MDS 3.0 Update

Region V
Long Term Care
Provider Association Meeting
December 8, 2010
Christine Vause

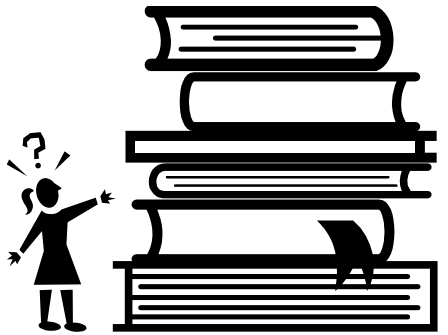
Agenda

- Revisions to State Operations Manual (SOM)
  - Temporary modifications to survey process
  - Revisions to Interpretive Guidelines
- Transmissions update
- Clarification of frequently asked MDS 3.0 coding questions
- Resources/References

Updates to State Operations Manual (SOM)

Appendix P- changes to survey process and some forms

Appendix PP- no changes in regulatory wording but changes in Interpretive Guidelines



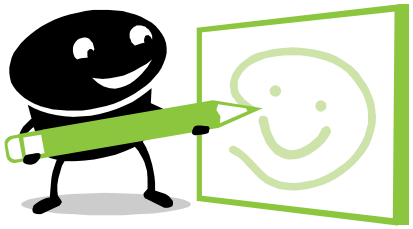
Appendix P Changes

- Temporary changes in survey process due to:
  - Temporary inability to run Quality Measure/ Quality Indicator (QM/QI) reports
  - Inability to select offsite sample and concerns based on MDS data

Changes to Offsite Sample Selection

- Reverts to pre-1998 process (prior to QI/QM's)
- Offsite selection of concerns/residents will be based on the following:
  - Results of complaint investigations
  - Previous CMS-2567
  - CASPER 3 & 4 reports
  - Info from Ombudsman
  - Waivers and variances
  - Other pertinent information
  - At entrance conference, the Administrator will be given copies of the CASPER 3 and 4.

Questions for Providers

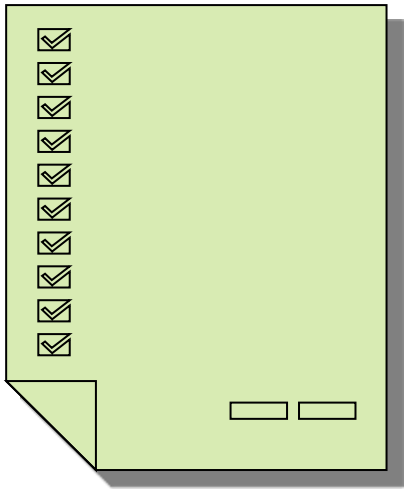


- Who will tour with the surveyors? Who is knowledgeable regarding the **current** condition and care needs of the individual residents?

- How else can data be obtained data for use by the facility's QA committee? QI/QM reports unavailable for facility use in guiding **internal** Quality Assurance or Quality Improvement activities.

Changes in Survey Forms
CMS-802

- CMS-802 "Roster/Sample Matrix"
- Changes because of references to MDS 2.0 coding
- Separation of data
  - Falls/Fractures
  - Abrasions/Bruises
  - Behavioral symptoms
  - Depression



- Includes changes to the provider instructions

CMS-802
Impact for Providers

Facilities must manually code:

- Fecal impaction
- 9 or more medications
- Range of motion/contractures (for neck or anything else not represented by MDS data)
- Activities
- Language/communication
- Specialized rehab (“H” for health rehabilitative services MI/MR)
- Assistive devices (assistive devices for eating)

CMS-672
"Resident Census & Conditions of Residents"

- No revisions to the actual form
- Revisions were made to the form's instructions for finding required data on the MDS 3.0
- Facility must manually code some fields

CMS-672
Impact for Providers

Facilities must manually code:

- Bedfast residents
- In chair all or most of time
- Contractures (code manually for neck)
- Psychiatric diagnosis (code manually for any not listed on MDS 3.0)
- Dementia (code manually for any types not listed on MDS 3.0)
- Behavioral symptoms
- Receiving health rehab services for MI/MR
- With rashes

Manual coding (cont)

- Ostomy care
- Receiving injections (omit B-12)
- Assistive devices with eating
- Residents who do not communicate in the dominant language of the facility
- Non-oral communication devices
- Advanced directives
- Received influenza vaccine
- Received pneumococcal vaccine

Appendix PP- Changes in Interpretive Guidelines

GENERAL CHANGES

- References to coding MDS 2.0 items
- References to CAAs, ARDs, timing and definitions
- References to electronic storage of MDS data, discharge assessments, entry tracking records

