The MDS Mentor

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The MDS Mentor is published in March, June, September, and December each year.

ACRONYMS:

Activities of Daily Living (ADL)

Assessment Reference Date (ARD)

Centers for Medicare and Medicaid Services (CMS)

CMS Long-Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 (RAIM3)

Minimum Data Set (MDS)

Omnibus Budget Reconciliation Act (OBRA)

Prospective Payment System (PPS)

Resource Utilization Group (RUG)

Skilled Nursing Facility/ Nursing Facility (SNF/NF)

Care Planning Questions and Answers (Q & A)

The article: *The LVN and Initiating Care Plans* in the September 2012 issue of **The MDS Mentor** generated many questions. MDS staff conferred with Texas Board of Nursing (BON) staff to obtain the following answers. BON staff are the experts for RN/LVN scope of practice issues. Please address future questions to them.

Q: Can LVNs initiate (begin, start) a new care plan? I can find nothing specific in the MDS 3.0 RAI Manual or DADS rules that prohibit it, yet I have been informed it is not allowed.

A: No, it is beyond the scope of practice for LVNs to initiate a new care plan. Please review the LVN Scope of Practice information on the Texas Board of Nursing BON website. It is true there is nothing specific in the RAI Manual or DADS rules that prohibit LVNs from beginning the care plan. However, LVNs are prohibited from initiating care plans by BON rules as outlined in the Texas Nursing Practice Act, the BON LVN Scope of Practice position Statement and the BON Frequently Asked Questions.

Q: Can an LVN formulate nursing diagnoses for care plans?

A: No, it is beyond the LVN scope of practice for LVNs to formulate or determine the nursing diagnoses on a care plan. Wandering, Pain, Risk for Falls, Risk for Aspiration, Self-Care Deficit r/t Bathing, Eating, Grooming, etc. are all nursing diagnoses. Slight wording changes (e.g., Fall Risk, Aspiration Risk, and/or ADL Deficit) do not change the fact that a nursing diagnosis has been formulated in the care plan. Current clinical standards and BON rules require RNs to initiate care plans and develop nursing diagnoses.

Q: Can nurses enter or use medical diagnoses in the formulation of the care plan?

A: Medical diagnoses are not nursing diagnoses. It is important that nursing and functional issues related to medical diagnoses are addressed in the care plan. For example, it would be inappropriate for an RN to enter End Stage Renal Disease (ESRD) as a nursing diagnosis in the care plan. Instead, based on an assessment of the person, the RN might consider including the following nursing diagnoses related to ESRD (*not an all inclusive list)* on the care plan:

- Excess fluid volume related to failure of kidneys to eliminate excess body fluid
- Nutrition imbalance: Less than body requirements related to effects of uremia
- Impaired skin integrity of lower extremities related to dry skin and itching
- Risk for infection related to invasive catheters and impaired immune function

Q: Can RNs delegate initiating care plans and formulation of nursing diagnoses to LVNs?

A: No, RNs may only delegate to unlicensed staff. RNs make assignments to LVNs and assign tasks within the LVN's competency and scope of practice.

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Care Planning Questions and Answers (Q & A)

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Q: Isn't it true that an RN may review and sign the care plan after an LVN has written it and developed all the nursing diagnoses?

A: No, writing the care plan and developing nursing diagnoses is beyond the LVN scope of practice. In addition, an RN signature on a care plan after the care plan has been initiated by an LVN and all of the nursing diagnoses were developed by an LVN, does not change the fact that an LVN initiated the care plan and developed the associated nursing diagnoses. It is beyond the LVN's scope of practice and an RN's signature can NOT make this care plan process valid.

Q: Facility management/corporate staff have developed templates, algorithms, guidelines, protocols and/or procedures so that if certain MDS items or care area assessments (CAAs) are triggered, then certain nursing diagnoses are automatically identified. LVNs are beginning the care plan and entering the identified nursing diagnoses on the care plan. Is that allowed?

