MDS Alert

MDS 3.0: Don't Delay: Nailing Down the Latest RAI Manual Revisions Will Pay

Make sure you're using these instructions now.

Wondering if you can code ADL help provided by hospice staff or if a resident coded as being on isolation can come out of his room? Check out the June RAI User's Manual update.

A lot of the changes "are things CMS has clarified verbally through Open Door Forums or other national calls or training," says **Rena Shephard, MHA, RN, RAC-MT, C-NE,** president and CEO of RRS Healthcare Consulting and executive editor for the American Association of Nurse Assessment Coordinators. In a June 2 interview with Eli, Shephard pointed to a number of clarifications that people have been hoping to see in the manual, including:

- Coding services at O0100. The manual states: "Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff." That includes trach care, dialysis, suctioning, oxygen therapy, and BiPAP/CPAP.
- Defining "facility staff" for counting ADL help. "The definition is facility employees and contract employees hired to work in the facility, such as contract rehabilitation therapists and nursing agency nurses," says Shephard. That doesn't include, according to the revised manual, "individuals hired, compensated or not, by individuals outside of the facility's management and administration. Therefore, facility staff does not include, for example, hospice staff, nursing/CNA students, etc."

- Directions stating facilities should not submit "non- OBRA, non-PPS assessments. Everyone has been clamoring for that," Shephard says.

The directive states: "Required MDS records are those assessments and tracking records that are mandated under OBRA and SNF PPS. Assessments that are completed for purposes other than OBRA and SNF PPS reasons are not to be submitted, e.g., private insurance, including but not limited to Medicare Advantage plans" (see page 5-1 of the revised manual).

The update also includes examples of unplanned discharge assessments, says Shephard. Chapter 2 of the revised RAI User's Manual now provides this language:

» "An unplanned discharge includes, for example: Acute-care transfer of the resident to a hospital or an emergency department in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation; or

- Resident unexpectedly leaving the facility against medical advice; or
- Resident unexpectedly deciding to go home or to another setting (e.g., due to the resident deciding to complete treatment in an alternate setting)."

CMS Clarifies Use of Dash for M0700

Jennifer Pettis, RN, WCC, RAC-MT, director of program development for Harmony Healthcare International, relays that she's "very glad" to see the manual clarify that you should use a dash in the following circumstances for coding M0700: Most Severe Tissue

Type for Any Pressure Ulcer:

"Stage 1 pressure ulcer

Stage 2 pressure ulcer with intact blister

Unstageable pressure ulcer related to non-removable

dressing/device Unstageable pressure ulcer related to suspected deep tissue injury" (page M-23).

"The dash is being used in these nstances because the wound bed cannot be visualized and therefore cannot be assessed," states the manual.

Know How to Code Isolation

The CMS team doing the manual revisions "worked with the Centers for Disease Control & Prevention and the infection control specialists at CMS to refine the instructions" for coding isolation, says **Teresa Mota, BSN, RN, CALA,** senior program coordinator for Quality Partners of Rhode Island.

In a nutshell: To qualify for isolation coded on the MDS, the resident must have an "active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission," states the revised RAI User's Manual. The resident ust require and receive "transmission-based precautions (contact, droplet, and/or airborne)," be alone in a room without a roommate -- and remain there. "This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.)," the manual states.

The revised instructions also clarify that a facility can code a resident on strict isolation at O100M when the patient goes out to dialysis and chemotherapy, etc., observes **Elisa Bovee, MS, OTR/L,** VP of Operations for Harmony Healthcare International in Topsfield, Mass. (see page 63 of this issue of MDS Alert for the full set of revised instructions).

Use, Document Clinical Judgment for Strict Isolation

Shephard thinks the updated instruction for coding isolation "is very helpful and much clearer." What the manual doesn't provide, however -- and what Shephard has heard people say they'd like to have -- is a "list of things, very black and white, of the infections you can capture for isolation and those you can't." Without the examples, "people have to make a judgment and they are afraid they will make the wrong one."

The revised manual does provide examples of when strict isolation criteria wouldn't apply, adds Shephard: "UTIs, encapsulated pneumonia, and wound infections" (see the instructions on page 63). Yet she can envision a scenario where the facility staff may decide to put a resident on strict isolation if he or she has a purulent wound infection caused by a "highly infectious bug" and the wound drainage isn't adequately contained. "As long as the documentation in the chart supports your clinical decision, you are going to be OK," she says. "I think this guidance really provides a pretty good summary of what the documentation would need to be ... so that when an auditor reads the chart, they can see the high level of contagion."

Editor's note: The RAI User's Manual revisions include numerous additional changes. Review the revised manual and change tables at www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage. See thenext MDS Alert for a focus on additional revisions.