Changes to the RAI manual effective October 1, 2013

CMS released on Friday, September 27 an updated version of the RAI manual that became effective October 1, 2013. The manual is found here>

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

"This page contains the current MDS 3.0 RAI Manual v1.11, effective October 1, 2013. This version of the MDS 3.0 RAI Manual incorporates clarifications to existing coding and transmission policy, integrates previously published Questions and Answers (Q & As) into the appropriate sections and addresses requested clarifications and scenarios concerning complex areas."

News of the major changes (e.g., new way to record therapy days) was part of the PPS final rule for rates beginning October 1, 2013 and information about these has already been widely circulated, but it is always important to look at the actual manual, which fully implements the policy.

See below for a summary and comments on these changes prepared by LeadingAge's special expert consultant on MDS-- Judy Whilhide Brandt, BA RN, RAC-MT

The October release of the RAI manual contained the following substantive changes:

Chapter 2
Section 2.6: Under Assessment Management Requirements and Tips for Discharge Assessments Added:
For a Discharge assessment, the ARD (Item A2300) is not set prospectively as with other assessments. The ARD (Item A2300) for a Discharge assessment is always equal the Discharge date (Item A2000) and may be coded on the assessment any time during the Discharge assessment completion period (i.e., discharge date (A2000) + 14 calendar days).
Comment: The purpose of a discharge assessment is to track quality for the Quality Measures. It is very important to open and complete this assessment in a timely manner.

Section 2.9:
Under the instructions for an EOT OMRA added on page 2-48:
In cases where the last day of the Medicare Part A benefit, that is the date used to code A2400C on the MDS, is prior to the third consecutive day of missed therapy services, then no EOT OMRA is required. If the date listed in A2400C is on or after the third consecutive day of missed therapy services, then an EOT OMRA would be required.

In cases where the date used to code A2400C is equal to the date used to code A2000, that is cases where the discharge from Medicare Part A is the same day as the discharge from the facility, and this date is on or prior to the third consecutive day of missed therapy services, then no EOT OMRA is required.
Comment: This is not new policy. This clarifies the fact that an EOT is not required unless the provider is going to bill at least three days to Medicare after the last therapy date.

Under the instructions for a COT OMRA changed wording and added instruction on page 2-50:
Required when the resident was receiving a sufficient level of rehabilitation therapy to qualify for an Ultra High, Very High, High, Medium, or Low Rehabilitation category and when the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) delivered, and other therapy qualifiers such as number of therapy days and disciplines providing therapy) changes to such a degree that it would no longer reflect the RUG-IV classification and payment assigned for a given SNF resident based on the most recent assessment used for Medicare payment.
Comment: This instruction is timely due to the new rules for calculating Rehab Medium. (see instructions in Section O & Chapter 6) If a resident received less than five distinct calendar days of therapy there will be no Rehab RUG, therefore the COT count will cease with the ARD of the assessment that does not earn a Rehab RUG.

Continuing COT OMRA instructions, added on page 2-51:
When the most recent assessment used for PPS, excluding an End of Therapy OMRA, has a sufficient level of rehabilitation therapy to qualify for an Ultra High, Very High, High, Medium, or Low Rehabilitation category (even if the final classification index maximizes to a group below Rehabilitation), then a change in the provision of therapy services is evaluated in successive 7-day Change of Therapy observation periods until a new assessment used for PPS occurs.
Comment: Not new policy. This clarification brings language into the manual from previous PPS clarification memos. A COT count begins the day after an ARD in which a Rehab RUG is earned, whether or not it is assigned due to CMI.

Under "Coding Tips and Special Populations" on page 2-52:
Note: In limited circumstances, it may not be practicable to conduct the resident interview portions of the MDS (Sections C, D, F, J) on or prior to the ARD for a standalone unscheduled PPS assessment. In such cases where the resident interviews (and not the staff assessment) are to be completed and the assessment is a standalone unscheduled assessment, providers may conduct the resident interview portions of that assessment up to two calendar days after the ARD (Item A2300).
Comment: This brings forward into the manual language from previous PPS memos. Many providers stopped this practice after the May release of the manual because it was not included at that time.

