

- Sixteen months later after MDS 3.0
- Rules in the head
- What is CMS doing about this ???
- MDS 3.0 Item changes
- Clarification questions



Sixteen months later; questions remain regarding the evaluation of what is coded and what is not, updates, changes, clarifications, new items, and new policies in MDS (Minimum Data Set) 3.0.

A speaker at the National RAI Coordinators Conference, held in St. Louis, MO in March 2012, said that we should all be “**cheer leaders**” and get excited, proactive, and energetic for the new tools that were created to make the life of the residents in nursing facilities better.

Some nurses working in nursing homes have a **set of “rules”** in their head that sometimes are difficult to let go. For example, breakfast in the nursing home should be at 7:00 a.m., nap time is at 1 p.m., resident should lay in bed on top of the covers with shoes on, a resident that has weight loss should be on supplements, and visiting hours in the nursing home are from 8:30 a.m. to 8:30 p.m. only. Clinicians need to have an open mind to adopt the culture change happening globally, statewide, in the community, and especially in their own nursing home. Many nursing homes tailored their activities based on the “culture change” and the residents need. *Do you have any rules in the head that you want to keep or is it something that you could let go?*

Some of these rules in the head are worth keeping. For example, if a resident needs to go to the bathroom, someone has to take the resident to the bathroom **no “buts”** about it, or when residents turn on their call light, any staff member should respond **without exception.**

In the 1990’s when MDS was newly implemented, many of the residents and family members in the nursing homes were not involved in residents’ assessment. In many cases the responsible party or family members were not attending resident’s care conferences. It may have been possible that families were not informed that they could be involved in the care. Families may not realize the importance of their contribution to residents’ care preferences, for example, how residents want their ADLs performed.

How can residents and family members acknowledge the value of the care provided to the resident? How do care providers know that residents and families value the caregiver’s services?

For example, a palliative resident living in a nursing home had a change for the worse in health condition and the resident’s condition was declining daily. When signs and symptoms indicated an impending death, the resident was sent out to

the hospital. On many occasions a resident dies without family members or familiar care givers present. Families verbalize regret when their loved ones die alone or en route to the hospital. There is a great chance that this resident's preference, as well as others, was to spend their last moments in their room in the nursing home with familiar faces and comforting surroundings.

As clinicians, we sometimes miss giving residents and families the opportunity to address their preferences for these situations. Making an effort to address the resident's preferences is important especially when situations or conditions are expected to happen during their nursing home stay.

Having said that, many clinicians and staff members who take care of residents are familiar with the resident's needs and wants in the nursing home. CMS created this RAI tool, but remember that MDS is only one set of the assessment tools.

During the RAI training in St. Louis, MO a speaker asked the participants what could be said about MDS 3.0 over a year later?

Is MDS 3.0 like **a walk in the park** or is this set **completely insane**? We believe that neither description fits MDS 3.0. For clinicians in the health care industry, this will be a continuous learning process in resident's assessment. There is plenty of room for improvement to learn and to work toward better results. Many aspects of MDS 3.0 can adapt to modern healthcare systems, which continually change to align with advance treatments and approaches. In MDS 3.0, new medications, new treatments, new responses, new policies, and new approaches are added to the data collection, which embraces Quality Measures based on the item responses. MDS 3.0 introduced new items, coding responses, and quality measures to try out and evaluate its benefits. These changes discover, correct, and clarify the elements of a better quality of care and quality of life for our beneficiaries. MDS 3.0 is a great assessment tool because the resident, family, and staff members are included in the data collection. Input from these individuals will have a great impact in developing individualized care plans designed with unique characteristics that capture the resident's preferences in activities of daily living with optimum care and quality.

Along with the advantages of MDS 3.0, there are some negative aspects reported by the MDS 3.0 users. Comments include: too many assessments, residents who go back and forth to the hospital create burdensome discharge assessments, and **WHY** are these residents going back and forth to the hospital? The multiple items and lengthy assessments as well as the frequency of the interviews are frustrating to residents and staff members. Comments from the residents include: *"didn't we just have this question before"* or *"how many times do you have to ask me those questions?"* Losing MDS coordinators because of the MDS workload is another concern.

And what is CMS doing about it?

- ◇ Working on decreasing the assessments
- ◇ Working on the planned and unplanned discharges
- ◇ Looking into fewer interviews
- ◇ The goal is to have fewer manual updates to semi-annual or to annual updates on identified issues



Life & Safety Code; CMS allows Nursing Home Waivers for Life and Safety culture change provisions;

There are 4 changes adopted in 2012 Life and Safety code like;

- ◇ allowing small kitchens to be open to corridors as long as they are contained
- ◇ Increasing the amount of wall space that may be covered by combustibles decorations
- ◇ permitting permanent groupings of furniture in the hallway
- ◇ Installing gas fireplaces in common area

Words of wisdom are;

- ⇒ Resident must always come first.
- ⇒ Check incidents and changes periodically.
- ⇒ Listen to common concerns from stakeholders.
- ⇒ MDS is just one tool to use when assessing a resident.

