MDS 3.0 - 2010
Minimum Data Set Training
Oct. 01, 2010 - Ready...Set...Go!

presented by
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OBJECTIVES
- At completion of training attendees will be able to:
  - Become familiar with the different MDS 3.0 forms
  - Understand new coding conventions for retained as well as new MDS items
  - Differentiate between & know when to do resident interviews vs. staff interviews
  - OBRA & Medicare PPS Schedule
  - MDS & Survey Relationship
  - MDS Coding & CAAs & CATs
  - Informational Resources

What is the MDS?
- MDS stands for Minimum Data Set
- Core set of screening, clinical & functional status elements gathered for all residents in NHs/SBs that participate in Medicare and/or Medicaid
- Data is used for:
  - Care planning & management - primary
  - Reimbursement – Medicare PPS - $$$
  - Survey process – State & Federal
  - Reporting on Quality Measures to the public
    • Nursing Home Compare
    • National Quality Initiatives

Does MDS apply to me?
- Yes, a LTC /SB facility, & Licensed by the State, & Certified by Medicare, & have a Medicare /Medicaid Provider # for reimbursement ($$$)
- No, State licensed-only, LTC/SB facility does NOT participate in either Medicare / Medicaid reimbursement & residents reside in non-certified units of your facility

Swing-Bed information in Chapter 2
Confidentiality
- Privacy Act - protects against misuse of confidential, identifiable, pt. data
- Have contractual privacy agreements in place (staff, software vendors)
- HIPAA- Health Insurance Portability & Accountability Act of 1996
- Standards/formats for submitting electronic claims & other health transactions
- See RAI manual more information

What is the RAI?
- Resident Assessment Instrument
- A structured, standardized approach for applying a problem identification process
- Helps NH staff look at residents holistically as individuals for whom quality of life & quality of care are mutually significant & necessary
- Comprised of 3 basic components:
  - MDS version 3.0 (Minimum Data Set)
  - Care Area Assessment Process (CAA)
  - RAI Utilization Guidelines

Who is required to have an RAI?
- Any resident in a LTC certified bed, who has been in the facility 14 days or more
- Applicable Swing Bed Units do the MDS assessment for reimbursement (PPS) and the new discharge assessments
- Not required for licensed only facilities, or for licensed only part of a Medicare/Private facility

Who does the RAI?
- Facilities need policies & procedures for “who does what sections”
  - Federal regulations require the RAI be conducted or coordinated with appropriate participation of health professionals
  - Facility must ensure those who participate have knowledge to do an accurate & comprehensive assessment
- RAI –conducted/coordinated by an RN who signs & certifies assessment complete at Z0500A & B
Resources Needed
- Evidence/research based protocols or tools for assessment & care planning
- Internet Access (up-to-date)
  - CMS
  - IFMC websites
  - QTSO
  - healthfacilities.info

Website Addresses
- MDS & Manuals:
- CMS web-based MDS training:
- IFMC: QM/QI manuals
  - www.qtso.com
- CDPHE - website for training registration, resources, & the MDS Newsletters
  - healthfacilities.info

Review common MDS Terms for training
- MDS - Minimum Data Set
- IDT - Interdisciplinary Team
- ARD - Assessment Reference Date - **A2300**
  - End/start of look-back (observation) period
  - Use entire 24 hrs of the ARD to assess resident
  - Begins at 12:00 a.m. & ends at 11:59 p.m.
- Z0500B date = Completion date of assessment only (not CAAs or care plan)
  - MDS 2.0 was named the “R2b” date
  - Must complete within 14 days of the ARD

ARD Review cont.
- A2300: Assessment Reference Date
  - Midnight to Midnight
  - ARD Oct 01, 2010 or later = MDS 3.0
  - ARD of Sept. 30 or before = MDS 2.0
  - MDS 3.0 ARD now the date used to determine the due date for next MDS
  - Timing compliance = from ARD to ARD

New

Reference the MDS 3.0 Manual
**ARD Review cont.**

- Leave some time between ARD & completion (Z0500B) because only a few instances when the ARD/completion dates could be the same
- If resident dies on, or before, originally scheduled ARD
  - Adjust ARD to equal (the same) d/c date
  - ARD & Z0500B can = the same date in this case
  - Be sure everything occurring to resident prior to death or d/c is coded on the MDS

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**MDS 2.0 vs. MDS 3.0 & October 1st, 2010 Implementation**

<table>
<thead>
<tr>
<th>ARD 9/30 or earlier = MDS 2.0 form</th>
<th>ARD 10/01 or later = MDS 3.0 form &amp; rules</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARD 9/15 &amp; completed before 10/01/10 = MDS 2.0 rules</td>
<td></td>
</tr>
</tbody>
</table>

- If ARD 9/30 (MDS 2.0 Form) but completed 10/01 or later, then the next MDS = 1st MDS 3.0, but based on MDS 2.0 R2b date of 10/01 or later date.
- Then 2nd MDS 3.0 will be based on the ARD of the prior MDS 3.0 form - ARD to ARD (3.0 rules)

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**Review of Terms cont.**

- **ASAP** - Assessment Submission and Processing
- **CASPER** (MDS reporting system) Certification and Survey Provider Enhanced Reports
- **QM/QI** & Provider MDS reports
- **Z0500B** - Attestation of Assessment Completion date & Signed by RN Assessment Coordinator
  - Z0500B date determines compliance with Federal assessment timing regulations
  - completion can be no more than 14 days from ARD

Reference MDS 3.0 Manual

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**Review of Terms cont.**

- **Care Area Assessment = CAA**
- CAA process replaces RAP process & includes:
  - Care Area Triggers (CATs) similar to RAP triggers
  - Review of Care Areas uses evidenced based tools, expert endorsed research, clinical practice guidelines & other resources.
  - Chapter 4 - RAI Manual contains the CAA process information; Appendix C contains the CAAs themselves

Reference the MDS 3.0 Manual
Review of Terms cont.

