The MDS Mentor

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VOLUME 5, ISSUE 3 SEPTEMBER 2012

INSIDE THIS ISSUE:

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 Area Assessment (CAA) - the Critical Link

Section V, Care Area Assessment (CAA) Summary, of the comprehensive MDS 3.0 item set lists 20 care areas. The first 18, from "Delirium" to "Physical Restraints," carried over from MDS 2.0 to MDS 3.0. The final two, "Pain" and "Return to Community Referral," were added for MDS 3.0. From page V-1 of the RAIM3, "Care Areas are triggered by MDS item responses that indicate the need for additional assessment based on problem identification, known as "triggered care areas," which form a critical link between the MDS and decisions about care planning."

While CMS staff developed Appendix C of the RAIM3 to provide checklists to aid in assessing each of the 20 care areas, there is no federal or state requirement that the checklists or any other specific tool or process be used. From page 4-3 of the RAIM3, "The CAA process does not mandate any specific tool for completing the further assessment of the triggered areas, nor does it provide any specific guidance on how to understand or interpret the triggered areas." Although staff must use a tool, CMS does not prescribe a specific tool or process.

The RAIM3 continues, "Instead, facilities are instructed to identify and use tools that are current and grounded in current clinical standards of practice, such as evidence-based or expert-endorsed research, clinical practice guidelines, and resources. When applying these evidence-based resources to practice, the use of sound clinical problem solving and decision making (often called "critical thinking") skills is imperative." Therefore, facility staff needs to determine the current, evidence-based tool or tools they will use to facilitate the CAA process.

The CAA process is, from page 4-3 of the RAIM3, "required only for OBRA comprehensive assessments (Admission, Annual, Significant Change in Status, or Significant Correction of a Prior Comprehensive)." There is no requirement to complete the CAA process for quarterly or stand-alone Medicare PPS MDS. Resuming reading on page 4-3 of the RAIM3, "However, when a Medicare PPS assessment is combined with an OBRA comprehensive assessment, the CAAs must be completed in order to meet the requirements of the OBRA comprehensive assessment."

Because there is no specific tool, format or location in the clinical record that is required to be used to document the CAA process, page 4-7 of the RAIM3 instructs, "Written documentation of the CAA findings and decision making process may appear anywhere in a resident's record; for example, in discipline-specific flow sheets, progress notes, the care plan summary notes, a CAA summary narrative, etc… If it is not clear that a facility's documentation provides this information, surveyors may ask facility staff to provide such evidence. Use the "Location and Date of CAA Documentation" column on the CAA Summary (Section V of the MDS 3.0) to note where the CAA information and decision making documentation can be found in the resident's active clinical record." (Continued on the next page)

Care Area Assessment (CAA) - the Critical Link

"Expect problems and eat them for breakfast."

Alfred A. Montapert

"Even if you fall on your face, you're still moving forward."

Victor Kiam

A few examples follow:

1. Write a CAA Summary Note utilizing current on-line resources listed on page C-84 and C-85 in Appendix C of the RAIM3 and the resident's clinical record. The "Location and Date of CAA Documentation" column should list "CAA Summary Note, xx/xx/xx" where xx/xx/xx is the date of the note.
2. Utilize the checklists in Appendix C and the resident's clinical record. The "Location and Date of CAA Documentation" column should list "CAA Checklist #xxx, xx/xx/xx" where xxx is the number or numbers of the CAA Checklists that were used.
3. Review the resident's clinical record , aided by a current textbook on assessing to care planning. The "Location and Date of CAA Documentation" column should list "NN, xx/xx/xx , Lab xx/xx/xx" where NN is Nurse's Notes. Ensure staff are able to define all abbreviations they use.

A comprehensive MDS assessment, whether combined with other reasons for assessment or not, may NOT be transmitted until V0200C2 contains the date the care plan was completed and staff checks the Care Area in V0200, Column B, to confirm a triggered care area is addressed in the care plan.