Questions and CMS responses;

- Can states require a discharge return not anticipated to be submitted when the provider originally completed a discharge return anticipated and the resident doesn't return in a specified time period (for some it was 15 days and others 30 days)?
- CMS Response:
No, it is a violation of CMS policy for the provider to inactivate the original D/C return anticipated record and submit a new D/C return not anticipated with a new D/C date (the end of bed hold date). From CMS's discussions with states, there are other ways to address these issues without violating CMS submission policy.

Manual/Guide Updates

The manual/guide updates are effective April, 2012. Providers will have access to the manuals on www.qtso.com and on their state welcome pages.

MDS 3.0 Provider Users Guide; Revised sections 4, 5, and Appendix A

Clarifications

Q. Clarification regarding instances when assessments are not combined properly.

A. In the RAI Manual, Section 2.8, there are certain instances when scheduled and unscheduled PPS assessments must be combined. Specifically if the ARD for an unscheduled PPS assessment falls within the ARD window (including grace days) of a scheduled PPS assessment, and the ARD for the scheduled assess-

ment would be set for a day after that of the unscheduled assessment, then the assessments must be combined.

There may be times when unscheduled and scheduled PPS assessments are not combined properly. In past clarifications, CMS had indicated that the assessments would be treated “as if” they had been combined properly. This was intended to indicate that, from a billing perspective, the unscheduled assessment would be used to set payment, since that is the assessment with which the scheduled assessment would have been combined. Despite this clarification, there was still some confusion regarding cases where scheduled and unscheduled assessments were not combined properly. Therefore we wish to clarify that if a scheduled assessment ARD is set for a day that is after the ARD is set for an unscheduled assessment, and the ARD for the unscheduled assessment is set for a day within the scheduled assessment ARD window, then the scheduled assessment is not used for payment purposes.

When an unscheduled assessment and a scheduled assessment were supposed to be combined but were not, the payment is controlled by the unscheduled assessment.

There are still a lot of questions for clarification in PPS Assessments policy. [More clarifying information can be viewed on this website; https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TrainingMaterials.html](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TrainingMaterials.html)

Quality Measures Reports

The MDS 3.0 Facility and Resident Quality Measure Preview reports were posted at www.qtso.com. They are available in each facility shared folder in the Casper Reporting application. These reports are similar to the MDS 2.0 Facility and Resident Quality Measures Preview reports, but they have been updated to contain the new MDS 3.0 Quality Measures.

The Facility Preview report displays the quarterly numerator, denominator, and percent values for each of the publicly-reported MDS 3.0 Quality Measures. The preview report allows facilities to see their measure percent values prior to being posted on the Nursing Home Compare website.

The MDS 3.0 Resident Review report displays the list of residents who triggered one or more of the Publicly reported Quality Measures.

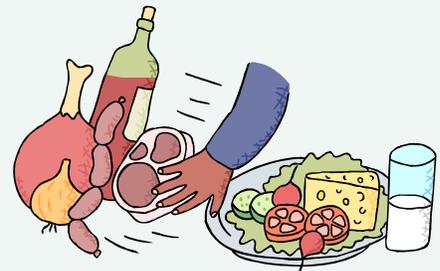
The report contains QM data for the fourth quarter (Q4) of 2011. The short stay measure data are based on a six-month time frame, from July 1, 2011 through December 31, 2011. The long stay measures data are based on a three-month time frame, from October 1, 2011 through December 31, 2011.

The modified survey process will remain in place until further notice. Other traditional survey processes, for example, changes to the 802/672 forms and instructions, as well as Appendix P revisions, are still being completed.

CMS continues with improvements and enhancements to the Nursing Home MDS 3.0 Clinical Assessment Item Set. CMS MDS systems were updated to reflect these changes in March 2012 as facilities began using and submitting the new MDS 3.0 Item Set on April 1, 2012.