- V0200B2 – Completion Date for CAAs
  - No later than 14th day of stay for an Admission (entry day +13) or,
  - No later than 14 days after ARD (A2300) of a Comprehensive MDS, – Annual, SCSA, etc.
  - V0200B2 = Federal timing compliance date
  - Replaces VB2 date for MDS 2.0
  - Not on a Quarterly, Discharge or PPS assmt.
    • No change for MDS timing compliance

Reference MDS 3.0 Manual

Review of Terms cont.

- V0200C2 – Completion Date for Care Plan
  - No more than 7 days after CAA date – no change

- OBRA - Omnibus Budget Reconciliation Act

- PPS – Prospective Payment System - $$$
  – PPS MDS mandated by the Balanced Act 1997 – for Medicare Part-A SNF stay - Reimbursement

Reference the MDS 3.0 Manual

Review of Terms cont.

- OMRA - Medicare PPS assessment for start or end of therapy; & resident still requires skilled nursing
- CMS - Centers for Medicare & Medicaid Services
- ADL – Activities of Daily Living
- QIES - QIES Technical Support
- IFMC – Iowa Foundation for Medical Care
- NH = Nursing Home
- SB = Swing Bed unit
- LTC = Long Term Care

Reference the MDS 3.0 Manual

More Abbreviated items

- Due to limited space in slides, these words may also be abbreviated:
  - Assmt. = Assessment
  - SCSA – significant change in status assmt.
  - d/c = Discharge
  - PU = Pressure Ulcer
  - DTI = Deep Tissue Injury
  - tx. = Treatment
  - Rx. = Medication

Reference the MDS 3.0 Manual
MDS 2.0 to MDS 3.0
A New Direction …

- Resident characteristics & LTC have changed in the past 20 years
- Improvements in assessment methods & tools = improve the relevance, accuracy & validity of data
- Need to increase resident’s voice through more resident interview items
- Request to increase user satisfaction & usability of information

What will MDS 3.0 do?

- MDS 3.0 has been designed to improve:
  - Reliability
  - Accuracy
  - Usefulness/clinical relevance
  - Increase discharge to community options
- Enhanced accuracy supports:
  - Legislative intent that MDS be a tool to improve clinical assessment
  - Credibility of programs that rely on MDS data

Focus on Resident Voice

- **MDS 3.0 focuses on obtaining more information through new resident interviews**
  - When resident interview is not possible, Staff assessment is conducted
  - Also coding decision points to allow resident interview to stop & proceed to staff interview
- Helps ensure residents attain/maintain highest practicable well-being through increased
  **resident-centered care**

Where does MDS information come from?

- **Multiple methods**
  - Observation
  - Interview
  - Record Review
- **Resident MDS data from multiple sources**
  - Resident, Resident, Resident
  - Family, significant others
  - Physician
  - Clinical record
  - Clinical staff (IDT)
New Features of MDS 3.0, 10/01/2010

- Structured Resident Interviews
- DISCHARGE - now a resident assessment
- Deleted d/c prior to 14th day & no Admission completed item (was d/c – 08)
- More instructions, definitions, clarifications included on MDS 3.0 forms
  - Larger font & more user-friendly formatting
  - Separate page for most MDS sections

New Features of MDS 3.0

- Admission MDS 3.0 – a new criteria
  - Never Admitted to NH/SB before (initial)
  - Previous Resident of NH/SB, but discharged return NOT anticipated
  - Previous Resident of NH/SB, but discharged return anticipated, & just returned to NH/SB after a 30-day absence
  - some training language states: “resident d/c’d return anticipated, but NO return within 30 days” – same concept

New MDS 3.0 Look Back Periods

- Most items = a 7 day look-back period
- The following items have different time frames:
  - D0200 or D0500 - Mood items = last 14 days
  - J0100 - J0850 Pain items = last 5 days
  - J1700 - J1900 Falls = some new criteria
  - O0100 – Special Treatments/Procedures = last 14 days

RAI User’s Manual Version 3.0

- Changes in all Chapters
  - Source for completion of MDS
  - 6 chapters, appendices & index
    - Chapter 1: Overview of the RAI
    - Chapter 2: Assessments for the RAI
      - Types of Assessments – OBRA & PPS
      - Schedules for completion
      - Significant Change in Status when Hospice chosen
**MDS 3.0 Chapter 2 – Some New Changes**

- **A2300: Assessment Reference Date**
  - The ARD remains the end point of the observation period; **now also the date used to determine when the next MDS is due**

- **A2400: Medicare Stay**
  - Asks if resident has had a Medicare covered stay since most recent entry, & if so, what was the start date & end date of that stay

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**MDS 3.0 – Chapter 2 – New Changes**

- **Significant Change in Status**
  - Required when hospice is chosen
  - For those with a PASRR Level II evaluation

- **Discharge/Entry tracking**
  - Discharge tracking requires an assessment, except for death in facility
  - No longer discharge prior to initial assessment
  - Entry record – 2 types Admission & re-entry

- **PPS assessments**
  - End of therapy OMRA—ARD time frame change
  - New instructions r/t billing at default rate

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**MDS 3.0 Chapter 3**

- **Chapter 3, Item-by-item guide to MDS**
  - New scripted resident interviews required in 4 areas: Cognition, Mood, Routine & Activity Preferences, & Pain
  - New ADL coding choice for activity occurred less than 3 times, new flow chart (algorithm)
  - Pain management added
  - New Mathematical rounding for height & weight

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**MDS 3.0 Chapter 3 cont.**

- **Chapter 3 cont.**
  - Pressure ulcer assessments adapted NPUAP guidance - no more back staging
  - Capture PU present prior to Admission and/or those PUs occurring while hospitalized
  - Special treatments capture “while not a resident” and “while a resident”
  - PT, OT, SP/L minutes separated into individual, concurrent & group
  - New expanded discharge section Q with focus on return to community & referral
MDS 3.0 Manual

- Chapter 4: CAA Process & Care Planning
- Chapter 5: Submission & Correction
- Chapter 6: Medicare SNF/PPS
- Appendices & Index:
  - Glossary of Terms, State & Federal contacts, CAA Resources, Interviewing tips, CPS scores, MDS Item Matrix Resources

MDS & Care Planning

- Care planning remains the major focus of MDS
- MDS = Foundation of a resident’s care plan
- Snapshot of a resident taken at the time of the assessment
- Inaccurate MDS data easily leads to an inaccurate plan of care
- Accurate care plans help residents achieve their goals & reach their highest practicable levels of well-being

OBRA MDS - What? & Why?