The LVN and Initiating Care Plans

- Licensed Vocational Nurse (LVN)
- Registered Nurse (RN)
- Free Nursing Diagnoses List website http://nursing-concept.**blogspot**.com/2009/02/free-nursing-care-plans-based-on.html

While the primary focus for *The MDS Mentor* is federal and state RAI requirements, other agency policies also affect current nursing practice in nursing facilities. The Texas Board of Nursing (BON) is the regulatory authority for nursing practice requirements in Texas. One frequently asked question and answer posted at http://www.bon.texas.gov/practice/faq-practice.html is: "***Can a LVN initiate/develop the nursing care plan?*** **Staff recommends you review Rule 217.11, Standards of Nursing Practice, as well as the Guideline for LVN Scope of Practice (available on the "Nursing Practice Information" section of the BON web site under "Scope of Practice.") Rule 217.11(2)(A)(ii) and (iii) clarifies that LVNs may not initiate care plans, but they should contribute to the planning and carrying out of nursing care and participate in the development of and modifications to the ongoing nursing care plan. Only the RN may develop the initial nursing care plan and make nursing diagnoses [Rule 217.11(3)(A)(ii) and (iii)]. This difference between LVN and RN scope of practice is based on differences in educational preparation of nurses licensed at each level as defined in the Differentiated Entry Level Competencies for Graduates of Basic Nursing Education Programs in Texas (DELC). DELC may be viewed in its entirety or downloaded from the "Nursing Education Information" page of the BON web site."**

Hence, a LVN may not initiate care plans. Also, a RN's signature after a LVN initiates a care plan does not comply with the BON rule. In addition, while the RAIM3, page 4-8, "does not specify a care plan structure or format," the care plan "must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being." Finally, a few staff have said nursing diagnoses are not used in the resident's care plans; but review of the care plans reveal the following nursing diagnoses are documented: Failure to Thrive, Anxiety, Incontinence, Risk for Aspiration, Risk for Falls, Risk for Injury, Urinary Retention and Wandering. Furthermore, a slightly reworded nursing diagnosis is still a nursing diagnosis (e.g., "Self-Care Deficit: Toileting" changed to "ADL Deficit in Toileting").

Sling Lift Transfer Coding Clarification

Evaluating Activities of Daily Living (ADLs) includes evaluating all the aspects of the ADL, defined on page G-2 of the RAIM3, as "ADL ASPECTS: Components of an ADL activity. These are listed next to the activity in the item set." The steps for assessment for all the ADLs included in item G0110 and listed on page G-3 of the RAIM3 include the following:

> When reviewing records, interviewing staff, and observing the resident, be specific in evaluating each component as listed in the ADL activity definition. For example, when evaluating Bed Mobility, determine the level of assistance required for moving the resident to and from a lying position, for turning the resident from side to side, and/or for positioning the resident in bed.

In another example, from either page G-1 or directly from the MDS Item Set for item G0110B, when evaluating transfer, staff would determine the level of assistance required for moving the resident "between surfaces including to or from bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)."

Recently, CMS staff were asked to clarify the components of a transfer when a sling lift (or Hoyer lift, a brand name) is used. CMS staff responded: if the person is able to perform actions that are part of the transfer (e.g., sits on the edge of the bed and assists with sliding onto the transfer sling; partially weight-bear stands and sits on the transfer sling; or positions themselves in the sling), that would be considered assisting in ADL aspects that are part of the transfer activity. A person who simply folds their hands across their chest or puts their hand on a bar while in the sling lift is not performing actions that can be considered as assisting with a transfer.

The coding instructions from page G-5 of the RAIM3 inform staff that **extensive assistance** is coded "if resident performed part of the activity over the last 7 days, help of the following type(s) was provided three or more times:

-- Weight-bearing support provided three or more times.

-- Full staff performance of activity during part but not all of the last 7 days."

