Meyers & Stauffer (i.e., referenced as Patty and Teena below) took the liberty to respond to these concerns presented by the Associations to provide you with the review functions as well as reference to the RAI Manual to support the current review provisions. We would be happy to discuss further and or answer any questions. We hope this is helpful.

Note:

- Concerns below are in black text
- Responses to concerns are in blue text
- RAI manual references are in red text

- **Section D:**
    - On separate occasions, both Patty and Teena have indicated that specific examples of resident mood concerns be present in the medical record, during the assessment period, if the MDS nurse coded in the Staff Assessment of Resident Mood. The RAI manual indicates that coding this section should come entirely from an interview with the staff members. Good practice would indicate that they would then care plan any concerns, but it is not required prior to coding the MDS.
    - One record was not validated because the information the Social worker received during the interview, and documented on the MDS, did not match was written on the plan of care. Yes, the care plan, and documentation in the medical record should be updated, but it doesn't change the information gathered using interview, which should be placed on the MDS.

      Reviewer: When reviewing "Staff Assessment of Resident Mood" items the documentation typically provided by the facility is from interviewing the staff, family and etc. including referencing the ARD and/or observation period. Documentation could be found in nurses' notes or a work sheet with the ARD including a signature by a staff member. Staff assessment of resident mood items is not unsupported it there is not a care plan.

      RAI Manual: PHQ-9© Resident Mood Interview is preferred as it improves the detection of a possible mood disorder. Therefore, staff should complete the PHQ-9-OV© Staff Assessment of Mood in these instances so that any behaviors, signs, or symptoms of mood distress are identified. Interview staff from all shifts who know the resident best. Conduct interview in a location that protects resident privacy. The RAI manual does not prescribe what supporting documentation might include. Since there are no specifics the RN Reviewer takes any reference and frequency noted in the medical record. Section D0500 A-J; pages D-12 through D-15. Notice staff responses on pages D-13 through D-14.

- **Section G:**
    - I realize that we cannot use the MDS as a source document for coding; however, the level of specificity required for justifying ADLs is very cumbersome and time consuming. If the coding for ADLS is based on interview, or observation, and does not match the medical record documentation identically, an acceptable note to cover all of the

requirements is: “Through interview with staff and resident, as well as direct observation of their care, it was determined that the resident received extensive assistance of two staff members at least three times during the assessment reference period for bed mobility.” The note must say “received” not “required” or “needed” in order to be accepted. It must also reference the assessment reference period. Also, it must indicate “staff members”, not “persons” or “x1”, as the reviewers indicate it could mean a family member, hospice worker, etc. The note also must indicate that the assistance happened at least three times, to satisfy the rule of three. When you have to write this note to justify one ADL, it’s not so bad, but when you have to write it for every ADL, it is very time consuming.

RN Reviewer: Facility’s provide a variety of ADL documentation, such as but not limited to; number of episodes during each shift, narrative documentation that reflects late loss ADLs, notes in the individual sections of Section G in the facility software that reference ADL documentation from the MDS Nurse, notes stating “ Through interview with staff and resident as well as direct observation of their care, it is determined resident received extensive assistance of two staff members at least three or more times during. Currently the RN Reviewer is accepting any of above documentation to support ADLs.

RAI Manual: Consider all episodes of the activity that occur over a 24-hour period during each day of the 7-day look-back period, as a resident’s ADL self-performance and the support required may vary from day to day, shift to shift, or within shifts. The four “late loss” ADLs include; bed mobility, transfer, eating and toilet use, not all 10 ADLs. The Rule of 3 (a method developed by CMS to help determine the appropriate code to document ADL Self-Performance) is used to support ADL coding on the MDS. Page G-6; third bullet under the Rule of 3 states, “In order to properly apply the Rule of 3, the facility must first note which ADL activities occurred, how many times each ADL activity occurred, what type and what level of support was required for each ADL activity over the entire 7-day look-back period. Without the occurrences reported it is difficult to satisfy the reported value. Section G0110 A, B, H, I; pages G-1 through G-24.

