The MDS Mentor

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VOLUME 4, ISSUE 2

DECEMBER 2013

TEXAS Department of Aging and Disability Services

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

ACRONYMS:

Assessment Reference Date (ARD)

Centers for Medicare & Medicaid Services (CMS)

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

Interdisciplinary Team (IDT)

Minimum Data Set (MDS)

Omnibus Budget Reconciliation Act (OBRA)

Prospective Payment System (PPS)

Registered Nurse (RN)

Resource Utilization Group (RUG)

Resident Assessment Instrument (RAI)

Skilled Nursing Facility/ Nursing Facility (SNF/NF)

Chapter One: Facility Responsibilities

As outlined on pages 1-7 to 1-8 of the RAIM3, "Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require:

(1) the assessment accurately reflects the resident's status

(2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals

(3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts.

Nursing homes are left to determine:

(1) who should participate in the assessment process

(2) how the assessment process is completed

(3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual."

To ensure the MDS is accurate, it is extremely important the coding follow the instructions in the current RAIM3 and be supported by documentation in the clinical record. As of 10/1/13, the current RAIM3 is Version 1.11. Even though software developer's may have coding tips imbedded in the MDS software, it is a facility responsibility to ensure those tips are current and accurate, even as changes and clarifications occur. It is also a facility responsibility to ensure that coding of the MDS is NOT based solely on tips, but

on a thorough understanding of the detailed instructions in the RAIM3. In addition, from page 1-8 of the RAIM3: "While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS."

It is very important for a RN to either conduct or coordinate each assessment with appropriate health professionals. This means a facility RN is responsible to ensure that each MDS is accomplished by an IDT that is aware of and complying with their responsibilities for scheduling, completion and transmission of MDS data. This responsibility may not be delegated to a Licensed Vocation Nurse (LVN), including the LVN MDS Coordinator. As noted on page 1-8 of the RAIM3, "...even nursing homes that have been granted a RN waiver under 42 CFR 483.30 (c) or (d) *(Continued on the next page)*
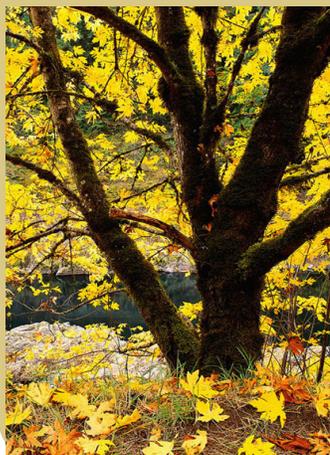
Chapter One: Facility Responsibilities

must provide a RN to review and sign off the assessment as complete." Many facilities have more than one RN authorized to sign the MDS as complete. When there is more than one RN, it is a facility responsibility to ensure which RN or RNs are responsible to ensure MDS records are conducted or coordinated appropriately and when. Over the past several months, several issues have been identified that RN oversight may have prevented. For example, there were issues with multiple missing entry, death and discharge records; as well as multiple missing OBRA and Medicare assessments. In addition, there were issues with backdating the ARD in A2300 for assessments in A0310A or A0310B of the MDS and the routine late scheduling or completion of MDS records. Other issues include completion of MDS assessments with an ARD after the date of discharge from the facility or transmission of MDS assessments that have not been properly signed in Z0400 for accuracy or in Z0500 for completeness.

When the RAIM3 is not specific as to the discipline that must be assigned to complete a RAI-related task, it is a facility management responsibility to determine who should participate in the assessment process. The RAIM3, page 1-8, offers guidance on making staff assignments: "Given the requirements of participation of appropriate health professionals and direct care staff, completion of the RAI is best accomplished by an interdisciplinary team (IDT) that includes nursing home staff with varied clinical backgrounds, including nursing staff and the resident's physician. Such a team brings their combined experience and knowledge to the table in providing an understanding of the strengths, needs and preferences of a resident to ensure the best possible quality of care and quality of life. " Further down on page 1-8, the RAIM3 advises, "...nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment." Facility staff have the requisite knowledge when they are trained, have access to the current instructions for the RAIM3 sections they are assigned to complete and are acting within the scope of practice for their license or certification.