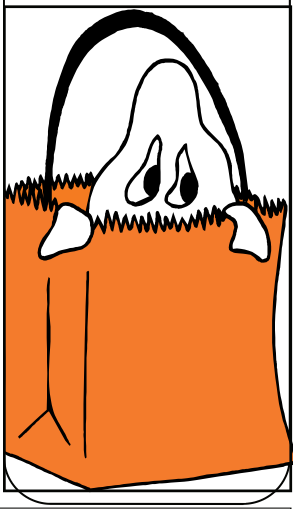
Continuing on page G-5, **total dependence** is coded "if there was full staff performance of an activity with no participation by resident for any aspect of the ADL activity. The resident must be unwilling or unable to perform any part of the activity over the entire 7-day look-back period."

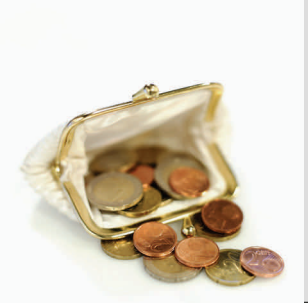
Therefore, if a resident folds their arms or places their hand on the bar once situated in the sling lift (an action that is not a component or aspect of the ADL activity of transfer), and if this same resident requires full staff performance of those components that are a part of the ADL activity of transfer every time transfer occurs during the 7-day look-back period, the correct code would be **total dependence**.

I don't know that there are real ghosts and goblins, but there are always more trick-or-treaters than neighborhood kids.
~Robert Brault, Poet

I'll bet living in a nudist colony takes all the fun out of Halloween.
~Author Unknown

Hold on, man. We don't go anywhere with "scary," "spooky," "haunted," or "forbidden" in the title.
~From Scooby-Doo





IMPORTANT NOTES: CHANGE IS COMING!

1. The Texas Medicare Administrative Contractor (MAC) is changing to Novitas Solutions at https://www.novitas-solutions.com. For Medicare Part A, this change will be effective on 10/29/12. For Medicare Part B, it will be effective 11/19/12.
2. The next RAIM3 revision has been delayed. Expect the new RAIM3 to be posted by CMS in late October or early November 2012.

Top Four Medicare Questions Asked by Texas Providers

1. Question: When is a Change of Therapy (COT) evaluation required?

Answer: A COT evaluation is scheduled every 7 days after the ARD of the last PPS MDS, except for an End of Therapy with Resumption (EOT-R). For an EOT-R, a COT evaluation is scheduled 6 days after the resumption of therapy date in O0450B. If the evaluation results in a lower or higher Rehab classification (index maximized), the COT must be completed unless the ARD for a scheduled PPS MDS ARD is properly set on or before the date the COT is due.

2. Question: A resident came in late on Friday and was discharged on Sunday. A Medicare 5-day still needs to be completed. How do I set the ARD today, the Monday after the resident was discharged?

Answer: Facility staff may not set an ARD for a scheduled PPS MDS on Monday because the resident is no longer on Medicare Part A. When a resident on a Medicare Part A stay is discharged, the Assessment Reference Date (ARD) of a scheduled PPS assessment may be adjusted to the day the resident is discharged only when the ARD for the scheduled PPS assessment was set prior to the day of discharge. From page A-26 of the RAIM3, "When the resident dies or is discharged prior to the end of the look-back period for a required assessment, the ARD must be adjusted to equal the discharge date." The solution to this issue is to set the ARD for the Medicare 5-day upon admission to the facility, either in the facility MDS software or on a hard copy of Section A of an MDS Item Set.

3. Question: When a resident is in the window for a scheduled PPS MDS and the requirements for a COT are met, does the COT have to be combined with the scheduled PPS MDS or not?

