



CDPH

CA MDS 3.0 NUGGETS

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Revised RAI 3.0 User's Manual v1.13

On October 2015, CMS implemented the revised RAI 3.0 user's manual v1.13 and MDS forms. This version clarified existing coding, transmission policy, and addresses the scenarios of complex areas. This includes the full manual, replacement pages, and change tables for both documents.

The changes in these updates are currently posted on the CMS website. Unlike previous versions, v1.13 contains a footer [October 2015] on every page, and the Table of Contents no longer lists version numbers for each chapter or section.

The pages may look different from the previous RAI

versions, but replacement pages have not been provided because the changes did not affect the content.

MDS 3.0 RAI Manual v1.12R and MDS 3.0 RAI Manual v1.12R errata, previously posted in the download section, are now posted on the Archived MDS 3.0 RAI Manuals webpage. To crosswalk the changes made to this year's manual, please refer to the October 2015 Replacement Manual Pages and Change Tables.

The latest versions of the RAI 3.0 User's manual, October 2015 is available for download at this link:

[https://www.cms.gov/Medicare/Quality-](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS3ORAIManual.html)

[Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS3ORAIManual.html](https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS3ORAIManual.html)

The state and regional RAI/MDS contacts are updated on Appendix B of the RAI 3.0 Manual v1.13, and located in the download section of the page.

Providers in the state of California can send MDS 3.0 technical and clinical queries to: MDSOASIS@cdph.ca.gov or call (916) 324-2362.

Please listen carefully to prompt messages as menus have changed.

Must-read RAI 3.0 changes

The changes in Chapter 2 (pages 2-4) under section **2.3 Responsibilities of Nursing Homes for Completing Assessments** provide new guidance for clinicians in dealing with Omnibus Budget Reconciliation Act (OBRA) and Prospective Payment System (PPS) assessments prior to certification.

The completion and submission of OBRA and/or PPS assessments are a

requirement for Medicare- and/or Medicaid-certified long-term care facilities. However, even though OBRA does not apply until the provider is certified, facilities are required to conduct and complete resident assessments prior to certification as if the beds were already certified. If the facility completed MDS assessments prior to facility's certification date, tech-

nically these assessments are not OBRA required, yet the completion of MDSs demonstrate compliance with certification requirements. Since the data on these pre-certification assessments was collected and completed with an Assessment Reference Date (ARD) or target date prior to certification date of the facility, CMS does not **(continued on page 2)**



Content Highlights

- *Completion of MDS Assessment prior to certification are not OBRA required.*
- *Last day of survey after compliance determination, facilities can submit MDS records.*
- *DHCS 6170 form, PASRR Level 1 evaluation on-line.*
- *New POLST form for NPs, PAs signature under AB 637 implemented on 1/01/2016.*
- *SCSA MDS assessments are performed when there is improvement or decline.*

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(Must read....continued from page 1) have the authority to receive MDS records and providers cannot submit MDS records to the Quality Improvement and Evaluation System (QIES) and Assessment and Submission Processing (ASAP) System.

When the survey is completed and the nursing home is substantially in compliance, the certification date starts on the last day of the survey. The facility can begin to submit OBRA and PPS required assessments to the QIES ASAP.

For OBRA assessments, the determination of the MDS assessment is from the resident's actual date of admission. Please note that if a facility completes an Admission Assessment prior to the certification date, there is no need to do another Admission Assessment. The facility will simply continue with the next expected assessment according to the

OBRA schedule using the actual admission date as Day 1. Since the first assessment submitted will not be an Entry or OBRA Admission assessment, but a Quarterly, Discharge, etc., the facility may receive a sequencing warning message, but they should still submit the required-assessment.

For PPS assessments, please note that Medicare cannot be billed for any care provided prior to the certification date. Therefore, the facility must use the certification date as Day 1 of the covered Part A stay when establishing the Assessment Reference Date (ARD) for the Medicare Part A SNF PPS.

NOTE: Even in situations where the facility's certification date is delayed due to the need for a resurvey, the facility must continue conducting and completing resident assessments according to the original schedule.

In chapter 2 page 5 of the RAI user's manual, the new guidance on Change of

Ownership (CHOW) **when the new owner assumes assets and liabilities of the prior owner.** The assessment schedule for existing residents continues, and the facility continues to use the existing provider number. Staffs with QIES user IDs will continue to use the same QIES user IDs.