Under "2.13 Factors Impacting the SNF Medicare Assessment Schedule: Resident

Takes a Leave of Absence [LOA] from the SNF" on page 2-72 added two paragraphs: Moreover, a SNF may use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for an unscheduled PPS assessment, but only in the case where the ARD for the unscheduled assessment falls on a day that is not counted among the beneficiary's 100 days due to a leave of absence (LOA), as defined above, and the resident returns to the facility from the LOA on Medicare Part A. For example, Day 7 of the COT observation period occurs 7 days following the ARD of the most recent PPS assessment used for payment, regardless if a LOA occurs at any point during the COT observation period. If the ARD for a resident's 30-day assessment were set for November 7 and the resident went to the emergency room at 11:00pm on November 14, returning on November 15, Day 7 of the COT observation period would remain November 14 for purposes of coding the COT OMRA.

Finally, there may be cases in which a SNF plans to combine a scheduled and unscheduled assessment on a given day, but then that day becomes an LOA day for the resident. In such cases, while that day may still be used as the ARD of the unscheduled assessment, this day cannot be used as the ARD of the scheduled assessment. For example if the ARD for a resident's 5-day assessment were set for May 10 and the resident went to the emergency room at 1:00pm on May 17, returning on May 18, a facility could not complete a combined 14-day/COT OMRA with an ARD set for May 17. Rather, while the COT OMRA could still have an ARD of May 17, the 14-day assessment would need to have an ARD that falls on one of the resident's Medicare A benefit days.
Comment: This may sound like a new policy change to many, but in other parts of the manual, the rules have always been that we must use a day of the Medicare benefit period only for a PPS ARD.

Chapter 3

The recent controversy on how to interpret the instructions for coding ADLs in Section G0110 has been resolved. The instructions for this section have been re-written, with a new algorithm and examples.

Page G-4: Added under the general coding instructions for each ADL Activity:
To assist in coding ADL Self-Performance items, facilities may augment the instructions with the algorithm on page G-7.
Comment: The old ADL algorithm was a major source of misinterpretation. It is critical to read the entire section, to include the examples. Once this is read and understood, the algorithm can be a useful aid, but it is not a substitute for reading the manual.

Coding Instructions for G0110, Column 1, ADL Self-Performance on page G-4:
Comment: In the following core instructions for coding this section, we have italicized and underlined the additions:

Code 0, independent: if resident completed activity with no help or oversight **every time** during the 7-day look-back period *and the activity occurred at least three times.*

Code 3, extensive assistance: if resident performed part of the activity over the last 7 days, and help of the following type(s) was provided **three or more times**: three or more times:
— Weight-bearing support provided **three or more times, OR**
— Full staff performance of activity ***three or more times*** during part but not all of the last 7 days).

Instructions for the Rule of Three now on page G-5 have been re-written and re-organized. Substantive additions are underlined and italicized:

The Rule of 3
• *The "Rule of 3" is a method that was developed to help determine the appropriate code to document ADL Self-Performance on the MDS.*
• *It is very important that staff who complete this section fully understand the components of each ADL, the ADL Self-Performance coding level definitions, and the Rule of 3.*
• *In order to properly apply the Rule of 3, the facility must first note which ADL activities occurred, how many times each ADL activity occurred, what type, and what level of support was required for each ADL activity over the entire 7-day look-back period.*
• The following ADL Self-Performance coding levels are exceptions to the Rule of 3:
– ***Code 0, Independent*** *– Coded only if the resident completed the ADL activity* ***with no help or oversight every time*** *the ADL activity occurred during the 7-day look-back period and the activity occurred at least three times.*
– **Code 4, Total dependence –** Coded only if the resident required **full staff performance** of the ADL activity **every time** the ADL activity occurred during the 7-day look-back period and the activity occurred three or more times.
– ***Code 7, Activity occurred only once or twice*** *– Coded if the ADL activity occurred* ***fewer than three times*** *in the 7-day look back period.*
– **Code 8, Activity did not occur –** Coded only if the ADL activity **did not occur** or **family and/or non-facility staff provided care 100% of the time** for that activity over the entire 7-day look-back period.

