

CA MDS NUGGETS

California Department of Public Health VOLUME 2 ISSUE 3 DECEMBER 2012

UPDATED RAI MANUAL 3.0 VERSION 1.09

The revised RAI User Manual was posted last November 7, 2012 effective upon release.



*MDS 3.0 RAI Manual

- * All Change Tables and Replacement Pages for MDS 3.0 version 1.09
- * QM ID by CMS reporting Module V1.09 for User's Manual MDS 3.0 QM User's Manual V6.0.
- * MDS 3.0 QM User's Manual V6.0– contains detailed specifications for MDS 3.0 quality measures.

The updated MDS 3.0 RAI manual is now posted on CMS website :

[MDS 3.0 RAI manual](#)

The new version of the data specifications involves updates to several State-required items in sections of the MDS. CMS also incorporated updated clarification for the stand alone PPS OMRA assessments, coding tips, treatments and procedures, and correction requests into the RAI manual. There was no effect on the implementation of the data submission specifications. Whatever clinicians have been doing in the last two years (since MDS 3.0 was rolled out in October, 2010) should still be active, except for the changes introduced in April, 2012. The Errata (v3) and Errata (v4) that were released in April of 2012 must be followed.

The revised traditional survey process may start with the new revised CMS 672 and 802 forms, which (continued on page 2)

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Revision of Appendix P, Chapter 9 of the SOM (State Operation Manual)-

On September 27, 2012 the S & C Letter 12-45-NH was posted on the CMS website. The memorandum includes the Revisions to Appendix P of the SOM Survey Protocols that have been revised for the Traditional Survey process for Long Term Care Facilities to reflect changes for the:

- ⇒ Minimum Data Set (MDS) 3.0;
- ⇒ New Quality Measures (QM) Reports;
- ⇒ Revised CMS forms 672 and 802

Sampling and reviewing residents receiving psychopharmacological medications, specifically antipsychotic medications.



CHANGES

(from page 1) ... were implemented on October 1, 2012 and must be used by December 1st, 2012. After that date, every one should be using the revised CMS 672 and 802 forms in nursing home surveys. The forms and instructions are available and posted under S&C Letters 12-45-NH pdf on CMS website.

The RAI continues to emphasize quality of life and quality of care, these are significant to residents in nursing homes, whether their stay is short or long.

Updates in the RAI Manual MDS 3.0 versions

An MDS with an Assessment Reference Date (ARD) after November 7, 2012, will be subject to the revised RAI manual instructions, which became effective upon release. The changes mainly clarify important regulation updates. Some are corrected typing errors or changes in page number/s.

For instance track changes in Appendix A are about the Designated Local Contact Agency. Each state has a designated local contact agency responsible for contacting the individual with information about community living options. This local contact agency may be a single entry point agency, an Aging/Disabled Resource Center, an Area Agency on Aging, a Center for Independent Living, or other state contractor.

In the CAA (Care Area Assessment) section, determination of expected outcomes forms the basis for establishing a resident's specific care plan interventions that are designed to help the resident progress toward achieving specific goals. The CAA also assists the Interdisciplinary team (IDT) in determining which staff or family member needs to be involved to support the expected resident outcomes, because it promotes the resident's active participation in the process (chapter 1, RAI manual track changes). As always, good assessment is the starting point for good clinical problem solving, decision making, and creating sound care plans.

Chapter 6 Clarification

Early Assessment

In the case of early COT (Change of Therapy) OMRA, the early COT would reset the COT calendar such that the next COT OMRA, if deemed necessary, would have an ARD set for 7 days from the early COT ARD. For example, a facility completes a 30-day assessment with an ARD of November 1 which classifies a resident into a therapy RUG. On November 8 which is day 7 of the COT observation period, it is determined that a COT is required. A COT OMRA is completed for this resident with an ARD set for November 6, which is day 5 of the COT observation period as opposed to November 8 which is day 7 of the COT observation period. This COT OMRA would be considered an early

assessment and, based on the ARD set for this early assessment would be paid at the default rate for the two days this assessment was out of compliance. The next seven day COT observation period would begin on November 7, and end on November 13.

