Meet the challenges of the MDS 3.0
Caralyn Davis, Staff Writer

What’s the difference between a problem and a challenge? A problem is only a source of distress, but a challenge is an opportunity, offering proactive individuals the chance to develop and implement mitigation strategies or even solutions. Looked at in this light, the MDS 3.0 and the RUG-IV skilled nursing facility prospective payment system (SNF PPS) offer MDS coordinators multiple opportunities to take the lead to upgrade facility processes and ultimately improve both patient care and facility reimbursement. Some challenges are new to the MDS 3.0, but interestingly many are holdovers from the MDS 2.0 that have been exacerbated by MDS 3.0 implementation. These key challenges include the following:

Administrators who are out of the loop.
When SNF PPS first began in 1998, it was common to see administrators and a team of five or six staff members at training conferences and educational seminars, notes Theresa Lang, RN, BSN, WCC, vice president of clinical consulting at Specialized Medical Services Inc. in Milwaukee, Wis. But as time has passed—and financial constraints have increased—many administrators have distanced themselves from the MDS/RAI process.

“One way to quickly educate administrators about the MDS process is to ask them to participate in the triple-check meeting that the facility uses to ensure accurate Medicare billing,” says Lang. “This will help them realize how complex the system is and what the demands are.”

Documentation typically involves a process for recording information as a means of providing evidence. Employees must understand the importance of documentation requirements, as well as what can occur when documentation is inaccurate or missing.

Try to make at least one person happy every day, and in ten years you may have made 3,650 persons happy, or brightened a small town by your contribution to the fund of general enjoyment.
—Sydney Smith
Jacksonville, FL

April 16 – 18 Preconference
April 18 – 20 Conference

If anyone is an expert at Dancing Naked it’s me. You’ll find out what kind of naked dancing I’m talking about at the big spring conference...clothes are optional but your open hearts, wild laughs, and caring concerns must be in your pockets. I’m not a clinician, I like to say I’m a word artist, but I know a lot about living, life, sacrifice and how important it is to feed and nourish your own soul.

My work as a novelist is all about empowering my readers to listen to what their own hearts are telling them and I use my own life path as the backdrop for my writing and for what I am going to share with you in lovely Jacksonville.

I’ve been around the block a few times, actually more than a few times, and I’m often so far behind I think I’m first. We can focus on the race, our position in the race or we can run at our own speed, say to hell with the critics and do what we know is right and true for us. I always joke that when I die I’m going to be really smart and I’m going to share with you my own bumps and bullseyes—which are just like yours. You all work hard and I’m going to encourage you to play hard too. There’s not enough of that going on. You also touch and help so many lives—even if you sit in your office a good portion of the day—your work is an affirmation of all that is good and sometimes someone else needs to point that out to you. Life is all about balance and I hope to get you to lighten up and remember to keep your fingers on the edges of your own hearts as you work so hard to do that for others.

I’m a bestselling author but I’m also am a woman, a mother, a partner and broad who has been there and that gives me worldly qualifications times ten. Sign up for the conference because it’s not only going to be warm in Jacksonville—it’s going to be fun, educational, and inspiring.

And don’t worry—I’m not really going to talk for an hour. I want to see wine in your glasses when I’m up there and that’s going to help you when the dancing naked stuff happens.

See you in April!
involved in the triple-check process,” says Lang. “This will help them realize how complex the system is and what the demands are.”

It’s also important to educate administrators on specific issues that affect the MDS process, such as the impact of MDSs not being done timely, the impact of software issues, the impact of unscheduled assessments, and the time management issues related to

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unscheduled assessments, says Lang. “Administrators are so busy that they often don’t realize what is going on, so MDS coordinators need to make the connections for them through education.”

**Interdisciplinary team members not doing their part.**

A team approach is critical “to successfully managing the volume of MDSs that needs to be done at any given point in time,” says Carol Siem, MSN, RN, RN, BC, GNP, RAC-CT, a clinical educator for QIPMO at the Sinclair School of Nursing at the University of Missouri-Columbia and the chair of the AANAC board of directors. “So each of the disciplines needs to be doing its own sections—and be held accountable to doing them in an accurate and timely fashion.”

