

MDS 3.0 updates

MDS 3.0 Section "S" & The New POLST

All Medicare and/or Medicaid certified nursing facilities should be using the updated Minimum Data Set (MDS) 3.0 section "S" dated October 1, 2014. Section "S" is specific to California and completion is mandatory. The specification for October 1, 2014 implementation of section "S" is posted at the Centers for Medicare & Medicaid Services (CMS) Quality Improvement & Evaluation System (QIES) Technical Support website. This section must be included in Item Sets; NC–Nursing Comprehensive Assessment, NQ–Nursing Quarterly Assessment, and NT–Nursing Tracking /ND–Nursing Discharge Assessment. Do not use MDS 3.0 section "S" dated April 2011 after October 1, 2014.

If the Assessment Reference Date (**ARD**) on the MDS assessment is on or before September 30, 2014, use the MDS section "S" dated April 2011. If the **ARD** of the MDS assessment is on or after October 1, 2014, use the MDS section "S" dated October 1, 2014.

For coding MDS 3.0 section "S," the clinician must read the resident's current Physician Orders for Life-Sustaining Treatment (POLST) form, which is in the resident's medical record (chart) and reference responses on MDS 3.0 section "S."

Changes in section "S" accommodate the current POLST implemented on October 1, 2014, as well as a crosswalk to responses in all POLST versions: October 2010, April 2011, and October 2014.

Previous POLST versions will be honored after the 2014 form begins, but it is preferable to use a 2014 POLST and void older versions when POLST is updated.

Changes on the POLST form clarify and assist patients in better understanding each treatment option. These changes were developed by the Coalition for Compassionate Care of California (CCCC) and approved by the California Emergency Medical Services Authority (EMSA).

The POLST is available at the CCCC website. Please follow the link : <http://coalitionccc.org/>

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Special Points of Interest

- **New MDS section "S" information**
- **Key changes to POLST Form**
- **Quick Reminders about POLST**
- **MDS 3.0 section "S" dated October 1, 2014**
- **S & C Letter 14-43-NH, Completion of MDS Discharge Assessment**
- **Key changes in the new RAI 3.0 manual**
- **COT OMRA Completion Requirement**
- **Section "Q" coding information & LCA**



The California Department of Public Health, Licensing & Certification released an All Facility Letter (AFL) on Section “S” form, coding updates and information about the new POLST form. Please follow the link:

<http://www.cdph.ca.gov/certlic/facilities/Documents/LNC-AFL-14-20.pdf>

The Coalition for Compassionate Care of California is offering POLST classes. Please visit their website:

<http://coalitionccc.org/>

(continued from page 1) *Mds 3.0 Section S and The New POLST....*

Key changes to POLST form:

- In order to be consistent with Section A, treatment choices for Sections B and C are reversed with each section beginning with the most aggressive and invasive treatment choices.
- In Section B, the choice of “Limited Additional Interventions” is renamed “Selective Treatment,” and the choice of “Comfort Measures Only” is renamed “Comfort-Focused Treatment.” Goal statements are added for each treatment choice in Section B.
- In Section B, the “Full Treatment” option features a box indicating: “Trial Period of Full Treatment.”
- “Address” is clarified and reads “Mailing Address.”

The goal statements (POLST 2014, section B):

(Please refer to POLST form dated October 1, 2014 for medical interventions. The information below is NOT to be used as a reference in completing a POLST form).

1. **Full Treatment**– primary goal of prolonging life by all medically effective means.
2. **Selective Treatment**– goal of treating medical conditions while avoiding burdensome measures.
3. **Comfort- Focused Treatment**– primary goal of maximizing comfort.



Quick POLST Reminders

- POLST is a voluntary form.
- Previously completed POLST forms remain valid.
- Copy the POLST on ultra pink paper to help ensure the document stands out and is followed, but it is valid when printed or faxed on plain paper.
- Ensure the Advance Directive and POLST are consistent.



S & C Letter 14-43 NH

On August 25, 2014, CMS released S & C Letter 14-43- NH for completion of Minimum Data Set (MDS) 3.0 Discharge Assessments.

Memo Summary

Completion of MDS 3.0 Discharge Assessments for Transfers from Medicare and/or Medicaid-Certified Beds to Non-Certified Beds: Discharge assessments are required and are critical to ensure the accuracy of Quality Measures (QMs), and aid in resident care planning for discharge from a certified facility.

