is all that gets changed and then it is resubmitted. Section X1100 E is the date that it is corrected and the submission date will be the current date. When the new assessment is submitted, it will frequently be coded with an error as a late submission and could have an effect on Medicare PPS Payment.

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Chapter 6 - No Q&As

S&C and Non-MDS 3.0 Manual questions:

- 1 **Question:** When surveyors are reviewing the MDS should they be looking only at the OBRA assessments to make their determinations or also include the PPS assessments? When the SOM refers to the RAI, I take that to mean the whole package (the comprehensive assessment, CAA's and Utilization guidelines since that is the definition of RAI). Additionally, OBRA requires a quarterly assessment and those assessments would also be reviewed.

Since PPS assessments are sub-sets of data, they do not provide a complete picture of the resident; their purpose is payment and gathering information for quality measures/indicators, not for determining the comprehensive plan of care. CAAs cannot be done using PPS assessments as not all of the MDS items that trigger CAAs are included in those assessments. Certainly the PPS assessments need to be accurate, but the LTC regulations were developed in consort with the OBRA required assessments not PPS assessments.

ANSWER: Surveyors will generally only be reviewing the OBRA Assessments during a survey whether it is a standard survey or QIS survey, meaning the Admission, Quarterly, Annual and Sig Change assessments, but there may be circumstances where the Medicare PPS assessment might also be viewed.

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2. **QUESTION:** To meet the 15-month's worth requirement for MDS information being in the chart, as found in the RAI Manual on pages 2-6 and 2-7: Do I understand correctly that these jRAVEN reports can be placed in the residents' charts so that the entire MDS assessments do not need to be in the charts? Do I understand correctly that if a private software company provides reports containing the same information that the JRAVEN reports do, that these private software company reports can be put in residents' charts so that the entire MDS assessments do not need to be in the charts?

ANSWER: Please see page 2-5 of the MDS 3.0 manual 2.4 - Responsibilities of Nursing Homes for Reproducing and Maintaining Assessments. The Federal regulatory requirement requires nursing homes to maintain all resident assessments with the previous 15 months in the resident's clinical record. This requirement applies to all MDS assessment types regardless of the form of storage (electronic or hard copy). There is a S&C letter (Ref: S&C: 11-31-NH) issued recently. "Changes to MDS 3.0 Assessment Formatting Policy: On February 1, 2011, CMS revised its MDS 3.0 assessment formatting policy by issuing version 1.0.5 of jRAVEN, the CMS data entry software application that nursing home and swing bed providers use in collecting, maintaining, and submitting MDS 3.0 assessment information. This version of jRAVEN allows users to add more signature lines to item Z0400 of the MDS 3.0 as needed to capture attestations of all individuals completing some portion of a particular assessment. Also on February 1, 2011, CMS made a decision that the print format provided by jRAVEN for a MDS 3.0 assessment is acceptable for review in the nursing home survey process. Providers do not need to provide printed copies of blank items on the MDS 3.0. For those providers who utilize the services of a software program other than jRAVEN, the printed copies of the MDS 3.0 are acceptable if they display the following: The item identifier; The item description; The item response; The assessment

reference and resident birth dates; and Identifiers including resident name." A facility would still need to have the CAA's available in the resident's record when they were required also.

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3. **Question:** If an MDS is rejected due to a software edit, and the clinician opens the MDS up and corrects the issue, should the signature date be adjusted? The state nurse practice act, and the RAI manual don't have guidance that I have seen (although it might be right under my nose). I know that with the 3.0 data specifications changing, that some rejections have occurred solely because the MDS was locked with one data spec and submitted after CMS updated the transmission software with another data spec. To fix these in the past, I just had to open them and lock them again. For these situations, I don't feel that the MDS should necessarily have to be re-dated and re-signed. Of course, if a true resident data field is changed, then the assessment has changed and should be re-dated.

Answer: When a record has been rejected from the QIES ASAP database, the facility is informed by way of the Validation Report that they are to make the appropriate corrections to the record as needed and resubmit the record. They are also referred to the current data specifications to identify the acceptable values for the item that caused the rejection. Making the appropriate correction is all that is required because the submission wasn't accepted; the signature date does not need to be adjusted. Nothing other than what was incorrect needs to be changed. See page 5-5 of the MDS 3.0 manual. AHFSA RAI Panel - June 2011

This guidance is being provided on this date and in specific response to the submitted question or scenario. The recipient should be aware that guidance regarding the responses to questions may be time-limited, and may be superseded by guidance published by CMS at a later date. It is each provider's responsibility to stay current with the latest CMS guidance.