- **Section I:**
    - If the physician signs the physician order sheet each month, but a diagnosis is missing, or if it is cut off mid-way through, the signature will not be accepted by the reviewers. Even if the resident is receiving a medication or treatment for the diagnosis, if the diagnosis “fell” off of the physician order sheet, it will not be validated in a review. The community would have to find the diagnosis on another signed document within 60 days of the ARD. In one case, COPD was cut off with only “CO” showing, so it was not accepted.
    - Initially, reviewers were not accepting diagnoses such as Multiple Sclerosis, or Hemiplegia, which may not need a treatment or medication during the assessment reference period. They are now accepting the diagnosis as current if there is a care plan detailing how the diagnosis affects the resident’s care.

    RN Reviewer: When reviewing Section I, the RAI manual requires diagnosis identification in the 60-day look-back and documentation is required by the physician, etc. This 60-day verification may be found in medical record sources such as progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available. If a diagnosis/problem list is used, only diagnosis confirmed by the physician should be entered. Page I-6 of RAI manual. Therefor if the diagnosis drops off a document, and cannot be found elsewhere it would be unsupported.

RAI Manual: The items in Section I are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status.

There are two look-back periods for this section:

- Diagnosis identification is a 60-day look-back (as described above).
- Diagnosis status; active or inactive is a 7-day look-back period.

Determine whether diagnoses are active: Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses. (Page I-6) Pages I-5 through I-14.

- **Section J:**

  - The reviewers have indicated on several occasions that in order to code shortness of breath while lying flat, there needs to be documentation that the resident has difficulty with breathing when lying flat due to COPD, Emphysema, or Asthma. The RAI does not indicate that the shortness of breath has to be the result of these three conditions. It could be coded regardless of cause.

    RN Reviewer: This MDS item is part of a RUG string. In other words, shortness of breath while lying flat would never require to be reviewed UNLESS it was part of the COPD diagnosis. When reviewing this item there does not need a diagnosis to support this item; rather a diagnosis is needed to include this item.

    RAI Manual: Review the medical record for staff documentation of the presence of shortness of breath or trouble breathing. Interview staff on all shifts, and family/significant other regarding resident history of shortness of breath, allergies or other environmental triggers of shortness of breath.

    - If shortness of breath or trouble breathing is observed, note whether it occurs with certain positions or activities.
    - Check shortness of breath or trouble breathing hen lying flat (J1100C) if shortness of breath or trouble breathing is present when the resident attempts to lie flat. Also code this as present if the resident avoids lying flat because of shortness of breath. (Page J-21 through 23)

- **Section K:**

  - For a resident who receives tube feeding at night, who also eats during the day, the reviewers indicate that I&O is needed to determine caloric intake by tube - unless - the specific amount of tube feeding to be delivered is written in the order, and eating during the day is ordered as pleasure foods. In this case, they did give us the work around; however, it would be nice to have this clarified officially.

RN Reviewer: When supporting this item the facility would need the calories of the "by mouth" intake of the resident plus the tube feeding documentation of the caloric intake. Typically an I&O (intake and output recording) is a fluid measure, not a calorie count.

RAI Manual: Review intake records to determine actual intake through parenteral or tube feeding routes. Calculate proportion of total calories received through these routes (in this case tube feeding).

- The RAI manual clearly demonstrates how to calculate caloric intake when the resident is receiving tube feedings as well as nutritional oral intake. See RAI Manual page K-15, example one for details.

- **Section O:**

  - A resident had orders for radiation therapy two times per week. The nurses signed the order for radiation therapy twice a week on the MAR. They had documentation from the transportation company, indicating that the resident was transported to and from the radiation unit. They also had documentation in the nurse's notes that the resident returned to the community following radiation therapy. The reviewer would not accept this information. In order to validate the radiation, the community needed written proof, within the assessment reference period, from the radiation company. This same situation happened with other outside services such as chemotherapy and dialysis.

    RN Reviewer: The documentation needed to support this item is verification that the resident actually received these treatments with the 14-day window.

    RAI Manual: Per the RAI manual, page O-2, "Review the resident's medical record to determine or not the resident received or performed any of the treatments, procedures, or programs within the last 14 days."

  - Earlier in the process the reviewers indicated multiple times that Restorative evaluations must be completed during the assessment reference period. The manual does not specify this, only that the evaluation must be completed periodically. We have explained this to the reviewers and they have stopped asking for specific dates.

    RN Reviewer: To support the restorative program evidence of a periodic evaluation by the licensed nurse must be present. The exception review does not look for this evaluation to be conducted within the observation period of the assessment.

    RAI Manual: Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record. Page O-36.