

Missing Assessments

Submission of late discharge assessment

Failure to transmit missing assessments, late or incomplete discharge assessments resulted in inaccurate facility roster lists and affected some facilities with inaccurate Facility Final Validation Reports. Centers for Medicare & Medicaid Services (CMS) released the S & C Letter, dated August 23, 2013, regarding the Minimum Data Set (MDS) 3.0 discharge assessments that have not been completed and/or submitted by the deadline of September 30, 2013. The California Department of Public Health (CDPH) also released an All Facility Letter (AFL) in early September 2013 reminding all nursing facilities to submit the discharge assessment records by September 30, 2013. The MDS/OASIS technical support unit, and the Federal System Support Unit (FSSU) of CDPH worked diligently with nursing facilities to aid in correction of errors and assisting in the submission process to CMS Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing System (ASAP) to meet the CMS deadline.

Review of Facility's MDS Final Validation Report must be a common practice to ensure that error messages are corrected, and if needed the record must be re-submitted and make sure it is accepted by CMS QIES ASAP system. In some cases when facilities use a third party for MDS transmission, they do not receive their Final Validation Report on a regular basis after transmission occurred. It is critical for a nursing facility to have The Facility's Final Validation report messages each time MDS transmission occurs.

For a variety of reasons missing assessments occurred during the transmission process. Many of the missing assessments have misspelled names, wrong or missing initials or suffixes different from the original records. Others have listed the wrong gender, social security number, date of birth, along with other inconsistent information.

Before the record is transmitted, the clinician must ensure the accuracy of the information. When accurate information came in later after MDS records were completed and transmitted to the QIES system and the original record with errors were not corrected, the



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succeeding MDS record oftentimes resulted in more than one resident identifier because the system was unable to recognize and identify the resident. With different information, the system created another resident identification using different information within the same profile.

It was also discovered that some assessment records were submitted to the **State only, but not to the federally required (when MDS assessments should be submitted to Federal) submission (A0410 SUBMISSION REQUIREMENT = 2)**. When a facility is 100% certified for Medicare/Medicaid, the facility is required to do a discharge assessment and the Assessment Reference Date (ARD) item A2300 must be equal to the date of discharge, (A2000). Submitting accurate information to the appropriate authority is also key to accurate submission of MDS records. The RAI user's manual 3.0 instruction emphasized on item A0410: Submission Requirement; (per RAI manual instruction) there must be a Federal and/or State authority to submit MDS assessment data to the MDS National Repository. Nursing homes must be certain to submit MDS assessments under the appropriate authority.

We acknowledged the hard work of facility staff to correct issues and re-submit one or more times before the record is accepted into the QIES ASAP system. However, the facility must have a system to make sure that transmissions are completed accurately and regularly to avoid missing assessments.

Changes in the RAI manual 3.0, October 2013

For **Discharge Assessment**, the ARD is not set prospectively as with other assessments. The ARD for a Discharge assessment may be coded any time during the Discharge assessment completion period {i.e., discharge date (A2000) + 14 calendar days}. For **Unplanned Discharges**, the facility should complete the discharge assessment to the best of their abilities. The use of dash, "-", is appropriate when 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 an assessment. The facility may combine the Discharge assessment with another assessment when requirements for all assessments are met.

(Refer to RAI manual 3.0, page 2-36 for examples of unplanned discharge assessments).

Page 2-48. In cases where the last day of the Medicare Part A benefit, the date used to code A2400C (End of the most recent Medicare stay) is prior to the third consecutive day of missed therapy services, **then no EOT (End of Therapy) OMRA would be required.** If the date listed in end date of most recent Medicare stay (A2400C) is on or after the third consecutive day of missed therapy services, **then EOT OMRA would be required.**

In cases where the date used to code A2400C is equal to the date used to code A2000, that is, cases where the discharge from Medicare Part A is the same day as the discharge from the facility, and this date is on or prior to the third consecutive day of missed therapy services, then **no EOT OMRA is required.** Facilities may choose to combine the EOT OMRA with the discharge assessment under the rules outlined for such combinations in Chapter 2 of the MDS RAI manual.