No. According to current clinical standards and BON staff, care plans must be initiated and nursing diagnoses must be developed by RNs based on their assessment and knowledge of the specific resident. This process results in a care plan that is accurate and individualized for the resident's care. The process described in the question is not based on an RN assessment of the resident and would not result in an individualized plan of care.

Q: Can LVNs have input into the resident's care plan with approaches/interventions/assignments and timelines?

A: Yes, in coordination with the interdisciplinary team which includes an RN, an LVN may have input for these items on the care plan.

Q: Can we continue to send RN/LVN Scope of Practice questions related to care planning requirements to Texas MDS staff?

A: No. BON staff are the experts for RN/LVN scope of practice issues. Please address future questions to them.

MDS Training Requirement Reminder

Texas Health and Human Services Commission's (HHSC) Office of Inspector General (OIG) wants to remind all nursing facility providers that the Registered Nurse (RN) Assessment Coordinator must complete the HHSC-approved MDS Training prior to completing an MDS for Texas Medicaid reimbursement. This training must be repeated every two years. The Long Term Care Medicaid Information (LTCMI) form (1 TAC §371.214(c)) must include the name and license number of the RN Assessment Coordinator completing the MDS.

If signatures are different on the MDS and the LTCMI form, OIG staff may verify these nurses' MDS training and RN licensure status with Texas State University and the Texas Board of Nursing, respectively. If the training is not completed, and/or the RN license is not verified, the MDS may be considered invalid and payment may be adjusted.

To take the training, go to Resource Utilization Group (RUG) Training: Continuing Education: Texas State University. To verify training with Texas State University, call (512) 245-7118.

Write it on your heart that every day is the best day in the year. - Ralph Waldo Emerson

An optimist stays up until midnight to see the New Year in. A pessimist stays up to make sure the old year leaves. - Bill Vaughn

Cheers to a New Year and another chance for us to get it right. - Oprah Winfrey

The Next Three Top Medicare Questions asked by Texas Providers

Building on the top three Medicare related questions article in the September 2012 issue of The MDS Mentor, questions five (5) through seven (7) are covered in this edition.

Question 5. If facility staff completed and submitted an End of Therapy with Resumption (EOT-R) but the resident did not meet the requirements to earn the same RUG-IV therapy classification level that had been in effect prior to the EOT-R (unable, refused, died or discharged), what is required?

Answer: If the EOT-R assessment has already been transmitted and accepted, then the MDS must be modified to an EOT by correcting O0450A to "0. No", removing the date in O0450B and leaving O0450B blank. If the EOT-R had been completed but not submitted, and it was still in the encoding period, O0450A would be corrected to "O. No" and O0450B would contain no date (be blank) prior to transmission, making the submitted assessment an EOT. From page 2-48 of the RAIM3, "In cases where therapy resumes after an EOT OMRA is performed and more than 5 consecutive calendar days have passed since the last day of therapy provided, or therapy services will not resume at the same RUG-IV therapy classification level that had been in effect prior to the EOT OMRA, an SOT OMRA is required to classify the resident back into a RUG-IV therapy group and a new therapy evaluation is required as well." In addition, there are excellent examples on page 2-49 of the RAIM3 that should be reviewed by facility staff. Staff may not leave the EOT-R uncorrected, as this would result in classifying the resident back into a rehabilitation RUG by an EOT-R when therapy did not resume at the same RUG-IV therapy classification that had been in effect prior to the EOT OMRA. In this case, a Start of Therapy (SOT) would be required.

Question 6. How does a late COT affect when the next COT evaluation is due?