- MDS assessments & schedule - Federal regulations, 1987 (42 CFR 483.20)
  - Clinical/functional assessment
  - Over 705 MDS items
- Quality-of-care & Quality-of-life issues
- State Operations Manual (SOM)

9 federal MDS tags for OBRA Assessments

- F272 - Resident assessment using the RAI
- F273 - Admission assessment
- F274 - SCSA (Significant Change Status Assessment)
- F275 - Annual assessment
- F276 - Quarterly assessment
- F278 - Accuracy of assessments
- F279 - Comprehensive care plans
- F286 - Maintain 15 months of MDS data
- F287 - Accurate Encoding & transmitting the MDS
MDS 3.0 Coding Conventions

- Does not include data from a hospital stay except for certain items in limited sections
- Check-mark those items that say “check all that apply” if specified conditions are met
- If conditions not met, leave boxes empty
- Use numeric response for MDS items that require a coded response

More MDS 3.0 Coding Conventions

- Z = none of the above apply (New)
- 9 = Unable to answer (New)
- - = item not assessed, code a dash
- Some items have skip patterns—when encountered leave those “skipped” items blank
- When a resident interview is required this symbol is present

MDS 3.0 Resident Interviews

- Ask all residents capable of any communication for information about what’s important in their care
- Interviewing = collaborative process
- 4 specific areas of MDS 3 require direct resident interview - primary source of information if possible
  - Cognition – special criteria to follow
  - Mood
  - Routines & Activity Preferences
  - Pain

MDS 3.0 Interview Basics

- Basic approaches to increase effectiveness:
  - Establish rapport: Introduce yourself, find a quiet, private area, & explain purpose of questions
  - Sit where resident can see you clearly, & be sure resident can hear what you are saying
  - Ask if resident would like an interpreter
  - Ask questions as written, say & show item responses – cue cards – large print
  - Break the questions apart if necessary
MDS 3.0 Interview Basics

- If resident unable to answer a question, move on to another question
- Break up the interview if resident becomes tired – Except for the BIMS (Section C) all in 1 session
- Don’t try to talk the resident out of an answer
- Record the resident’s response
- Respond to resident feelings
- Encourage resident to verbalize their desires

MDS 3.0 General Coding Tips

- For most assessment items it will be obvious what code, or number to select
- At times, you may need to just jot down the response on form & go back later to calculate the answer
- Do not interrupt the flow of the interview to do your calculations

MDS 3.0 Staff Interviews

- When residents are unable, or refuse, to participate in the 4 specific resident interview items, do a staff assessment
- Staff assessments/observations focus on the same questions/items as the resident interview
- Staff will base their responses on observations made of the resident during care & activities

MDS 3.0 Documentation Guidelines

- MDS - primary source document & duplicative documentation not required, but ...
- MDS completion doesn’t remove facility’s responsibility for more detailed assessments or documentation of a relevant care issue
- An expectation of trained/licensed health care professionals & good clinical standards of practice

NO CHANGE
MDS 3.0 Guidelines cont.

- Assessments conducted/ coordinated by a RN
- RN may delegate MDS completion to clinical staff knowledgeable about resident
- IDT sign & date in Section Z0400
- MDS RN Coordinator signs & dates after all assessments completed at Z0500A & B

**NO Change in Concept – just MDS Item Numbering**

MDS 3.0 Transmissions/Submissions

- Facility must transmit within 14 days of a MDS completion date (used to be 31 days)
- Must transmit, at least monthly, all MDS assessments & re-entry MDSs from previous month
- There are various MDS timing completion dates
- Review Chapter 2
- Tag F287 = MDS sent more than 14 days after completion

**New for MDS 3.0 - develop a good process now for timely submissions**

MDS 3.0 Submission Time Frames

<table>
<thead>
<tr>
<th>Type of Assessment/Tracking</th>
<th>Primary Reason (A0310A &amp; A0310F)</th>
<th>PPS Reason (A0310B)</th>
<th>Final Completion or Event Date</th>
<th>Submit By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Assessment</td>
<td>A0310A = 01</td>
<td>All values</td>
<td>Z0500C2</td>
<td>V0200C2 + 14</td>
</tr>
<tr>
<td>Annual Assessment</td>
<td>A0310A = 03</td>
<td>All values</td>
<td>V0200C2</td>
<td>V0200C2 + 14</td>
</tr>
<tr>
<td>Significant Change</td>
<td>A0310A = 04</td>
<td>All values</td>
<td>V0200C2</td>
<td>V0200C2 + 14</td>
</tr>
<tr>
<td>Sign. Correction Full Assessment</td>
<td>A0310A = 05</td>
<td>All values</td>
<td>V0200C2</td>
<td>V0200C2 + 14</td>
</tr>
<tr>
<td>Quarterly Review Assessment</td>
<td>A0310A = 06</td>
<td>All values</td>
<td>Z0500B</td>
<td>Z0500B + 14</td>
</tr>
<tr>
<td>Sign. Correction Prior Quarterly Audit</td>
<td>A0310A = 06</td>
<td>All values</td>
<td>Z0500B</td>
<td>Z0500B + 14</td>
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<tr>
<td>PPS Assessment</td>
<td>A0310A = 09</td>
<td>01 through 07</td>
<td>Z0500B</td>
<td>Z0500B + 14</td>
</tr>
<tr>
<td>Discharge Assessment</td>
<td>A0310F = 10 or 11</td>
<td>99</td>
<td>Z0500B</td>
<td>Z0500B + 14</td>
</tr>
<tr>
<td>Death in Facility</td>
<td>A0310F = 12</td>
<td>99</td>
<td>A2000</td>
<td>A2000 + 14</td>
</tr>
<tr>
<td>Entry</td>
<td>A0310F = 01</td>
<td>99</td>
<td>A1600</td>
<td>A1600 + 14</td>
</tr>
<tr>
<td>Modification or Inactivation Request (X0100 = 2 or 3)</td>
<td>A0310A and A0310F</td>
<td>All values</td>
<td>X1100E</td>
<td>X1100E + 14</td>
</tr>
</tbody>
</table>