Change of Therapy (COT) OMRA (Chapter 2, section 2.9, page 2-51 & 2-72 of the RAI manual).

When the most recent assessment used for PPS, excluding an End of Therapy OMRA, has a sufficient level of rehabilitation therapy to qualify for an Ultra High, Very High, High, Medium, or Low Rehabilitation category (even if the final classification index maximizes to a group below Rehabilitation), then a change in the provision of therapy services is evaluated in **successive 7-day Change of Therapy observation periods until a new assessment used for PPS occurs.**

Note: In limited circumstances, it may not be practicable to conduct the resident interview portions of the MDS (Sections C, D, F, and J) on or prior to the ARD for a standalone unscheduled PPS assessment. **In such cases where the resident interviews** (and not staff assessment) are to be completed and the assessment is a standalone unscheduled assessment, providers may conduct the resident interview portions of that assessment **up to two calendar days after the ARD** (Item A2300).

Skilled Nursing Facilities (SNF) may use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for an unscheduled PPS assessment, but only in the case where the ARD for the **unscheduled assessment falls on a day that is not counted among the beneficiary's 100 days due to a leave of absence (LOA)**, as defined above, and the resident returns to the facility from the LOA on Medicare Part A. For example, Day 7 of the COT observation period occurs 7 days following the ARD of the most recent PPS assessment used for payment, regardless if an LOA occurs at any point during the COT observation period. If the ARD for a resident's 30-day assessment were set for November 7 and the resident went to the emergency room at 11:00 pm on November 14, returning on November 15, Day 7 of the COT observation period would remain November 14 for the purposes of coding COT OMRA.

Finally there may be cases in which a SNF plans to combine a scheduled and unscheduled assessment on a given day, but then the day **becomes an LOA day for the resident. In such cases, while that day may still be used as the ARD of the unscheduled assessment, this day cannot be used as the ARD of the scheduled assessment.** For example, if the ARD for a resident's 5-day assessment were set for May 10 and the resident went to the emergency room at 1:00 pm on May 17, returning on May 18, a facility could not complete a combined 14-day/COT OMRA with an ARD set for May 17. Rather, while the COT OMRA could still have an ARD of May 17, the 14-day assessment would need to have an ARD that falls on one of the resident's Medicare A benefit days. (RAI manual page 2-72)

Section G-0110 Page G-3 & G-4

Consider all episodes of the activity that **occurred 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. There are many possible reasons for these variations to occur, including but not limited to mood, medical condition, relationship issues (e.g., willing to perform for a nursing assistant that he or she likes), and medications. **The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident's ADL self-performance over the last 7-day period, 24 hours a day** (i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well).

To assist in coding ADL Self-performance items, facilities may augment the instructions with the [algorithm on page G-7 of the RAI manual 3.0, October 2013](#). This section involves two

part ADL evaluation: **Self performance**, which measures how much of the ADL activity the resident can do for himself or herself, and **support provided**, which measures how much facility staff support is needed for the resident to complete the ADL. It is recommended that the ADL Self-Performance evaluation be completed for all ADL activities before the ADL Support evaluation.

The Rule of 3

The **"Rule of 3"** is a method developed in determination of the appropriate code to document ADL Self-performance on the MDS.

It is very important that staff who complete this section fully understand the components of each ADL, the ADL self-performance, and the Rule of 3.

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**.

Instructions for the Rule of 3 can be found on page G-3 of the RAI manual 3.0 version of October 2013 release.

Note: If none of the instructions meet the coding scenario, code "supervision".

There are also exceptions to Rule of 3 in coding ADL Self-Performance, these are:

- Code 0, Code 4, and Code 8 – as the definition for each of these levels is very specific and cannot be entered on the MDS unless it is the level that occurred every time the ADL occurred.
- Code 7 - as this code only applies if the activity occurred fewer than 3 times.

