OCTOBER 2017 RAI MANUAL UPDATES

CMS released the updated RAI Manual on August 31, 2017 for use with Assessment Reference Dates (ARD) on or after Oct 1, 2017. There are two sections that are completely new, a new ADL algorithm, and some surprising coding instructions.

CHAPTER 2, SECTION 2.5, PAGE 2-11

Interdisciplinary Team (IDT[1]) is a group of professional disciplines that combine knowledge, skills, and resources to provide the greatest benefit to the resident.

[1]42 CFR 483.21(b)(2) A comprehensive care plan must be (ii) Prepared by an interdisciplinary team, that includes but is not limited to - the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident, and, to the extent practicable, the participation of the resident and the resident's representative(s).

COMMENTARY

This language is consistent with the new requirements for person centered care planning that will be required for Phase 2 implementation of the new Requirements of Participation.

CHAPTER 2, REQUIREMENTS FOR SIGNIFICANT CHANGE IN STATUS ASSESSMENTS

Page 2-22:

A **"significant change"** is a major decline or improvement in a resident's status that:

1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting";
2. Impacts more than one area of the resident's health status; and
3. Requires interdisciplinary review and/or revision of the care plan.

Page 2-25:

Guidelines for Determining a Significant Change in Resident's Status:

Decline in two or more of the following:

- Resident's decision-making ability has changed
- Presence of a new mood item not previously reported and/or an increase in the symptom frequency
- Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment;

- Any decline in an ADL physical functioning area (at least 1) where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment and does not reflect normal fluctuations in that individual's functioning;
- Resident's incontinence pattern changes or there was placement of an indwelling catheter;
- Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days);
- Emergence of a new pressure ulcer at Stage 2 or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status;
- Resident begins to use a restraint of any type when it was not used before; and/or
- Emergence of a condition/disease in which a resident is judged to be unstable.

Improvement in two or more of the following:

- Any improvement in an ADL physical functioning area (at least 1) where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment and does not reflect normal fluctuations in that individual's functioning;
- Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases;
- Resident's decision making improves;
- Resident's incontinence pattern improves.

COMMENTARY

The additional guidance for ADL decline and improvement is a welcome change. It is very easy for ADLs in Section G0110 to appear to meet the old criteria for significant change when the changes did represent normal fluctuations.

SIGNIFICANT CORRECTION TO PRIOR COMPREHENSIVE ASSESSMENT, PAGE 2-30:

A **"significant error"** is an error in an assessment where:

1. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment and/or results in an inappropriate plan of care; and
2. The error has not been corrected via submission of a more recent assessment.

COMMENTARY

There are two types of significant correction MDS assessments:

1. Significant Correction to Prior Comprehensive Assessment and
2. Significant Correction to Prior Quarterly Assessment

It is curious the definition of a "significant error" has changed for the Significant Correction to Prior Comprehensive, but not for "prior quarterly." Here is that definition on page 2-34 when discussing Significant Correction to Prior Quarterly:

A **"significant error"** is an error in an assessment where:

1. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment; and
2. The error has not been corrected via submission of a more recent assessment.

CHAPTER 2, SECTION 2.7, THE CARE AREA ASSESSMENT (CAA) PROCESS AND CARE PLAN COMPLETION, PAGE 2-41

It is important to note that for an Admission assessment, the resident enters the nursing home with a set of physician-based treatment orders. Nursing home staff should review these orders and begin to assess the resident and to identify potential care issues/ problems. Within 48 hours of admission to the facility, the facility must develop and implement a Baseline Care Plan for the resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of care (42 CFR §483.21(a)). In many cases, interventions to meet the resident's needs will already have been implemented to address priority issues prior to completion of the final care plan. At this time, many of the resident's problems in the 20 care areas will have been identified, causes will have been considered, and a baseline care plan initiated. However, a final CAA(s) review and associated documentation are still required no later than the 14th calendar day of admission (admission date plus 13 calendar days).

CARE PLAN COMPLETION, PAGE 2-42

Care plan completion based on the CAA process is required for OBRA-required comprehensive assessments. It is not required for non-comprehensive assessments (Quarterly, SCQA), PPS assessments, Discharge assessments, or Tracking records. However, the resident's care plan must be reviewed after each assessment*,* as required by §483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.

COMMENTARY

The baseline care plan was added to a bullet under the heading "CAA Completion" and could easily be missed. This is also a new requirement for Phase 2 of the Requirements of Participation. There were no changes in guidance for a comprehensive person-centered plan of care in Chapter 4, but the new interpretative guidelines for care planning in Appendix PP of the State Operations Manual (SOM) must be carefully read and incorporated into the care planning process.

