RAI Version 2.0 Q&As
April-June 2008

Questions on Section 2 – Quarterly Assessments

Question - A nursing home corporate consultant is initiating a move for her MDS coordinators to do multiple quarterly assessments to capture acute conditions and potentially raise revenues. She is saying that the coordinators can do more than 3 quarterlies (even 4-6 or more) in a year. In these situations there have not been any Significant Changes. Would this be a safe and legal practice with solid basis from the RAI manual?

Answer - There is nothing in the RAI User's Manual at this time to prohibit the completion of additional quarterly assessments. However, completing a MDS to capture acute conditions is not the intent of the manual. While there is no prohibition against doing more than 3 quarterly assessments, at the last RAI conference, it was stated that CMS has begun to gather information on facilities that have more than 4 quarterly assessments in the data base during a 12 month period before an annual or SCSA is completed.

In addition, if a Quarterly is being completed when a resident is having an acute episode, the facility should determine whether or not J5a needs to be coded and also should determine whether or not a SCSA needs to be completed following the criteria in Chapter 2 of the User's Manual.

AHSFA RAI Panel 04/01/2008

Question on Section D

Question – A resident in a N.H. is blind in one eye; he is also cognitively impaired. The nurse asked if he should be coded for side vision loss. She had not made observations as described in the manual on p. 3-59 nor had she done a health record review. She was considering coding based on the diagnosis alone. She indicated resident's cognition prevented accurate verbal response from the resident.

I indicated to her she should follow the process as described on p.3-59 to determine accurate coding and not just use the diagnosis. Was this correct or is there a better response? Any insight would be appreciated.

Answer - Your response to the provider was both thoughtful and appropriate. The process as outlined in the manual should be followed. The manual indicates the resident should be observed during his daily routine; should be asked about any vision problems; and the primary nursing assistant and direct care staff on each shift, if possible, should be asked whether or not the resident appears to have difficulties related to decreased peripheral vision. This process allows the person coding this item to get input from multiple sources, which greatly increases the probability that the coding will be accurate. If the individual responsible for coding this item does not follow the process as outlined in the manual, they may potentially code it incorrectly. Coding this item based on diagnosis alone is inappropriate.

AHSFA RAI Panel 04/02/2008

Question on Section G

Question - Could you comment on facilities delegating CNAs to complete sections of the MDS having to do with ADLs. Is this becoming a more frequent practice? Has CMS ever commented on this?

Answer – The manual indicates (page 1-18) that it is the facility's responsibility to determine who has the knowledge, skills and abilities to complete the MDS. In most cases, participants will be licensed health professionals. Nursing assistants should certainly be a source of information, but there is more to assessing a particular area than what the nursing assistant can provide.

In some facilities nursing assistants use electronic charting for ADLs. When it is time for an assessment, the MDS coordinator pulls the electronic information and enters it into the MDS program. However, the MDS nurse would still have to make a determination as to the appropriateness of the coding and resolve any inconsistencies.

AHSFA RAI Panel   04/21/2008

Question on Section H

Question - State reimbursement allows for reimbursement of both a catheter and
an ostomy. Recently we have seen that facilities are checking both H3d (indwelling catheter) and P1af (ostomy) for a supra-pubic catheter.
Should a supra pubic catheter also be coded at P1af?

Answer - The appropriate coding for a supra-pubic catheter would be: H3d
(indwelling catheter), H3i (ostomy present), and P1(a)(f) could also be coded if nursing assistance is required (see page 3-183 in the RAI User's Manual).

AHSFA RAI Panel   04/01/2008

Question on Section J

Question – Scenario: The resident has good control moving from a low bed to the mattress on the floor. If a resident in bed deliberately flips onto his stomach and then crawls out of bed to a mat on the floor is this considered a fall?

Staff considers it a safe transfer. It is a deliberate movement; the resident wants to move to the mat on the floor. Sometimes it is witnessed but at other times staff walks in and finds him on the mattress. There have been no injuries. The resident is unable to state why he does it but he does deliberately flip on to his stomach and then lowers himself to the mat.

The MDS criteria for J4 Accidents say that the distance from one level to another is not a factor. What if it is a deliberate action?

Answer - There are many questions that the facility must address before making a determination. Observation and assessment of the specific resident and what this behavior actually represents, is a key issue. Has this resident had previous falls? Is the low bed and mat in place because the resident has a history of falls? What is his motivation for getting out of bed?