Answer: It depends. Was an intervening PPS assessment, that controlled payment, submitted and accepted with an ARD set between the assessment for which the COT was due and the COT that was actually completed? When an intervening assessment controls payment, a late COT is <u>not</u> used to reset the count for the next COT. However, when no intervening assessment exists, the late COT <u>does</u> reset the count for the next COT. Consider the following examples:

- A 14 day PPS MDS ARD 9/10. COT required on 9/17. Late COT ARD on 9/20 resets the date the next COT is due because there is no intervening assessment. Next COT evaluation is due 9/27.
- A 14 day PPS MDS ARD 9/10. COT required on 9/17. EOT ARD on 9/22. Late COT ARD on 9/23 does NOT reset the date the next COT is due because there is an intervening PPS assessment. COT evaluation is due 9/29 because an EOT was completed and controlled payment as of 9/22.

Question 7. Should we keep the FY2012 RUG IV Education and Training SNF PPS Clarification documents now that the information has been incorporated into the RAIM3? Has the inactivation clarification been changed? It was not included in the recent RAIM3 update.

Answer: It is recommended that staff keep the SNF PPS Clarification documents for reference and training purposes. They contain detailed explanations and examples not found in the RAI Manual that staff may find helpful. For example, item 8 from the March 2012 Conference on inactivation still applies. However; in any conflict between the RAIM3 and the clarifications, the RAIM3 prevails. For example, the therapy start date after an EOT-R is now the original start date from the EOT-R and not the O0450B date from the EOT-R.

Quality Measure – Falls with Major Injury

Facility staff have asked how to review the measure specification for "MDS 3.0 Measure (#0674): Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay)" found in the *MDS 3.0 QM User's Manual* and included below:

Numerator

Long-stay residents with one or more look-back scan assessments that indicate one or more falls that resulted in major injury (J1900C = [1, 2]).

Denominator

All long-stay nursing home residents with one or more look-back scan assessments except those with exclusions.

Exclusions

Resident is excluded if one of the following is true for ***all*** of the look-back scan assessments:

The occurrence of falls was not assessed (J1800 = [-]), OR
The assessment indicates that a fall occurred (J1800 = [1]) AND the number of falls with major injury was not assessed (J1900C = [-]).

Note the numerator and denominator reference the look-back scan for long stay residents. Long-stay residents are residents with 101 or more cumulative days in the facility. In addition to including the target assessment, page 7 of the *QM User's Manual* defines **look-back scan** to "Include an earlier assessment in the scan if it meets all of the following conditions: (a) it is contained within the resident's episode, (b) it has a qualifying RFA, (c) its target date is on or before the target date for the target assessment, and **(d) its target date is no more than 275 days prior to the target date of the target assessment**." {*Item d was bolded for emphasis.}* The RFA (reason for assessment) in this case is any OBRA, PPS, or Discharge assessment. This article refers to an assessment found in the look-back scan as a "qualifying assessment."

Example: A facility runs a quality measure report with a target period of July – December 2012. The target assessment is a Quarterly Assessment with an ARD on October 15, 2012. Any qualifying assessments with a target date on or after January 14, 2012 (275 days before the target assessment's ARD), means the resident will be counted in the denominator. Any qualifying assessments with a target date on or after January 14, 2012, which report a major fall with injury will trigger the quality measure and the resident will be counted in the numerator.

Traditional Irish Holiday Blessing

May love and laughter light your days,
and warm your heart and home.
May good and faithful friends be yours,
wherever you may roam.
May peace and plenty bless your world
with joy that long endures.
May all life's passing seasons
bring the best to you and yours.

MDS News in Review

- October 10, 2012 - The *MDS 3.0 QM User's Manual V6.0* and *QM ID by CMS Reporting Module V1.0 for User's Manual V6.0* were posted on the CMS MDS Quality Measure webpage. These postings were effective immediately.
- October 29, 2012 - The Texas Medicare Administrative Contractor (MAC) changed to Novitas Solutions for Medicare Part A.
- November 7, 2012 - The RAIM3 V1.09 was posted on the CMS MDS RAI Manual website. It replaced V1.08 and was effective immediately.
- November 11, 2012 - The Texas Medicare Administrative Contractor (MAC) changed to Novitas Solutions for Medicare Part B.
- November 29, 2012 - CMS posted RAIM3 V1.09 Replacement Manual Pages & Change Tables.