However, the MDS 3.0 hasn’t solved the problem of interdisciplinary team members dragging their feet completing assessments. “Many MDS coordinators still spend a phenomenal amount of time tracking down other departments—chasing activities and dietary and social services, for example—to make sure they do their MDSs timely,” says Lang. “If anything, the problem has escalated with the 3.0.”

Another common problem is lack of documentation support for the activities of daily living (ADLs), says Cindy Perrault, RN, RAC-MT, a nurse consultant for White Bear Lake, Minn.-based Pathway Health Services and an AANAC master teacher. “Some facilities still are not documenting ADLs. It was a problem with the MDS 2.0, and it is still a problem in every single building that I go into.”

At some facilities, MDS coordinators aren’t following up adequately. “Some MDS nurses are not going out onto the floor to verify ADL coding. They just take what’s on the documentation and put it on the MDS,” says Perrault. “Or if they do go out and talk with the aides to clarify the coding, they don’t document what they’ve learned in the chart.”

But at many facilities, the problems run deeper. For example, “the staff, nurses included, often don’t understand the difference between limited assistance and extensive,” says Perrault. “So facilities are missing the boat when it comes to documenting bed mobility and eating in particular.”

Another issue is that many nurse aides “only chart once a shift, sometimes before the shift even ends,” she explains. Other facilities have trouble charting even that much. “I recently was in two buildings where they had no documentation for the ADLs at all except for a sporadic note,” says Perrault. While that’s an extreme example, the prevailing attitude among many members of the clinical team is that it is OK to “have a hole here or a hole there” in the documentation.

Often the DON and the other floor nurses have blinders on about ADL coding. “They think it is the nursing assistants’ responsibility, and they say, ‘We have an MDS coordinator to keep track of that,’” says Perrault. “So they are not there mentoring the nursing assistants if the nursing assistants are the ones who are documenting.”

Meet the challenges, continued from page 1

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DONs should be doing spot audits of ADL documentation to use in performance evaluations because those evaluations are critical to holding staff accountable, recommends Perrault. “When I go into facilities, I ask DONs, ‘Do you have disciplinary actions for nurses who choose not to sign the MARS [medication administration record sheet]?’ They answer, “Of course we do.” So then I say, ‘ADL documentation affects your reimbursement and your care planning. Why don’t you track that kind of performance as well?”

Impact of therapy software on tracking unscheduled assessments.

The degree of sophistication and the automation of the therapy provider have a significant impact on an MDS coordinator’s ability to track unscheduled assessment windows, says Lang. “Therapy companies that use major therapy software vendors can provide daily reports on residents and how they are doing in their seven-day windows. But some therapy providers, particularly in-house programs, often don’t have strong software. They might even be using the clinical software for therapy. In those cases, the tracking and reporting features just aren’t there, and keeping track of unscheduled assessment windows is an entirely manual process.”

MDS coordinators facing this situation should insist that therapy and nursing meet every day, suggests Lang. “They need to look at where these residents are: “We get meeting’ed to death when we could be more efficient with our time, combining some of those meetings and running them more efficiently so they don’t take as long,” says Siem.

What is happening related to potential COT, SOT, or EOT OMRAs?” (Lang recommends billing also be included in these daily meetings.)

And in cases where the therapy company has good software but it isn’t integrated with the facility’s clinical software, “administrators need to make sure that MDS coordinators have read-only access to those records,” adds Perrault. “Many MDS coordinators would have a much easier time tracking therapy minutes without talking to therapy every day if they had easy access to the therapy software records.”

Unsustainable workloads.

Many MDS coordinators are struggling with “other duties as assigned,” says Siem. “They are doing more than just the MDS.” For example, in Missouri most MDS nurses are on call a certain number of times per month. They also might be tracking falls and infections.

In addition, MDS nurses are often attending multiple meetings per week. “We get meeting’ed to death when we could be more efficient with our time, combining some of those meetings and running them more efficiently so they don’t take as long,” says Siem.