INTRO TO CHAPTER 3 PAGE 3-3

With the exception of certain items (e.g., some items in Sections K and O), the look-back period <u>does not</u> extend into the preadmission period unless the item instructions state otherwise. In the case of reentry, the look-back period <u>does not</u> extend into time prior to the reentry, unless instructions state otherwise.

COMMENTARY

CMS is cleaning up an old mistake that most providers didn't realize ever happened. When we converted to the MDS 3.0 in October 2010, the instructions in Section G said the look back period was seven days or since the last admission/reentry. A few years ago, during a revision of Section G, that line dropped out. This revision clears that up. Unless the coding instructions for an item specifically allow the look back

period to extend into the pre-entry timeframe, the look back period only goes back to the first day of the stay.

CHAPTER 3, SECTION A2400: MEDICARE STAY A-35 & A-36

COMMENTARY

In the update for October of 2016, CMS added two erroneous coding examples under this section:

- Example 3 on page A-35 and
- Example 5 on page A-36.

It's not helpful to explain what the error was. The important point is this: If the last covered day of a Medicare stay is on or one day before a physical discharge, we must combine the Part A PPS discharge with the OBRA discharge. It's a forced combination if A2400C is coded correctly. Section GG is not required on this combination if the physical discharge is

- Unplanned, or
- To the hospital or
- The SNF stay is less than 3 days

CHAPTER 3, SECTION G0110A ADL SELF PERFORMANCE

NEW ADL ALGORITHM PAGE G-8

COMMENTARY

The old ADL algorithm has been completely replaced. This is not a change in coding instructions for Column A, Self-Performance. The Rule of Three instructions have been re-worded. It is an attempt to clear up confusion over proper coding.

NEW CODING TIPS FOR G0110A SELF PERFORMANCE FOR MECHANICAL LEFT TRANSFERS PAGE G-9 & G-10

•Some residents are transferred between surfaces, including to and from the bed, chair, and wheelchair, by staff, using a full-body mechanical lift.

•Whether or not the resident holds onto a bar, strap, or other device during the full-body mechanical lift transfer is not part of the transfer activity and should not be considered as resident participation in a transfer.

•Transfers via lifts that require the resident to bear weight during the transfer, such as a stand-up lift, should be coded as Extensive Assistance, as the resident participated in the transfer and the lift provided weight-bearing support.

COMMENTARY

These coding tips clarify two things:

- "holding on" during a full-body mechanical lift transfer is not considers assisting in that transfer.
- If the resident bears weight during a transfer, (e.g. a stand up lift), this is an example of extensive assist and not total assistance.

New Coding Tips for G0110 Self Performance in Toileting Page G-9 and G-10

•How a resident turns from side to side, in the bed, during incontinence care, is a component of Bed Mobility and should not be considered as part of Toileting.

•When a resident is transferred into or out of bed or a chair for incontinence care or to use the bedpan or urinal, the transfer is coded in G0110B, Transfers. How the resident uses the bedpan or urinal is coded in G0110I, Toilet use.

Commentary

This is news to many MDS coders who considered that a resident's movement in the bed for the purpose of toileting was counted under "toileting" and not "bed mobility." These tips are likely to require retraining for any staff given responsibility to document ADLs. This could lower the ADL score for "toileting" for those cases.

Additionally, the reason for the transfer into or out of the bed is crucial to know which ADL to capture. If the transfer is for incontinence care or bedpan/urinal use, it is captured in "toileting" and not "transfers."

G0600C Mobility devices – Wheelchair use Page G-40

Check G0600C, wheelchair (manual or electric): if the resident normally sits in wheelchair when moving about. Include hand-propelled, motorized, or pushed by another person. **Do not include geri-chairs, reclining chairs with wheels, positioning chairs, scooters, and other types of specialty chairs**.

COMMENTARY

The great geri-chair debate is put to rest. For years, CMS has been stating verbally that geri-chairs are not included as wheelchars here and finally this instruction has made it's way into the coding instructions.