MDS & Survey Relationship

- Surveyors review MDS Assessments, RAPs, Care Plans, & QM/QI reports
- Surveyors review medical records, observe/interview resident, family, staff
- If discrepancies found, survey process continues
- Missing Assessments and/or Inaccurate MDS
- Inaccurate Assessments =
  - Inaccurate RAPs, Care Planning
  - Reimbursement - billing

**NO CHANGE**
**Missing and/or Inaccurate MDS**

- MDS Deficiencies cited alone or together with related resident care tags
- Common Causes:
  - MDS not conducted, completed, encoded, submitted, or accepted
  - Only PPS assessments conducted
  - MDS, resident, & chart don’t match

**Some reasons MDS errors found**

- Not actually observing/interviewing
- Carrying over prior Assessment data
- Not using correct observation periods
- Inaccurate or miscoding MDS items
- Lack of communication between IDT
- Facility not using current RAI Manual

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**2 Types of MDS Assessment Schedules**

- **OBRA - clinical - functional**
  - Admission, Quarterly, Annual, Significant Change in Status Assessment (SCSA), Significant Correction, and Discharge

- **PPS - reimbursement - $$$**
  - 5, 14, 30, 60 & 90-day, re-admission /return, Start/End of Therapy, Swing Bed -Clinical Change in Status schedule conducted for Medicare payment

**Types of MDS 3.0 Forms**

- MDS 3.0 assessment forms
  - **OBRA & PPS (Medicare Part A)**
  - Special section for OMRAs
    - Start/End of Therapy
    - Swing Bed clinical change
    - Entry / Reentry or Death in Facility-Tracking form
    - Discharge Assessment
    - Error Correction
MDS 3.0 Assessment Forms

- 13 separate item sets
  - Includes both NHs & Swing Beds
  - OBRA & PPS
- Type of assessment done determines MDS item set required
- Data specifications identify which MDS items are included in each item set
- The forms print out longer (up to 38 pages)

Types of MDS 3.0 Forms & Length

- OBRA
  - Comprehensive = 38 pages
  - Quarterly = 33 pages
  - Discharge = 27 pages
- PPS – 33 pages (same as OBRA Quarterly)
- NH OMRA – Start of Therapy = 12 pages
- NH Start of Therapy & Discharge = 29 pages
- NH OMRA = 20 pages
- NH OMRA and Discharge = 32 pages
- Entry/Reentry or Death in Facility - a Tracking form = 8 pages

MDS 3.0 Item Sets

- NC = Nursing Home Comprehensive
- NP = NH PPS (like the MDS 2.0 MPAF)
- NQ = Nursing Home Quarterly
- ND = Nursing Home Discharge
- NSD = NH OMRA Start of Therapy & Discharge
- NOD = Nursing Home OMRA Discharge
- NO/SO = Nursing Home & Swing Bed OMRA

MDS 3.0 Item Sets

- NS/SS = NH & SBed OMRA-Start of therapy
- NT/ST = NH & SBed Tracking
- SP = Swing Bed PPS
- SSD = Swing Bed OMRA- start of therapy & discharge
- SOD = Swing Bed OMRA Discharge
- SD = Swing Bed Discharge
NH & SB Entry & Discharge Forms

- NEW PROCESS -

- Tracks residents entering & leaving NH/SB
- **Entry Record** – 2 types Admission & Reentry
- A0310F = 01
  - Completed every time person admits or re-enters NH or SB (use NT/ST Form)
  - Complete within 7 days of entry/reentry date, & submit within 14 days
  - Required in addition to initial OBRA or PPS – a stand-alone document
  - Do not combine with any MDS
  - Same submission batch ok, but separate form

Entry Tracking

- **Admission (A1700 = 1)**
  - First OBRA assessment = an Admission
  - Complete every time person admitted for the first time or readmitted following discharge return not anticipated
- **Reentry (A1700 = 2)**
  - Complete every time person readmitted after discharge return anticipated

Those who come & go frequently ...

- For a resident who goes in & out of the facility on a relatively frequent basis, and return is expected within the next 30 days, the resident may be **discharged with return anticipated**.
- This status requires an **Entry Tracking record each time** the resident returns to the facility, and a **discharge assessment each time** the resident is discharged.
- The NH may combine the Admission assessment with the discharge assessment when applicable.

See page 2-19 of MDS 3.0 manual

NH/SB Entry Record Admission Example

- Mr. S. admitted to NH/SB Feb. 5, 2011 following a stroke. Regained most of function & d/c’d home return not anticipated March 29, 2011. 5 months later, Mr. S. had surgery- total knee replacement. Returned to NH/SB for therapy Aug. 27, 2011.