Chapter Two: RAI Completion

"The requirements for the RAI are found at 42 CFR 483.20 and are applicable to all residents in Medicare and/or Medicaid certified long-term care facilities. The requirements are applicable regardless of age, diagnosis, length of stay, payment source or payer source. Federal RAI requirements are not applicable to individuals residing in non-certified units of long-term care facilities or licensed-only facilities. This does not preclude a State from mandating the RAI for residents who live in these units." (RAIM3, page 2-2). Texas does mandate use of the RAI in these units. Outside of Texas, contact your State RAI Coordinator for information. The RAI (MDS, Care Area Assessments and Utilization Guidelines) must be completed for:

• All residents of a Medicare (Title 18) SNF or a Medicaid (Title 19) NF. This includes certified SNFs or NFs in hospitals, regardless of payment source.

• Hospice Residents: When residing in a SNF or NF for the hospice benefit, the facility must comply with the Medicare or Medicaid participation requirements.

• Short-term or respite residents residing more than 14 days on a certified unit.

• Special population residents (e.g. pediatric or those with a psychiatric diagnosis).

• Part A SNF level of care recipients in swing bed facilities. Swing bed providers must complete the MDS assessment types in A0310B, A0310C, A0310D and A0310F, but not those in A0310A.

"There's no harm in hoping for the best as long as you're prepared for the worst."
— Stephen King, Different Seasons

"If I could learn to treat triumph and disaster the same, then I would find bliss."
— Kathie Lee Gifford

"I always tried to turn every disaster into an opportunity."
— John D. Rockefeller

If you live long enough, you'll make mistakes. But if you learn from them, you'll be a better person. It's how you handle adversity, not how it affects you. The main thing is never quit, never quit, never quit.
— William J. Clinton

Chapter Two: Setting the ARD

I know The MDS Mentor readers join me in gratitude for the five plus years of outstanding technical service and innovation provided by Andy Alegria. Providers have missed Andy but state staff still enjoy working with him as the State ASPEN Coordinator.

I also know The MDS Mentor readers will join me in a big Texas welcome for the new MDS Automation Coordinator, Brian Johnson, who started in August 2013.

One of the most basic steps of the RAI process is setting the ARD for MDS assessments. As noted on page 2-8 of the RAIM3, the ARD "... refers to the last day of the observation (or "look back") period that the assessment covers for the resident. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. The facility is required to set the ARD on the MDS Item Set or in the facility software within the required timeframe of the assessment type being completed. This concept of setting the ARD is used for all assessment types (OBRA and Medicare-required PPS) and varies by assessment type and facility determination."

After reading this passage, two questions are frequently asked:

1. How is an ARD set in the facility software or on an MDS Item Set? The answer is facility staff set the ARD in the facility software by logging in and then opening up their MDS software program and completing the steps necessary to identify the resident in A0500 and the ARD in A2300. Facility staff set an ARD on a paper copy of Section A of an MDS Item Set by identifying the resident in A0500 and the ARD in A2300. Although not required by federal regulations, it is strongly recommended that staff sign and date somewhere on Section A when they set the ARD. The ARD is a RUG item and reviewers may ask for evidence the ARD was set appropriately. Also, staff needs to ensure that the correct date the name and the ARD were created is entered in Section Z0400 when the MDS is signed for accuracy.

2. Another frequent question that results is "How does setting the ARD vary by assessment type?" To answer this question, read the bullets below:

- For A0310A MDS, the ARD must be set for the current day's date or a future date. There is no back-dating allowed and no ARD is set for a date after the resident's discharge from the facility.

- For A0310B MDS, the ARD must be set for any day in the window prior to the window opening or while the window is open. Once the window closes, the only ARD that may be set is the current day's date, and then only if the resident is still on Part A. No ARD may ever be set for this type after the Part A stay ends.

- For A0310C MDS, the ARD must be set no later than two (2) days after the date the facility determined for the ARD has passed. Once this two day allowance for back-dating the ARD passes, the only ARD that can be set is the day's date and then only if the Part A stay has not ended. This two day flexibility to back-date the ARD applies after discharge, but only when used to appropriately set an ARD within the time frame for the Part A stay.

- For A0310F MDS, there is no ARD for an Entry or Death in Facility tracking record. For the discharge assessments in this item (A0310F=10 or 11), the ARD may be set for the date of discharge up to 14 days after discharge, allowing for the assessment to be completed by day 14 as required.