Answer: It is up to facility staff to decide when to combine a COT with a scheduled PPS MDS when COT requirements are met and to ensure the RAIM3 and SNF PPS clarification rules below are followed :

—When the scheduled PPS MDS is combined with the COT, the ARD must be set for day 7 of the COT observation period (the date the COT ARD was due to be set) and it must also be a valid date in the window for the scheduled PPS MDS, following the rules in the RAIM3 for setting ARD (page 2-8).

—When the COT is not combined with a scheduled PPS MDS, the ARD for the scheduled PPS MDS must be set in the window for the assessment, but may be set either on or prior to the date the COT was due.

—When a COT is due in the window for a scheduled PPS MDS, the ARD for the scheduled PPS can never be after the date the COT requirements were met (i.e., day 7 of the COT observation period), whether the COT is combined with the scheduled PPS MDS or not.

—BEWARE: If facility staff elects to complete the scheduled PPS MDS without the COT, when a COT is required, the scheduled PPS must have a least one payment day prior to the resident being discharged from Part A. When a resident is discharged from Medicare Part A prior to one payment day, then the scheduled PPS MDS was not required (i.e., scheduled PPS MDS are required for payment only) and the COT will become a missed assessment. However, if the scheduled PPS has no payment days because another required assessment take effect (e.g., a subsequent COT or EOT) but the resident was not discharged from Part A, the COT will NOT be considered a missed assessment.

—Facility staff may set a separate ARD for a separate COT, when a COT is due in the window for a scheduled PPS MDS, but the scheduled PPS MDS is completed separately without it. If the resident is discharged prior to the first payment day for the scheduled assessment, the COT may be completed within 14 days of the ARD, because the ARD was set in the correct timeframe for the MDS being performed.

4. Question: Do facility staff transmit the scheduled PPS MDS completed for residents on Medicare Part C (Medicare Advantage/Medicare HMO)?

Answer: No, Medicare Part C PPS MDS are NOT to be transmitted to CMS. From page 5-1 of the RAIM3, assessments “completed for purposes other than OBRA and SNF PPS reasons are not to be submitted, e.g., private insurance, including but not limited to Medicare Advantage plans.” Therefore, do not combine Medicare Part C PPS MDS with OBRA MDS that must be transmitted.

Correcting MDS Records: Myth and Reality

Correcting MDS records is one of the most common topics that the state MDS coordinators discuss with people who contact the state for MDS help. Chapter 5 of the RAIM3 discusses MDS corrections in detail so reference that first for answers to any questions about corrections. MDS correction clarifications can be found in the MDS portion of the DADS MDS website (web search "Texas MDS") under "Step 6: Correct your data". After reviewing those two resources, contact the state MDS coordinators with any follow-up questions. The following are some common myths about MDS corrections.

Myth: The state MDS staff can fix mistakes in facility MDS records.

Reality: The state MDS staff is not allowed, and does not have access, to correct facility MDS records. Facilities are responsible for making their own corrections to MDS records.

Myth: The only MDS records that need to be corrected are those with billing issues.

Reality: If there is incorrect data on one or more MDS records (including demographic information such as resident name or social security number) then all MDS records with incorrect data must be corrected. This not only may affect billing but also meets the RAIM3 and state rule requirements that MDS records contain accurate data. Correcting data quality errors also may prevent residents from being listed on the CASPER Missing Assessment report and improves long term care research accuracy.

Myth: There are reasons to inactivate MDS records other than those listed in the RAIM3.

Reality: The only reasons to inactivate MDS records are listed in Section 5, page 5-12, of the RAIM3; only a few "Section A" items qualify. Regardless of the reason for inactivation, new corrected MDS records must be assessed and submitted per the inactivation clarification on the DADS MDS website under "Step 6: Correct your data."

Myth: "I would like to inactivate the modification I just made and do another modification."