Background

CMS is reinforcing the requirement for, and the importance of, completing MDS 3.0 Discharge Assessment Record when a resident transfers from a Medicare and/or Medicaid certified bed (i.e., a bed located within a Skilled Nursing Facility (SNF) or a Nursing Facility (NF) to a Non-Certified Bed). CMS previously communicated the importance of Discharge Assessments with the issuance of S&C Memorandum 13-56-NH: Minimum Data Set (MDS) 3.0 Discharge Assessments that have not been completed and/or submitted by August 2013.

Regulatory Requirements

Federal Regulation 42 CFR §483.12(a) Transfer and Discharge; defines transfer and discharge as, “movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.” Federal Regulations 42 CFR §483.20(f) Automated Data Processing Requirements include facilities to “electronically transmit encoded, accurate, and complete MDS data to the CMS System, including a subset of items upon a resident’s transfer, reentry, discharge, and death.”

Responsibility of Nursing Homes for Completing Discharge Assessments (CMS Policy)

Discharge assessments are required for residents that are transferred to non-certified beds housed under the same certified facility. The *Long-term Care Facility Resident Assessment Instrument User’s Manual, Version 3.0 (RAI User’s Manual)* applies to all certified beds. Page 2-2 states, “the requirements for the RAI are found at 42 CFR 483.20 and are applicable to all residents in Medicare and/or Medicaid certified long-term care facilities.” All Omnibus Budget Reconciliation Act (OBRA)-required assessments, including Discharge Assessments, are required assessments. Nursing Facilities and Skilled Nursing Facilities must complete and submit to the Quality Improvement and Evaluation System (QIES), Assessment Submission and Processing (ASAP) system in accordance with the requirements outlined in the RAI User’s Manual. Failure to submit required assessments may re-

sult in inaccurate Quality Measures (QM) and survey citations, as well as a negative impact on discharge planning activities.

Updated RAI 3.0 Manual is now available

The RAI User’s Manual Version 1.12 is available in the Download section of the CMS’ Nursing Home Quality Initiatives website:

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>

Changes include:

Page A-4: The item set changes on section A0310. Type of Assessment : Option 06. Readmission/return assessment was removed.

Page A-7: Changes on item A0410: “Unit Certification or Licensure Designation” instead of “Submission Requirements.”

Page A-7: The facility must consider Medicare and/or Medicaid status, as well as, state’s authority to collect MDS records. Nursing homes and swing-bed facilities must be certain they submit MDS assessments to the Quality Improvement and Evaluation System (QIES) Assessment and Submission Processing (ASAP) System for those residents who are in a Medicare and/or Medicaid certified beds.

Page A-11: Added option 9. Unable to determine.

Page A-22: A1600: Entry Date is now on the current form.

Page A-22, Definition of Entry Date: the initial date of admission to the facility, or date the resident most recently returned to your facility after being discharged.

Page A-25: A1900: Admission Date, (Date this episode of care in this facility began). Admission date may be the same as the Entry Date (A1600) for the entire stay (i.e. if resident is never discharged).

Pages K-16 & 17: # 3 scenario is added to section K0710. Percent Intake by artificial route; calculation on total fluid intake of the resident during the entire 7 days.

Page O-3: item O0250: Influenza vaccine and, clarification on item O0100F, Ventilator and Respirator. **Resident receiving closed-system mechanical ventilation includes those residents receiving ventilation via endotracheal tube (e.g., nasally or orally intubated) as well as those residents with a tracheostomy.**

Page O-4: The National Drug Code Directory link:

<http://www.fda.gov/drugs/informationondrugs/ucm142438.htm>

Page O-9: Additional information on Influenza Vaccine.

Pages X-1 -X-7: There are a few examples of old and new items in section X. Please refer to the new item set.

<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-43.pdf>

Transition for Implementation of FY 2015 SNF PPS MDS 3.0

Policy Changes

Revision to Change of Therapy (COT) Other Medicare Required Assessment (OMRA), Completion Requirements

Policy Summary

For the reason specified in the FY 2015 Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Final Rule (79 FR 45647 through 45649) and FY 2015 PPS Proposed Rule (79 FR 25786 through FR 25788), providers are permitted, in certain circumstances, to complete a COT, OMRA for a resident who is not currently classified into a Resource Utilization Group, Version 4 (RUG-IV) therapy group, or receiving a level of therapy sufficient for classification into a RUG-IV therapy group. These circumstances are limited to cases in which the resident had qualified for a RUG-IV therapy group on a prior assessment during the resident's current Medicare Part A stay and had no discontinuation of therapy services between Day 1 of the COT observation period for the COT OMRA that classified the resident into his/her current non-therapy RUG-IV group and the Assessment Reference Date (ARD) of the COT OMRA that reclassified the resident into a RUG-IV therapy group.