Consider carefully if the resident has been observed crawling out of bed on some occasions and has also been observed rolling out of bed in the past. How would one know, if it was not witnessed, that the resident intended to get out of bed on this particular occasion? If the person cannot communicate well and is cognitively impaired, how do you know what is "deliberate" and what is not? How much control does he really have if he has to "flip" over rather than turn over in the bed?

It really needs to be based on good clinical observation and judgment and only the ones at the bedside can answer these questions. After much discussion, the panel believes there are just too many variables to give you a definitive response. We believe the determination can be found in the answers to these questions.

AHSFA RAI Panel 05/13/2008

Questions on Section K

1. K5a

Question –Scenario: Pt admitted with ankle surgery. Resident was in hospital from 5-8 thru 5-14. Throughout her hospital stay she was constipated and nauseated post surgery. RD noted on 5-13 that resident's PO's are sips and bites. Patient received IV fluid of Ringers Lactate 50 ml per hour on 5-9 and IV Normal Saline with KCL 2 bags on 5-9 and 5-11 and 1 bag on 5-12. The ARD was 5-16. Under these circumstances can we code IV fluids under section K?

Answer – The panel agreed that even though the documentation to support the need for extra fluids came later, fluids provided after the recovery room could be counted.

AHSFA RAI Panel 05/22/2008

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2. K5b

Question – If the Resident still has a gastric tube, and no longer receives any nourishment through the tube, but the tube is still PRESENT. Are we still checking this section?

Answer - The panel reviewed this and all agree that the definition on page 3-153 speaks to the "Presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system" to mean just that...the presence of the tube. So, it can be coded even if not used.

AHSFA RAI Panel 05/21/2008

Questions on Section M

1. M5i

Question - If Aloe Vesta Body Wash and Shampoo is used to bathe a resident (it contains a humectant to retain moisture, aloe barbadensis to sooth irritated skin and an antimicrobial to fight bacteria) can this be coded in M5i (other Preventative or Protective Skin Care)?

Answer - Yes, these items could be coded at M5i.

AHSFA RAI Panel 04/01/2008

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2. M4b

Question - Person fell at home & burned her wrist on a heater during the fall. After time in the hospital, she was admitted to a facility. The facility coded the area on the wrist as an abrasion & documented that it was scabbed over. They have hospital documentation to support.

On 4/8/08 the physician & the wound nurse felt that "something" was under the scab. To feel the area, it felt like a "bump" & the edges of the scab were curling up. The physician ordered soaks to be applied. The scab has since loosened itself & fell off, exposing the tendon underneath. How should the area be coded?

Answer – The panel doesn't understand why this would have been coded as an abrasion. The information provided indicated this originated as a burn that never healed and there was nothing to say that pressure or circulation was involved. The panel would support coding this as a burn at M4b. The burn event itself did not have to happen in the past 7 days, just the presence of the skin problem.

AHSFA RAI Panel   05/07/2008

Questions on Section P

1. P1b

Question – On page 3-185, P1b says, "the therapy treatment may occur either inside or outside the facility". What does this mean?

Answer - On page 3-185 of the RAI Manual, the end of the second paragraph says, "The therapy treatment may occur either inside or outside the facility." This refers to "where" the therapy can be provided, thus the location does not matter. The resident can receive the therapy treatments in the nursing home or they can go out of the actual facility and receive the therapy in another setting (clinic, hospital, etc.) The key is that the therapy is provided after the individual has been admitted to the nursing home and it meets all of the other criteria (physician order based on a therapist evaluation and is documented in the clinical record and plan of care).

AHSFA RAI Panel   05/02/2008

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2. P2d

Question - I have had questions raised in regards to P2d "Resident-Specific Deliberate Changes in the Environment to Address Mood/Behavior/Cognitive Patterns." A facility has modified a locked unit to enable freedom of movement and to cue the cognitively impaired. These are deliberate environment changes such as providing bureau in which to rummage. Should P2d be checked for the residents in the locked unit since they modified the entire unit to enable freedom of movement?

What if a resident is placed in a secure unit so he/she can walk without being attended or restrained in a Merry Walker? Would P2d be checked?

Answer - Page 3-191 of the RAI User's Manual refers to this item as, "Adaptation of the milieu focused on the resident's individual mood/behavior/cognitive pattern." To determine whether or not to code this item, you need to consider if the environment has been adapted to address the needs of the individual who's MDS is being coded. If the facility can identify environmental changes specifically benefiting this resident, code this item. It would not be appropriate to code this item just because the unit is secure.