In situations where the **new owner does not assume assets and liabilities of the previous owner,** the new owner completes an Admission Assessment and Entry Tracking record for all residents, thus code the following: A0310F=01, A1600=date of ownership change, A1700=1 (admission), and A1800=02. Staff who worked for the previous owner **cannot** use their previous QIES user IDs to submit assessments for the new owner as this is now a new facility. They **must** register for new user ID for the new facility.

(Reference RAI 3.0 Chapter 2, October 2016)

Change of Therapy (COT) Other Medicare Required Assessment (OMRA)

Change of Therapy (COT) is required when the resident receives sufficient level of rehabilitation therapy to qualify for Ultra High, Very High, High, Medium, or Low Rehabilitation category. When the intensity of the therapy changes to such a degree that no longer reflect the RUG-IV classification and payment assigned, based on the most recent assessment used for Medicare payment. This level of rehabilitation changes are indicated by the total reimbursable therapy minutes (RTM) delivered, and other therapy qualifiers such as number of therapy days and disciplines providing the therapy,



Additional guidance is located on page 2-52 of the updated RAI manual, under the **seventh bullet.**

In cases where a resident is discharged from the SNF **on or prior to Day 7** of the COT observation period, then no COT OMRA is required. More precisely, in cases where the date coded for Item A2000, which is the Discharge Date on or prior to Day 7 of the COT observation period, then no COT OMRA is required. If a SNF chooses to complete the COT OMRA in this situation, they may combine the COT OMRA with the Discharge assessment.

In cases where the last day of the Medicare Part A benefit (the date used to code A2400C on the MDS) is prior to Day 7 of the COT observation period, then no COT OMRA is re-

quired. If the date listed in A2400C is on or after Day 7 of the COT observation period, then a COT OMRA would be required if all other conditions are met.

Finally, in cases where the date used to code A2400C is equal to the date used to code A2000 that is, cases where discharge from Medicare Part A is the same day as the discharge from the facility and this date is on or prior to Day 7 of the COT observation period, then no COT OMRA is required. Facilities may choose to combine the COT OMRA with the Discharge assessment under rules outlined for such combination in chapter two of the RAI Manual.

Changes to POLST form with effective date

January 1, 2016

The information in the new Physician Order for Life-Sustaining Treatment (POLST) was written by Coalition for Compassionate Care of California (CCCC) and posted on their website on December 18, 2015. The Emergency Medical Services Authority (EMSA) approved the revisions to 2016 POLST form. The revision of the 2016 California POLST is available for download at the following website:

<http://capolst.org/>

Under Assembly Bill 637 signed by Governor Jerry Brown in August 2015 with effective date of January 1, 2016, nurse practitioners and physician assistants under the supervision of a physician and within their scope of practice are authorized to sign POLST forms and make them actionable medical orders.

In November 2015, over 600 health care professionals attended the webinar about the new POLST form and AB 637. Thirty-six questions were asked during the webinar. Interested parties can download the PDF documents and an encore presentation of this webinar is available on YouTube. On the front page of the POLST form, changes were made in *Section D: Information and Signatures*, this allowed space for NP/PA signature and license/certification information. On the back page of the form, there is now a space for NPs and PAs to note the name of their supervising physician and new information under the *Directions for Healthcare Providers Section*.

Remember:

- AB 637 did not go into effect until January 1, 2016. POLST forms signed by nurse practitioners or physician assistants prior to January 1, 2016 date are not valid.
- Previous versions of POLST documents are still valid.
- Best practice is for NPs and PAs to only use the revised POLST form (with an effective date of 01/1/2016) because previous versions do not contain the necessary signature lines or clarifying language and instructions.

Completion of the POLST form remains optional and should start with a conversation with healthcare professionals and patient. Remember the POLST should not be a part of Admission package in nursing facilities.

There are few questions in the MDS help desk about POLST regarding changes in MDS 3.0 section "S" for California. In the latest POLST implemented on January 1, 2016, there are no changes in the medical treatment information section A, B, and C of the POLST. For POLST forms completed prior to January 1, 2016 with no changes in the current plan of treatment, it is not necessary to complete a new POLST. The previous POLST versions dated 1/1/2009, 4/1/2011 or 10/1/2014 are still valid if there are no changes.

A Significant Change in Status Assessment (SCSA)

A Significant Change of Status Assessment (SCSA) is a comprehensive assessment for a resident that must be completed when the Inter-Disciplinary Team (IDT) has determined that a resident meets the significant change guidelines for either **improvement or decline**. It can be performed at any time after the completion of an Admission assessment, and its completion dates (MDS/CAA (s)/care plan) depending on the date the IDT's determination was made the resident change is significant. Completion of a SCSA assessment is required when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider), or changes hospice providers and remains a resident at the nursing home.