(Refer to page G-7 of the RAI user manual for Rule of 3 instruction if activity occurred 3 or more times at multiple levels but not 3 times at any one level).

Section K

Section K added one more column to item K0710, "K0710A". The proportion of total calories resident received during the entire 7 days through parenteral or tube feeding and K0710B average fluid intake per day by IV or tube feeding during the entire 7 days.

Section M



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DEFINITION

The “Rule of 3” is a method that was developed to help determine the appropriate code to document ADL Self-Performance on the MDS.

Co-treatment– when two clinicians (therapists or therapy assistants), each from a different discipline, treat one resident at the same time with different treatments, both disciplines may code the treatment session in full. All policies regarding mode, modalities and student supervision must be followed as well as all other federal, state, practice and facility policies. Example given on page O-21 of the RAI Manual 3.0 version, released October 2013.



On items Mo210, Mo300, and Mo610, the word non-epithelialized were removed.

On item Mo7004, “necrotic” was removed and the word “Eschar” remains.

Section O

On Items O400, the “co-treatment minutes” in all therapy disciplines are added responses.

On item Oo420, Distinct Calendar Days of Therapy are also an additional item. Record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.

Oo450. Resumption of Therapy - Complete only if A0310C=2 (End of Therapy assessment) or 3 (Both Start and End of Therapy assessment) and A0310F (not entry/discharge record)= 99.

Section Q

On item Qo500B. (Return to Community) **Ask the resident** (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): **“Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?”**

On item Qo550 **“legally authorized representative”**, this phrase is added to the question.

Section Z

Additional coding tips and special instructions to this section included in October 2013 release:

If an individual completing portion/s of the MDS is not available to sign (e.g., staff members who are no longer employed by the facility and left completed MDS sections but unsigned), portions of the MDS may be verified with the medical record and/or resident/staff/family interview as appropriate. For these sections, the person signing the attestation must review the information for accuracy and sign for those portions on the date the review was conducted. For sections requiring resident interviews, the person signing the attestation for completion of such section/s should interview the resident to ensure the accuracy of the information and sign on the date the verification occurred.

Clarification on Completion timing in chapter 5-2 of the RAI manual:

For Admission assessment, the MDS Completion Date (Z0500B) must be no later than 13 days after the Entry Date (A1600).

For Admission assessment and Care Area Assessment (CAA) Completion Date (V0200B2), must be no later than 13 days after the Entry Date (A1600). For Annual assessment, the CAA Completion Date (V0200B2) must be no later than 14 days after the ARD (A2300).



Q&A's Q1. Our facility is waiting for arrival of flu vaccines. In the meantime, if a resident's MDS assessment is due during the flu season before the facility receives the vaccines or facility is not prepared to administer the vaccines, how should section O0250C be coded, (5) "not offered" or (9) "none of the above"?

A1. The answer can be found on page O-8 of the RAI manual, example # 4:

Mr. K. wanted to receive the influenza vaccine if it arrived prior to his scheduled discharge October 5th. Mr. K. was discharged prior to the facility receiving their annual shipment of influenza vaccine, and therefore, Mr. K. did not receive the influenza vaccine in the facility. Mr. K. was encouraged to receive the influenza vaccine at his next scheduled physician visit. O0250A would be coded "o" no; O0250B is skipped, and O0250C would be coded 9, none of the above.

Rationale: Mr. K. was unable to receive the influenza vaccine in the facility due to the fact that the facility did not receive its shipment of influenza vaccine until his discharge. None of the codes in O0250C, influenza vaccines not received, state reason, are applicable.

Q2. When a facility has a Medicare/Medicaid certified unit and a non-certified unit and MDS assessments are completed and submitted for residents in a certified unit, is discharge assessment required when resident is discharge from a certified unit to a non-certified unit?