AHSFA RAI Panel 04/01/2008

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3. P3

Question - We recently did training on Restorative Nursing. A question was asked if volunteers could be used for restorative care. The RAI Manual on page 3-193 under Training and Skill Practice states - - - "provided by any staff member or volunteer under the direction of a licensed nurse." Would volunteers be an acceptable practice for nursing rehabilitation/restorative care? What would be the legal requirements for volunteers?

Answer - There are a number of factors to be considered.
Yes, on page 3-193 under "TRAINING AND SKILL PRACTICE" the manual indicates that certain types of activities can be provided by a volunteer under the supervision of a licensed nurse. However the panel wants to caution you that this has some state specific implications in that you must check your own state rules and regulations governing the use of volunteers in nursing homes.

This is also a nursing delegation function and the volunteers would need to be trained. The delegation would come under the license of the nurse providing supervision, and the nurse would need to document that the volunteer is competent to complete the delegated function. Nursing would still be responsible to set it up, monitor, and evaluate to assure the program is appropriate for the resident, and ensure it is implemented in the correct and safe manner.

Additionally, due to privacy issues, the facility would need to be very careful regarding the type of information about each resident that would be shared with the volunteer.

Finally, certain restorative programs like exercise groups and make-up application lend themselves well to volunteer participation, but clearly these must be specific to the needs of the residents(s) involved.

AHSFA RAI Panel 04/24/2008

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4. P6

Question - A resident is sent to the E.R. and kept overnight (sometimes as long as 2 days) but never admitted. Where and how would this be coded? It does not seem to fit the intent for P.5 (not formally admitted) or P.6. ....not admitted to hospital for an overnight stay at the time of the ER visit. According to staff, the resident was kept overnight but not 'admitted' to the hospital.

Answer - If a resident is held in the ER for more than 24 hours but not admitted, a discharge tracking would still be required, followed by a reentry. If an assessment is completed/due at that time, the ER visit would be captured in P6, provided it is in the look-back period.

AHSFA RAI Panel 05/02/2008

Questions on RUGS (Resource Utilization Groups) Section 5 (page 5-5) Section 6 (pages 6-2,3,4,8)

1. RUGs for MDS 3.0

Question – Our Medical Director named some areas that he felt required a lot of

nursing intervention and yet didn't impact a RUG score from what we could tell. Those are: Intermittent catheterizations, diarrhea (captured in Section H but not impacting Case Mix Index, isolation precautions for MRSA, VRE and C-Diff. Are we missing something and is there an avenue? Are there any provisions for any of these in 3.0?

Answer - Of the 600+ items on the MDS only 108 predict resource utilization.
Until we see the final MDS 3.0 tool and the results of the STRIVE (Staff Time and Resource Verification), we will not know which items remain, which were added (if any) and which were removed. The STRIVE Project will provide accurate information for updating payment systems for nursing facilities.

AHSFA RAI Panel 05/30/2008

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2. RUGs and ADL score over 10

Question - If a patient has an ADL score of 18 and also has impaired cognition and/or verbal and physical abuse issues, do they end up as a Behavior or Cognition Rug or a high Physical - my grid doesn't have anything in Behavior or Impaired Cognition over an ADL score of 10?

Answer – That is correct, when ADL index scores exceed 10, the resident is no longer in those categories but could go to reduced physical function (PE1, PE2).

AHSFA RAI Panel 05/30/2008

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3. Rehab RUG

Question - When a patient comes in to our Extended Care & Rehab facility sometimes they might not start Rehab right away (for one reason or another). When they finally do start Rehab how can we capture the Rehab RUG when their admission comprehensive already was completed? We don't think we're eligible to do a Sig Change although the director did say that in one sense they've "improved" enough to start rehab.

Answer - If you are doing the comprehensive initial admission OBRA assessment early,
you may want to delay that until later in the resident's stay - perhaps an ARD of
day 10 or 11 and see if that helps. If this is a Medicare resident, the Rehab RUG would or could be captured on the next Medicare assessment, assuming that the 5 day was done, then the 14 day could capture the minutes and thus the Rehab RUG. A Sig Change should only be done if it meets the criteria for a significant change.

AHSFA RAI Panel 05/30/2008