RAI Panel Q&As
August-September 2008

Assessment Questions

Question – I understand that if a facility misses an assessment and discovers it shortly thereafter, they should do an assessment with a current ARD now. For example, if a facility missed an April quarterly assessment and discovered it in May, they would do a quarterly in May and transmit. They would be out of compliance with the assessment schedule for the period from April until the assessment was done in May. Correct?

Answer – YES, that is correct. Additionally, the facility would have gotten a warning error message saying that the quarterly assessment was late.

AHFSA RAI Panel 08/07/2008

Question - What if a facility does not discover that they missed an assessment for many months? Let's say they do a quarterly in May and an annual in August on a resident. Then, they discover that the quarterly that was due in February was never done. What do they do?

Answer – There is nothing to do at this point – just get back on schedule; the next quarterly would be due in November. If an assessment has been missed and it is now time to do another assessment, the facility needs to complete the one that is due now and forget the old one.

AHFSA RAI Panel 08/07/2008

Question – The facility found they didn't do an admission assessment when they got ready to do their quarterly. I know they can't backdate nor create an assessment that wasn't done. Do they now do a comprehensive assessment for their quarterly and get a warning that it is out of sequence or will there be other consequences?

Answer - We are glad you sought clarification. The facility needs to complete a full assessment (admission)as soon as possible. They cannot go back and recreate the assessment from the missing time period. The AB1-Date of Entry, would be the actual admission date but the ARD would have to be current. They will be considered out of compliance with the requirements for the time period that a valid assessment was not present, so the sooner they can establish a new assessment reference date (ARD) and complete the assessment the better. They should also document in the resident's record, to explain why it was being done that way.

There may also be state specific requirements that apply to these types of situations that will need to be considered in addition to the federal requirements.

AHSFA RAI Panel 08/07/2008

G1b(B) ADL Support Provided
Question – When using a sit to stand lift, if 1 person is operating the lift for a transfer, would G1b(B) be coded "3" (ADL Support Provided - two person transfer)? Would the lift itself be count as a person, as well as the person running the lift?

Answer – No, a standing lift is an assistive device, not a person.

AHFSA RAI Panel 08/27/2008

Section I

I1z Quadriplegia

Question – In the September 2007 ICD-9-CM Coordination and Maintenance Committee Meeting, "Functional Quadriplegia" was defined as "the inability to move due to another condition (severe contractures, arthritis, etc.) and functionally the patient is the same as a paralyzed person." Would this include a resident with dementia who is bedridden, or frail, or in the end stage of life?

Answer – New ICD-9 diagnostic codes in the Symptom chapter have been proposed but currently there is no such diagnosis as functional quadriplegia. It is the responsibility of the physician, not the billing or medical records department, to provide the correct diagnoses.
Regardless of the cause, if the physician is willing to provide the diagnosis of quadriplegia, and it meets the rest of the criteria, it can be coded under I1z.

AHFSA RAI Panel 09/10//2008

Section M

Question - If a hematoma was surgically removed, does it then become a surgical wound?

Answer – On page 3-166 (M4g) says a surgical wound includes "healing and non-healing, open or closed surgical incision, skin graft or drainage site on any part of the body." If surgery was performed, then we would assume it would be reasonable to code it as surgical wound.

AHFSA 08/22/2008

Question - A resident was run over with her car; How would you code this type of wound?

Answer - We don't have enough information to respond to this. Were there bruises, abrasions, skin tears, broken bones? Was surgery involved?
The resident should be assessed for the wounds that were received during this accident and then all wounds should be coded accordingly. For example if she sustained a hip fracture then it would be coded in section J – If the injuries don't fit elsewhere, then code the injury at I3.

AHFSA 08/22/2008

Section P

P1ac or O3 for Intrathecal Injection

Question - Should an intrathecal injection (no IV tubing is used and there is no artificial "port" to use) be coded at P1ac?