Section GG0130: Self-Care Admission (Start of Medicare Stay) Page GG-2

Steps for Assessment

8. Assess the resident's self-care status based on direct observation, the resident's self-report, family reports, and direct care staff reports documented in the resident's medical record during the assessment period. For Section GG, the admission assessment period is the first three days of the Part A stay starting with the date in A2400B, which is the Start of most recent Medicare stay. On admission, these items are completed only when A0310B = 01 (5-Day PPS assessment).
9. Residents should be allowed to perform activities as independently as possible, as long as they are safe.
10. For the purposes of completing Section GG, a "helper" is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). Thus, does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration such as hospice staff, nursing/certified nursing assistant students, etc. Therefore, when helper assistance is required because a resident's performance is unsafe or of poor quality, only consider facility staff when scoring according to amount of assistance provided.
11. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
12. Section GG coding on admission should reflect the person's baseline admission functional status, and is based on a clinical assessment that occurs soon after the resident's admission.
13. The admission functional assessment, when possible, should be conducted prior to the person benefitting from treatment interventions in order to determine a true baseline functional status on

admission. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.

14. If the resident performs the activity more than once during the assessment period and the resident's performance varies, coding in Section GG should be based on the resident's "usual performance," which is identified as the resident's usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the resident's Self-Care performance varies during the assessment period, report the resident's usual performance, **not** the resident's most independent performance and **not** the resident's most dependent performance. A provider may need to use the entire 3-day assessment period to obtain the resident's usual performance.
15. Refer to facility, Federal, and State policies and procedures to determine which staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.

COMMENTARY

None of these re-worded or newly added instructions represents a change in policy for collecting functional status in the first or last three days of a Part A stay.

ADMISSION OR DISCHARGE CODING TIPS, PAGE GG-5

Admission: The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay.

- For the 5-Day PPS assessment, code the resident's functional status based on a clinical assessment of the resident's performance that occurs soon after the resident's admission. This functional assessment must be completed within the first three days (3 calendar days) of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay and the following two days, ending at 11:59 PM on day three. The assessment should occur, when possible, prior to the resident benefitting from treatment interventions in order to determine the resident's true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.

Discharge: The Part A PPS Discharge assessment is required to be completed when the resident's Medicare Part A Stay ends (as documented in A2400C, End of Most Recent Medicare Stay), either as a standalone assessment when the resident's Medicare Part A stay ends, but the resident remains in the facility; or may be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or one day before the resident's Discharge Date (A2000). Please see Chapter 2 and Section A of the RAI Manual for additional details regarding the Part A PPS Discharge assessment.

- For the Discharge assessment (i.e., standalone Part A PPS or combined OBRA/Part A PPS), code the resident's discharge functional status, based on a clinical assessment of the resident's performance that occurs as close to the time of the resident's discharge from Medicare Part A as possible. This functional assessment must be completed within the last three calendar days of the resident's Medicare Part A stay, which includes the day of discharge from Medicare Part A and the two days prior to the day of discharge from Medicare Part A.

[For both Admission and Discharge Functional Status Assessments, GG-5]

- When coding the resident's usual performance, "effort" refers to the type and amount of assistance the helper provides in order for the activity to be completed. The 6-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.
- If the resident does not attempt the activity and a helper does not complete the activity for the resident, code the reason the activity was not attempted. For example, Code 07 if the resident refused to attempt the activity, Code 09 if the resident did not perform this activity prior to the current illness, exacerbation, or injury, or Code 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.

COMMENTARY

No new guidance in this section. Re-wording and new bullet points to clarify expectations

PAGE GG-6, EATING CLARIFICATION

- Clinicians may code the eating item using the appropriate response codes if the resident eats using his/her hands rather than using utensils (e.g., can feed himself/herself using finger foods). If the resident eats finger foods with his/her hands independently, for example, the resident would be coded as 06, Independent.

COMMENTARY

The definition of "Eating" for Section GG did not change, but the manual now instructs us that the word "utensils" in the definition can also mean the resident's hands.

PAGE GG-6, RE-WORDING AND NEW LANGUAGE ON DASHES IN SECTION GG

- Coding a *dash* ("-") in these items indicates *"No information."* CMS expects dash use for SNF QRP items to be a rare occurrence. Use of dashes for these items may result in a reduction in the annual payment update. If the reason the item was not assessed was that the resident refused (Code 07), the item is not applicable because the resident did not perform this activity prior to the current illness, exacerbation or injury (Code 09), or the activity was not attempted due to medical condition or safety concerns (Code 88), use these codes instead of a dash ("-"). Please note that **a dash may be used for GG0130 Discharge Goal items provided that at least one Self-Care or one Mobility item has a Discharge Goal coded using the 6-point scale**. Using the dash in this allowed instance does not affect APU determination. Further information about the use of a dash ("-") for Discharge Goals is provided below under Discharge Goal(s): Coding Tips.
- For the cross-setting quality measure, the *Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function*, a minimum of one Self-Care or Mobility Discharge Goal must be coded per resident stay on the 5-Day PPS assessment. Even though only one Discharge Goal is required, the facility may choose to code more than one Discharge Goal for a resident.