Making changes goes back to educating the administrative team so they understand what is “humanly possible,” says Siem. Otherwise, both the facilities and the MDS coordinators will be in an untenable position when something critical is bypassed. For example, the director of nursing at a Missouri facility recently fired the MDS coordinator because she hadn’t been completing discharge assessments timely. The DON didn’t understand that one MDS coordinator couldn’t manage a 130-bed building. The facility had instituted a “team approach” to the MDS, so the DON believed that had sufficiently alleviated the pressure on the MDS coordinator, points out Siem.●
MDS Documentation, continued from page 1

is missing or inaccurate. Nurse leaders whose team members do not know how and what to document are at risk for negative outcomes including reduced RUG scores, lost reimbursement, and even suspicion of fraudulent practices.

There are a number of reasons for inaccurate RUG scores for short or long-stay residents. The following examples can result in both under- or over-payment to the facility:

• Using outdated MDS manuals

• Poor understanding of MDS definitions

• Lack of understanding of coding rules

• Coding that does not portray the individual’s actual performance

• Inadequate documentation to support coding of the individual’s true performance

• Contradictions in information recorded in the medical record and ultimately on the MDS.

Educate nurses so they understand how to document and code late loss ADLs. Accurately recording self-performance and staff support in the categories of bed mobility, transfer, toilet use and eating will result in RUG scores that reflect the individual’s actual performance.

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of bed mobility, transfer, toilet use and eating will result in RUG scores that reflect the individual’s actual performance. Following MDS guidelines and documenting evidence of depression and treatment assists a facility to achieve accurate RUG scores under Special Care High, Special Care Low, and Clinically Complex when the Depressed/Not Depressed split is understood. If staff do not receive adequate education in these areas, underpayment or overpayment may result.

Inaccurate coding impacts more than a facility’s reimbursement. Charges of fraudulent practices may result. In one recent example, CNAs who were inadequately trained in how to code self and staff performance made a significant documentation error. A resident had required supervision with no physical help from staff (1/0) for ambulation and transfer. CNAs properly coded this on the ADL flow sheet. The resident experienced a fall that resulted in an

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CUE UP THE CODES

Choose the proper code for each ADL based on the description of self-performance. Circle the correct answer.

<table>
<thead>
<tr>
<th>Bed Mobility:</th>
<th>0 1 2 3 4 7 8</th>
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<tbody>
<tr>
<td>Resident can move in bed, turn side to side independently, but needs staff to pull self up in bed or chair—always.</td>
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<tr>
<th>Transfer:</th>
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<tr>
<td>Resident can stand and pivot into chair, but chair must be put in position and staff must standby, hands on, in case resident wobbles—always.</td>
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<td>Resident is vegetative.</td>
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<tr>
<td>Resident requires help getting up from bed/chair but can walk to and from dining room or activities using a walker with supervision—always.</td>
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<th>Locomotion on Unit:</th>
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<td>Resident uses wheelchair independently usually, but occasionally (1 time in this look back period) walks to activities using a walker which requires supervision.</td>
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<th>Locomotion off Unit:</th>
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<tr>
<td>Resident only left unit one time during look back and at that time needed to be taken back and forth in the wheelchair.</td>
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<td>Resident has been sick and has not gotten dressed in the past 7 days, however, staff is able to take on and off pajamas for hygiene.</td>
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<th>Eating:</th>
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<tr>
<td>Resident is able to eat and drink independently, but does not remember to eat and often needs cuing to remind her to eat related to dementia. She also was given hydration three times via a g-tube in place only because of her unwillingness to take adequate hydration orally.</td>
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<td>Resident uses urinal at night independently, but requires complete assistance getting on and off toilet during day, including hygiene.</td>
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<td>Resident is in a coma.</td>
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injury necessitating extensive assistance of two CNAs (3/3). The inadequately trained CNAs continued copy-cat charting by recording a code of 1/0 even after the fall. The injury was a reportable incident to the Department of Health, and when records were viewed by the investigating surveyor, the charting inaccuracy was discovered. The surveyor determined that the notification to the DOH was not timely, and the inaccurate charting came under suspicion of an attempted cover-up. The Attorney General’s Office was called in, and the CNAs were charged with falsifying a medical record. This incident resulted in eight CNAs from one facility being terminated, and they are awaiting a final decision from authorities.