For more specifics on setting the ARD for OBRA MDS, review the "RAI OBRA-required Assessment Summary" from pages 2-15 and 2-16 of the RAIM3..

For more specifics on setting the ARD for Medicare PPS MDS, review the "Medicare Scheduled and Unscheduled MDS Assessment, Tracking Records, and Discharge Assessment Reporting Schedule for SNFs and Swing Bed Facilities" from pages 2-42 to 2-44 of the RAIM3.
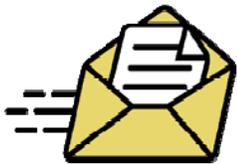
Registered Nurse Assessment Coordinator (RNAC)

The Texas Health and Human Services Commission Office of Inspector General (HHSC-OIG) reminds all nursing facility providers that every Registered Nurse Assessment Coordinator (RNAC) must complete the HHSC-approved MDS training prior to completing an MDS for Texas Medicaid reimbursement. This training must be repeated every two years.

To take the training, go to http://www.txstate.edu/continuinged/CE-Online/RUG-Training.html.

To verify training with Texas State University, call (512) 245-7118.

The Long Term Care Medicaid Information (LTCMI) form (1 TAC § 371.214 (c)) must include the name and license number of the RNAC signing the MDS. If signatures are different on the MDS and the LTCMI form, the MDS may be considered invalid and payment may be adjusted.

Access and Electronic Signatures

Question: Our NF utilizes remote access points (computer terminals) that are all networked and able to access our server. They are not stand-alone. However, we do have read-only access and would be able to provide access to multiple reviewers. Also, it would not interfere with nursing facility operations. Will this be acceptable?

Answer: Yes!

OIG nurse reviewers will need access to any electronic medical records for those residents being reviewed. Access to all facility resident records is not required and could raise potential privacy and security concerns. If a facility is unable to provide electronic access to multiple reviewers via a stand-alone system (one that does not interfere with nursing facility activities), the facility may be asked to provide hard copies of the clinical records to the reviewers. Nurse reviewers will not be able to enter electronic systems with flash drives due to potential security risks and virus infection.

Electronic signatures and storage requirements are defined in the Resident Assessment Instrument (RAI) and OIG's rules (1 TAC § 371.214). Although 1 TAC § 371.214(p)(2) states that "a nursing facility that utilizes a clinical record system which is entirely electronic must maintain a hard copy of all MDS assessments in the recipient's clinical record," CMS Services updates allow completed MDS forms to be stored electronically with specific guidelines. OIG will follow the CMS RAI guidelines as stated in 1 TAC § 371.212(a)(1), which notes: "Requirements for completing the MDS are derived from the RAI, including the MDS, specified by the Department of Aging and Disability Services (DADS). The nursing facility must adhere to any updates by CMS in addition to state specific mandates. To the extent such CMS updates conflict with DADS specific mandates, the CMS updates shall control."

RUG Change Submission Process Beginning with MDS 3.0 Reviews

As referenced in 1 TAC § 371.214(q)), a facility must request a reconsideration to be eligible to request any subsequent appeals. The Resource Utilization Group (RUG) and the associated per diem rate specified in the reconsideration determination remain in effect during the formal appeal process.

In addition, after the reconsideration, any net overpayments from the reconsideration RUG changes will be recouped from the facility and will be reflected in the facility's Remittance and Status Report.

The Four Late Loss Activities of Daily Living used by the RUG are:

G0110A — Bed mobility

G0110B — Transfer

G0110H — Eating (Column 1 only)

G0110I — Toilet use

Activities of Daily Living

Activities of Daily Living (ADL) must be documented in the clinical record during the seven-day look-back period. ADL self-performance - what the resident actually did for him/herself - must also be documented in the seven-day look-back period. The documentation must be chronicled, be consistent and be descriptive of the resident's actual self-performance within the stated look-back period of seven days.

This documentation is supported by the following references:

• 1 TAC § 371.212(a)(2). "Completion of the MDS does not remove the nursing facility's responsibility to document in a clinical record a detailed assessment of all relevant issues that affect the recipient. All clinical record documentation must chronicle, support, and be consistent with the findings of, rather than conflict with, each MDS assessment. Documentation must contain pertinent facts, findings, and observations about an individual's health history including past and present illnesses, treatments, and outcomes to support the care the recipients are receiving. Inconsistent and unsupported findings will not be validated and may result in an adjustment in the RUG-III classification."

