

What's New with MDS 3.0

CMS (Centers for Medicare and Medicaid Services) continues to update and clarify the MDS 3.0 process and revisions have been made to the RAI manual for clearer interpretation and instructions.

Two years have passed since MDS 3.0 was implemented, and the journey continues. CMS has recently released a new policy on the modification and inactivation process for MDS 3.0 records that have error/s and have been submitted to CMS QIES ASAP system.

OLD POLICY:

Prior to May 19, 2013, an **Inactivation request** was required to address errors in the following items:

- ◆ A0200: Type of Provider
- ◆ A0310: Type of Assessment
- ◆ A1600: Entry Date (on Entry tracking record; A0310F=1)
- ◆ A2000: Discharge Date (on Discharge/Death in Facility record; A0310F=10-12)
- ◆ A2300: Assessment Reference Date (ARD).

NEW POLICY:

Effective May 19, 2013, a **Modification** may now be used for typographical errors in the following items:

- ◆ A0310: Type of Assessment; where there is no Item Set Code (ISC) change
- ◆ A1600: Entry Date
- ◆ A2000: Discharge Date
- ◆ A2300: Assessment Reference Date (ARD)
- ◆ Clinical Items (B0100-V0200C)

An **Inactivation Request** is still required for errors in the following items:

- ◆ A0200: Type of Provider
- ◆ A0310: Type of Assessment; where there is an ISC change

In This Issue

- MDS Updates Inactivation/Modification
- New Definitions of Resident's Participation, Guardian, etc.
- CMS Memo about MDS 2.0
- Use of Dashes (Qs & As, A5)

Special points of interest:

- * Section Q Goal Setting/Discharge Planning
- * Coding clarification for Quadriplegia Diagnosis
- * Qs & As

Changes to MDS 3.0 Manual

Inactivation/Modification Policy

CMS (Center for Medicare & Medicaid Services) hosted the ODF (Open Door Forum) provider's teleconference on May 2, 2013. The call was about the new policy in MDS 3.0's correction of data errors in MDS. It includes the instructions in Inactivation and Modification of MDS data. The updated MDS 3.0 Manual is available for the public and was posted on the CMS website in May 2013. Follow this link:

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

Facilities should correct any errors necessary to insure that the information in the QIES ASAP system accurately reflects the resident's identification, location, overall clinical status, or payment status.

A modification request should be used when an MDS record (assessment, Entry tracking record or Death in Facility tracking record) is in the QIES ASAP system, but the information in the record contains clinical and demographic errors.

Effective May 19, 2013, a modification may be used for
typographical errors in the following items:

- ◇ A0310: Type of Assessment; where there is no **Item Set Code (ISC) change**.
- ◇ A1600: Entry Date (Item A0310F=1)
- ◇ A2000: Discharge Date (Item A0310F= 10, 11, 12),
- ◇ A2300: Assessment Reference Date (ARD) on an OBRA or PPS
- ◇ Clinical Items (Items B0100-V0200C)

An inactivation request is still required for the following errors:

- ◇ A0200: Type of Provider
- ◇ A0310: Type of Assessment; **where there is an ISC change**.

***Note:** The ARD (Item A2300) can be changed when the ARD on the assessment represents a data entry/typographical error. However, the ARD cannot be altered if it results in a change in the look back period and alters the actual assessment timeframe. Consider the following examples:

- When entering the assessment into the facility's software, the ARD, intended to be 02/12/2013, was inadvertently entered as 02/02/2013. The interdisciplinary team (IDT) completed the assessment based on the ARD of 2/12/2013 (that is, the seven day look back was 2/06/2012 through 2/12/2013. This would be an acceptable use of the modification process to modify the ARD (A2300) to reflect 02/12/2013.
- An assessment was completed by the team and entered into the software based on the ARD of 1/10/2013 (and seven day look back of 1/04/2013 through 1/10/2013). Three weeks later, the IDT

determines that the date used represents a date that is not compliant with the PPS schedule and proposes changing the ARD to 1/07/2013. This would alter the look back period and result in a new assessment (rather than correcting a typographical error); this would not be an acceptable modification and shall not occur.

***Note:** The Type of Assessment items (Item A0310) can only be modified when the Item Set Code (ISC) of that assessment does not change. In other words, if the Item Subset (full list can be found in Chapter 2, Section 2.5) would change, **the modification cannot be done**. Consider the following examples:

- A stand-alone discharge assessment (ISC= ND) was completed and accepted into the ASAP system. The provider later (that is, after the day of discharge) determined that the assessment should have been a 30-day PPS assessment combined with a Discharge assessment (ISC=NP). **This modification would not be allowed** as the ISC for Discharge assessment combined with the 30-day PPS is different than the stand-alone Discharge ISC. This is an example of a missing 30-day.
- An Admission assessment (ISC=NC) was completed and accepted into ASAP system. The provider intended to code the assessment as an Admission and a 5-day PPS assessment (ISC=NC). The modification process could be used in this case as the ISC would not change.