- **Code entry record** for Aug 27, 2011 return:
  - A0310F = 01
  - A1600 = 08-27-2011
  - A1700 = 1

Complete by Sept.3rd (A1600 + 7), submit by Sept. 10th (A1600 + 14).
A separate Admission MDS due by Sept 9th (A1600+13), &/or PPS.
MDS 3.0 Discharge Reporting -A310F

- Each time a resident discharges & returns, a d/c assessment followed by an entry record will be required - Not associated with NH bed hold status or opening & closing of medical record
- Discharge tracking no longer just completion of a form (identifying discharge type & status)
- Exception - “Death in Facility”
- Two categories of Discharge:
  - Discharge assessments
  - Death in facility record

MDS 3.0 Discharge Reporting -A310F

- Completed when resident is discharged from the facility, (see definition of discharge), or when resident is admitted to an acute care hospital.
- Completed when resident has a hospital observation stay greater than 24 hours.
- Completed on a respite resident every time they are discharged from the facility
- May be combined with another OBRA or PPS Medicare required assessment when requirements for all assessments are met

Discharge Assessment

- Discharge return not anticipated
- A0310F= 10
  - Resident leaves - not expected back
  - Complete & submit within 14 days of discharge
  - Demographic, administrative & clinical items
  - If Resident returns = a New Admission assessment required (OBRA & PPS if applicable)

May be combined with another OBRA or PPS

MDS 3.0 Discharge Assessment

- Discharge return anticipated -A0310F = 11
  - Resident d/c’d to hospital & return is expected, or
  - Respite resident who comes in & out frequently & return expected,
  - Complete & submit within 14 days of discharge
  - If Resident just returned after a 30-day absence, an Admission is required, &
  - An entry record is required upon return to facility

May be combined with another OBRA or PPS
Discharge Reporting

- **Death in facility record - New**
  - A0310F = 12
  - Complete when resident expires in facility, or when on a LOA
  - Complete within 14 days after resident's death & submit within 14 days after resident's death
  - Do not complete a discharge assessment or combine "Death in facility" record – A0310F-12 - with other assessment type

Leave of Absence (LOA)

- Temporary home visit
- Temporary or therapeutic leave
- Hospital observation < 24 hours, and Not Admitted
- No requirement for completion of either a discharge or entry record
  - NO CHANGE

A0310A = OBRA Assessments

**Federal Reason for Assessment**

1. Admission
2. Quarterly
3. Annual
4. Significant Change in Status
5. Significant Correction, prior Comprehensive
6. Significant Correction, prior Quarterly
99. NOT OBRA required assessment

and A0310F = OBRA Discharge Assessment

OBRA – Admission (A0310A) = 01

- Resident's 1st entry to facility, after being d/c'd return not anticipated, or if resident returned after a 30-day absence, even if d/c'd return anticipated
- MDS (Z0500B) & CAAs (V0200B2) completed within 14 days of admission (Date of entry +13 days)
- Care Plan completed (V0200C2) within 21 days of admission

- A Comprehensive assessment -
OBRA - Quarterly (A0310A) = 02

- Tracks & monitors resident’s status/gradual onset of change between comprehensive assessments
- MDS (Z0500B) completed within 14 days of ARD (A2300)
- The ARD now drives the due date for completion
- No more than 92 days from ARD to ARD (A2300)

<table>
<thead>
<tr>
<th>If</th>
<th>Then</th>
</tr>
</thead>
<tbody>
<tr>
<td>During Quarterly review, staff determine Care Plan does NOT meet resident’s clinical status &amp;/or needs</td>
<td>A SCSA (A0310A = 4) should be conducted in place of the Quarterly (&amp; Care Plan revised)</td>
</tr>
</tbody>
</table>

NO CHANGE

~ A Comprehensive assessment ~

OBRA - Annual (A0310A) = 03

- Completed following the 3rd Quarterly
- No more than 92 days from prior Quarterly ARD (A2300)
- No more than 366 days from prior comprehensive ARD (A2300)
- MDS (Z0500B) & CAAs (V0200B2) completed within 14 days of ARD (A2300)

~ A Comprehensive assessment ~

OBRA - SCSA (A0310A) = 04

Significant Change in Status

- Required comprehensive assessment
- No later than 14 days after determining a significant change in status has occurred
- SCSA = improvement or decline; either physical or mental
- MDS (Z0500B) & CAAs (V0200B2) completed within 14 days of ARD (A2300)

~ A Comprehensive assessment ~

Review criteria examples in MDS Manual
OBRA - SCSA (A0310A) = 04 (cont.)

- SCSA is defined as a major change that:
  - Is not self-limiting
  - Requires staff intervention
  - Impacts more than 1 area of health
  - Requires Care Plan review/revision
- Know what criteria doesn’t require a SCSA
- Know criteria for Residents with a terminal condition

SCSA - Residents with a Terminal Condition

- CMS requires facilities to complete a SCSA due to the importance of ensuring the coordination of responsibilities & care planning between the facility and the Hospice staff
- CMS requires a SCSA completion with the election or revocation of Medicare Hospice, or other type of structured Hospice.

See pgs. 2-21 & 2-25 in MDS 3.0 manual

SCSA - Residents w/ known or suspected MH/MR/DD

- May need PASRR Level II eval.- Determination made by comparing current status to most recent comprehensive & quarterlies
- PASRR is not a RAI requirement, but an OBRA provision required to be coordinated w/ the RAI.
- Intended to help facilities coordinate PASRR w/ the SCSA
- Referral should be made as soon as criteria is evident, don’t wait until completion of the SCSA

SCSA - Residents w/ known or suspected MH/MR/DD

- Check state PASRR program requirements for specific procedures. PASRR contact for state MH/MR/DD authorities & state Medicaid agency available at: http://www.cms.hhs.gov/
- Provide state authority with referrals, independent of SCSA findings. PASRR Level II functions as an independent assessment process, in parallel with the RAI
- Have a low threshold for referral to SMH/MR/DDA, so authorities may exercise their expert judgment about when a Level II evaluation is needed
OBRA – A0310A = 05 (cont.)