RAI Manual November Changes

The MDS 3.0 RAI User's Manual version (RAIM3) V1.09 was released to the public on November 7, 2012. Significant changes to this version were minimal.

The "MDS 3.0 RAI Manual (v1.08) Errata (v.3 and 4)" changes are incorporated.
Chapter 2 and Chapter 6 incorporate Medicare follow-ups and clarifications that were posted on the CMS FY 2012 RUG-IV Education & Training webpage. The changes clarify numerous PPS and OMRA scheduling and billing issues.
Section I changes clarify "active diagnoses".
Section K adds weight gain definitions.
Section M differentiates between scabs and eschar in M0210.
Section N clarifies the importance of eliminating or reducing resident medications to what is most effective for the resident's assessed condition.
Section O changes "strict isolation" to "single room isolation" in O0100 and changes O0400 coding instructions.
Section X adds instructions for when inactivation is required instead of modification for specific items. It also adds coding instructions for X0900E when modifying the record.
Chapter 4 has multiple additions and corrections made to section 4.10.
Chapter 5 changes completion timing to "must" instead of "may" or "should".
Appendix A redefines "Continence".

Q0490 Clarified

Q0490: Resident's Preference to Avoid Being Asked Question Q0500B (RAIM3 page Q12-Q13)

Code 0, no: if there is no notation in the resident's clinical record that he or she does not want to be asked Question Q0500B again. Clarification: Code 0 if Q0550 was most recently answered "No" or "Unknown or uncertain" on a prior assessment where Q0550 was not blank.

Code 1, yes: if there is a notation in the resident's clinical record to not ask Question Q0500B again, except on comprehensive assessments. Clarification: Code 1 if Q0550 was most recently answered "Yes" on a prior assessment where Q0550 was not blank.
Unless this is a comprehensive assessment (A0310A=01, 03, 04, 05), skip to item Q0600, Referral.
If this is a comprehensive assessment, proceed to the next item Q0500B.

Code 8, Information not available: if there is no information available in the resident's clinical record or prior MDS 3.0 assessment. Clarification: Code 8 if there is no record that Q0550 has been previously answered.

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Useful Web Links

DADS MDS Web Site: Texas MDS site for MDS policy, procedures, and clinical and technical information (including The MDS Mentor). http://www.dads.state.tx.us/providers/MDS/

Sign up for MDS Resource E-mail updates: Go to http://www.dads.state.tx.us/, click on the "E-mail updates" tab and follow the directions. The "DADS Texas Minimum Data Set (MDS) Resources" emails are the key line of communication for MDS updates and alerts to nursing home and swing bed facilities from the DADS MDS staff.

Centers for Medicare & Medicaid Services (CMS) MDS 3.0 website : MDS 3.0 RAI Manual, Item Sets (forms), related MDS 3.0 materials and left-side table links to MDS technical information and MDS 2.0.
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

Centers for Medicare & Medicaid Services (CMS) FY 2012 RUG-IV Education & Training: Clarification and follow-up documents related to Medicare MDS.
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/RUGIVEdu12.html

QIES TECHNICAL SUPPORT OFFICE (QTSO): MDS 3.0/2.0, jRAVEN/RAVEN and CMSNet (Verizon) information. Validation Report Messages, Guides, Training and DAVE/DAVE 2 Tip sheets.
https://www.qtso.com/

Quality Reporting System (QRS): DADS information site on Texas nursing homes.
http://facilityquality.dads.state.tx.us/qrs/public/qrs.do

Nursing Home Compare: CMS site that compares nursing homes in a given area.
http://www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteria.asp

5 Star Technical Manual: Explains data used to create the 5 Star Report.
http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html

This guidance is being provided on the published date of The MDS Mentor. The reader should be aware that guidance regarding topics in The MDS Mentor may be time-limited, and may be superseded by guidance published by CMS or DADS at a later date. It is each provider's responsibility to stay current with the latest CMS and DADS guidance.