(from RAI manual version 3.0, October 2012, Chapter 2-73)

Late Assessment

If the SNF fails to set the ARD within the defined ARD window for a Medicare-required assessment, including the grace days, and the resident is still on Part A, the SNF must complete a late assessment. The ARD cannot be earlier than the day the error identified.

If the ARD on the late assessment is set **for prior to the end of the period during which the late assessment would have controlled the payment**, had the ARD been set timely, and/or **no intervening assessments have occurred, the SNF will bill the default rate for the number of days that the assessment is out of compliance**. This is equal to the number of days between the day following the last day of the available ARD window (including grace days when appropriate) and the late ARD (including the late ARD). **The SNF would then bill the Health Insurance Prospective Payment System (HIPPS) code established by the late assessment for the remaining period of time that the assessment would have controlled payment.**

If the ARD of the late assessment is set **after the end of the period during which the late assessment would have controlled the payment**, had the assessment been completed timely, or in cases when **an intervening assessment** has occurred and the resident is still on Part A, the provider must still complete the assessment. The ARD can be no earlier than the day the error was identified. **The SNF must bill all covered days during which the late assessment would have controlled payment had ARD been set timely and at the default rate regardless of the HIPPS code calculated from the late assessment.**

Missed Assessment

If the SNF fails to set the ARD of the scheduled PPS assessment prior to the end of the last of the ARD window, including grace days, and the resident is no longer a SNF Part A resident and as a result a Medicare-required assessment does not exist in the QIES ASAP, there is not an assessment based RUG the provider may bill. In order to bill for Medicare SNF Part A services, the provider may submit a valid assessment that is accepted into the QIES ASAP. The provider must bill the rug category that is verified by the system. If the resident was already discharged from Medicare Part A when this is discovered, an assessment may not be performed.

DEFINITIONS

5% WEIGHT GAIN IN 30 DAYS

Start the resident's weight closest to 30 days ago and multiply it by 1.05 (or 105%). The resulting figure represents a 5% gain from the weight 30 days ago. If the resident's current weight is equal to or more than the resulting figure, the resident has gained more than 5% body weight.

PHYSICIAN-PRESCRIBED WEIGHT LOSS REGIMEN

A weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. It may employ a calorie-restricted diet, or other weight loss diet and exercise. It can also include planned diuresis. It is important that weight loss is intentional.



10% WEIGHT GAIN IN 180 DAYS

Start with the resident's weight closest to 180 days ago and multiply it by 1.10 (or 110%). The resulting figure represents a 10% gain from the weight 180 days ago. If the resident's current weight is equal to or more than the resulting figure, the resident has gained more than 10% body weight.

BODY MASS INDEX (BMI)

Number calculated from a person's weight and height. BMI is used as a screening tool to identify possible weight problems for adults.

Steps for Assessment (updated 11/29/2012)

*This item compares the resident's weight in the **current observation period** with his or her weight at two snapshots in time:*

- At a point closest to **30-days** preceding the current weight.
- At a point closest to **180-days** preceding the current weight.

Section K

There are added definitions, coding instructions for new admission and subsequent assessments in recording weights on section K. Mathematically round weights as described in Section K0200B before the weight calculation (*RAI manual, sections K-4 and K-5*).

For **New Admission**, ask the resident, family or significant other about weight loss over the past 30 and 180 days. Consult the physician, review transfer documentation and compare the admission weight. If the admission weight is less than the previous weight, calculate the percentage of weight loss.

Complete the same process to determine and calculate weight loss /gain comparing the admission weight to the weight 30 and 180 days ago.

For **Subsequent Assessments**: from the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 30 days ago. If the current weight is less /more than the weight in the observation period 30 days ago, calculate the percentage of the weight loss/gain.

Use the same process for 180 days snapshot: from the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 180 days ago, then calculate the percentage of the weight loss/gain.

This item does not consider weight fluctuation outside of these two time points, although the resident's weight should be monitored on a continual basis and weight loss assessed and addressed on the care plan as necessary.

Examples—(copied from April 2012 RAI manual)

1. Mrs. J has been on a physician-ordered calorie-restricted diet for the past year. She and her physician agreed to a plan of weight reduction. Her current weight is 169 lbs. Her weight 30 days ago was 172 lbs. Her weight 180 days ago was 192 lbs.