COMMENTARY

In several places throughout GG coding instructions they added language to clearly state that as long as one goal is selected in Col 2 on Admission GG, the rest of the goals must be dashed, and these dashes do not count towards the 2% APU reduction.

ADMISSION OR DISCHARGE CODING TIPS. ADDED BULLETS ON GG-7 & GG-22

- Completion of the Self-Care items is not required if the resident has an unplanned discharge to an acute-care hospital, or if the SNF PPS Part A Stay is less than 3 days.
- Completion of the Mobility items is not required if the resident has an unplanned discharge to an acute-care hospital, or if the SNF PPS Part A Stay is less than 3 days.

COMMENTARY

This was left out of the coding instructions last year. It was in the data specifications for the form, but this addition will help to lesson confusion over this issue.

EXAMPLES FOR GG0130A EATING

PAGE GG-7:

Eating: Mr. M has upper extremity weakness and fine motor impairments. The occupational therapist places an adaptive device onto Mr. M's hand that supports the eating utensil within his hand. At the start of each meal Mr. M can bring food and liquids to his mouth. Mr. M then tires and the certified nursing assistant feeds him more than half of each meal.

PAGE GG-8:

Eating: Mr. R is unable to eat by mouth since he had a stroke one week ago. He receives nutrition through a gastrostomy tube (G-tube), which is administered by nurses.

Coding: GG0130A, Eating would be coded 88, Not attempted due to medical condition or safety concerns.

•**Rationale:** The resident does not eat or drink by mouth at this time due to his recent-onset stroke. This item includes eating and drinking by mouth only. Since eating and drinking did not occur due to his recent-onset medical condition, the activity is coded as 88, Not attempted due to medical condition and safety concerns. Assistance with G-tube feedings is not considered when coding this item.

COMMENTARY

Throughout the "eating" examples in this section they changed all instances of "food" to "food and liquid." The definition of "eating" on the form is unchanged, but we are to consider food and fluid in this item. The other main focus in the "eating" examples is how to use the codes for "did not occur.". There are two examples here but careful reading of the new language in the GG coding instructions will help to clarify proper coding.

CLARIFICATIONS FOR TURNING IN SECTION GG, ADDED PARAGRAPH, PAGE GG-22:

The turns included in the items GG0170J and GG0170R (walking or wheeling 50 feet with 2 turns) are 90-degree turns. The turns may be in the same direction (two 90-degree turns to the right or two 90-degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right). The 90-degree turn should occur at the person's ability level and can include use of an assistive device (for example, cane or wheelchair.

COMMENTARY

This was clarified in the CMS "Q&A" documents last year and now is in the manual.

CODING TIPS FOR GG0170E, CHAIR/BED-TO-CHAIR TRANSFER, ADDED LANGUAGE PAGE GG-29

If a mechanical lift is used to assist in transferring a resident for a chair/bed-to-chair transfer and two helpers are needed to assist with a mechanical lift transfer, then Code 01, Dependent, even if the resident assists with any part of the chair/bed-to-chair transfer.

CODING TIPS FOR GG0170R AND GG0170S, WHEELCHAIR ITEMS - NEW GUIDANCE PAGE GG-38

The intention of the wheelchair items is to assess the resident's use of a wheelchair for self-mobilization at admission and discharge when appropriate. The clinician uses clinical judgment to determine if the resident's use of a wheelchair is appropriate for self-mobilization due to the resident's medical condition or safety.

Do not code wheelchair mobility if the resident only uses a wheelchair when transported between locations within the facility. Only code wheelchair mobility based on an assessment of the resident's ability to mobilize in the wheelchair.

If the resident walks and is not learning how to mobilize in a wheelchair, and only uses a wheelchair for transport between locations within the facility, code the wheelchair gateway items at admission and/or discharge items—GG0170Q1 and/or GG0170Q3, Does the resident use a wheelchair/scooter—as 0, No.

Answering the question in this way invokes a skip pattern which will skip all remaining wheelchair questions.

Admission assessment for wheelchair items should be coded for residents who used a wheelchair prior to admission or are anticipated to use a wheelchair during the stay, even if the resident is anticipated to ambulate during the stay or by discharge.