Here are additional guidelines to assist in determining if a change is significant or not.

Improvement in two or more of the following:

- Any improvement in an ADL physical functioning area where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment;
- Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases;
- Resident's decision making changes for the better;
- Resident's incontinence pattern changes for the better;
- Overall improvement of resident's condition.



**For clinical and technical
MDS questions, please call
or e-mail to:**

Susana Belda, RN, RAC-CT

RAI Education Coordinator

Phone # 916.324.2362

Email: MDSOASIS@cdph.ca.gov

Lori Ann Sturgeon

RAI Automation Coordinator

Phone # 916.324.2362

California Department of Public Health
Center for Health Care Quality
Licensing and Certification
Long Term Care Appeals and Provider
Certification Section
P. O. Box 997377, MS 3201
Sacramento, CA 95899-7377

Transition to ICD-10

Effective October 1, 2015, all providers must use International Classification of Diseases (ICD) 10 codes on all claims.

The ICD is used to standardize codes for medical conditions, diagnosis, and institutional procedures. ICD-9 had not been updated for more than 35 years and contained outdated, obsolete terms, inconsistent with current medical practice. The Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes will continue for outpatient, ambulatory, and office-based procedure coding.

CMS released provider-training videos that offer helpful tips for ICD-10 implementation. According to CMS, "ICD-10 will improve coordination of a patient's care across providers, advance public health research and emergency response through detection of disease and adverse drug events, support innovative payment models that drive quality of care, and enhance fraud detection efforts."

ICD-10 information and resources for providers:

<http://www.cms.gov/Medicare/Coding/ICD10/Downloads/AMA-CMS-press-release-letterhead-07-05-15.pdf>

<http://www.cms.gov/Medicare/Coding/ICD10/index.html>

Frequently asked questions:

<http://www.cms.gov/Medicare/Coding/ICD10/Downloads/ICD-10-guidance.pdf>

<http://www.cms.gov/Medicare/Coding/ICD10/CMS-Sponsored-ICD-10-Teleconferences.html>

PASRR online training information



Every individual entering a Medicaid-certified Nursing Facility (NF), or experiencing a significant change of condition once they are a resident of a NF, is federally mandated to receive a Pre-Admission Screening and Resident Review (PASRR). This federal requirement, established in 1986, ensures individuals are not inappropriately placed in nursing homes for long-term care. PASRR requires that all applicants to a Medicaid-certified nursing facility are:

- 1) Evaluated for mental illness (MI) and/or intellectual disability/developmental disability (ID/DD) or related condition.
- 2) Offered the most appropriate setting for their needs (in the community, nursing facility, or acute care setting); and,
- 3) Receive services they need in those settings. A level 1 PASRR screen [Department of Health Care Services (DHCS) 6170 form] is required for all individuals entering a Medicaid Certified NF. Level II evaluation are required if an individual is diagnosed with or suspected of having MI/ID/DD or related condition. A Level II evaluation not required (i. e., hospital discharge exemption) if an individual is discharged from a hospital to a Medicaid-certified NF and his/her stay is expected to **last no more than 30 days**. However, if the resident stay in the NF is longer than 30 days, the PASRR must be completed by calendar day 40.

(continued on page 5)

PASRR...(continued from page 4)

Until 2015, DHCS manually processed Level 1 PASRR evaluations submitted by NFs by fax or mail. DHCS processed 20,000 handwritten Level 1 screenings, 8,000 referrals, and over 7,000 evaluation issues identified by a contractor, annually. The evaluation issues resulted in DHCS issuing 6,000 five-page Determination Letters and a minimum of 500 Reconsideration Letters. Processing time ranged from 40-50 days, which exceeded the federal timeline of 4 to 9 days. A DHCS analysis of processing times indicated an automated process would reduce costs for both state and NFs. Automation reduced the processing time to 4 to 5 days, and enabled NF residents to receive care expediently. Therefore, DHCS established an automated web-based system on January 1, 2015, and following a six-month implementation period, stopped accepting paper/faxed Level I forms on June 1, 2015. To date, the majority of the NFs statewide are enrolled and successfully using the new system.