MDS 3.0 Items Changes

- Additional item A0050 formerly X0100 Type of transaction –Add new record/ Modify existing record/ Inactivate existing record
- A0310G– Planned/unplanned discharge– planned/unplanned/blank
- A1510A– Level II PASRR conditions: Serious Mental Illness
- A1510B– Level II PASRR conditions: Mental Retardation
- A 1510C– Level II PASRR conditions: Other related conditions
- K0310– Weight ;gain
- K0510A1– Nutrition approach– Not Res: parenteral/IV feeding
- K0510A2– Nutrition approach– Res: parenteral/IV feeding
- K0510B1– Nutrition approach: Not Res: feeding tube
- K0510B2– Nutrition approach: Res: feeding tube
- K0510C-1– Nutrition approach: Not Res: mechanically altered
- K0510C-2– Nutrition approach: Res: mechanically altered diet
- K0510D-1– Nutrition approach: Not Res: therapeutic diet
- K0510D-2– Nutrition approach: Res: therapeutic diet
- K0510Z1– Nutrition approach: Not Res: none of the above
- K0510Z2– Nutrition approach: Res: none of the above
- M1040G– Skin Tear (s)
- M1040H– Moisture Associated Skin Damage (MASD)
- N0410A– Medication received: Days: antipsychotic
- N0410B– Medication received: Days: antianxiety
- N0410C– Medication received: Days: antidepressant
- N0410D– Medication received: Days: Hypnotic
- N0410E– Medication received: Days: anticoagulant
- N0410F– Medication received: Days: antibiotic
- N0410G– Medication received: Days: diuretic
- Q0490– Resident’s preference to avoid being asked
- Q0550A– Re-asking resident preference
- Q0550B– Re-asking resident preference source



MDS 3.0 RAI Manual (v1.08) and MDS 3.0 Item Subsets (v1.10.4)

Changes to the MDS 3.0 RAI Manual (v1.08) and MDS 3.0 Item Subsets (v1.10.4) have been posted for April 1, 2012 release. The MDS 3.0 RAI Manual (v.108) is currently posted under the Download section of the CMS MDS 3.0

Training page at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TrainingMaterials.html> and will be posted under the Download section of the CMS MDS 3.0 RAI Manual page at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html> in the near future. Change Tables and Pages for (v1.08) of the MDS 3.0 RAI Manual are also available.

The revised MDS 3.0 Item Subsets (v1.10.4) are posted under the Download section of the MDS 3.0 Technical Information page at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html>

Clarification to March 2012 National Providers Conference Presentation

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/RUGIVEDu12.html>

You can find the SNF PPS Clarification Memo for March 2012 from this website;

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/RUGIVEDu12.html>

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/RUGIVEDu12.html>



A few more updates and clarifications:

- Based on the comment about the distinction between the manner in which an early or late unscheduled assessment will affect the COT ARD calendar, both the early and late assessments affect the COT ARD calendar. The basic change is to treat these assessments equally.
- Rehab Medium issue. Some residents who might have 3 days of therapy were classing into Rehab Medium, which requires 5 days of therapy. The Grouper can not separate the type of therapy a resident is receiving into distinct calendar days. Someone who receives 2 days of Occupational Therapy and 3 days of Physical Therapy is being classified into Rehab Medium, even though the therapy might have only been provided on 3 distinct calendar days. This isn't the intent of the policy; however, the Grouper can't be updated to reflect the intent of the policy.
- Facilities that receive the Rehab Medium Rug should bill the Rehab Medium Rug. The other Level of Care criteria are still in effect. If a resident doesn't meet the Level of Care criteria, the resident doesn't qualify for the SNF benefit. Specifically, if a resident does not meet the requirement of daily skilled care, then the resident does not qualify for the SNF Part A benefit, regardless of what RUG they might qualify for. Regardless of the RUG assigned, facilities must ensure that the resident still qualifies for the SNF benefit under Medicare Part A based on the services provided the resident .
- Question about the new forms, An S&C Memo or other form of communication will be issued. Appendix P will be changed, MDS 3.0-forms 672,802, accompanying exhibits in the SOM had to be changed before the forms can be used.





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References:

- ◆ 2012 RAI User Manual Updates 3.0 version
April 2012
- ◆ RAI State Coordinator Conference- March
2012
- ◆ CMS All State SMA/RAI Teleconference
February to April 2012

Inactivation Clarification:

Once an assessment is completed, edited, and accepted into the QIES ASAP system, providers may not change a previously completed MDS assessment as the resident's status changes during the course of the resident's stay. The MDS must be accurate as of the date of the ARD established by the time of the assessment. Providers should have a process in place to ensure assessments are accurate prior to submission.

When a provider determines that an event date (ARD of any assessment, entry date, and discharge date) or item **A0310 (Type of Assessment)** is **inaccurate** the provider must inactivate the record in the QIES ASAP system, then complete and submit a new MDS 3.0 record with the correct event date or type of assessment, ensuring that the clinical information is accurate.

If the ARD is entered incorrectly and the provider does not correct it within the encoding period, the provider must complete and submit a new MDS 3.0 record. In this instance a new ARD date must be established based on MDS requirements, which is the date the error is determined or later, but not earlier.

(Reference RAI User Manual, MDS 3.0 version, Page 5-12)

Notes from CMS about inactivation and MDS Tracking Entry record;

- ⇒ CMS is looking at the inactivation issue (Discharge Assessment and Death in the Facility). At this time continue to follow the policy for inactivation until further notice.
- ⇒ Remember MDS Entry tracking record must be done, it is the first item set completed for all residents. CMS clarified that when facility staff neglect the tracking records to go back to December 2010, complete and submit the tracking records.