Significant Correction of Prior Full Assessment

- Complete when uncorrected major error discovered in prior comprehensive assessment
- Complete no later than 14 days after determining major error has occurred

NO CHANGE

OBRA – A0310A = 05 (cont.)

Significant Correction of Prior Full Assessment

- Major error:
  - Resident’s overall clinical status has been miscoded on MDS
  - Care Plan derived from erroneous assessment does not reflect resident’s clinical status or meet their needs

NO CHANGE

Review of OBRA MDS Assessments

- Admission – within 14 days of entry
- Annual – minimum every 366 days (from ARD)
- Significant Change – promptly, within 14 days of determination of a Sig change
- Quarterly – no less frequently than once every 92 days (from ARD)
- Discharge Assessment

OBRA Assessments Used Most Frequently

Review OBRA MDS Schedule

- Admission = completion no later than day 14
- Quarterly – 92 days from ARD to ARD
- Quarterly – 92 days from ARD to ARD
- Quarterly – 92 days from ARD to ARD
- Annual = no later than 366 days from prior comprehensive ARD & no later than 92 days from prior quarterly ARD

What happens to schedule after SCSA?
Question:

What are the MDS OBRA Admission assessment completion date requirements?

Answer: The initial Admission MDS must be completed (Z0500B & V0200B2) no later than Admission day + 13 days = 14th day.

NO CHANGE to rules, just coding numbers.

Question:

How many days after the ARD must an Annual, SCSA, or Quarterly MDS assessment be signed as complete?

Answer: An Annual, SCSA, or Quarterly MDS must be signed complete at Z0500B no later than 14 days after the ARD.

NO CHANGE to rules, just coding numbers.
**Question:**
What MDS item determines the end of the observation (look-back) period?
- a) A2300 – ARD (old A3a)
- b) Z0500B (old R2b)
- c) V0200B (old VB2)
- d) V0200C (old VB4)

**Answer:** (a) ARD - A2300.
Use all 24 hours of every observation day.

**NO CHANGE to rules, just coding numbers.**

**Question:**
An OBRA Admission requires completion of the ??? to be no later than day 14 of the resident’s stay?
- a) Z0500B
- b) V0200B2
- c) V0200C2
- d) All of the above
- e) a and b

**Answer:** (e) a and b.

**NO CHANGE to rules, just coding numbers.**

**Question – True or False?**
When scheduling an Annual MDS assessment, one must only consider the last annual completion date.

**False.** Consider the last ARD dates for both the prior Quarterly, and the prior OBRA Comprehensive MDS.

**NEW**

**Question:**
Is a new Admission MDS completed on any resident you discharged to hospital as “return anticipated” & resident returned in less than 30 days?”

**Answer: NO.**
Code A1700 as a reentry
Components of PPS - Eligibility $$$

- Required by Balanced Budget Act -1997 for (SNFs) for Medicare Part A beneficiaries
  - Phased in beginning 7/01/1998
  - Swing Beds added in 2002
- Medically necessary 3-day hospital stay, & receive Part A care within 30 days of qualifying hospital stay
- Receive skilled nursing, rehabilitation, or both
- Part A care needed for condition treated during qualifying hospital stay

Review Medicare SNF Manual for all PPS regulations

PPS (cont.)

- Uses specific MDS items for PPS evaluation of resident's condition - e.g.,
- Resident’s ADLs & cognitive status, behavioral problems & medical diagnosis
- Classifies into $$$ groups that represent direct care resources needed
  - Resource Utilization Groups = RUGs

Medicare - PPS Assessments - $$$

- Classify residents into different resource utilization groups
  - MDS 2.0 = RUG III - 53 Grouper
  - MDS 3.0 = RUG IV - 66 Grouper
- Completed periodically within a designated PPS assessment schedule
  - NOT the same assessment schedule as OBRA MDS, though can be combined if compliance dates coincide

PPS (cont.)

- 8 major classification groups
  - Rehabilitation plus extensive services
    - Rehabilitation
    - Extensive services
  - Special care
  - Clinically complex
  - Impaired cognition
  - Behavior problems
  - Reduced physical function
Medicare – PPS Assessments – $$$

- MDS utilized to calculate reimbursement - $$$
- Determine changes in care – Start/End of Therapy -still require Skilled Nursing - Other Medicare Required Assessment (OMRA)

May Combine PPS with MDS Schedule

A0310B - PPS Medicare Assessments $$$

Code:
- 01 = 5-day
- 02 = 14-day
- 03 = 30-day
- 04 = 60-day
- 05 = 90-day
- 06 = Readmission/return
- 07 = Unscheduled assessment used for Medicare PPS (OMRA, SCSA, Clinical Change, Sig. Correction)
- 99 = Not PPS assessment

A0310B – Medicare PPS Assessments $$$

<table>
<thead>
<tr>
<th>PPS Assessment</th>
<th>ARD (Grace days)</th>
<th>$$$ Days</th>
<th>Completion Date (Z0500B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-Day Readmit/return</td>
<td>1-5 (6-8)</td>
<td>1-14</td>
<td>Within 14 days of ARD</td>
</tr>
<tr>
<td>14-Day</td>
<td>11-14 (15-19)</td>
<td>15-30</td>
<td>Within 14 days of ARD</td>
</tr>
<tr>
<td>30-Day</td>
<td>21-29 (30-34)</td>
<td>31-60</td>
<td>Within 14 days of ARD</td>
</tr>
<tr>
<td>60-Day</td>
<td>50-59 (60-64)</td>
<td>61-90</td>
<td>Within 14 days of ARD</td>
</tr>
<tr>
<td>90-Day</td>
<td>80-89 (90-94)</td>
<td>91-100</td>
<td>Within 14 days of ARD</td>
</tr>
</tbody>
</table>