There are two key activities that a nurse leader can take to avoid negative outcomes related to coding and documentation. First, every employee must understand how and why to document accurately. Provide detailed education that includes a return demonstration by the employee to demonstrate competency in coding and documenting. Place a special emphasis on late loss ADLs and coding compliance. Include this training in new employee orientation, repeat it annually and with any MDS coding updates. Second, perform audits of existing MDSs for a random 10% of residents in the facility. If concerns are identified, expand the audit sample, looking for trends.

Perform audits of existing MDSs for a random 10% of residents in the facility. If concerns are identified, expand the audit sample, looking for trends. Determine that individuals completing sections of the MDS have current manuals, and that they refer to them. Incidences have occurred in which MDS 2.0 definitions were remembered, and MDS 3.0 changes were not followed. As audits reveal weakness or inaccuracies, provide targeted education to address the issues. Schedule audits periodically and report outcomes to the Quality Assessment and Assurance Committee. The entire team can work together to achieve documentation, coding, and reimbursement success.

Did you know our Certified Nurse Executive (C-NE) certification covers many of the topics outlined in this article? Available in a live conference workshop during our 2012 annual conference, you can complete the Administrative Oversight of the MDS 3.0 module along with nine others to obtain this career changing leadership certification. Successful completion will help you to understand the connection between MDS 3.0 items and RUG-IV categories and identify key concepts the nurse leader should consider to ensure an effective MDS/RAI process in their facility. Learn more by clicking here.

Cue up the Codes Answer Key

Bed Mobility: 3 | Weight bearing
Transfer: 2 | Guided maneuvering
Walk in Room: 8 | Activity did not occur
Walk in Corridor: 1 | Oversight, cuing
Locomotion on Unit: 0 | Rule of 3—Independent
Locomotion off Unit: 7 | Only occurred once
Dressing: 4 | Full staff performance
Eating: 3 | Rule of 3—can’t code as total for hydration
Toilet use: 3 | Rule of 3—code most dependent, except total
Personal hygiene: 4 | Total dependence
AANAC’s Medicare University (MU) helps you know “what you don’t know” when it comes to Medicare. We cover the complex details in a simple, understandable and concise manner that provides you the knowledge to sort through the paperwork and requirements, improve your daily meetings and turn on the light for others in your facility.

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Dear Betty,

What can we do to reduce resident falls? We are 98% restraint-free and individualize the use of personal alarms. Is there anything else we should do? Our fall rate is still too high.

QA Manager

Dear QA Manager,

According to the Centers for Disease Control (CDC), every year one-in-three adults over the age of 65 falls. 90% of hip fractures for that group result from falls, and those who sustain hip fractures are 20% more likely to die in the following year. 35% of fall injuries occur among residents unable to ambulate. The most common causes of nursing home falls are muscle weakness and ambulation or gait problems. Falling is often a sign of health problems, incorrect use of walking aids, poorly fitting shoes, poor lighting, incorrect bed height, and medication side affects.

Trembley and Barber at Colorado State University identified five risk factors that increase the likelihood of falls. The more risk factors a resident has, the more likely it is that a fall will occur. Assess residents for the following:

- **Osteoporosis** Porous bones are less resistant to stress and more prone to fractures. This can result from hormonal changes, calcium and vitamin D deficiency, and decreased physical activity. Prevention includes an adequate supply of calcium, sufficient Vitamin D to enhance calcium absorption, sunlight exposure, and regular weight-bearing exercise.

- **Lack of Physical Activity** Failure to exercise results in poor muscle tone, decreased strength, and loss of bone mass and flexibility. Prevention includes regular exercise designed to increase muscle and bone strength, and to improve balance and flexibility. Physical therapy, participation in exercise groups, restorative nursing programs, or a floor walk program improve strength and balance.

- **Impaired Vision** Cataracts, glaucoma, and other disease states impair depth perception, visual acuity, peripheral vision, and glare tolerance. Impaired vision impacts safe navigation in the physical environment. Schedule eye exams and treat vision-imparing conditions. Use color and contrast in the environment so items stand out. Color-defined balance-aiding devices such as grab bars and handrails and the regular cleaning of eye glasses support vision. Provide adequate lighting in all areas.

