

## 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

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### 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

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### 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**

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## 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

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## 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

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## 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

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## 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**

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## Resources Needed



- RAI User's Manual, Version 3.0 dated May/June 2010 & keep manual current
- Evidence/research based protocols or tools for assessment & care planning
- Internet Access (up-to-date)
  - CMS
  - IFMC websites
  - QTSO
  - [healthfacilities.info](http://healthfacilities.info)

Colorado Health Facilities website for training registration, resources, & the MDS Newsletters

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## Website Addresses



- MDS & Manuals:  
[www.cms.gov/NursingHomeQualityInits/25\\_NHQIMDS30.asp](http://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp)
- CMS web-based MDS training:
  - <http://surveyortraining.cms.hhs.gov/pubs/satellite/>
- IFMC: QM/QI manuals
  - [www.gtso.com](http://www.gtso.com)
- CDPHE - website for training registration, resources, & the MDS Newsletters
  - [healthfacilities.info](http://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

Not new

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## 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](#)

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### 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 1<sup>st</sup>, 2010 Implementation

Sep. 30, 2010 | Oct. 1<sup>st</sup>, 2010

ARD 9/30 or earlier =  
MDS 2.0 form

ARD 10/01 or later =  
MDS 3.0 form & rules

ARD 9/15 & completed  
before 10/01/10 = MDS  
2.0 rules

If ARD 9/30 (MDS 2.0 Form) but completed 10/01 or later, then the next MDS = **1<sup>st</sup> MDS 3.0**, but based on MDS 2.0 R2b date of 10/01 or later date.

Then **2<sup>nd</sup> 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](#)

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### 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

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### 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**
  - OBRA MDS–mandated by Federal regulations (1987) Comprehensive & Quarterly *Clinical focus of MDS*
- **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

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### 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
- **QTSO** – 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

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### 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

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## 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

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## 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

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## 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**

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## Where does MDS information come from?

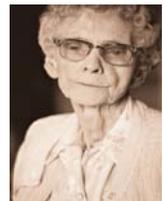
### ■ Multiple methods

- 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 14<sup>th</sup> 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

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## New Features of MDS 3.0

- **Admission MDS 3.0 – a new criteria**
  - Never Admitted to NH/SB before (initial) ← **Same**
  - 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**

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## 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**



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## 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



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## 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

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## 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

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## 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

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## 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)



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## 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 Haven't changed
- **F278** – Accuracy of assessments
- **F279** – Comprehensive care plans
- **F286** – Maintain 15 months of MDS data
- **F287** – Accurate Encoding & transmitting the MDS

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## 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

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## 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**



**New**

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## 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**



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## 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

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## 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

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## 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 Section C

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## 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

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## 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**

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### 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**

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### 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**

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### MDS 3.0 Submission Time Frames

Type of Assessment/Tracking	Primary Reason (A0310A/A0310F)	PPS Reason (A0310B)	Final Completion or Event Date	Submit By
Admission Assessment	A0310A = 01	All values	V0200C2	V0200C2 + 14
Annual Assessment	A0310A = 03	All values	V0200C2	V0200C2 + 14
Significant Change	A0310A = 04	All values	V0200C2	V0200C2 + 14
Sign. Correction Full Assessment	A0310A = 05	All values	V0200C2	V0200C2 + 14
Quarterly Review Assessment	A0310A = 02	All values	Z0500B	Z0500B + 14
Sign. Correction Prior Quarterly Asmt.	A0310A = 06	All values	Z0500B	Z0500B + 14
PPS Assessment	A0310A = 99	01 through 07	Z0500B	Z0500B + 14
Discharge Assessment	A0310F = 10 or 11	99	Z0500B	Z0500B + 14
Death in Facility	A0310F = 12	99	A2000	A2000 + 14
Entry	A0310F = 01	99	A1600	A1600 + 14
Modification or Inactivation Request (X0100 = 2 or 3)	A0310A and A0310F All values	All values	X1100E	X1100E + 14

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### 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**



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### 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

NO CHANGE



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### 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



NO CHANGE

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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



OBRA & PPS Schedules may be combined– ck. rules

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### 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

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## 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)**

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## 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**

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## 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

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## 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

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## 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**

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## 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

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## Those who come & go frequently ... **NEW**

- 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

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## 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. 3<sup>rd</sup> (A1600 + 7), submit by Sept. 10<sup>th</sup> (A1600 + 14).

A separate Admission MDS due by Sept 9<sup>th</sup> (A1600+13), &/or PPS.