Transition Policy

This policy is effective October 1, 2014. More specifically, the COT OMRA which would be used to reclassify the resident into a RUG-IV therapy group from a RUG-IV non-therapy group, pursuant to the rules associated with this policy outlined in the FY 2015 SNF final rule (79 FR 45647 through 45649) and the MDS, Version 3.0 manual, must have an ARD set for on or after October 1, 2014.

Change of Therapy assessment policy update

The COT OMRA is used to classify a resident into a new RUG when based on therapy services provided during the previous seven days, and the resident no longer qualifies for the RUG into which they are currently classified for payment.

COT OMRA may be completed when a resident is not currently classified into a RUG-IV therapy group, but only if *both of the following conditions* are met:

1. Resident has been classified into RUG-IV therapy group on a prior assessment during the resident's current Medicare Part A stay.

2. No discontinuation of therapy services (planned or unplanned) occurred between Day 1 of the COT observation period for the COT OMRA that classified the resident into his/her current non-therapy RUG-IV group and the ARD of the COT OMRA that reclassified the resident into RUG-IV therapy group.

Please refer to the RAI 3.0 manual, October 2014, pages 2-51 to 2-53, for COT OMRA instructions.

Medicare/Medicaid certified unit to non-certified unit

Pages 2-10, bullet 4: "Resident is transferred from a Medicare and/or Medicaid certified bed to a non-certified bed." Please refer to page 3, S & C letter 14-43 NH, for memorandum summary and regulatory requirements.

Resident Admitted on Hospice Care

Pages 2-21 & 2-22: Where hospice election occurs after the admission assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice election so that only the admission assessment is required. In such situations, a Significant Change of Status Assessment (SCSA) is not required. If a resident is admitted on the hospice benefit but decides to discontinue it prior to the ARD of the Admission assessment, the facility completes an admission assessment and checks the Hospice Care item, O0100K. Completing an admission assessment followed by SCSA is not required. Where hospice revocation occurs after the admission assessment ARD, but prior to its completion, facilities may choose to adjust the ARD to the date of hospice revocation so only the admission assessment is required. In such situations, an SCSA is not required.

Page 2-33: Entry tracking record is coded as reentry every time a person:

- is readmitted to this facility, **and** was discharged with return anticipated from this facility, **and**
- returned within 30 days of discharge. **See RAI manual Section 2.5. Reentry for greater detail.**

Example of Discharge-Return Not

Anticipated coding:

Mr. K was transferred from a Medicare certified bed to a non-certified bed on December 12, 2013 and plans to remain long term in the facility. Code the December 12, 2013 Discharge assessment as follows:

A0310F= 10

A2000= 12-12-2013

A2100= 2

Reference: Pages 2-36 -2-38

For discharge assessment, the ARD (Item A2300) is not set prospectively as with other assessments. The ARD (Item A2300) for a discharge assessment is always equal to the discharge date (Item A2000) and may be coded on the assessment any time during the discharge assessment completion period (i.e., discharge date (A2000) + 14 calendar days).

The use of dash, "-", is appropriate when the staff are unable to determine the response to an item, including interview items. In some cases, the facility may have already completed some items of the assessment, and should record those responses, or may be in the process of completing the assessment. The facility may combine the discharge assessment with another assessment when all requirements are met.

For unplanned discharges, the facility should complete the Discharge assessment to the best of its abilities.

Page 2-48: If the resident received therapy Friday, but was not scheduled for therapy on Saturday or Sunday, and refused therapy for Monday then Saturday would be counted as "Day 1". The first day after the last therapy treatment was provided whether therapy was scheduled or not for that day.

For the purpose of determining when an EOT OMRA must be completed, a treatment day is defined as in Chapter 3, Section O, 15 minutes of therapy a day. If a resident receives less than 15 minutes of therapy in a day, it is not coded on the MDS and it cannot be considered a day of therapy.

MDS 3.0 Section Q. Participation In Assessment and Goal Setting

There are 20 Care Area Assessments (CAA) that may trigger resident's condition from MDS 3.0 collected data. The facility's Interdisciplinary Team (IDT) determines the connections and the underlying causes and other pertinent areas, and if care plan is necessary to be implemented or continued.