- **Medications** Psychoactive drugs reduce alertness, effect balance and gait, and cause orthostatic hypotension. Have your pharmacy conduct a targeted medication review for residents who fall. Monitor for orthostatic hypotension. Learn the side effects of medications, use the lowest dose possible, and regularly assess to determine if the drug is still needed.

- **Environmental Hazards** These include objects on the floor that cause tripping, poor lighting, lack of grab bars, poorly located or mounted grab bars, and furniture that is not sturdy or that blocks free movement. Practice regular walk-through by staff to identify and address hazards that may lead to falls.

You probably noticed that the five risk factors are interconnected. Have your team assesses each resident to address these risk factors. Provide staff education to raise overall safety awareness. Include all departments so everyone takes responsibility for preventing falls. Seek staff ideas to create a safety-conscious atmosphere where care plans meet each resident’s fall prevention needs. Use the Falls Care Area Assessment (CAA) in your efforts. Study incident/accident reports looking for trends. Do more falls occur on one unit or shift? Are particular caregivers on duty when most falls occur? Develop a list of fall-related things you want to know, such as response to call bells, timely toileting assistance, and more. As you implement these steps you will finally see those numbers falling instead of your residents!

Betty Frandsen, RN, NHA, MHA, C-NE, has worked in long term care for over 30 years, including 14 years as a Director of Nursing, and as an Administrator in both Pennsylvania and New York. She served as Vice President of Education and Regulatory Affairs for AANAC, and is a past president of NADONA/LTC.

**If you have a nursing management or leadership question that Betty could help with, send your problem to iserio@aanac.org.**
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- **Reimbursement:** Learn how to code accurately to ensure your facility receives the reimbursement that it has earned.

- **Quality Assurance and Improvement:** Get the strategies to minimize survey deficiencies, mitigate risky situations and plan for facility success.

- **Leadership:** Reenergize your ability to lead and communicate with those in your care, their families and peers in your organization.

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The workshop schedule is subject to change and is updated regularly. To see a full AANAC Training Partner workshop schedule, visit aanac.org/workshops
Technical help and highlights.

AANACConnect launched just over two weeks ago, and it’s been a resounding success among our members. To help you maximize your experience with our newest member benefit, we’ll be including a section in each issue of the LTC Leader to provide you with additional information to teach you new tricks, provide technical help and highlight content from various communities.

Get fast results with precise posting

With a variety of communities to choose from, you may be curious about the best place to post your specific question to get a quick accurate response. Use this as a guideline:

- **MDS Connection**: We all know that some of the hardest questions will inevitably be about coding and the MDS 3.0. The MDS Connection community is monitored by the experts that many of you know already including: Ron Orth, Rena Shephard and Judy Wilhide-Brandt. When you need MDS information, MDS Connection is the only place to go for answers.

- **Medicare**: This government program can be overwhelming to professionals in LTC. Reach out to your peers and other experts for superior advice to get you the medicare help you need.

- **Survey Management & Preparedness**: Survey time is always a stressful time. But you can reduce your anxiety by sharing policies and best practices with colleagues so you have the answers you need before the surveyors even show up at your front door.

- **LTC Network**: When your question doesn’t seem to fit in one of the other communities, there’s always room for discussion in the LTC Network. This all-members community is where you can connect with peers and friends on all things LTC including: clinical and medication questions, behavior challenges with residents (and sometimes families), healthcare information technology or even just a funny story or success from your day.

There’s always a new community waiting for you to explore and join. From member-created groups to state groups and more, you can view all the available discussions through the communities page.

**LTC Network**:

**Thread Subject**: Foley Catheter Question

**Posted by**: Gale Siegel

We have a resident who had a foley catheter inserted due to a sacral pressure ulcer exacerbated by urinary incontinence. The pressure ulcer healed a few weeks ago. We were going to remove the catheter, but the resident absolutely refuses to have it removed. All risks vs. benefits have been reviewed with her, but she still wants it left in place. Is there any problem from a survey standpoint if we leave it in due to resident’s wishes and comfort? Thank you.