A2. Yes, when resident in a Medicare/Medicaid certified unit is discharged to a non-certified unit and MDS records are collected and transmitted to the QIES ASAP system, the facility must perform a discharge assessment and transmit the MDS records. This is the only way the QIES ASAP system be able to recognized that the resident has been discharged from a Medicare/Medicaid certified unit.

Q3. How to code items K0710A and K0710B for column 3 if resident received IV fluids within 7 days?

A3. From page K-14 of the RAI manual 3.0 version, examples are given on calculation of total calories from IV or tube feeding. Review the intake records to determine actual intake through parenteral or tube feeding routes.

- If the resident took no food or fluids or took just sips of fluids, stop here and use code 3, 51% or more.
- If the resident had more substantial oral intake, consult with the dietitian.

For item **K0710A1**; calculate the proportion of total calories the resident received daily through parenteral or tube feeding "While NOT a Resident" (while resident is in the hospital) divided by how many days the resident was in the hospital within the entire 7-day look back period. **K0710B1**;

calculate the average fluid intake per day by IV or tube feeding "While Not a Resident". The total amount of fluids the resident received daily should be divided by the number of days the resident was in the hospital during the entire 7-day look back period.

For item **K0701A2**, calculate the proportion of total calories the resident received daily through parenteral or tube feeding while a resident and **K0710B2**, calculate the average fluid intake daily for IV or tube feeding and divide by how many days the resident is in the nursing home.

For item **K0710A3**; calculate the proportion of the total calories received through parenteral or tube feeding While Not a Resident and While a Resident, add and divide by 7 days.

For item **K0710B3**; calculate the average fluid intake in the last 7 days While NOT a Resident and While a Resident, add and divide by 7 days, even if the resident did not receive IV fluids and/or tube feeding on each of the 7 days (please refer to page K-15 of the RAI manual 3.0, October 2013).