Not all triggered care areas identify deficits or problems. Some triggered areas indicate strengths. For example, Item G0900A, "resident believes he/she is capable of increased independence in at least some ADLs." This area in ADLs may be a potential for improvement. (RAI manual 3.0 chapter 4, CAA).

When section Q (#20 CAA) is triggered, documentation of the discharge plan is required. Decisions in discharge planning may have a great impact to the quality of life of a resident in a nursing facility.

The intent of section Q is to record the participation and expectations of the resident, family members, or significant other or others in the assessment, and to understand the resident's overall goals. **Discharge planning follow-up** is a regulatory requirement (CFR 483.20(I)(3)). Section Q of the MDS uses a person-centered approach to insure that all individuals have the opportunity to learn about home and community based services, and receive long term care in the least restrictive setting possible. Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.

Residents who actively participate in the assessment process and in developing their care plan through interview and conversation often experience improved quality of life and higher quality of care based on their needs, goals, and priorities.

Whenever possible, the resident must be actively involved in their plan of care. Their care plan should be resident-driven and individualized unless the resident is not capable of doing so. Residents' involvement in their care address the dignity and self-determination survey and certification requirements (CFR §483.15 **Quality of Life**). (RAI manual 3.0, Chapter 3, section Q)

If the resident is unable to understand the process, his or her family

member, significant other, and/or guardian/legally authorized representative, should be invited to the assessment process whenever possible.

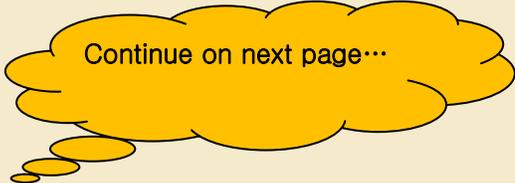
Steps for assessment and coding instruction guidance in the RAI 3.0 user manual is available in chapter 3 section Q. Multiple examples, and scenarios guide clinicians in coding MDS section Q. In some instances coding the resident as having a clear goal to return home even if staff believe that this is unlikely based on available social supports, should be coded based on the resident's expressed goals.

Returning home or discharging to a non-institutional setting can be very important to a resident's health and quality of life. It is important to discuss with residents their interest in talking with Local Contact Agency (LCA) experts about returning to the community. There are various community resources providing support to benefit these residents allowing them to return to a community setting.

The clinician must read the questions and code the responses appropriately. If the response is "Yes" to a question in item Q0400, "is active discharge planning already occurring to return to the community?" skip to item Q0600. Referral.

Q0500: Return to Community. Follow-up actions initiating and maintaining collaboration between the nursing home and the local contact agency to support the resident's expressed interest in transitioning to community living. This includes the nursing home supporting the resident in achieving his or her highest level of functioning and the local contact agency providing informed choices for community living.

Please follow the link: <http://www.dhcs.ca.gov/services/ltc/Pages/MDS3,SectionQ.aspx>



Continue on next page...

These are two items from MDS 3.0 section Q items, October 2014.

Q0400. Discharge Plan

Enter Code

A. Is active discharge planning already occurring for the resident to return to the community?

0. No

1. Yes → Skip to Q0600, Referral

Q0600. Referral

Enter Code

Has a referral been made to the Local Contact Agency? (Document reasons in resident's clinical record)

0. No - referral not needed

1. No - referral is or may be needed (For more information see Appendix C, Care Area Assessment Resources #20)

2. Yes - referral made

In coding Item Q0500. Return to the community, the facility must follow the coding instructions in the RAI manual. At the initial assessment and in subsequent follow-up assessments (if applicable) assure the resident questions are routine and asked of all residents. If the resident would like to speak to someone about the possibility of returning to live in the community, that signals a request for more information, therefore, contact someone about available support in the community. Answering “Yes” does not commit the resident to leave the nursing home at a specific time; nor does it ensure the resident will be able to move back to the community. Answering “No”, is not a permanent commitment either. Inform the resident he/she can change his/her decision (i.e., whether or not he or she wants to speak with someone) at any time.

(reference: RAI manual 3.0 Q0500, Steps for Assessment)

The **Code of Federal Regulations (42 CFR) F284 §483.20(I)(3)**, requires a post-discharge plan of care, developed with the participation of the resident and his or her family, which assists the resident to adjust to their new living environment.