Coding: K0300 would be coded **1, yes, on physician-prescribed weight-loss regimen. Rationale:**

- 30-day calculation: $172 \times 0.95 = 163.4$. Since the resident's current weight of 169 lbs. is more than 163.4 lbs., which is the 5% point, she **has not** lost 5% body weight in the last 30 days.
- 180-day calculation: $192 \times .90 = 172.8$. Since the resident's current weight of 169 lbs. is less than 172.8 lbs., which is the 10% point, she **has** lost 10% or more of body weight in the last 180 days. *Note: If the weight is more than 30 days prior to ARD then weigh the patient, If there are more than one weight recorded in 30 days prior to ARD then use the most recent weight.*

Section M

Code based on the presence of any ulcer (regardless of stage) in the past 7 days.

For **each** pressure ulcer, determine if the pressure ulcer was present at the time of admission/entry or re-entry, and not acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement.

Scabs and eschar are different both physically and chemically. Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. A scab is made up of dried blood cells and serum, sits on top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc.). A scab is evidence of wound healing. A pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2, and therefore, staging should not change. Eschar characteristics and the level of damage it causes to tissues is what makes it easy to distinguish from a scab. (see M-5 of the RAI manual).

Section N

While assuring that only those medications required to treat the resident's assessed condition are being used, it is important to assess the need to reduce these medications wherever possible, and ensure that the medication is the most effective for the resident's assessed condition.

As part of all medication management, it is important for the interdisciplinary team to consider non-pharmacological approaches. Educating the nursing staff and providers in conjunction with the use of medication may minimize the need, or reduce the dose and duration of those medications.

Section O

Code only when the resident requires transmission-based precautions and single room isolation (alone in a separate room) because of active infection. Do not code this item if the resident only has a history of infectious disease.

Code only when all of the following conditions are met:

1. The resident has an active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
3. The resident is in a room alone because of active infection and cannot have a roommate, regardless of whether the roommate has a similar active infection that requires isolation.
4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

Section X

Coding Instructions for X0900E, End of Therapy-Resumption

- Check the box if the EOT-R date (item O0450B) has been added to the modified record (i.e., the provider has determined that the EOT-R policy was applicable after submitting the original EOT record not

indicating a resumption of therapy date in item O0450B).

- Do not check this box if the modification is correcting the EOT-R date (item O0450B) in a previous EOT-R assessment. In this case, the reason for modification is an item Coding Error and box X0900D should be checked.

Coding Instructions for X0900Z, Other Error Requiring Modification

- Check the box if there are any errors in the prior QIES ASAP record that were caused by other types of errors not included in Items X0900A through X0900E.
- Such errors include any other type of error that causes a QIES ASAP record to require modification under the Correction Policy. An example would be when a record is prematurely submitted prior to final completion of editing and review. Facility staff should describe the "other error" in the space provided with the item.

Please refer to section X of the RAI manual 3.0, October 2012 for updated information.

SHORT STAY THERAPY: We cannot put all the changes made in the few pages of the newsletter; however, we included most of the highlights. There are several examples given on OMRAs from Chapter 6 of the RAI manual (pages 6-10 through 6-13). The short stay rehabilitation therapy must meet all eight conditions. The #5 condition stated that the ARD (A2300) of the SOT OMRA may not be more than 3 days after the SOT date (Item O0400A5, O0400B5, or O0400C5, whichever is earliest), not including the SOT date. This is an exception to the rules for selecting the ARD for a SOT OMRA, because it is not possible for the ARD for the Short Stay Assessment to be 5-7 days after the start of therapy, when therapy must have been able to be provided for only 1-4 days.

DEFINITION

USED FOR PAYMENT- an assessment is considered to be "used for payment" in that it either controls the payment for a given period, or with scheduled assessments may set the basis for payment for a given period.

ON ADMISSION- is defined as: as close to the actual time of admission as possible.

Determining Item Set (ISC) Reference Table can be found on page 2-77 of the RAI Manual, 3.0 version, October 2012

The item set for a particular MDS record is completely determined by the reason for assessment Items (A0310A, A0310B, A0310C, A0310D, and A0310 F). Item set determination is complicated and standard MDS software from CMS and private vendors will automatically make this determination. This section provides manual lookup tables for determining the item set, when automated software is unavailable.