There are few items for which the modification process shall not be used. These items require the following correction measures if an error is identified:

- An inactivation of the existing record followed by submission of a new corrected record is required to correct an error of the Type of Provider (Item A0200)
- An MDS 3.0 manual Assessment Correction/Deletion Request is required to correct:
 - ◇ Submission Requirement (Item A0410),
 - ◇ State-assigned facility submission ID (FAC_ID)
 - ◇ Production/test code (PRODN_TEST_CD).

There are several processes put in place to assure that the MDS data are accurate both at the provider and in the QIES ASAP system. If an error is discovered within 7 days of the completion of an MDS and before submission to QIES ASAP system, the response may be corrected using standard editing procedures on the hard copy (cross out, enter correct response, initial and date) and/or correction of the MDS record in the facility's database. The resident's care plan should also be reviewed for any needed changes.

Errors identified after the encoding and editing period must be corrected within 14 days of identifying the errors. If the record in error is an Entry tracking record, Death in Facility tracking rec-

ord, Discharge assessment, or PPS assessment record (i.e., MDS Item A0310A=99), then the record should be corrected and submitted to the QIES ASAP system. The correction process may be more complex if the record error is an OBRA comprehensive or quarterly assessment record (i.e., Item A0310A=01 through 06).

Errors that inaccurately reflect the resident's clinical status and/or resulted in an inappropriate plan of care are considered **significant errors**. All other errors related to the coding of MDS items are considered **minor errors**. If the only errors in the OBRA comprehensive or Quarterly assessment are minor errors, then the only requirement is for the record to be corrected and submitted to the QIES ASAP system.

When an error is discovered (except for those items listed in the preceding paragraph and instances listed in the Section 5.8, Special Manual Correction Request) in an MDS 3.0 Entry tracking record, Death in Facility tracking record, Discharge assessment, or PPS assessment that is not an OBRA assessment (where Item A0310A=99), the provider must take the following actions to correct the record:

1. Create a corrected record with **all** items included, not just the items in error.
2. Complete the required Correction Request Section X items and include with the corrected record. Item A0050 should have a value of 2 indicating a modification request.
3. Submit this modification request record.

When any **significant error** is discovered in an OBRA comprehensive or Quarterly assessment in the QIES ASAP system, the nursing home must take the following actions to correct the OBRA assessment:

1. Create a corrected record with **all** items included, not just the items in error.
2. Complete the required Correction Request Section X items and include with the corrected record. Item A0050 should have a value of 2 indicating modification request.
3. Submit this modification request record.
4. Perform a **new** Significant Correction to Prior Assessment or Significant Change in Status Assessment and update the care plan as necessary.

A significant Change in Status Assessment would be required only if correction of the MDS item/s revealed that the resident met the criteria for a Significant Change in Status Assessment.

If criteria for Significant Change in Status Assessment were not met, then a Significant Correction to Prior Assessment is required.

When errors in an OBRA comprehensive or Quarterly assessment in the QIES ASAP system have been corrected in a more current OBRA comprehensive or Quarterly assessment (Item A0310A=01 through 06), the nursing home is not required to perform a new additional assessment (Significant Change in Status or Significant Correction to

Prior assessment). In this situation, the nursing home has already updated the resident's status and care plan. However, the nursing home must use the Modification process to assure that the erroneous assessment residing in the QIES ASAP system is corrected.

For more detailed MDS correction instructions please refer to RAI Manual 3.0 Chapter 5, May 2013 updates.

If the assessment was performed for Medicare purpose only (A0310A=99 and A0310B=01 through 07) or for a discharge (A0310A=99 and A0310F=10 or 11), no SCSA or a SCPA is required. The provider would determine if the Medicare-required or discharge assessment should be modified or inactivated. CAA (Care Area Assessments– Section V) and updated care planning are not required with Medicare only and Discharge assessments. (RAI manual, p 5-9)

An inactivation should be used when a record has been accepted in the QIES ASAP system but the corresponding event did not occur. For example, a Discharge assessment was submitted for a resident but there was no actual discharge. An inactivation (Item A0050=3) **must** be completed when any of the following items are inaccurate:

- Type of Provider (Item A0200)
- Type of Assessment (A0310) **when the Item Subset would change had the MDS been modified**
- Entry Date (Item A 1600) on an Entry tracking record (Item A0310F=1) **when the look-back period and/or clinical assessment would change had the MDS been modified**
- Discharged Date (Item A2000) on a Discharge/Death in Facility record (Item A0310F)= 10, 11 ,12) **when the look-back period and/or clinical assessment would change had the MDS been modified**
- Assessment Reference Date (Item A2300) on an OBRA or PPS assessment **when the look-back period and/or clinical assessment would change had the MDS been modified.**

When inactivating a record, the provider is required to submit an electronic Inactivation Request record. This record is an MDS record but only the Section X items and Item A0050 are completed. This is sufficient information to locate the record in the QIES ASAP system, inactivate the record and document the reason for inactivation.

(Above information are copied from the RAI Manual 3.0 version May 2013).





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DEFINITION

Resident's Participation in Assessment

The resident who actively engages in interviews and conversations to meaningfully contribute to the completion of the MDS 3.0. Interdisciplinary team members should engage the resident during assessment time in order to determine the resident's expectations and perspective during assessment.

Guardian/Legally Authorized Representative

A person who is authorized, under applicable law, to make decisions for the resident, including giving and withholding consent for medical treatment.

Family or Significant Other

A spousal, kinship (e.g., sibling, child, parent, nephew), or in-law relationship, a partner, housemate, primary community caregiver or close friend. Significant other does not, however, include staff at the nursing home.

SECTION Q : PARTICIPATION IN ASSESSMENT AND GOAL SETTING

MDS 3.0 is designed to maintain the quality of life and provide quality of care for residents admitted in nursing homes. Planning for resident's discharge is part of the RAI processes. Residents who actively participate in the assessment process and development of resident's care plans, through interviews oftentimes experience improved quality of life and higher quality of care, based on residents needs, goals, and priorities. Residents who actively engage in routine communication and are involved in completion of MDS have an easier pathway in determining goals and expectations. Short stay residents with goals identified and in place more often have a successful discharge transition.

Inviting resident and family members is one of the most important aspects in care planning processes. The IDT (Interdisciplinary Team) of the facility gets to meet the resident with their love ones face to face and talk about the plan of care. The staff has an opportunity to explore important information that oftentimes is not written in the History and Physical or medical records. This essential information allows the staff to see the resident expressing their wishes such as; to go back home and sleep in their own bed, or play with their pets again, or meet friends in their neighborhood and in the community. Residents goals and what is important to them at this moment in their life should be taken seriously.

Addressing the resident's dignity and self-determination in nursing homes are part of survey & certification requirements, which is under (CFR 483.15 ,Quality of Life).

Resident should be asked if he/she desires to invite family members or significant others to participate in the assessment process. If the resident is not able to participate, family members, significant others or an authorized representative can provide information about resident's needs, goals, and priorities.

Some clinicians are having difficulty coding the item/s in section Q of the MDS 3.0 specifically item Q0400 to Q0600. Identifying the intent of the section, coding instructions, and steps for assessment are helpful guides when questions arise. Use the definition box in the RAI manual to clarify items and identify the steps that are helpful in completing MDS assessments.

Discharge may cause anxious feelings or feelings of uncertainty to some residents, and staff may or may not recognize these issues. For instance, some patients may live alone without home support or some families can help but not on a regular basis. Clear approaches and explanation of the discharge process can develop a much better communication to residents and family members.

On MDS 3.0, section Q0400A Discharge Plan question;

Q0400A. Is active discharge planning already occurring for the resident to return to the community? The response has two options;

- o. No (if the response is "1", then to continue with the rest of the question)
1. Yes -> Skip to Q0600, Referral (if the response is "yes", it is a skip pattern)

Skip to Q0600, Referral - the question is, "**do we have to refer the patient to the Local Contact Agency (LCA), every time we have a "Yes" answer on item Q0400?** The answer is **no**.

A "**yes**" response means there is an active discharge plan occurring for the resident to return to the community; skip to item Q0600.

If the resident has an active discharge plan to return home or to his/her previous living condition,



DEFINITIONS: Discharge ; to release from nursing home care, can be to home, another community setting, or healthcare setting.

referral to LCA may not be needed. Reasons to proceed to care plan or not must be documented in resident's clinical record.