A0310B – 5-day vs. Readmission/Return PPS

- 5-day Medicare PPS
  - First (initial) Medicare-required assessment –opens the 100 day period
  - Must have at least one 5-day assessment
- Readmission/ Return Medicare PPS
  - Conducted when during a SNF Part A stay, resident is hospitalized (d/c RA), readmitted and continues to require/receive Part A SNF-level of care

NO CHANGE
A0310C - PPS Other Medicare Assessments

OMRA - $$$

Code:
0 = No
1 = Start of Therapy assessment
2 = End of Therapy assessment
3 = Both Start & End of Therapy assessment

Start of Therapy (SOT) OMRA -optional
– Completed only to classify a resident into a RUG-IV Rehab + Extensive or Rehab group
– Will be Rejected if non-therapy RUG – cannot be used for Medicare billing
– Must Set the ARD 5-7 days after Start of Therapy
– Be attentive to Case Mix Indices (CMI)

End of Therapy (EOT) OMRA
– Required to establish a new non-therapy RUG but still requires SNF services - see item 20150
– 1st non-therapy day is day #1
– Day 1 = 1st day therapy services would normally be provided - Important – gives facility & therapy an option to determine this date
– Must Set the ARD 1-3 days after all Therapy Ends & Skilled Nursing continues

MDS 3.0 Combining PPS Assessments

– NEVER combine PPS scheduled assessments
– May combine scheduled PPS with unscheduled PPS assessment (Section 2.10 in manual)
– May combine any PPS with any OBRA assessment
– Pages 2-49 to 52 in MDS manual
PPS & Events before 8th Day of SNF stay

- Expires in the facility or while on a LOA, transfers, discharges to NH bed (not a SNF bed), discharges from facility
  - Complete PPS assessment as best as possible to get a RUG assigned – otherwise a default rate
  - No assessment = default
  - Short Stay Assessment policy may apply – Rehabilitation +Extensive Services or Rehab RUG only
  - Refer to Chapter 6, Section 6.4 for details

PPS - Admitted to Hospital & Returns

- Even if admission is less than 24 hrs, and/or not over midnight – PPS schedule is restarted
- If coded as "Discharge return Anticipated"
  - Code 1st PPS as a Readmission/Return
  - If coded as "Discharge return NOT Anticipated"
  - Code 1st PPS as a new 5-day Medicare, as long as resident still eligible for Part A skilled services, and has remaining days left in benefit period

The type of Discharge completed determines whether a 5-day or return/re-admission PPS

PPS – Not Admitted to Hospital & Returns

- Out over midnight, but less than 24 hrs, and NOT admitted to Hospital – PPS schedule is NOT restarted
- Payment implications though
- Day preceding that midnight is NOT a covered Part A day – "midnight rule" – resident not there
- Adjust Medicare schedule by skipping the “absent day” in calculating when the next PPS assessment is due
- E.g. – resident to hospital on Weds. Day 22 at 10 p.m. & returns at 5 a.m. Thurs., next day. Weds is not billable. Day of his return, Thurs. becomes Day 22 of Part A stay

NO CHANGE

PPS – Resident leaves & returns during Observation Period

- The ARD is not altered if beneficiary is out of the facility for a temporary LOA during part of the observation period
- In this case, the facility may include services furnished during beneficiary’s temporary absence (when permitted under MDS coding guidelines; see Chapter 3), but may not extend the observation period
- See Chapter 2, pgs 2-62 to 65 for many other examples on factors that impact the PPS schedule
Question:
Medicare resident has already had 5 & 14-day PPS completed. Returns to hospital, Admitted, then comes back to SNF. What MDS Medicare assessment form is coded next?

Answer: Code A0310B = 06 Medicare readmission/return assessment

Chapter 6 - MDS & PPS Impact

- Data collected used to update payment systems for Medicare & Medicaid facilities
- Based on analysis of findings, CMS developed the RUG-IV classification system that uses MDS 3.0 data elements
- CMS has both Conference Calls re: SNF/PPS but also on their website are spreadsheets, power-point slides and other information
- www.cms.gov/SNFPPS/02_Spotlight.asp

Expected Order of MDS Records

- See pg. 2-65, and Charts on pgs. 2-66 to 67
- For example, the 1st record for a resident is:
  - an Entry record with entry type (Item A1700) indicating an admission,
  - and the next record is an Admission MDS, a 5-day PPS, a Discharge, or Death in facility
- The QIES ASAP system will issue a warning when an unexpected record is submitted
  - No ASAP system warnings for Swing Beds
RUG IV Criteria

- Classifications
  - Special Care divided into High and Low
  - Combined Behavior and Impaired Cognition
  - 8 groups with 66 categories
  - Section O changes
    - Only services “while a resident” in NH = $$
    - Columns for “while a resident & NOT a resident”
    - Certain conditions/services added or removed resulting in placement in different categories
    - Concurrent Therapy is divided in half for calculating the RUG

RUG IV Criteria, cont.

- ADL
  - Used as split within most categories (not Extensive Services)
  - Index scores have been recalibrated with range from 0-16
  - Minimum score for many categories is a 2
  - 5 conditions require a minimum score of 5
  - Support provided now also used with Eating
  - IV/ Parenteral & TF not calculated with Eating ADL

RUG IV Criteria, cont.

- Depression
  - Used as end split for Special Care (high and low) & Clinically Complex
  - Total Severity Scores from PHQ-9 or PHQ-9-OV used

- Restorative Nursing
  - Used as end split in Behavioral Symptoms & Cognitive Performance & Reduced Physical Function
  - Used also as qualifier for RLX, RLB & RLA

RUG IV Criteria, cont.