MDS Correction Policy

The MDS must be accurate as of the ARD. Minor changes in the resident's status should be noted in the resident's record (e.g., in progress notes), in accordance with standards of clinical practice and documentation. Such monitoring and documentation is a part of the provider's responsibility to provide necessary care and services. A significant change in the resident's status warrants a new comprehensive assessment (see Chapter 2 of the RAI Manual 3.0 version for details).

It is the responsibility of the provider to ensure that any corrections made to a record are submitted to the QIES ASAP system in accordance with the MDS Correction Policy.

The Correction Policy Flowchart is on page 5-14 of the RAI Manual 3.0 version.

The correction process depends upon the type of errors. **MDS records that have not yet been accepted to QIES ASAP** system, are the following:

— those records that have been submitted and rejected,

— production records that were inadvertently submitted as test records,

— records that have not been submitted at all.

Since these records were never accepted in the QIES ASAP system, these can be corrected and resubmitted without special correction procedures.

Changes can be made during the encoding period for any item **provided** the response refers to the same observation period. The provider is responsible for verifying that all responses in the computer file match the responses on the paper form. Any discrepancies must be corrected in the computer file during the 7-day encoding period. In addition, the provider is responsible for running encoded MDS assessment data against CMS and State-specific edits that software vendors are responsible for building into MDS Version 3.0

computer systems.

There were a number of facilities in California that their MDS submissions were not seen in the CMS and state data base. Majority of the records submitted were either late or rejected. There were no final validation reports available to ensure the submissions were accepted or not.

To avoid these types of errors, make sure that the submitter **prints the final validation report each time the MDS submission is made**. It is the provider's responsibility to read the Facility Final Validation Report and make the correction/s as necessary.

Errors and warning messages need to be looked at and corrected as needed.

This is the rule of thumb in OBRA comprehensive and quarterly assessment errors: Errors that inaccurately reflect the resident's clinical status and/or result in an inappropriate plan of care are considered **significant errors**. All other errors related to the coding of the items are considered **minor errors**.

If B0100 (Comatose) is zero (0) or a dash (-) and A0310G is two (2) and A0310A is 99 and A0310B is 99, then all active items D0100 (Should Resident Mood Interview be conducted?) through D0650 (Safety Notification) **must be blank** (^).

Action: Make appropriate corrections to the record and resubmit. Refer to the current data specifications to identify the acceptable values for this item.

Error Message -3778c-Inconsistent A1550 items: If the resident's age is 22 years or older and A0310A does not equal 01, then 1550A through A1550Z must equal blank (^).

Action: Make appropriate corrections.

Error Message -1007-Duplicate Assessment: The submitted record is a duplicate of a previously submitted record.

Action: Determine why this record was submitted multiple times.

DO NOT resubmit this record as it is already in the database.

Identification of Record to be Modified/Inactivated; The section X items from X0200 through X0700 identify the existing QIES ASAP database assessment or tracking record that is in error. In this section, reproduce the information **EXACTLY as it appeared on the existing erroneous record**, even if the information is **incorrect**. This information is necessary to locate the existing record in the database. Example: If the data entry error is then identified on the previously submitted and accepted record for Resident's First Name, "Jane" and the correct name should be "Jan," Jane will be entered in this item.

This will permit the MDS system to locate the previously submitted assessment that is being corrected. The Correction Policy Flowchart that was released in May 2011 remains the same. It is on the 3.0 version of the RAI manual, page 5-14 (Error found in MDS assessment or tracking form).

RESIDENT LEAVES THE FACILITY AND RETURNS DURING OBSERVATION PERIOD

The ARD is not altered if the beneficiary is out of the facility for temporary LOA during part of the observation period. The facility may include the services furnished. The Medicare assessment schedule is not restarted however, the midnight rule applies. The day preceding the midnight is not a covered Part A. Skip that day in calculating when the next Medicare assessment is due. One example given in the manual is that, if the resident goes to the Emergency Room at 10 p.m. Wednesday, day 22 of his Part A stay, and returns at 5 a.m. the next day, Wednesday is not billable to Part A day. As a result, the day of his return to the SNF, which is Thursday, becomes day 22 of his Part A stay.