The responses for gateway admission and discharge walking items (GG0170H1 and GG0170H3) and the gateway admission and discharge wheelchair items (GG0170Q1 and GG0170Q3) do not have to be the same on the admission and discharge assessments.

COMMENTARY

The key to this new guidance is "self-mobilization." This is new guidance for the RAI Manual, although CMS did offer this guidance in the SNF-QRP Q&A documents after the manual was posted. There are several new coding examples for wheelchair use throughout this section. Careful review of these new examples will help to clarify understanding.

SECTION H0100: INTERMITTENT CATHETERIZATION, PAGE H-2

•~~Sterile~~ Insertion and removal of a catheter through the urethra for bladder drainage.

•Self-catheterizations that are performed by the resident in the facility should be coded as intermittent catheterization (H0100D). This includes self-catheterizations using clean technique.

COMMENTARY

By deleting the word “steril” and added a bullet about self-catheterization, CMS has expanded the definition to include residents who perform self-catheterization.

SECTION I, NEW DEFINITION OF UTI, PAGE I-8

Item I2300 Urinary tract infection (UTI): The UTI has a look-back period of 30 days for active disease instead of 7 days.

Code only if both of the following are met in the last 30 days:

1. It was determined that the resident had a UTI using evidence-based criteria such as McGeer, NHSN, or Loeb in the last 30 days, **AND**
2. A physician documented UTI diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days.

Facilities are expected to use the same nationally recognized criteria chosen for use in their Infection Prevention and Control Program to determine the presence of a UTI in a resident.

Example: if a facility chooses to use the Surveillance Definitions of Infections (updated McGeer criteria) as part of the facility’s Infection Prevention and Control Program, then the facility should also use the same criteria to determine whether or not a resident has a UTI.

Resources for evidence-based UTI criteria:

- Loeb criteria: https://www.researchgate.net/publication/12098745_Development_of_Minimum_Criteria_for_the_Initiation_of_Antibiotics_in_Residents_of_Long-Term-Care_Facilities_Results_of_a_Consensus_Conference
- Surveillance Definitions of Infections in LTC (updated McGeer criteria): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538836/
- National Healthcare Safety Network (NHSN): •https://www.cdc.gov/nhsn/ltc/uti/index.html

COMMENTARY

This is the first substantive change in the codling rules for UTI since the MDS 2.0 began. It is important for MDS coordinators to know what criteria the facility uses to diagnose and treat UTIs. This coding change has the potential to cause the UTI Quality Measure to trigger more often. Under the old coding rules, there were often UTIs being tracked in the facility infection control program that could not be coded on the MDS due to the strict coding rules.

SECTION J1700 DEFINITION OF A FALL PAGE J-27

CMS understands that challenging a resident’s balance and training him/her to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.

SECTION L: NEW DEFINITION OF EDENTULOUS, ADDED CODING TIPS PAGE L-1 & L-3

EDENTULOUS: Having no natural permanent teeth in the mouth. Complete tooth loss.

The dental status for a resident who has some, but not all, of his/her natural teeth that do not appear damaged (e.g., are not broken, loose, with obvious or likely cavity) and who does not have any other conditions in L0200A–G, should be coded in L0200Z, none of the above.

Many residents have dentures or partials that fit well and work properly. However, for individualized care planning purposes, consideration should be taken for these residents to make sure that they are in possession of their dentures or partials and that they are being utilized properly for meals, snacks, medication pass, and social activities. Additionally, the dentures or partials should be properly cared for with regular cleaning and by assuring that they continue to fit properly throughout the resident's stay.

SECTION M SKIN CONDITIONS: INTENT – NEW GUIDANCE, PAGE M-1

CMS is aware of the array of terms used to describe alterations in skin integrity due to pressure. Some of these terms include: pressure ulcer, pressure injury, pressure sore, decubitus ulcer, and bed sore.

Acknowledging that clinicians may use and documentation may reflect any of these terms, it is acceptable to code pressure-related skin conditions in Section M if different terminology is recorded in the clinical record, as long as the primary cause of the skin alteration is related to pressure.

For example, if the medical record reflects the presence of a Stage 2 pressure injury, it should be coded on the MDS as a Stage 2 pressure ulcer.

COMMENTARY

This is a nod to the updated language and guidance from the National Pressure Ulcer Advisory Panel. What remains unchanged is this: If the primary cause of the skin alteration is pressure, it is coded as a pressure ulcer in Section M.