MDS 3.0 Item Q0600. Has a referral been made to the Local Contact Agency? Document reasons in resident's clinical record if:

0. No– referral not made
1. No-referral is or may be needed (For more information see Appendix C, Care Area Assessment Resource # 20)
2. Yes– referral made

[The coding instructions for these responses were explained in section Q of the RAI manual, 3.0 version.](#)

Code 2, yes: Referral made; if referral was made to the local contact agency, for example, the resident responded **“yes” to Q0500B, “Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?”**

Answering **“yes”** will initiate a contact by someone with more information about support available living in the community. However, answering yes does not commit the resident to leave the nursing home at a specific time, nor does it ensure that the resident will be able to move back to the community. On the other hand answering **“no”** is not a permanent commitment, this means that, when the resident is asked the facility is providing the resident an opportunity and exploring a possibility of receiving ongoing care in a different setting.

A **“yes”** response to item Q0500B will trigger follow-up care planning and contact with the designated LCA about the resident's request within approximately **10 business days**. The SNF/NF should not assume that the resident cannot transition out of the SNF/NF level of care. The SNF/NF can talk with LCA about what is available that does not require family support. If the level of the cognitive impairment is such that the resident does not understand Q0500, a family member, significant other, guardian, and/or decision-maker for that individual could be asked the question.

The Care Area Assessment (CAA) # 20 When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident expresses interest in returning to the community.

The State Medical Agencies have designated Local Contact Agencies and a State point of Contact (POC) to coordinate efforts to implement Section Q designated LCAs for their SNFs and NFs. The local contact agencies may be single entry point agencies, Aging and Disability Resource Centers, Money Follows the Person programs, Area Agencies for Aging, Independent Living Centers, or other entities the State may designate.

Local Contact Agency (LCA) Point of Contact List;

<http://www.dhcs.ca.gov/services/lc/Pages/MDS3,SectionQ.aspx>

Make the resident comfortable during care plan meetings and communicate directly to them. If the resident is not able to

understand, invite the family or significant others when possible.

Unless the resident's goals for care are clearly understood, their needs and priorities may not be met. Remember that the resident's goals are the basis for care planning.

MDS section Q items are included in Comprehensive, Quarterly, Discharge, PPS and PPS-OMRA Assessments, for Nursing Home Facilities and Swing Bed Hospitals.

What is Nursing home Compare?

Nursing Home Compare allows consumers to compare information about nursing homes. It contains quality of care information on every Medicare and Medicaid-certified nursing home in the country, including 15,000 nationwide.

The Five Star Rating created by CMS assists consumers in comparing nursing homes and identifying areas of questions.

The Five Star Quality Ratings of overall and individual star performance are based on health inspections, quality measures, and the staffing, which are based on the hours of care provided per resident by the staff performing the nursing care tasks.

Note:

- Information on nursing home compare is not an endorsement or advertisement for any nursing home. Five Star Quality Rating is not a substitute for visiting nursing homes.
- Nursing homes are not included on Nursing Home Compare if they are not certified to participate in Medicare and Medicaid. These Nursing Homes can be licensed by the state. (from Medicare.gov website, 2/13/2013).

Quality Measures (What's New?)

Three Files related to the MDS 3.0 QM User's Manual have been posted.

1. MDS QM User's Manual V8.0 contains detailed specification for the MDS 3.0. QM User's Manual V8.0 is available under the Downloads section.
2. Quality Measures Identification Number by CMS Reporting Module Table V1.2 documents CMS quality measures calculated using MDS 3.0 data and reported in a CMS reporting module. A unique CMS identification number is specified for each QM. The table is available under the download section.
3. Documentation of the Changes Made to the MDS 3.0 QM User's Manual V6.0 to V7.0 and V7.0 to V8.0 (April 2013). The changes document is available under the Downloads section.

Quality Measure Link:

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

QUADRIPLEGIA : Coding on item I5100 of MDS 3.0 for quadriplegia diagnosis is not clearly defined in the RAI User's manual. CMS

received several coding questions to clarify the definition and for appropriate coding. It was discussed briefly in the All State RAI/SMA teleconference last March. The topic was included in the CMS ODF Long Term Care agenda held on March 21, 2013. In a nutshell, in order to code Quadriplegia on the MDS 3.0 as an active diagnosis, there must be a physician-documented diagnosis of Quadriplegia. It is up to the physician to medically determine and provide appropriate documentation and provide diagnoses according to the resident's assessment. Coding quadriplegia is limited to spinal cord injuries and must be a primary diagnosis and not as a result of another condition.

For individuals with functional deficits that renders functional immobility due to debilitating illnesses that caused the individual a similar paralysis as in quadriplegia, the diagnosis must be coded on the MDS but not on the quadriplegia item (I5100).

Examples of Diagnoses:

- Cerebral Palsy spastic quadriplegia type, would be coded under I4400, Cerebral Palsy.
- Severe Rheumatoid Arthritis with functional impairment in mobility would be coded under I3700.
- End Stage Alzheimer's that could result in severe functional impairment would be coded under I4200, Alzheimer's Disease.