QUALITY MEASURES

QM (Quality Measures) Reports—this report used to identify indicators of potential problems or concerns that may warrant investigations. They are not a determination of facility's compliance with the long term care requirements.

The QMs are created from counts of nursing facility long-stay residents or short-stay residents who have certain conditions or problems (e.g. falls resulting in major injury).

CMS encouraged consulting the CASPER (Certification And Survey Provider Enhanced Reports) Reporting MDS Provider User's Guide & MDS 3.0 Quality Measures User's Manual (v6.0 09-17-2012) in order to understand the reports and to use them properly.

Definitions like Stay, Episode, Admission, Re-entry, Cumulative days in facility (CDIF), Short Stay, Long Stay, Target Date, Look back Scan, Numerator and Denominator are explained in the MDS 3.0 QM User's Manual.

For example, for long-stay residents, fall Quality Measures are computed by:

1.) counting residents in the facility who had a fall resulting in major injury, and

2.) computing the percentage of the residents in the facility who had valid MDS data and who experienced a fall. The detailed logic for defining the resident-level outcome for each QM is recorded in the QM Sample and Record Selection Methodology Section, and in the QM logic Specification section of the manual.

The QM User Manual also explains how QM samples are selected using several steps, for example selecting residents whose late episode either ends during the target period or is ongoing at the end of the target period. If the CDIF is less than or equal to 100 days, the resident is included in the short-stay sample. If the CDIF is greater than or equal to 101 days, the resident is included in the long-stay sample.

Note that all residents who are selected in Step 1 above will be placed in either the short-stay or long-stay sample and that the two samples are mutually exclusive. If resident has multiple epi-

sodes within the target period, only the latest episode is used.

The **Target Dates that are used** are the entry dates (A1600), the discharge records (A0310F=10, 11) or the death-in-facility records (A0310F=12), and other records that target dates are equal to the assessment reference date(A2300). (See MDS 3.0 Quality Measures User's Manual, page 3).

The **Facility Characteristic Report** provides a demographic information about the resident population (in percentage) for a selected facility compared to all facilities in the state and nation wide.

The **Facility Quality Measures Report** provides facility status for each of the MDS based QMs as compared to the state and national average.

The facility QM Report is generalized using the current MDS records in the State MDS database at the time the report was generated.

The resident Level QM reports are calculated using the most recently transmitted MDS records, e.g. the annuals, the significant change of status, the quarterly assessments or the initial admission MDS records.

QM is a part of Nursing Home Quality Initiative CMS effort to improve quality of care in nursing homes.

RESOURCES LINKS:

For Nursing Home Quality Initiatives

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html?redirect=/nursinghomequalityinits/25_nhqimds30.asp

For Quality Measures User's Manual

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-Users-Manual-V60.pdf>

CMS Open Door Forum link;

http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF_SNFLTC.html

For Nursing Home Compare

<http://www.medicare.gov/NursingHomeCompare/search.aspx?bhcp=1>

For updated RAI Manual;

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInitsMDS30RAIManual.html>

For Errata, April 2012

DEFINITIONS

INTERVENING ASSESSMENT Refers to an assessment with an ARD set for a day in the interim period between the last day of the appropriate ARD window for a late assessment (including grace days, when appropriate) and the actual ARD of the late assessment.

DAYS OUT OF COMPLIANCE Refers to the number of days between the day following the last day of the available ARD window, including grace days when appropriate, and the late ARD (including the late ARD) of an assessment.



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



CALIFORNIA, LAKE TAHOE,
Lakes.....



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A reminder from CMS Policy for Privacy Act Implementation & Breach Notification dated July 12, 2007 applies:

— All PII (**Personal Identifiable Information**), whether it is for a CMS employee, a provider, or a beneficiary, shall not be transmitted via e-mail unless it is sent as an attachment that has been appropriately encrypted using CMS-approved encryption software.

— All documents that contain privacy information shall be clearly marked as **FOR OFFICIAL USE ONLY-PRIVACY ACT INFORMATION CONTAINED HEREIN.**

References:

- * Updated RAI Manual 3.0 version, October 2012
- * CMS State RAI/SMA Joint Call Meeting from May 2012 through November 2012
- * CMS Nursing Home Quality Initiatives
- * QIES Technical Support Web site
- * S & C Letters 12- 45-NH