Instructions for the Rule of 3:

When an ADL activity has occurred ***three or more times****, apply the steps of the Rule of 3 below* ***(keeping the ADL coding level definitions and the above exceptions in mind)*** *to determine the code to enter in Column 1, ADL Self-Performance. These steps must be used in sequence. Use the first instruction encountered that meets the coding scenario (e.g., if #1 applies, stop and code that level).*

1. When an activity occurs **three or more times at any one level**, code that level.

2. When an activity occurs **three or more times at multiple levels, code the most dependent level *that occurred three or more times***.

3. When an activity occurs **three or more times and at multiple levels, but not three times at any one level**, apply the following:

    a. *Convert episodes of full staff performance to weight-bearing assistance when applying the third Rule of 3, as long as the full staff performance episodes did not occur every time the ADL was performed in the 7-day look-back period. It is only when **every** episode is full staff performance that Total dependence (4) can be coded. Remember, that weight-bearing episodes that occur three or more times or full staff performance that is provided three or more times during part but not all of the last 7 days are included in the ADL Self-Performance coding level definition for Extensive assistance (3).*
    b. *When there is a combination of full staff performance and weight-bearing assistance that total three or more times—code extensive assistance (3).*
    c. *When there is a combination of full staff performance /weight-bearing assistance and/or non-weight-bearing assistance that total three or more times—code limited assistance (2).*

If none of the above are met, code supervision.

ADL algorithm on Page G-5 has been replaced with a new algorithm on page G-7 that matches the new instructions.

Information added 0n page G-9 **under examples for coding "8" Activity did not occur:**
Locomotion would be **coded 8, activity did not occur**: if the resident was on bed rest and did not get out of bed, and there was no locomotion via bed, wheelchair, or other means during the look-back period *or if locomotion assistance was provided by family and/or non-facility staff 100 % of the time over the entire 7-day look-back period.*
Added to the paragraph that is now on page G-10, after an example of a probing interview by the MDS coder with a CNA:
In this example, the assessor inquired specifically how Mrs. L. moves to and from a lying position, how she turns from side to side, and how the resident positions herself while in bed. A resident can be independent in one aspect of bed mobility, yet require extensive assistance in another aspect, *so be sure to consider each activity definition fully*. If the RN did not probe further, he or she would not have received enough information to make an accurate assessment of the actual assistance Mrs. L. received. *This information is important to know and document* because accurate coding *and supportive documentation* provides the basis for

reporting on the type and amount of care provided.
Comment: Note the importance of documentation to support ADL coding.

Beginning on page G-19, several examples of ADL coding with rationale are provided. These examples greatly assist understanding of the ADL coding rules and should be read carefully and completely.

A new definition of urinary continence was introduced on page H-7:
Any void that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting.
Comment: Previously, the void could not be considered continent unless it occurred in a commode, bedpan or urinal. Now, a voluntary void into an inappropriate location is sill considered an episode of continence.

K0700 is now K0710 with the introduction of a new column for the MDS. This is the section where the percentage of intake and fluid by artificial route is coded. The new column is K0710A3 and K0710B3. These questions ask if the percentage of calories and fluid coded here were performed during the entire 7 days.
Interestingly enough, there are no specific coding instructions for Column 3, as there are for Column 1 and 2. And, on page 6-28 in the Medicare RUG grouper, the tube feeding RUG classification system now uses the new Column 3 to calculate the RUG, instead of Columns 1 and 2:
Tube feeding classification requirements:
(1) K0710A3 is 51% or more of total calories OR
(2) K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.
Comment: This took many providers by surprise because it was not mentioned in the SNF Final Rule, but it was discussed in the Transition Memo published a few days prior to this release.