Revisions to Requirements

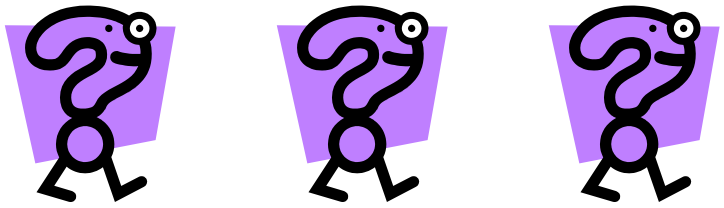
- F272 Resident Assessment
  - Replaces terminology of RAPs with CAAs
  - Directs that the CAA process needs to be documented for each resident

- F274 Significant Change Assessments
  - Guidelines now include that a significant change assessment is generally indicated when a resident elects or revokes the hospice benefit
  - Provides clarification of other criteria for significant change of condition to more closely match the MDS 3.0 RAI Manual

Revisions to Requirements (cont)

- F286 Medical Records
  - Maintain 15 months of MDS records in active clinical file
  - MDS data may be maintained electronically regardless of whether the entire record is electronic
  - If the facility does not have an electronic signature process, a hard copy of the signature page must be maintained in the active record
  - Must be kept in a central location

F286 Questions for Providers



- How can MDS records be made readily accessible to all professionals (consultants, physicians, etc.)?

- What preparations can be made to have MDS information “readily and easily accessible for review by the State Survey agency and CMS”?

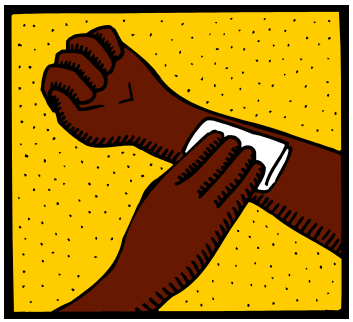
Revisions to Requirements (cont)

- F287 requirements regarding MDS transmission:
  - Replaces transmission to the State with transmission to the CMS/MDS System
  - Replaces *monthly* transmission with transmission *within 14 days*

Revisions to Requirements (cont)

- F310 ADL's
  - Definitions regarding resident's ability to perform Activities of Daily Living (ADL's) revised to meet the MDS 3.0 RAI Manual
  - Did the CAA identify the residents strengths and needs?

Revisions to Requirements (cont)



- F314 Pressure Ulcers
  - Changes in language regarding staging of pressure ulcers
  - References changed to match MDS 3.0 RAI Manual
  - Staging according to National Pressure Ulcer Advisory Panel (NPUA)

Transmissions Update

- Assessment Submission and Processing (ASAP)

  system issues regarding transmission “have been resolved.”

  Any comments???

- Transition from MDS 2.0 to MDS 3.0
  - Only for the first MDS 3.0 assessment- item A0310E should be coded a “1” yes for all existing residents
  - If such assessments have been coded as ‘0” (no) then the assessment needs to be corrected
  - Future assessments should be coded based on the resident’s status at the time of assessment

Impact of Submission Issues on Providers

- ASAP system experienced delays in record editing and validation report creation in the early stages of MDS 3.0 implementation.
- Some problems were related to MDS 3.0 vendor software issues
- F287 requires LTC facilities to transmit MDS data within 14 days

Compliance Issues
F287

- ASAP system date stamp that file has been received will be considered evidence that the MDS was transmitted timely
- If the facility is not in compliance with the timeframe (which is not a result of the ASAP's transmission issues) F287 will be cited as a level one deficiency.

Submission Issues Impact (cont)

- Scope/Severity will be an “A”, “B”, or “C” depending on how many assessments were not transmitted in a timely manner.

- **This will only be in effect from October 1, 2010 to December 31, 2010**

CLARIFICATION OF MDS CODING QUESTIONS

Frequency of Interviews

- At this time frequency will remain unchanged
- The intent of the interviews is to ensure resident needs are not inadvertently overlooked- the status of a resident can change abruptly- thus what may appear as a “redundant” interview is actually a “safety valve” for each resident
- CMS will re-evaluate the frequency of interviews and provide updates as deemed appropriate

Section M- Pressure Ulcers

Present on Admission:

- For each pressure ulcer, determine if it was present at the time of admission and not acquired while the resident was in the care of the Skilled Nursing Facility
- Review for location and stage at time of admission or reentry. If the pressure ulcer was present on admission and subsequently worsened to a higher stage during the resident's stay, the pressure ulcer is coded at that higher stage, and **that higher stage should not be considered as "present on admission."**

Section M- Pressure Ulcers (cont)

- If the pressure ulcer was unstageable on admission and becomes stageable later, it should be considered as "present on admission" at the stage at which it first becomes stageable. If it subsequently worsens to a higher stage, **that higher stage should not be considered "present on admission."**