Reality: You cannot inactivate or modify part of an MDS record, only the entire MDS record. There is only one copy of an individual MDS record in the CMS database; modifications are not stored separately from the original MDS record. Submitting the original MDS record is like hanging a painting on the wall with a green apple. When a facility submits a modification, and changes an item in the MDS, the original MDS record in the CMS database is replaced by the entire, new modified version of the MDS record. The painting with a green apple is taken down and replaced by a painting with a red apple (the apple being the modified MDS item). If an inactivation is sent, the entire MDS record is permanently removed from the active database. Likewise, the painting of the red apple is permanently removed from the wall. Instead of using an inactivation to fix an incorrect modification, send another modification that corrects any incorrect items. In the analogy, we would replace the painting of the red apple with a painting of a yellow apple.

MDS Coding Tip: Documentation

A physician's order alone is never proof that a resident received specific care or services, it is only proof the care or services were ordered. To provide evidence the resident actually received the care or services, especially during Resource Utilization Group (RUG) reviews, nursing facility staff must be able to produce appropriate supporting documentation. For example, a resident's Medication Administration Record may provide documentation a medication was administered while a resident's Treatment Administration Record may provide evidence a treatment was completed.

MDS News in Review

- June 2012 - CMS posted information related to monitoring the impact of certain FY 2012 policy changes on various aspects of the SNF PPS. For a frequency of rehabilitation RUGs and other MDS PPS statistics monitored by CMS, click the "SNF Monitoring" link at http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Spotlight.html
- June 29, 2012 - CMS posted the MDS 3.0 QM User's Manual V5.0 and errata.
- August 15, 2012 - Under "Step 1: Take Training" of the DADS MDS website, the "MDS training in Texas" section has been revised.
- August 15, 2012 - CMS posted the updated jRAVEN 1.1.5.1 software. Please download and install the newest version if you use jRAVEN.

Discharge versus Death in Facility

If a resident qualifies for a Discharge assessment, the resident no longer qualifies for a Death in Facility tracking record, and vice versa. Facilities need only send one, not both. In fact, sending both a Discharge and a Death in Facility record makes MDS reporting and long term care research more difficult and may skew the results of the report or research. After reviewing pages 2-34 to 3-36 of the RAIM3, it will be clear:

Example 1: If a resident leaves the nursing facility for any reason, is then admitted to a hospital, and then dies, the facility submits a Discharge assessment, not a Death in Facility tracking record.

Example 2: If a resident leaves the nursing facility, and dies in the ambulance on the way to the hospital, then the facility submits a Death in Facility tracking record, not a Discharge assessment, because the resident is considered on a Leave of Absence.

Example 3: A resident leaves the nursing facility at 2 PM on Monday and arrives at the hospital for what is intended to be a 23 hour observation stay. The resident is not admitted to the hospital and dies at 3 PM on Tuesday while still at the hospital. A Discharge assessment is required, not a Death in Facility tracking record, because the resident died while out of the nursing facility over 24 hours for a hospital observation stay. Even though hospital staff ordered a 23 hour observation stay, the actual time the resident was out of the nursing facility prior to dying at the hospital was 24 hours or greater, so it no longer qualifies for a Leave of Absence.

Section B - Vision

RAIM3 Coding Instructions for item B1000 on page B-10 state:

Code 0, adequate: if the resident sees fine detail, including regular print in newspapers/books.
Code 1, impaired: if the resident sees large print, but not regular print in newspapers/books.

The addition of the words "with glasses or other visual appliances" just means that if residents use them, the facility is to assess the adequacy of vision with these assistive devices in place. The code would be "0 – Adequate," if the resident sees fine detail with or without visual appliances.

RAIM3 Coding Instructions for item B1200 on page B-12 state:

Code 0, no: if the resident did not use eyeglasses or other vision aid during the B1000, Vision assessment.
Code 1, yes: if corrective lenses or other visual aids were used when visual ability was assessed in completing B1000, Vision.

B1200 would be coded as "0 - No," if no corrective lenses (contacts, glasses, or magnifying glass) were used to complete B1000.

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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.