M0210: UNHEALED PRESSURE ULCER(S), CODING TIPS, PAGE M-5

Mucosal pressure ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made. Therefore, mucosal ulcers (for example, those related to nasogastric tubes, nasal oxygen tubing, endotracheal tubes, urinary catheters, etc.) should not be coded here.

COMMENTARY

The second sentence in this section is entirely new. This expands the previous guidance on "oral mucosal pressure ulcers" to all types of mucosal pressure ulcers. None are coded as pressure ulcers on the MDS.

PRESSURE ULCER WORSENING, PAGE M-27

Pressure ulcer "worsening" is defined as a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1-4 (using the staging assessment system classifications assigned to each stage; starting at stage 1, and increasing in severity to stage 4) on an assessment as compared to the previous assessment.

COMMENTARY

In several places, language was added to further explain what 'worsening' is, without changing policy.

SECTION N, MEDICATIONS: ADDED OPIOIDS TO N0410 AND ADDED NEW SECTION FOR ANTIPSYCHOTIC MEDICATION REVIEW

OPIOID MEDICATIONS, N0410H, PAGE N-10

Opioid medications can be an effective intervention in a resident's pain management plan, but also carry risks such as overuse and constipation. A thorough assessment and root-cause analysis of the resident's pain should be conducted prior to initiation of an opioid medication and re-evaluation of the resident's pain, side effects, and medication use and plan should be ongoing.

CODING TIP, MULTIPLE THERAPEUTIC CATEGORIES, PAGE N-7

Medications that have more than one therapeutic category and/or pharmacological classification should be coded in **all** categories/classifications assigned to the medication, regardless of how it is being used. For example, prochlorperazine [Compazine] is dually classified as an antipsychotic and an antiemetic. Therefore, in this section, it would be coded as an antipsychotic, regardless of how it is used.

CODING TIP, GUIDANCE WHEN REFERENCE MATERIALS VARY FOR THERAPEUTIC CATEGORY, PAGE N-8

In circumstances where reference materials vary in identifying a medication's therapeutic category and/or pharmacological classification, consult the resources/links cited in this section or consult the medication package insert, which is available through the facility's pharmacy or the manufacturer's website.

CODING TIP, TSOACS, PAGE N-9

Anticoagulants such as Target Specific Oral Anticoagulants (TSOACs), which may or may not require laboratory monitoring, should be coded in N0410E, Anticoagulant

CODING TIP, ADDED THE WORD "MELATONIN", PAGE N-10

Herbal and alternative medicine products are considered to be dietary supplements by the FDA. These products are not regulated by the FDA.

Therefore, they should not be counted as medications (e.g., **melatonin**, chamomile, valerian root).

Keep in mind that, for clinical purposes, it is important to document a resident's intake of such herbal and alternative medicine products elsewhere in the medical record and to monitor their potential effects as they can interact with medications the resident is currently taking.

For more information consult the FDA website:
http://www.fda.gov/food/dietarysupplements/usingdietarysupplements/.

N0450: ANTIPSYCHOTIC MEDICATION REVIEW: NEW SECTION, PAGE N-11

COMMENTARY

This section was added to comprehensive and quarterly item sets

N0450A: **DID THE RESIDENT RECEIVE ANTIPSYCHOTIC MEDICATIONS SINCE ADMISSION/ENTRY OR REENTRY OR PRIOR OBRA ASSESSMENT, WHICHEVER IS MORE RECENT?**

Steps for Assessment

1. Review the resident's medication administration records to determine if the resident received an antipsychotic medication since admission/entry or reentry or the prior OBRA assessment, whichever is more recent.

2. If the resident received an antipsychotic medication, review the medical record to determine if a gradual dose reduction has been attempted.

3. If a gradual dose reduction was not attempted, review the medical record to determine if there is physician documentation that the GDR is clinically contraindicated.

COMMENTARY

This is not a seven-day lookback. MDS Coordinators must develop a system of communication so that any antipsychotic given since the last entry or the last OBRA assessment is captured here for what could be up to a three-month lookback period.

N0450B & C: HAS A GRADUAL DOSE REDUCTION (GDR) BEEN ATTEMPTED? IF SO ENTER DATE OF LAST GDR.

N0450D&E: PHYSICIAN DOCUMENTED GDR CLINICALLY CONTRAINDICATED.

If a physician documented that a CDR was clinically contraindicated, enter the date of that determination.

CODING TIPS AND SPECIAL POPULATIONS, PAGE N-13

Any medication that has a pharmacological classification or therapeutic category as an antipsychotic medication must be recorded in this section, regardless of why the medication is being used.