In Section M, the phrase "unhealed (non-epithelized) pressure ulcer has been replaced by "unhealed pressure ulcer" whenever it occurs throughout this section. Also, all references to the phrase "necrotic tissue (eschar)" have been replaced by "eschar."

Section O0400: In the blocks used to record therapy minutes, there is a new line for each discipline for co-treatment minutes. All co-treatment minutes are also recorded in the mode of delivery – individual, concurrent or group – so this block is not a RUG calculator field. It is simply a breakout of how many minutes listed on the MDS were provided via co-treatment.

Starting on page O-19, there is new instructional language for delivery of rehabilitative therapy in a SNF that mirrors language in the "improvement standard" lawsuit (Jimmo vs. Sebelius: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf) finalized in January 2013, making it clear that skilled therapy may provided for maintenance, and not

just improvement. CMS has until January 24, 2014 to update all applicable manuals and training materials, but it seems they started here (new material underlined):

-the services must be provided with the expectation, based on the assessment of the resident's restoration potential made by the physician, that the condition of the patient will improve materially in a reasonable and generally predictable period of time; or, the services must be necessary for the *establishment* of a safe and effective maintenance program; *or, the services must require the skills of a qualified therapist for the performance of a safe and effective maintenance program.*

On page O-20, under "non-skilled services" the new guidance continues:

As noted above, therapy services can include the actual performance of a maintenance program in those instances where the skills of a qualified therapist are needed to accomplish this safely and effectively. However, when the performance of a maintenance program does not require the skills of a therapist because it could be accomplished safely and effectively by the patient or with the assistance of non-therapists (including unskilled caregivers), such services are not considered therapy services in this context. Sometimes a nursing home may nevertheless elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services *even when the involvement of a qualified therapist is not medically necessary*. In these situations, the services shall **not** be coded as therapy in item O0400 **Minutes**, since the specific interventions would be considered restorative nursing care when performed by nurses or aides. Services provided by therapists, licensed or not, that are not specifically listed in this manual or on the MDS item set shall **not** be coded as therapy in Item 0400. These services should be documented in the resident's medical record.

In situations where the ongoing performance of a safe and effective maintenance program does not require any skilled services, once the qualified therapist has designed the maintenance program and discharged the resident from a rehabilitation (i.e., skilled) therapy program, the services performed by the therapist and the assistant are **not** to be reported in item O0400A, B, or C **Therapies** The services may be reported on the MDS assessment in item O0500 **Restorative Nursing Care**, provided the requirements for restorative nursing program are met.

In the May 2013 release, there was conflicting guidance on the therapy start date used after an EOT-R. On page O-27 the instructions concerning therapy start date on subsequent assessments after an EOT-R were corrected for consistency. When an EOT-R is completed, the Therapy Start Date on the next PPS assessment is the same as the Therapy Start Date on the EOT-R.

Item O0420, distinct calendar days of therapy, was added to conform to the new RUG calculation methodology announced in the SNF Final Rule. In order to obtain a

Rehab Medium or Rehab Low RUG, the qualifying days are no longer treatment days, but distinct calendar days of therapy.

A paragraph was added in the instructions for signatures in Z0400:

If an individual who completed a portion of the MDS is not available to sign it (e.g., in situations in which a staff member is no longer employed by the facility and left MDS sections completed but not signed for), there are portions of the MDS that may be verified with the medical record and/or resident/staff/family interview as appropriate. For these sections, the person signing the attestation must review the information to assure accuracy and sign for those portions on the date the review was conducted. For sections requiring resident interviews, the person signing the attestation for completion of that section should interview the resident to ensure the accuracy of information and sign on the date this verification occurred.