MDS Alert

RAI Update: RAI Manual Update Affects Payment, Quality Reporting

Here's what the key changes mean for your facility.

Those little changes to the MDS instructions can turn out to be bigger than you thought, unless you stay on top of them.

That's definitely the case with the August 2003 Long Term Care Resident Assessment Instrument (RAI) User's Manual for MDS Version 2.0 update. The numerous clarifications, additions and deletions, now in effect, may appear minor league at first glance, but some of them affect RUGs and quality indicators and measures.

The **Centers for Medicare & Medicaid Services** posted the revisions on its Web site to fix numerous "glitches" in the RAI instructions, according to **Mary Pratt**, a specialist with the **Centers for Medicare & Medicaid Services'** Center for Beneficiary Choices, Quality Measurement and Health Assessment Group.

Here's a rundown of some key changes and their implications for your facility:

1. **Exclusion of IVs, IV meds and blood transfusion provided during chemotherapy or dialysis.** "Don't code these treatments [in Sections K and P] unless they were also provided during the nursing home stay and not simply during chemotherapy or dialysis," Pratt advised participants at the September 2003 **American Association of Nurse Assessment Coordinators** conference in Las Vegas.

   Residents who receive chemotherapy or dialysis may automatically RUG into the clinically complex category, according to **Jan Zacny**, managing consultant with **BKD LLP** in Springfield, MO. But if facilities were coding IV fluids provided to residents during chemotherapy or dialysis and capturing a RUG-III group of extensive Service (SE), which we don't encourage, they are looking at a loss of about $70 a day, she says. "That's the average difference between extensive services and clinically complex RUGs payment.

   Pratt characterized the coding change as "reimbursement- related," since Medicare considers that it pays for the IVs and blood transfusion as part of the rate for dialysis or chemotherapy. Yet one AANAC conference participant pointed out that not all chemotherapy is exempt from SNF consolidated billing, which means that nursing facilities are, in some cases, paying for the treatment.

   Reimbursement Tip: Most of the cancer chemotherapy drugs are carved out of the SNF PPS rate - but not all of them. "For example, one drug that is given to patients with prostate cancer is not excluded and will cost a facility around $1,800," Zacny reports. So to verify if a chemotherapy drug is included under consolidated billing, check the SNF help file, which at press time had been updated on Nov. 8, 2002. Go to http://cms.hhs.gov/manuals/pm_trans/2002/memos and select program memo A-02-118. Page two of the PM allows you to download the zipped Excel spreadsheet (the SNF Help File): file name A02_118a.zip. Zacny says she expects the file to be updated in the next couple of months.

2. **More liberal coding instructions for counting physician visits and orders at P7 and P8, respectively.** CMS deleted the provision requiring physician assistants (PA) and nurse practitioners (NP) to be employed by the facility in order for their visits and orders to be coded in Section P. The update also added clinical specialists to the definition of who counts as a "physician" under visits and orders. That's all good news on the reimbursement front, considering that these MDS items count toward RUG classification in the clinically complex category. CMS has also clarified that facilities cannot count physician visits made during the resident's acute care stay.

Heads Up: CMS says it plans to release a further clarification, probably in the next month or two, differentiating between coding NP and PA visits and orders in Medicaid nursing facilities and Medicare SNFs, reports **Ruta Kadonoff**, senior health policy analyst with the **American Association of Homes & Services for the Aging**. "A preexisting statute makes distinctions between what NPs and PAs who are employed by the facility are allowed to do in SNFs versus NFs," she explains. The August 2003 update instructions will remain in effect until CMS releases any additional clarifications.

3. Directions for coding diseases and infections. Under I1 (diseases) and I2 (infection), make sure the resident's condition meets the description listed in the "definitions" section for each item. If it doesn't, don't try to make it fit, Pratt advised. Use I3 (other current diagnoses & ICD-9-CM codes) to code conditions not listed in Items I1 and I2. Record more specific ICD-9-CM codes for general disease categories listed in I1 and I2, if space allows. **Billing Tip:** Make sure ICD-9-CM diagnoses on the MDS and UB-92 identify and support the reason for admission and/or continuing stay and medical necessity of services.

4. More stringent pain coding. The update deletes instructions to code a "0" for "no pain" in Section J if the resident's goal for pain management is being met. Instead, providers may only code the resident as pain-free if that's actually the case during the observation period, "regardless of why he's pain free," Pratt said.

   Facilities that were relying strictly on the RAI manual may have been coding a "0" for residents who reported being satisfied with their level of pain management, says Cheryl Field, director of clinical and reimbursement services for LTCQ Inc. in Lexington, MA. "Yet the CMS broadcast on the QMs made it clear that if pain had been experienced you must code it," she notes. "So the RAI manual error was 'known' in the world of networking MDS coordinators."

   Even so, some nursing home providers continue to express concern about coding a resident as "0" for "no pain" at J2a when the person actually has pain serious enough to require morphine or other opioid medication.

   In addition, residents who make an informed decision to choose a certain level of pain control may still have enough pain (daily mild pain and one episode of moderate pain during the MDS assessment window) to get counted in the facility's pain quality measure. And that will make it appear as if the facility has a pain management issue.

   To resolve that dilemma, "the MDS really needs to evolve into an instrument that assesses the resident's goals for pain management and whether the facility is meeting those goals," Kadonoff says. "The MDS 3.0 draft doesn't go far enough in that regard." (For more information on how to manage the resident who refuses adequate pain management, see Pain Management story.)

5. A stricter definition of "program." A turning/repositioning program coded at Section M5c must be "organized, planned, documented, monitored and evaluated," Pratt said. CMS plans to do a better job of making clear that this definition applies to other programs provided by facilities and coded as such on the MDS, Pratt told AANAC attendees.

6. No wiggle room for calculating residents' weight change. Use the actual weight documented in the resident's clinical record to calculate the most accurate weight change recorded at K3, Pratt advised.

7. Clarification of what counts as a medication. When coding Section 01 (number of medications), don't count preventive preparations (e.g., ointments and creams used in wound care, eye drops and vitamins). To determine if a specific long-acting medication administered prior to the MDS observation period is still active and should be counted in O1, consult the physician, pharmacist and/or Physician's Desk Reference.

   IV additives (electrolytes and insulin added to the resident's TPN or IV fluids) also count in Section 01 and P1ac (IV medications). Coding at 01 can trigger quality indicator 6 (use of 9 or more different medications) over the 7-day

lookback.