Interpretive Guidelines §483.20(I)(3):

A post discharge plan of care for an anticipated discharge applies to a resident whom the facility discharges to a private residence, to another NF, SNF, or to another type of residential facility, such as a board and care home or an intermediate care facility for individuals with intellectual disabilities. Resident protection concerning transfer and discharge is found in the State Operation Manual (SOM) section **§483.12**. A “post-discharge plan of care,” means the discharge planning process includes assessing continuing care needs and developing a plan designed to ensure the individual’s needs will be met after discharge from the facility into the community.

Probes §483.20(I) (not all probes are mentioned):

- Is there evidence of a discharge assessment that identifies the resident’s needs and is used to develop the discharge plan?
- Is there evidence of discharge planning in the records of discharged residents who had anticipated discharge or those residents to be discharged shortly?
- Does the discharge summary have information identifying if the resident triggered the CAA for return to community referral?
- Do discharge plans address necessary post-discharge care?

Follow this link for CMS discharge planning check list:

<http://www.medicare.gov/Publications/Pubs/pdf/11376.pdf>

View a sample of the 2014 form and learn more about the changes to POLST at: <http://capolst.org/2014polst/>

To view the new MDS 3.0 Section “S”, please follow the link: <http://www.cdph.ca.gov/programs/LnC/Pages/MDS.aspx>

California POLST October 2014:

<http://capolst.org/2014polst/>

CMS Survey & Certification Letter 14-43:

<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-43.pdf>

CMS.gov MDS 3.0 Manual links for October 2014:

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>

For Regulatory Guidance:

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/SOM107ap_pp_Guidelines_tcf.pdf

For SNF PPS FY 2015 Rule:

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Spotlight.html>.

References:

RAI Manual 3.0 version, October 1, 2014
 Monthly All State CMS, RAI/SMA Teleconferences (9/16/14)
 CMS Nursing Home Initiative Website
 CMS ODF (Open Door Forum LTC) Provider’s Teleconference 9/17/14
 CDPH L & C All Facility Letter 14-20, 9/9/2014
 CMS Survey & Certification Letter 14-43, 8/25/2014
 Code of Federal Regulations (42 CFR § 483.20)

For MDS Clinical & Technical Questions
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The content of this newsletter may be time-limited and the information may be superseded by the guidance published by CMS and CDPH at a later date. Current information and updates on regulations from CMS and CDPH are the provider’s responsibility.

Resident	Identifier	Date
Section S		California
S9040A	California POLST	
Enter Code	Does resident have a California POLST form in chart?	
<input type="checkbox"/>	0. No	
<input type="checkbox"/>	1. Yes	
S9040B	CA- Item selected in California POLST Section A	
Enter Code	1. Attempt resuscitation/CPR	
<input type="checkbox"/>	2. Do not attempt resuscitation/DNR	
<input type="checkbox"/>	9. Not completed	
S9040C1	CA- Item selected in California POLST Section-B	
Enter Code	1. "Full Treatment" is the only box checked.	
<input type="checkbox"/>	2. "Full Treatment" AND "Trial Period of Full Treatment" are both checked.	
<input type="checkbox"/>	3. "Selective Treatment" or "Limited Additional Interventions" is the only box checked.	
<input type="checkbox"/>	4. "Selective Treatment" or "Limited Additional Interventions" AND "Transfer to hospital <i>only</i> if comfort needs cannot be met in current location" are checked.	
<input type="checkbox"/>	5. "Comfort-Focused Treatment" or "Comfort Measures Only"	
<input type="checkbox"/>	9. Not completed	
S9040D1	CA- Item selected in California POLST Section-C	
Enter Code	1. Long-term artificial nutrition, including feeding tubes	
<input type="checkbox"/>	2. Trial period of artificial nutrition, including feeding tubes	
<input type="checkbox"/>	3. No artificial means of nutrition, including feeding tubes	
<input type="checkbox"/>	9. Not completed	
S9040E	CA-POLST Section D- Signature of Physician	
Enter Code		
<input type="checkbox"/>	0. No	
<input type="checkbox"/>	1. Yes	
S9040F	CA- POLST D- Signature by Patient or Decisionmaker	
Enter Code		
<input type="checkbox"/>	0. No	
<input type="checkbox"/>	1. Yes	
S9040G	Discussed with in California POLST Section D	
Enter Code	1. Patient	
<input type="checkbox"/>	2. Legally recognized decisionmaker	
<input type="checkbox"/>	9. Not completed	
S9040H	California POLST Section D- Advance Directive:	
Enter Code	1. Advance directive available and reviewed	
<input type="checkbox"/>	2. Advance directive not available	
<input type="checkbox"/>	3. No advance directive	
<input type="checkbox"/>	9. Not completed	
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