

RAI Spotlight



RAI Manual Updates



CMS released version 1.13 of the Long-Term Care Facility Resident Assessment Instrument User's Manual (RAI Manual) on October 1, 2015 (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>) to coordinate with changes being made for FY 2016. While many of the changes involved updating material, e.g., web sites, some changes were more significant.

In addition, CMS posted a single .pdf file of the entire RAI Manual for use as an electronic version with bookmarks that you can click on to take you to each section of the manual.

New Facilities. New facilities must complete the MDS and care plans according to OBRA requirements before they are certified. To further clarify these requirements, on page 2-4, the RAI Manual now states:

“The completion and submission of OBRA and/or PPS assessments are a requirement for Medicare and/or Medicaid long-term care facilities. However, even though OBRA does not apply until the provider is certified, facilities are required to conduct and complete resident assessments prior to certification as if the beds were already certified.

Prior to certification, although the facility is conducting and completing assessments, these assessments are not technically OBRA required, but are required to demonstrate compliance with certification requirements. Since the data on these pre-certification assessments was collected and completed with an ARD/target date prior to the certification date of the facility, CMS does not have the authority to receive this into QIES ASAP. Therefore, these assessments cannot be submitted to the

(Continued on page 3)

MDS Corrections Teleconference

Date: January 14, 2016
Time: 1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)
Topic: MDS Corrections
Handouts: Power Point slides will be available about January 11 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: 76215237

Company Name: Myers and Stauffer Moderator: Cathy Petko
A recording of this conference will be available; directions for requesting this will be posted on the DOH Message Board.

Additional questions: qa-mds@pa.gov

RAI Coordinator
1-717-787-1816
qa-mds@pa.gov

Volume 10, Issue 2
November 2015

Questions about the RAI?

Please submit them to
qa-mds@pa.gov

Inside this issue:

| | |
|---|---|
| <i>Interviewing Teleconference Q & As</i> | 2 |
| <i>Staff Assessment Timing</i> | 2 |
| <i>Decrease in Antipsychotic Use</i> | 3 |
| <i>New PASRR Forms</i> | 4 |
| <i>Readmissions</i> | 4 |
| <i>Flu Vaccines in Nursing Homes</i> | 4 |





Interviewing Teleconference Q & As

On October 8, 2015, a training teleconference was provided on Interviewing. There was discussion about CMS' policy concerning the timing of Staff Assessments; this is covered in the article beginning on the bottom of this page.

The following questions were received:

Q: What can be counted as “non-medication pain intervention” at J0100C?

A: *Scheduled and implemented non-pharmacological interventions include, **but are not limited to:** bio-feedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electrical stimulation, radiotherapy, ultrasound and acupuncture. Herbal medications or alternative medicine products are not included in this category. (RAI Manual p. J-2)*

Interventions must be included as part of a care plan that aims to prevent or relieve pain and includes monitoring for effectiveness and revision of the care plan if stated goals are not met. There must be documentation that the intervention was received and its effectiveness was assessed. It does not have to have been successful to be counted.

Most interventions to relieve a resident's pain may be reported here as long as there is appropriate documentation and evaluation.

Q: How should the MDS be completed if the resident interview was not completed (missed)?

A: *This should almost be a Never Event. Review your procedures and put new processes into place, if necessary, to*

Staff Assessment Timing

The RAI User's Manual provides guidance for the timing of resident interviews within the “Steps for Assessment” such as “conduct the interview preferably the day before or day of the ARD.” In the absence of similar guidance on the timing of staff assessments, one interpretation is that staff assessment interviews should be completed after the ARD to allow collection of information from the entire observation period, up to and including 11:59 p.m. on the ARD.

On October 6, CMS clarified that, just as the Resident Interviews must be completed on or before the Assessment Reference Date (ARD), the Staff Interviews should also be completed on or before the ARD to assure that information relates to the observation period. CMS provided the following information:

assure that it will not happen again. For this individual situation:

- *Answer the gateway question, e.g., C0100, J0200, honestly: yes, the assessment should be conducted.*
- *Enter dashes in the rest of the resident interview items.*
- *Do not complete the resident assessment after the ARD.*
- *Do not complete the staff assessment.*
- *Document the reason the assessment was missed in the resident's clinical record.*

Work the CAA if you are aware that this is an issue for the resident. You are still responsible to see that interventions are put in place to assure that the resident receives the highest level of care.

Q: Is a resident who only can move his eyes considered to be interviewable?