• 1 TAC § 371.212(a)(3). "All coded items on the MDS assessments submitted for Medicaid reimbursement must be supported by documentation in the recipient's clinical record. Sources of other information (e.g., other health care professionals, family members) utilized for the MDS assessment must be identified and must be supported by the clinical record."

CMS states the following in the RAIM3 on pages 1-8 regarding the assessment process and documentation to support the care provided:

"In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the Interdisciplinary Team (IDT) completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.

While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident."

If Texas staff/providers have questions regarding the content of this article, or the articles on page 4, please contact Judy Knobloch at 512-491-2070 or Linda Carlson at 512-491-2065.

In addition, for more information on supporting documentation requirements for ADLs coded in Section G of the MDS, see Information Letter 13-76 located at http://www.dads.state.tx.us/providers/communications/2013/letters/IL2013-76.pdf.

MDS News in Review

1. On April 12, 2013, the CMS posted three files related to the MDS 3.0 Quality Measures (QM) User's Manual at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html.
- MDS 3.0 QM User's Manual v8.0 contains detailed specification for the MDS 3.0 quality measures.
- Quality Measure 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.
- Documentation of the Changes Made to the MDS 3.0 QM User's Manual v6.0 to v7.0 and also from v7.0 to v8.0 (April 2013).
2. On May 20, 2013, CMS posted the RAI Manual v1.10 and Change Tables at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html. On May 29, 2013, CMS updated the RAI Manual v1.10 to include six sections that had not been changed since v1.09 but were omitted: Chapter 3 Section F; Chapter 3 Section J; Chapter 3 Section S title page; Appendix D; Appendix F title page; and Appendix H title page. In addition, two minor edits were made to the coding tips in Chapter 2 (page 49) and Chapter 3 Section O (page 31). The footers on these two pages are marked with "(R)" and now read "May 2013 (R)". As a result, the two related Change Table files were updated to reflect these changes.
3. On September 25, 2013, CMS posted the RAI Manual V1.11 at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html. The MDS 3.0 RAI Manual V1.11 was effective October 1, 2013 and replaces V1.10.
4. A list of significant changes can be found in the document titled "RAI Manual V1.11 October 2013 Changes" on the Texas DADS MDS website in the document library at http://www.dads.state.tx.us/providers/MDS/library/.

Correction Policy May 2013 Update

The RAIM3 v1.10 released May 2013 introduced a new correction policy in Chapter 5 regarding what items may be corrected with a modification instead of an inactivation. The correction policy change is summarized in a PowerPoint presentation that is available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Inact_ModChange_final_public.pdf. Since valid records requiring inactivation for correction hinge on the Item Set Code (ISC), the "Nursing Home Item Set Code (ISC) Reference Table" in the RAIM3 on page 2-77 is an essential resource. Below is a table with a summary of the changes:

Effective May 19, 2013, a modification request is used to correct errors in the following items:
- A0310: Type of Assessment when there is **no** change in the Item Set Code (ISC)
- A1600: Entry Date on an Entry tracking record (Item A0310F = 1)
- A2000: Discharge Date (on Discharge/Death in Facility record; A0310F=10-12)
- A2300: Assessment Reference Date (ARD) - but only for a <u>typographical</u> error

A modification request is still required to correct errors in the following items:
- A1600 Entry Date on an assessment other than an Entry tracking record.
- All other Section A items, except A0410 and the two bullets listed under the last entry below.
- Clinical Items (B0100-V0200C)
- Z0500A and B, because whenever the RN signature was blank or was changed, the date in Z0500B must be modified to correct the date to the date when the RN whose signature appears actually signed.

An inactivation request is still required to correct errors in the following items:
- A0200: Type of Provider
- A0310: Type of Assessment when there is a change in the ISC.

NOTE: Correction of A0410 requires a Manual Assessment Correction/Deletion Request. Contact your State MDS Automation Coordinator.   SOURCE: RAIM3, pages 5-10 to 5-11

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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 "Subscribe" 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

NOTE: This guidance is being provided on the published date of The MDS Mentor (December 6, 2013). 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 abreast of the latest CMS and DADS guidance.