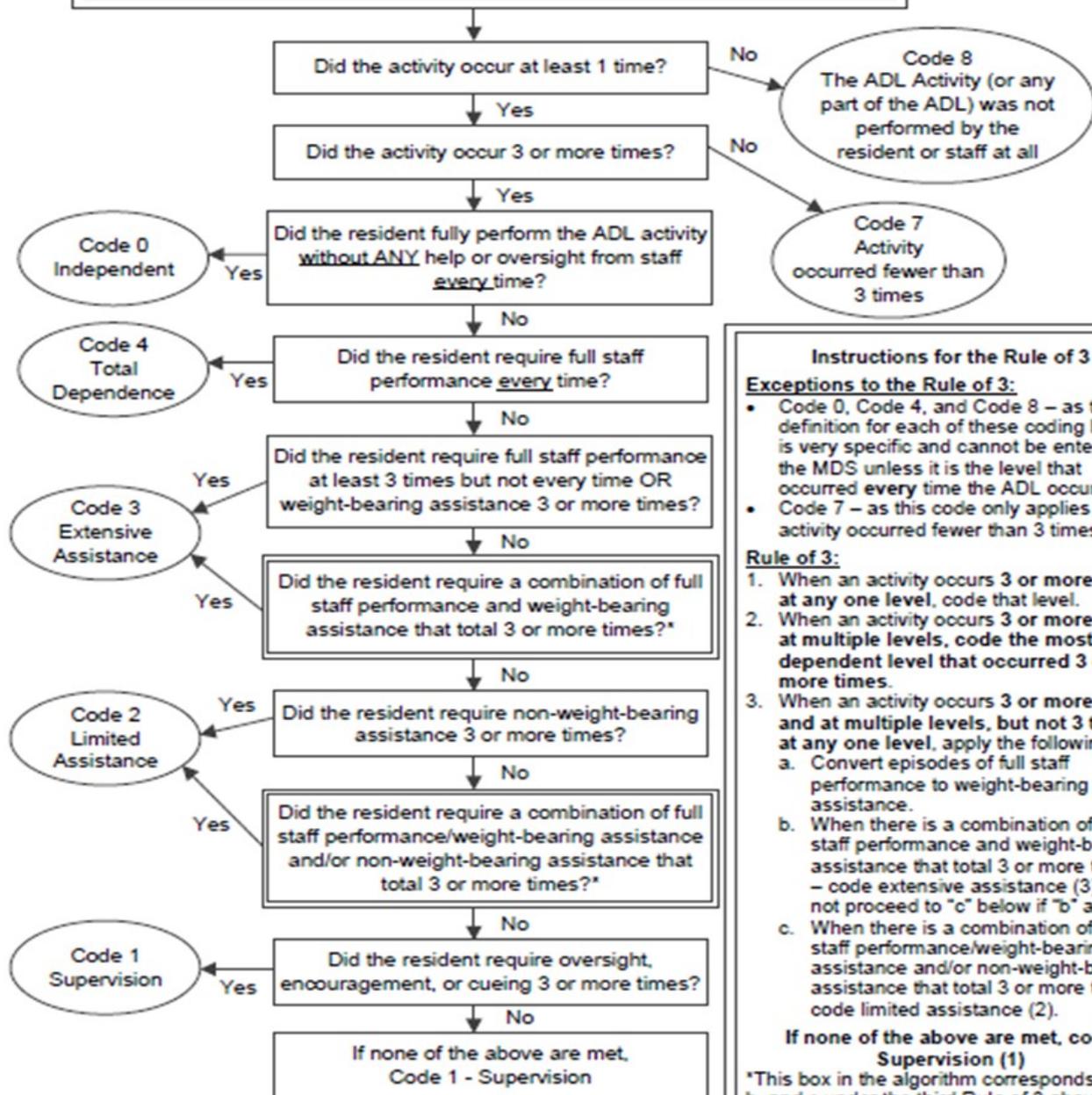


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G0110: Activities of Daily Living (ADL) Assistance (cont.)

ADL Self-Performance Algorithm

START HERE – Remember to review the instructions for the Rule of 3 and the ADL Self-Performance Coding Level Definitions before using the algorithm. STOP at the first code that applies when moving down the algorithm.



Instructions for the Rule of 3

Exceptions to the Rule of 3:

- Code 0, Code 4, and Code 8 – as the definition for each of these coding levels is very specific and cannot be entered on the MDS unless it is the level that occurred every time the ADL occurred.
- Code 7 – as this code only applies if the activity occurred fewer than 3 times.

Rule of 3:

1. When an activity occurs 3 or more times at any one level, code that level.
2. When an activity occurs 3 or more times at multiple levels, code the most dependent level that occurred 3 or more times.
3. When an activity occurs 3 or more times and at multiple levels, but not 3 times at any one level, apply the following:
 - a. Convert episodes of full staff performance to weight-bearing assistance.
 - b. When there is a combination of full staff performance and weight-bearing assistance that total 3 or more times – code extensive assistance (3). Do not proceed to "c" below if "b" applies.
 - c. When there is a combination of full staff performance/weight-bearing assistance and/or non-weight-bearing assistance that total 3 or more times, code limited assistance (2).

If none of the above are met, code Supervision (1)

*This box in the algorithm corresponds to a, b, and c under the third Rule of 3 above. The instruction in this box only applies when the third Rule of 3 applies, i.e., an activity occurs 3 or more times and at multiple levels, but not 3 times at any one level (e.g., 2 times non-weight-bearing, 2 times weight-bearing). If the coding scenario does not meet the third Rule of 3, do not apply a, b, or c of the third Rule of 3, answer "No," and then continue down the algorithm.



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References:

RAI Manual 3.0 version, October 2013
 Monthly All State CMS, RAI/SMA Teleconferences
 CMS Nursing Home Initiative Website
 CMS ODF (Open Door Forum) Provider's Teleconference

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Related links:

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

Quality Measures link:

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

Nursing Home Compare link:

<http://www.medicare.gov/nursinghomecompare/>

CA MDS Nuggets (CA MDS Newsletter):

<http://www.cdph.ca.gov/programs/LnC/Pages/MDSNewsletter.aspx>