**LTC Network** is a great place to post your general LTC questions. Check out this great example from one of our bronze most valuable members. Have you been through a similar experience in your facility? Share your expertise with Gale by clicking on the thread subject.

**MDS Connection**:

**Thread Subject**: SOT giving me AAA RUG

**Posted by**: Monika Bijak

Something is wrong here!! Med A admitted 12/12/12 with new gt—no other therapies. Speech started on 1/06/12—using ARD 1/10/12 SOT and will combining with 30 day. For the SOT—only have 3 days and 90 minutes of speech—nothing else. Getting AAA as my RUG, previous RUG were LE1.

1. Do I have to transmit a SOT?
2. If I do not have to transmit the SOT—would I have to transmit an EOT?

With increased scrutiny on fraudulent practices in nursing homes and the importance of RUG accuracy, Monika’s question is truly timely. See Carol Maher’s solution to ensure an accurate RUG and the correct reimbursement in the MDS Connection community on AANACConnect.
Reimbursement Tip

If a resident was admitted on Monday at 6:00 pm on Medicare Part A and expired on Tuesday at 2:30 pm, completing a 5-day would allow you to bill at the appropriate RUG for that one day. Without the MDS, the only option would be to bill at the default rate so it is always in the best interest of the facility to complete the assessment.

Jennifer Pettis, RN, WCC, RAC-MT, C-NE
Director of Program Development,
Harmony Healthcare International

Treatment of Members Policy

AANAC has posted the Treatment of Members Policy on the website. If you need to access it, please click here.

FAQ referral

Do you have a question you need answered NOW? Members of AANAC can go directly to the experts! Go to the FAQ section of the website. The answer may be right in front of you!
On the previous MDS, a resident was coded with a stage 2 pressure ulcer present on admission. I am currently completing a Discharge assessment, and the same pressure ulcer is now unstageable due to presence of eschar. I am coding this ulcer under M0300F, Unstageable—slough and/or eschar. Should I code this as present on admission? The RAI User’s Manual says not to code as present on admission if the wound has gone up to a higher stage, but stage is not determined at this time due to eschar. As example 3 on page M-17 of chapter 3 of the RAI User's Manual indicates, since it can no longer be staged as the stage 2 it was on admission (and clearly has not improved to a stage 1), it can no longer be captured as present on admission. But it would not be coded as worsened for M0800. It would be coded as worsened only if the stage increased. Onset of slough or eschar is not considered to be worsened for these purposes, according to the definition on page M-24 of chapter 3 of the RAI User’s Manual. It is “worsened” only if the stage increases. Also, as it says on the next page, “If a previously staged pressure ulcer becomes unstageable due to slough or eschar, do not code as worsened.”

Rena R. Shephard, MHA, RN, RAC-MT, C-NE (RRS2000@aol.com)

The 14-day assessment resulted in RUG score RUA. The first COT evaluation was still RUA. On day 29 COT evaluation it was RVA, but I did the 30-day assessment already on day 27. I don’t have to do a COT, am I correct?

Correct. If you completed your 30-day assessment with day 27 as the ARD, day 28 becomes the new day 1 for the next COT observation window. Day 29 is day 2, not day 7 anymore.

Carol Maher, RN-BC, RAC-CT (cmahero1211@earthlink.net)

Scenario:

Resident received therapy Dec. 22
Dec. 23 out for dialysis; sent to hospital from dialysis, not back in facility at midnight, not admitted as inpatient at hospital
Dec. 24 returned to facility, did not receive therapy
Dec. 25 did not receive therapy
Dec. 26 received therapy

Since Dec. 23 was not a billable day, is it included in the count for days without therapy requiring an EOT OMRA to be completed?

If the resident was already classified in a Rehab RUG, then yes, an EOT OMRA is required, since there were three consecutive days without therapy. CMS has clarified that LOA days count toward the three days.

Ronald A. Orth, RN, NHA, CPC, RAC-MT (raorth@clinicalreimbursement.com)
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AANAC | 400 S. Colorado Blvd., Suite 600 | Denver, Colorado 80226 | Phone 800.768.1880 | Fax 303.758.3588

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