A: *What patterns have been set up to communicate with this resident? If a question is asked, can he look to the right to indicate Yes, to the left to indicate No? This way of sharing information may be the only control the resident has for his life. Particularly for the identification of pain, try to establish a pattern to obtain information so you can help him to have a comfortable life.*

Q: How do you complete the Functional Abilities and Goals in Section GG?

A: *This is a new section that will be added to MDS 3.0 for completion beginning October 1, 2016. As the date comes closer, training will be provided.*



- “Staff interviews are not a replacement for Resident interviews, so should only be completed when resident is rarely or never understood, as directed in the RAI Manual.
- “Interviews” have to be completed within the look-back period (with the one exception of an off-cycle OMRA as directed p. 2-55).
- If the staff interview is warranted due to meeting the criteria to complete but the staff interviews were not completed in the look-back period, staff interviews cannot be done after the ARD.
- If the staff interview is warranted due to meeting the criteria to complete, but the staff interviews are not able to be done by the end of the ARD and there is supporting

(Continued on page 3)

Decrease in Antipsychotic Use



CMS is tracking the progress of the National Partnership to Improve Dementia Care in Nursing Homes by reviewing publicly reported measures. The official measure of the Partnership is the percentage of long-stay nursing home residents who are receiving an antipsychotic medication, excluding those residents diagnosed with schizophrenia, Huntington's Disease or Tourette's Syndrome.

In Quarter 4 of 2011, 23.9% of the long-stay nursing home residents were receiving an antipsychotic medication. Since

then, there has been a decrease of 24.8% to a national prevalence of 18.0% in Quarter 2 of 2015. In Pennsylvania, use has dropped from 22.3% in Quarter 4 of 2011 to 16.57% in Quarter 2 of 2015, a decrease of 25.7%. The report is available at https://www.nhqualitycampaign.org/files/AP_package_20151009.pdf.

The next MLN Call on Dementia Care will occur on Tuesday, December 1, 2015 at 1:30 PM. Register for the call at <http://www.eventsvc.com/blhtechnologies>.

RAI Manual Updates (cont'd)

(Continued from page 1)

QIES ASAP system.

For OBRA assessments, the assessment schedule is determined from the resident's actual date of admission. Please note, if a facility completes an Admission assessment prior to the certification date, there is no need to do another Admission assessment. The facility will simply continue with the next expected assessment according to the OBRA schedule, using the actual admission date as Day 1. Since the first assessment submitted will not be an Entry or OBRA Admission assessment, but a Quarterly, Discharge, etc., the facility may receive a sequencing warning message, but should still submit the required assessment."

COT Assessment. There has been confusion as to whether a COT assessment is required when Day 7 falls on the Discharge Date. Page 2-52 now contains clarifying information.

"In cases where the last day of the Medicare Part A benefit (the date used to code A2400C on the MDS) is prior to Day 7 of the COT observation period, then no COT OMRA is required. If the date listed in A2400C is on or after Day 7 of the COT observation period, then a COT OMRA would be required if all other conditions are met. Finally, 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 day 7 of the COT observation period, then no COT OMRA is required. Facilities may choose to combine the COT OMRA with the Discharge assessment under the rules outlined for such combination in this chapter."

ICD-10 Requirement. As of October 1, 2015, SNFs/NFs are required to use ICD-10 codes in MDS Section I8000 Additional Active Diagnoses. Some specific guidance was provided on page I-4 in the revised manual.

"If an individual is receiving aftercare following a hospitalization, a Z code may be assigned. Z codes cover situations where a patient requires continued care for healing, recovery, or long-term consequences of a disease when initial treatment for that disease has already been performed. When Z codes are used, another diagnosis for the related primary medical condition should be checked in items I0100-I7900 or entered in I8000. ICD-10-CM coding guidance with links to appendices can be found here: http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050855.hcsp?dDocName=bok1_050855."

Pressure Ulcers. Another clarification was added on page M-5 dealing with MDS Item M0210 Unhealed Pressure Ulcer(s).

"If a resident had a pressure ulcer that healed during the look-back period of the current assessment, but there was no documented pressure ulcer on the prior assessment, **code 0.**"

Staff Assessment Timing (cont'd)

(Continued from page 2)

data in the medical record within the look-back period to answer the questions, the questions can be answered per medical record review and encoded within the allowable time frames. However, if there is no supporting documentation in the medical record within the look-back period, then the answers should be dashed. (p. 2-36 "The use of the dash ('-') is appropriate when the staff are unable to determine the response to the item, including the interview items.")