Do not include GDRs that occurred prior to admission to the facility (e.g., GDRs attempted during the resident's acute care stay prior to admission to the facility).

Physician documentation indicating dose reduction attempts are clinically contraindicated must include the clinical rationale for why an attempted dose reduction is inadvisable.

This decision should be based on the fact that tapering of the medication would not achieve the desired therapeutic effects and the current dose is necessary to maintain or improve the resident's function, well-being, safety, and quality of life.

Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless physician documentation is present in the medical record indicating a GDR is clinically contraindicated. After the first year, a GDR must be attempted at least annually, unless clinically contraindicated.

Do not count an antipsychotic medication taper performed for the purpose of switching the resident from one antipsychotic medication to another as a GDR.

In cases where a resident is or was receiving multiple antipsychotic medications on a routine basis, and one medication was reduced or discontinued, record the date of the reduction attempt or discontinuation in N0450C, Date of last attempted GDR.

If multiple dose reductions have been attempted since admission/entry or reentry or the prior OBRA assessment, record the date of the most recent reduction attempt in N0450C, Date of last attempted GDR.

Federal requirements regarding GDRs are found at 42 CFR §483.45(d) Unnecessary drugs and 483.45(e) Psychotropic drugs.

O0300A, Is the Resident's Pneumococcal Vaccination Up to Date? Page O-13

New Tips

"Up to date" in item O0300A means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations.

If a resident has received one pneumococcal vaccination and it has been less than one year since the resident received the vaccination, he/she is not yet eligible for the second pneumococcal vaccination; therefore, O0300A is coded 1, yes, indicating the resident's pneumococcal vaccination is up to date.

Commentary

This is new guidance to determine status of the pneumococcal vaccination for the resident to match the latest guidelines from ACIP.

Respiratory Therapy, O0400D: Revised Definition, Page O-19 and Appendix A, Page A-19

O-19:. Respiratory therapy—only minutes that the respiratory therapist or respiratory nurse spends with the resident shall be recorded on the MDS. This time includes resident evaluation/assessment, treatment administration and monitoring, and setup and removal of treatment equipment. Time that a resident self-administers a nebulizer treatment without supervision of the respiratory therapist or respiratory nurse is not included in the minutes recorded on the MDS. Do not include administration of metered-dose and/or dry powder inhalers in respiratory minutes.

A-19: Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function. Respiratory therapy services include coughing, deep breathing, nebulizer treatments, aerosol treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse. A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws.

Commentary

Hand held metered-dose and/or dry power inhalers are no longer included in the definition of respiratory therapy for coding minutes in O0400D.

O0600 AND O0700: MD VISITS AND ORDERS, PAGE O-43 & O-44

CMS does not require completion of these items; however, some States continue to require its completion. It is important to know your State's requirements for completing this item.

If the State does not require the completion of this item, use the standard "no information" code (a dash, "**-**").

If state requires these items, new definition of what orders can be counted in O0700: Includes orders written by medical doctors, doctors of osteopathy, podiatrists, dentists, and physician assistants, nurse practitioners, clinical nurse specialists, **qualified dietitians, clinically qualified nutrition professionals or qualified therapists,** working in collaboration with the physician as allowable by state law.

COMMENTARY

If your state does not require these items, for example, for a RUG III State Case Mix grouper, they can be dashed. If your state does require them, there are three professions added to the orders that can be counted as determined in the new Requirements of Participation.

SECTION P: NOW INCLUDES ALARMS IN ADDITION TO RESTRAINTS

INTENT, PAGE P-1

Intent: The intent of this section is to record the frequency that the resident was restrained by any of the listed devices or an alarm was used, at any time during the day or night, during the 7-day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definitions in the appropriate categories.

COMMENTARY

It is clear that adding alarms to Section P does not make all alarms restraints. However, due to some language in the coding instructions and the new interpretative guidelines, many are wondering when an alarm is considered a physical restraint. This is already being interpreted differently among different state agencies. The crux of the dilemma is this: Is a sound that causes a resident to choose to sit down, due to fear or other factors, considered a physical restraint? If it is, this is a groundbreaking new definition. It has been clear for many years due to multiple studies that alarms do not prevent falls and can cause negative outcomes in our resident populations. This is a separate issue from whether a sound can be a physical restraint. We must seek guidance from our state survey agencies as national organizations continue to seek clarification from CMS.

P0200 ALARMS, PAGE P-8

An alarm is any physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected, and may include bed, chair and floor sensor pads, cords that clip to the resident's clothing, motion sensors, door alarms, or elopement/wandering devices.