Answer - The RAI Manual states that epidural, intrathecal and baclofen pumps can be counted at P1ac. If this had been an intrathecal *pump*, the rationale in the manual suggests that it be coded under P1ac(IV Medication) because the continuous administration of a substance would require frequent monitoring.
Given the circumstances in the example, the intrathecal injection directly into the site, without a port or a pump, would not
count per the manual. This was just one injection and would be coded under O3(Injections).

AHFSA 08/25/2008

P1a(d) Chest Tube Excretions

Question - When a resident has a chest tube, is the volume of fluid collected from the chest tube included in the output?

Answer - If there is clinical documentation showing monitoring and measurement of the chest tube excretions for at least 3 consecutive shifts, then it can be coded at P1a(d).

AHFSA RAI Panel 08/11/2008

Compound Fracture

Question - Resident fell & fractured femur. No surgery at the time of fracture. The bone then worked through the skin for a compound fracture. The resident is not a surgical candidate & refused surgery. The resident is now in traction & the fracture has been reduced.

Sections I and J4 should be coded. Should this scenario be coded elsewhere?

Answer - The facility will want to consider P1a(e) – Monitoring Acute Medical Condition. This resident is a poor candidate for surgery and/or is refusing surgery and, where there had been some sort of mobility, this person is now on full bed rest. Certainly there is a greater risk for a number of issues including pressure ulcers, so it would seem reasonable that this resident will require much closer monitoring and preventative measures put in place.

AHFSA RAI Panel 08/08/2008

P1b(e) Psych Therapy

Question – Can a MSW employed by the facility, code the physician ordered psychological therapy minutes she provides that is over and above her role as the facility social worker? The facility MDS coordinator thinks this would not be acceptable since she works for the facility and doesn't have a Medicare provider I.D. and these minutes would increase their RUG scores.

Answer – The keyword here is "licensed mental health professional." In Chapter 3 at P1b(e), the RAI Manual lists a psychiatric social worker as an example of a licensed mental health professional. The manual also specifies that if the state doesn't license a category of professionals, then the services provided by that individual cannot be coded for this item. The panel does not believe a Medicare provider I.D is relevant to the issue and Psychological therapy is not a RUG item.

AHFSA RAI Panel 09/08/2008

P3j Rehabilitation/Restorative Care

Question - Can a restorative program(P3j)be coded when the deficit is a language barrier(only speaking a foreign language)? The RAI manual mentions functional communication skills, but does this include a language barrier?

Answer –On page 3-54, the manual differentiates between speaking a different language versus having a functional problem. At P3j, the MDS is meant to capture Nursing restorative/rehab programs - often initiated after formalized physical, occupational, or speech rehabilitation therapy. Speech therapists are not involved in teaching foreign languages. If this person has no "functional" speech impediment & the only problem is "communication," then communication issues are captured in Section C.

AHFSA RAI Panel 08/27/2008

Extra RAPs

Question - "May I complete a RAP even if it is not triggered?"

Answer - See pages 1-13 to 1-14 of the RAI Manual, and a reference to the determining factor for the RAP process can be found on page 4-5, item #4, where it states: "Based on the review of assessment information, the interdisciplinary team

decides whether or not the triggered condition affects the resident's functional status or well-being and warrants a care plan intervention." Also, the manual states the RAP process may be applied to triggered and non-triggered items and even to items that are not listed - see item #2 same page. ~~The key words here are "warrants a care plan intervention." The facility must make the clinical judgment in this area.

AHFSA 08/22/2008

“I” Care Plans

Question - I have briefly mentioned the “I” care plans in training. My attendees want to know if CMS will be looking for them to be used in the near future.

Answer - On page 4-26 of the RAI Manual, it says, “It is not the intent of this chapter to specify a care plan structure or format.” Beginning on page 4-29, the manual also directs the reader to the care planning requirements at the specified F Tags.

In accordance with F279, a care plan must be oriented toward preventing avoidable decline and have measurable objectives. The Panel agrees that done correctly, the “I” care plans do have an individualized approach. However to this point, CMS has chosen not to dictate the format of the plan of care and we do not believe that stance will change.

AHFSA RAI Panel 09/02/2008