The gathering of information on the MDS is extremely important as it leads to the development of a resident-specific care plan. Several questions were raised during the teleconference on Interviewing on October 8, 2015, as to how to deal with information gained outside the time parameters for entry on the MDS. If you are aware of information that affects the resident's health status, you are responsible to see that the information is evaluated and incorporated into the resident's care plan as appropriate. The CAT does not have to trigger to allow you to work the appropriate CAA; the CATs are only a tool to aid you in interpreting MDS data responses.



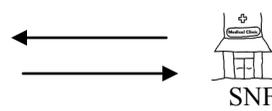
New PASRR Forms

All individuals who are admitted to a Medicaid certified nursing facility must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID)/developmental disability (DD), or related conditions regardless of the resident's method of payment.

Pennsylvania has made changes to the PASRR Level I and Level II forms based on recommendations from CMS. These updated forms will be effective January 1, 2016.

The Office of Long-Term Living is providing training on both new forms on multiple dates, the last being on January 13, 2016. Contact your Field Operations Representative for details about the available sessions. Registration is required. Handouts are available at <http://www.dhs.pa.gov/provider/longtermcarecasemixinformation/index.htm>; select OBRA Training Information from the list on the right side.

Readmissions



Hospital readmissions of Medicare beneficiaries discharged from a hospital to a skilled nursing facility are common: 23.5 percent of SNF stays resulted in a rehospitalization within 30 days of the initial hospital discharge. The average Medicare payment for each readmission was \$10,352 per hospitalization, for a total of \$4.34 billion in 2006. Of these rehospitalizations, 78 percent were deemed potentially avoidable.

This information is taken from a report detailing the development of the SNF Readmission Measure: All-Cause Risk-Standardized Unplanned Readmission Measure (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNFRM-Technical-Report-3252015.pdf>) which is being calculated beginning October 1, 2015 using fee-for-service Medicare claims. The SNF does not have to submit any further information for the calculation of this quality measure.

The measure is complex, not simply a calculation of the number of readmissions divided by number of Medicare Part A admissions. The SNF admission must occur within one day of discharge from the prior hospital stay. The readmission to the hospital must occur within 30 days of admission to the SNF. The resident must have been enrolled in Medicare Part A for the last 12 months so that data is available to calculate comorbidities. The resident's stay is excluded from the calculation for many reasons, e.g., prior proximal hospitalization was for the medical (non-surgical)

treatment of cancer or the resident was receiving rehabilitation care or prostheses fitting. This Quality Measure calculation produces a risk-adjusted readmission rate for each facility.

Beginning October 1, 2016, this measure will be intensified to include identification of potentially preventable hospital readmissions and to adjust the calculation accordingly (<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/MMS/Downloads/Draft-Measure-Specifications-for-Potentially-Preventable-Hospital-Readmission-Measures-for-PAC-.pdf>).

CMS also identified a need to update Chapter 8 of the Medicare Benefit Policy Manual at 20.2.3 Readmission to a SNF (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf>) dealing with readmission to Medicare Part A coverage. This section now reads:

“If an individual who is receiving covered post-hospital extended care, leaves a SNF and is readmitted to the same or any other participating SNF for further covered care within 30 days of the last covered skilled day, the 30-day transfer requirement is considered to be met. The same is true if the beneficiary remains in the SNF to receive custodial care following a covered stay, and subsequently develops a renewed need for covered care there within 30 consecutive days. Thus, the period of extended care services may be interrupted briefly and then resumed, if necessary, without hospitalization preceding the resumption of SNF coverage.”

Italics indicate new wordage added.



Flu Vaccines in Nursing Homes

The Agency for Healthcare Research and Quality funded a study on the effectiveness of flu vaccine in nursing homes which was published in the *Journal of the American Geriatrics Society*. The study found that administration of effective influenza vaccines in U.S. nursing homes saved about 2,560 lives and prevented more than 3,200 hospitalizations annually.

Researchers studied more than 1 million Medicare fee-for-service, long-stay nursing home residents between 2000 and

2009. With well-matched vaccines, deaths dropped by an estimated 2 percent; pneumonia/influenza hospitalizations dropped 4.2 percent. The study concluded that influenza vaccination is an important strategy for preventing both flu and pneumonia in these elderly adults.

Flu season has begun. Be certain that all your residents and their families have been educated on the benefits of vaccination and, unless medically contraindicated or refused, that the residents have received this year's vaccine.