- Cognitive Performance
  - BIMS
    - Summary Score of 9 or less
  - CPS
    - Moderate to severe impairment with a score of 3 or more

- OMRA
  - Start and end of therapy
  - Medicare Short Stay
**Additional Training Opportunities**

- CMS plans to produce multimedia materials including:
  - Distribution of CDs and/or DVDs
  - Satellite webcasts planned for early & late summer to cover item-by-item coding & impact of MDS 3.0 on Survey & Payment
  - A Web Based training program is being developed & will post on the CMS website late summer
  - Updates to MDS 3.0 manual post on CMS website

**Additional Training Opportunities**

- CMS plans to publish a document listing which item set should be used for each assessment type
- CMS plans to format & post these tools in an appendix in the MDS 3.0 Manual & on their Web site

**Begin Review of MDS 3.0 Resident Assessment Items for SNFs & Swing Bed Units**

**RAI MDS 3.0 Manual Guidelines**

- **Intent:** Explains what to code/record
- **Definition:** Explains key terms
- **Process:** Information sources & methods for determining correct response
- **Coding:** Item-by-Item instructions on how to answer each MDS item
Section A – Identification Items

- **Intent**: obtain unique, key information to:
  - Identify each resident: name, gender, age, etc.
  - Identify the NH/SB in which they reside, & reasons for assessment (RFA)
  - Admission /reentry date(s)
  - Review communication skills (language)

Section A - Identification Information

- **A0100 = Facility Provider Numbers**:
  - A0100A = National Provider Number (NPI)
  - A0100B = CMS Certification Number (CCN)
    - **MEDICARE**
    - A0100C = State Provider Number
      - **MEDICAID**
- **A0200 = Type of Provider**
  1 = Nursing Home (SNF/NF)
  2 = Swing Bed

Section A: Identification Information

- **A0310: Type of Assessment**
  - A0310A - Federal OBRA Reason
    - Admission
    - Quarterly
    - Annual
    - Significant Change in Status
    - Significant correction to prior comprehensive
    - Significant correction to prior quarterly
    - Not OBRA required assessment

- **A0310F – Entry/Discharge**

MDS Assessment Types - Review

- **OBRA Assessments**
  - Comprehensive Assessment = RAI
    - MDS+CATs+CAAs
    - Admission, Annual, Significant Change of Status, Significant Correction of prior comprehensive
  - **Non Comprehensive**
    - Quarterly Assessment, Significant Correction of prior quarterly, **Discharge**
    - No CATs or CAAs
MDS Assessment Types - Review

- **A0310 B: PPS Assessment**
  - **Scheduled**
    - 5, 14, 30, 60, 90, readmission/return assessment
  - **Unscheduled**
    - OMRA, significant or clinical change, significant correction
  - **Not PPS Assessment**

- **A0310C: PPS OMRA**
  - Start of therapy
  - End of therapy
  - Both Start and End of therapy

- **A0310E:** Is this the first assessment since most recent admission?
  - 0 = No
  - 1 = Yes

---

A0410 – A0700 – Identification items

- **A0410 – Submission Requirement**
- **A0500 – Legal Name of Resident**
- **A0600A – SSN #**: If no number available, dash fill all boxes
- **A0600B - Medicare Number**: exactly as it appears on documents
- **A0600B - Medicare Number**: if no information available, dash fill all boxes
- **A0700: Medicaid Number**

A0800 – A1100 Identification items

- **A0800 – Gender**
- **A0900 – Birth date**
- **A1000 – Race/Ethnicity**
- **A1100- Language**: Do they need or want an interpreter?
- **A1100A - Does resident need/want interpreter to communicate with a doctor or health care staff?**
- **A1100B - Document preferred language**
  - Determines if resident interviews should be done for specific assessments in Sections B, C, D and J
More Identification Items

- **A1200** – Marital Status
- **A1300** – Optional Resident Items
  - Medical Record #, Room #,
  - Name resident prefers to be called,
  - Lifetime Occupation
- **A1500** – preadmission screening & resident review (PASRR) – reports on results of PASRR

**A1500: Preadmission Screening and Resident Review (PASRR)**

- Complete ONLY if this is an Admission, **A0310A = 1 OBRA MDS**
- If Level II PASRR not required or found no serious mental illness or mental retardation related condition - Code 0 “no”
- If Level II PASRR was positive – Code 1 “yes”
- PASRR applies only to Medicaid-certified nursing facilities – (does not apply - Code 9)

State is responsible for providing specialized services to those with MI/MR (Medicaid)
Facility required to provide all other care & services appropriate to resident’s condition
Services specified in Level II PASRR determination & the evaluation report should be addressed in the plan of care
Identifies individuals who are subject to Resident Review upon change in condition

**More Identification items**

- **A1550** – Conditions r/t MR/DD Status
  - Check all that apply
  - Complete if 22yrs or older & Admission
  - Complete if 21 yrs. or younger & a Comprehensive OBRA assessment
- **A1600** – Entry Date (of this Admission/re-entry)
- **A1700** – Type of Entry
- **A1800** – Entered From
- **A2000** – Discharge Date
- **A2100** – Discharge Status
More Identification items

- A2200 – Previous ARD for Significant Correction
- A2300 – ARD – Assessment Reference Day
- A2400A – Has resident had a Medicare stay since most recent entry (admission or re-entry)?
  - 0 = NO - If "NO", do not answer B & C
  - Skip to B0100, Comatose- (1st MDS 3.0 skip pattern)
  - 1 = YES

A2400B – A2400C: Medicare Stay (New)

- A2400B - Start of Most Recent PPS Stay
  - Code the date of day 1 of this Medicare stay if A2400A coded 1 = yes
- A2400C - End Date of Most Recent PPS Stay
  - Code the date of last day of this Medicare stay if A2400A coded 1= yes
  - If stay is ongoing there will be no end date to report
  - Enter dashes to indicate the stay is ongoing

Good Job! So far we have …

- Reviewed many new MDS 3.0 items
- Reviewed many new Forms
- Reviewed Section A

“We must all hang together, or assuredly we will all hang separately.”

~~~ Benjamin Franklin