Code any type of alarm, ***audible or inaudible***, used during the look-back period in this section.

While often used as an intervention in a resident's fall prevention strategy, the efficacy of alarms to prevent falls has not been proven; therefore, alarm use must not be the primary or sole intervention in the plan.

The use of an alarm as part of the resident's plan of care does not eliminate the need for adequate supervision, nor does the alarm replace individualized, person-centered care planning.

Adverse consequences of alarm use include, but are not limited to, fear, anxiety, or agitation related to the alarm sound; decreased mobility; sleep disturbances; and infringement on freedom of movement, dignity, and privacy.

Alarms, Planning for Care, Page P-9

Individualized, person-centered care planning surrounding the resident's use of an alarm is important to the resident's overall well-being.

When the use of an alarm is considered as an intervention in the resident's safety strategy, use must be based on the assessment of the resident and monitored for efficacy on an ongoing basis, including the assessment of unintended consequences of the alarm use and alternative interventions.

There are times when the use of an alarm may meet the definition of a restraint, as the alarm may restrict the resident's freedom of movement and may not be easily removed by the resident.

Alarms, Coding Tips, Page P-9

Bed alarm includes devices such as a sensor pad placed on the bed or a device that clips to the resident's clothing.

Chair alarm includes devices such as a sensor pad placed on the chair or wheelchair or a device that clips to the resident's clothing.

Floor mat alarm includes devices such as a sensor pad placed on the floor beside the bed.

Motion sensor alarm includes infrared beam motion detectors.

Wander/elopement alarm includes devices such as bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exit sensors worn/attached to the resident that alert the staff when the resident nears or exits an area or building. This includes devices that are attached to the resident's assistive device (e.g., walker, wheelchair, cane) or other belongings. **Other alarm** includes devices such as alarms on the resident's bathroom and/or bedroom door, toilet seat alarms, or seatbelt alarms.

While wander, door, or building alarms can help monitor a resident's activities, staff must be vigilant in order to respond to them in a timely manner. Alarms do not replace necessary supervision.

Bracelets or devices worn or attached to the resident and/or his or her belongings that signal a door to lock when the resident approaches should be coded in P0200F Other alarm, whether or not the device activates a sound.

Do not code a universal building exit alarm applied to an exit door that is intended to alert staff when *anyone* (including visitors or staff members) exits the door.

SECTION Q, PARTICIPATION IN ASSESSMENT AND GOAL SETTING, PAGE Q-1

•Intent: Section Q of the MDS uses a person-centered approach to ensure that all individuals have the opportunity to learn about home- and community-based services and to receive long term care in the least restrictive setting possible. **This is also a civil right for all residents.** Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.

Coding Tips

While family, significant others, or, if necessary, the guardian or legally authorized representative can be involved, the response selected must reflect the resident's perspective if he or she is able to express it, **even if the opinion of family member/significant other or guardian/legally authorized representative differs.**

•This item is individualized and resident-driven rather than what the nursing home staff judge to be in the best interest of the resident. This item focuses on exploring the resident's expectations, not whether or not the staff considers them to be realistic. **Coding other than the resident's stated expectation is a violation of the resident's civil rights**

COMMENTARY

The added language makes it clear that we must talk with the resident or the resident's representative about his or her expectations for discharge and honor those wishes.

CHAPTER 4, CARE PLANNING, PAGE 4-10

The overall care plan should be oriented towards:

1. Assisting the resident in achieving his/her goals.

2. Individualized interventions that honor the resident's preferences.

3. Addressing ways to try to preserve and build upon resident strengths.

4. Preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence (e.g., palliative approaches in end of life situation).

5. Managing risk factors to the extent possible or indicating the limits of such interventions.

6. Applying current standards of practice in the care planning process.

7. Evaluating treatment of measurable objectives, timetables and outcomes of care.

8. Respecting the resident's right to decline treatment.

9. Offering alternative treatments, as applicable

10. Using an interdisciplinary approach to care plan development to improve the resident's abilities.

11. Involving resident, resident's family and other resident representatives as appropriate.

12. Assessing and planning for care to meet the resident's goals, preferences, and medical, nursing, mental and psychosocial needs.

13. Involving direct care staff with the care planning process relating to the resident's preferences, needs, and expected outcomes.

COMMENTARY

This revised list matches language in the new regulations about the Comprehensive Person Centered Care Plan.

CARE PLANNING TIPS, PAGE 4-11

The resident's care plan must be reviewed after each assessment, as required by §483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.

Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.