MDS Alert

RAI Compliance :Get Your SNF on Top of These 2 RAI Manual Changes

CMS posted the update in February with a December 2008 implementation.

The latest RAI User's Manual clarifications affect Medicare default-rate billing and UTI coding in Section I2 -- and raise additional questions and concerns in both cases.

The update says SNFs can bill the default rate if they missed doing a PPS assessment for a resident who's discharged or dies before the eighth day following the initial admission from a qualifying three-day hospital stay. CMS deleted language in the manual that said a SNF could only bill the default rate in that scenario for residents who were discharged or died before the eighth day of covered SNF care within a benefit period, although that language is in the final SNF PPS rule for FY 2009.

"The final rule is the regulation," however, says consultant **Rena Shephard, MHA, RN, RAC-MT, C-NE**, who notes that "it's confusing to try to sort out why CMS changed the language in the RAI User's Manual ..." The way CMS wrote the update, it could be referring to the first admission after a qualifying hospital stay but not the first eight days in the benefit period, she adds. "But you have to read the RAI manual and also the final rule implementing the regulations. And until somebody from CMS says otherwise, we have nothing else to go on," says Shephard, founding chair and executive editor of the American Association of Nurse Assessment Coordinators.

Your best bet: "Don't rely on the exception," advises **Jane Belt, MS, RN**, managing consultant with Plante & Moran Clinical Group in Columbus, Ohio. Complete the 5-day assessment with whatever information that's available so you can bill some RUG category rather than the default rate, she adds.

'**Significant Lab Findings**' **for UTI More in the Eye of the Physician**

For purposes of coding UTI in I2, the resident has to have significant lab findings to support the diagnosis of a symptomatic UTI. And people in most cases interpreted "significant lab findings" to be a positive urine culture and sensitivity, says **Ron Orth, RN, NHA, CPC, RAC-MT**, president of Clinical Reimbursement Solutions LLC in Milwaukee. But now CMS is allowing the attending physician to determine the level of significant lab findings and whether to do a urine culture. Thus, the "lab finding could be a urinalysis or some other type of lab test -- a CBC, for example -- in order to make that affirmative diagnosis," Orth says.

Take note: "The MDS still says you code symptomatic UTIs," such as a mental status or behavioral change, urinary frequency, urgency, flank pain, etc., Orth notes.

The clarification about lab findings has its upsides and downsides, opines **Daniel Haimowitz, MD, CMD**, in Levittown, Pa. He thinks CMS may have issued the change to defer to physician clinical judgment and also to address cases where staff is unable to obtain a catheterized specimen or clean catch. But it could lead to over-diagnosis and unnecessary antibiotic treatment, he cautions.

If the physician sees a patient with a fever, an elevated white count, and symptoms "strongly suggestive of UTI," Haimowitz thinks it's OK to treat the person empirically without a culture -- especially if the patient is frail or has a history of UTI and sepsis, etc. But ideally you should obtain a culture specimen before starting empirical therapy, although that's not always possible, he says.

Important: Make sure the physicians provide some documented rationale in the clinical record as to the laboratory findings and whether a culture is warranted and supports a diagnosis of UTI, advises Belt.

The facility could obtain an explanatory statement as part of a telephone order, suggests **Marilyn Mines, RN, RAC-CT,**

BC, manager of clinical services for FR&R Healthcare Consulting in Deerfield, Ill. As an example, the statement might read: "Keflex 500 mg tid for 10 days for symptomatic UTI (concentrated, odorous urine) with abnormal U/A lab results," Mines says