DHCS addressed the low percentage of statewide resident reviews. The Balanced Budget Act of 1996 (Act) eliminated annual resident reviews and required reviews upon a resident's significant physical or mental change of condition. The Act requires NFs to conduct a review and make a prompt determination (within 7 to 9 days), after the NF notifies the state mental health authority or state intellectual disability authority of the resident's significant change of condition.

Based on a national survey conducted in 2013, the PASRR Technical Assistance Center (PTAC) concluded Level 1 screens identified only 6% of the NF residents with positive indicators of a MI or ID/DD. This was inconsistent with MDS findings that 26% of residents had positive indicators. In response, DHCS revised the Level 1 screen and encouraged NFs to compare the Level 1 information with MDS results. If the Level 1 screen and MDS are positive, the NFs should complete a resident review Level 1.

Specifically, MDS 3.0 for item A1500 asks whether the resident has been identified by PASRR as having MI, ID or a related condition (RC). Item A1510 asks respondents to indicate the diagnosis if A1500 is marked "Yes." If the MDS results indicate there is a diagnosis, or a reasonable suspicion of MI or ID/DD, the NF should complete the DHCS 6170 form online and indicate they are requesting a resident review.

On July 7, 2015, DHCS, in partnership with PTAC, offered a webinar about the relationship between PASRR and MDS. The slides from that presentation, frequently asked questions, and a list of upcoming training opportunities are available at: <http://www.dhcs.ca.gov/services/MH/Pages/PASRR.aspx>

Additional technical assistance is available upon request by contacting the DHCS PASRR Section at:

MHPASRR@dhcs.ca.gov

By Rita McCabe, Chief, PASRR Section, MHSD-POCB
Department of Health Care Services

Coding Instructions for MDS 3.0 item A1500: Preadmission Screening and Resident Review (PASRR) are located on pages A-17 to A-21 of the RAI 3.0 user's manual, October 2015.

A1500. Preadmission Screening and Resident Review (PASRR)	
Complete only if A0310A = 01, 03, 04, or 05	
Enter Code <input type="checkbox"/>	Is the resident currently considered by the state level II PASRR process to have serious mental illness and/c ("mental retardation" in federal regulation) or a related condition? 0. No → Skip to A1550, Conditions Related to ID/DD Status 1. Yes → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions 9. Not a Medicaid-certified unit → Skip to A1550, Conditions Related to ID/DD Status
A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions	
Complete only if A0310A = 01, 03, 04, or 05	
↓ Check all that apply	
<input type="checkbox"/>	A. Serious mental illness
<input type="checkbox"/>	B. Intellectual Disability ("mental retardation" in federal regulation)
<input type="checkbox"/>	C. Other related conditions

A glimpse of the MDS and Staffing Focus Survey

MDS 3.0 and Staffing Focus Survey are the new focus for providers and state surveyors nationwide. After the roll out of MDS 3.0 in October 2010, this is the first focus survey expansion on MDS. CMS issued Survey and Certification (S&C) letters that provide memorandum summary, training information, enforcement implication, background and effective date of implementation. This information is available on the CMS website under S&C letters for Nursing Homes (NH) released in 2014 and 2015.

The S&C letters indicate five nursing facilities from the five voluntary states were surveyed in 2014 for an MDS/Staffing focused pilot review. Deficiencies were identified and cited on all but 1 of 24 reviews. The short-term pilot MDS-focused survey assessed the MDS coding practices and its relationship to resident care in nursing homes. After completing the pilot, CMS announced expansion of the surveys nationwide in 2015.

The surveys continue to assess compliance with 42 Code of Federal Regulations (CFR) §483.20 (Resident Assessment) and other applicable regulations that are identified during the review process. There are no new regulations involved in these surveys. The focus of the survey is on nursing home compliance with existing and long-standing regulations.

References and helpful links:

- The RAI User Manual 3.0, October 2015 v1.13
- Department of Health Care Services Online PASRR Level 1 Training Manual
Training for Acute Hospitals and Skilled Nursing Facilities
- The Department of Health Care Services, Online PASRR System Basics
- CMS ICD-10 Reminder Letter
- Coalition for Compassionate Care of California (CCCC)
- ◆ <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>
- ◆ <http://www.dhcs.ca.gov/services/MH/Pages/PASRR.aspx>
- ◆ <http://www.cdph.ca.gov/programs/LnC/Pages/MDS.aspx>
- ◆ <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-25.pdf>
- ◆ <http://Capolst.org>

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. It is the provider's responsibility to keep the current updates from CMS and the State.