It is inappropriate to code the functional status or symptoms associated with the debilitating diagnoses noted in the above examples.

If a physician-documented diagnosis of functional quadriplegia is secondary to a debilitating disease as described, the diagnosis can be coded in I8000. Additional active diagnoses can be coded by entering the appropriate ICD code for functional quadriplegia in the spaces provided in item I8000.

These clarifications will not be included in the spring 2013 RAI User's updates but CMS will continue to evaluate if additional language regarding coding Quadriplegia will be included in the future version.

Note: CMS officials emphasized not to use MDS 2.0 version definitions or references. Everyone should be using MDS 3.0 version for coding tips, and use as a reference in the RAI process.

Qs & As

Q1. Would it be coded in section "I" if the physician gives diagnosis of quadriplegia due to paralysis of both upper and both lower limbs, spinal cord injury, or other cause?

A.1. If the physician documents diagnosis of quadriplegia in the last 60 days and remains active in the last 7 days then quadriplegia can be coded.

Q2. If the care plan has diagnosis of quadriplegia, and the physician indicates that the care plan was reviewed and signed, does this meet the physician-documented criteria?

A2. No, It indicates that the physician was involved in care planning but still needs the actual diagnosis.

Q3. How to code G0110, with variable ADL support provided?

A3. Recent clarification in coding G0110; Activities of Daily Living (ADL) Assistance, Column 1: Self Performance.

Example given :

Supervision occurred **five times** in the look back period while **Limited Assistance** occurred **twice** and **Extensive Assistance and Total assistance** each occurred once. The correct code for G01101 would in this scenario, be **"1"** indicating Supervision. Because the threshold of **three or more times** of Supervision was met and there were not three or more instances of a single higher level, the correct code would be "1" indicating Supervision.

The ADL Self Performance Algorithm is located on page G-6 of the RAI manual 3.0 version.

Q4. When can the staff do the BIMS (Basic Interview for Mental Status)?

A4. BIMS can be done any time in the look back period. This is addressed in the YouTube video for this section.

Q5. What responses can we code for interview items for unplanned discharges?

A5. Discharge Assessment -There is an Assessment Management / requirements and Tips for Discharge Assessment in Chapter 2, page 36 of the RAI manual, 3.0 version. For unplanned discharges the use of **"dashes"** are appropriate when the staff are unable to determine the response item/s, including the interview item/s. Examples of unplanned discharges can be found in the RAI manual chapter 2, page 36 of the RAI manual, 3.0 version.

Q6. What is the procedure to handle signatures in Z0400 and Z0500 when the person who completed a section is no longer employed by the facility.

A6. Response - Another staff member should review the MDS section for accuracy and sign the section.

Q7. Parkinson's Disease - can Parkinsonism, Parkinsonian Symptoms or Parkinson Like Syndrome be coded in item I5300?

A7. Response - CMS guidance stated that these diagnoses are not the same as Parkinson's Disease and should not be coded in I5300.

Q8. What would be the negative impact in submitting to Submission Requirement, A0410. 1. Neither federal nor state required submission.

A8. If providers forgot to submit to **Submission Requirement (A0410)** coding 3. Federal required submission, then the facility will be out of compliance. There could be a survey impact because the assessments may not be submitted on time and the assessment will not be a part of Quality Measures.



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References:

RAI Manual 3.0 version, October 2012

Monthly All State CMS, RAI/SMA Teleconferences

CMS Nursing Home Initiative Website

CMS Quality Measures and Nursing Home Compare

CMS ODF (Open Door Forum) Provider's Teleconference

CMS Open Door Forum, Long Term Care, Teleconference

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Memo from CMS:

Effective April 1, 2013, facilities can no longer submit **MDS 2.0 assessment data** to the QIES CMS system. Submission pages on the state server will be removed on October 1, 2013. MDS 2.0 data must have target dates prior to October 1, 2010 and the data submitted will be rolled off 37 months after October 1, 2010. All MDS federally required (subreq3) assessments are available in the MDS 2.0 Nursing Home data group in QIES Workbench. **All MDS 2.0 database structures will be removed from state data bases in the first quarter of 2014.** When the MDS 2.0 database structures are removed, the client MDS 2.0 DMS will no longer function. To avoid confusion, remove MDS 2.0 DMS from your user workstation.

Related links:

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS3oRAIManual.html>

Quality Measures link:

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

Nursing Home Compare link:

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

Local Contact Agency (LCA) link:

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

CA MDS Nuggets

<http://www.cdph.ca.gov/PROGRAMS/LNC/Pages/MDSNewsletter.aspx>