Section M- Pressure Ulcers (cont)

- If a resident who has a pressure ulcer is hospitalized and returns with that pressure ulcer at the same stage, it **should not be coded as "present on admission" because it was present in the facility prior to the hospitalization.**
- If a current pressure ulcer worsens to a higher stage during a hospitalization, it is coded at the higher stage upon reentry and **should be coded as "present upon admission."**

Section M- Pressure Ulcers Considerations for Providers

- Adequate training of nurses who are assessing the resident's skin on admission or readmission from the hospital
- Treatment/Wound Care nurses should have consistent, up-to-date training in wound assessment including measurements, staging, and treatment options
- Thorough periodic documentation of the wound on admission and throughout the resident's stay
- Clear, concise documentation of the wound's status at the time the resident is sent to the hospital or ER

Section N- Medications Received

- Medication categories should only be checked if the resident received a medication that's approved use falls into the specified category. Do no code "off label" use of medications.
- For example, oxazepam (Serax) may be used as a hypnotic, but its pharmacological classification is as an antianxiety medication. It should be coded as an antianxiety medication.

Section O- Isolation of Infections

- Code only when the resident requires strict isolation or quarantine alone in a separate room because of active infection with a communicable disease, in an attempt to prevent the spread of illness.
- Do not code this item only if the resident has a history of infectious disease.
- Do not code this item if the “isolation” primarily consists of body/fluid precautions, because these types of precautions apply to everyone.
- Concerns regarding the coding instructions for Section O item 0100M are being forwarded to CMS-Baltimore.

Section Q- Discharge Plan

- Documents resident stay expectations, discharge planning, and possibility of return to community
- All residents are asked “Do you want to talk to someone about the possibility of returning to the community?”
- The Care Plan/ Discharge Team must work through the CAA for “Return to Community Referral” to identify potential barriers and challenges, consider cognitive skills and deficits and functional/mobility problems.

Community Referrals
Impact for Provider

- It is the facility's responsibility to make a referral to the State-designated local contact agency within 10 business days and document. This is not a regulation and the state can opt for more days BUT referral must be made timely.
- That agency has 10 business days to respond, however, in some more rural areas additional time may be needed.
- Communicate any challenges to family/resident/ referral agency.
- The facility will then continue to do Discharge Planning as they have always done
- Issues? CMS will be reviewing the Section Q coding this Spring.

Clinical MDS Questions

- State Agency RAI coordinators are available for clinical questions on MDS 3.0.
- If unable to answer, questions are forwarded to Baltimore for an answer and then the State RAI Coordinator will respond back to the provider.
- Copies of any answers given to providers by the State RAI coordinator are forwarded to Baltimore who compiles this information.

Technical MDS Questions

- Software issues should be referred to the facility's MDS software provider first
- Each State has an MDS Help Desk for automation and technical questions from providers in their State
- If the State MDS Help Desk is unable to respond to the question, there is a nationwide MDS/Oasis Help Desk:

  mds_help@ifmc.org
- CMS is gathering and compiling data on technical questions and problems too

Reimbursement-related Issues

- Issues are best directed to your MAC (Medicare Administrative Contractor) if related to Medicare reimbursement
- For Medicaid reimbursement issues refer to your state agency first
- If this does not resolve the issue then contact Irvin Thomas, Region V Irwin.Thomas@cms.hhs.gov

Next Steps for CMS

- Continue to evaluate data and comments from initial implementation of MDS 3.0 .
- All comments are valuable and being evaluated
- Re-assess the item set composition and item sets for each assessment (there are currently ten item sets)
- Modify instrument/guidance as appropriate
- Manual/item set update (tentative Spring, 2011)

State RAI Coordinators

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- WI Margaret Katz margaret.katz@wisconsin.gov

- Region V CMS

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  Christine Vause christine.vause@cms.hhs.gov

MDS HELP DESK
Phone Numbers

- Indiana MDS Help Desk 317-233-7206
- Illinois MDS Help Desk 888-586-8717
- Michigan MDS Help Desk 888-324-2647
- Minnesota MDS Help Desk 888-234-1315
- Ohio MDS Help Desk 614-466-0190
- Wisconsin MDS Help Desk 608-266-1718

State Agency Contacts
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- WI Chris Benesh chris.benesh@dhs.wisconsin.gov

Resource Sites

- Revised State Operations Manual- Appendix PP- Guidance to Surveyors: http://www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage_ enter S&C memo 10-33-NH officially posted on 10/01/10
- MDS 3.0 Web site for updates: http://www.cms.gov/NursingHomeQualityInits/25_BHQIMDS30.asp