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### 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:** NEW
  - Discharge assessments
  - Death in facility record

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### MDS 3.0 Discharge Reporting -A310F

NEW

- 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**

~ALL NEW~

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### Discharge Assessment

NEW

- **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

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### MDS 3.0 Discharge Assessment

NEW

- **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

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## 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

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## 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

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## 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

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## OBRA – Admission (A0310A) = 01

- Resident's 1<sup>st</sup> 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 ~

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**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)

**NEW**

**NEW**

**OBRA – Quarterly (A0310A) = 02**

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

**NO CHANGE**

**OBRA – Annual (A0310A) = 03**

- Completed following the 3<sup>rd</sup> 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

73

### 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

74

### 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

75

### 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 assmt. 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

76

**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
  - &/or
  - 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** ← NEW

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

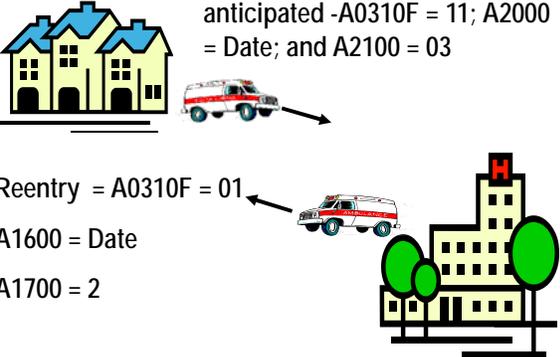
Quarterly – 92 days from ARD to ARD

↕ **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?

**Review**

Discharge assessment & return anticipated -A0310F = 11; A2000 = Date; and A2100 = 03



Reentry = A0310F = 01  
 A1600 = Date  
 A1700 = 2

81

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1 ADMIT	2 ARD	3 ARD	4 ARD	5 ARD	6 ARD	7 ARD
8 ARD	9 ARD	10 ARD	11 ARD	12 ARD	13 ARD	14 Complete
15	16	17	18	19	20	21 Complete
22	23	24	25	26	27	28
29	30	31	The 14 <sup>th</sup> & 21 <sup>st</sup> show the "no later than..." regulation for MDS & CAAs (14 <sup>th</sup> ), & the Care plan (21 <sup>st</sup> ).			

[REVIEW OBRA SCHEDULE](#)

82

**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 = 14<sup>th</sup> day.

NO CHANGE to rules, just coding numbers.



83

**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.



84

**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.

85

**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.



86

**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



87

**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



88

### 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

89

### 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**

90

### 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

91

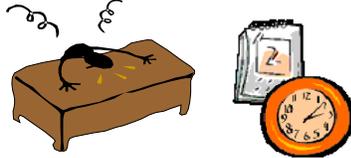
### PPS (cont.)

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

92

## 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

93

## 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

**Also, item A0310C – Start & End of Therapy**

94

## A0310B – Medicare PPS Assessments \$\$\$

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

95

## 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**

96

**A0310C - PPS Other Medicare Assessments**  
**OMRA - \$\$\$**

**Code:**

0 = No

1 = Start of Therapy assessment ← **NEW**

2 = End of Therapy assessment ← **NEW**

3 = Both Start & End of Therapy assessment

97

**A0310C - PPS Other Medicare Assessments OMRA**

**New**

- 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 (CMIs)

98

**A0310C - PPS Other Medicare Assessments OMRA**

- End of Therapy (EOT) OMRA **New**
  - Required to establish a new non-therapy RUG but still requires SNF services - see item Z0150
  - 1<sup>st</sup> non-therapy day is day #1
  - Day 1 = 1<sup>st</sup> 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

99

**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

100

### PPS & Events before 8<sup>th</sup> 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**

101

### 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 1<sup>st</sup> PPS as a Readmission/Return**
- If coded as "Discharge return NOT Anticipated"
  - **Code 1<sup>st</sup> 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**

102

### 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**

103

### 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

104

**REVIEW PPS - combined with an Admission OBRA MDS**

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1 <b>5</b>	2 <b>5</b>	3 <b>5</b>	4 <b>5</b>	5 <b>5</b>	6 <b>5</b>	7 <b>5</b>
8 <b>5</b>	9	10	11 <b>14</b>	12 <b>14</b>	13 <b>14</b>	14 <b>14</b>
15 <b>14</b>	16 <b>14</b>	17 <b>14</b>	18 <b>14</b>	19 <b>14</b>	20	21 OBRA
22	23	24	25	26	27	28 OBRA
29	30	31				

**OBRA & MEDICARE PPS- Completion always within 14 days of ARD**

**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

**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

**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](http://www.cms.gov/SNFPPS/02_Spotlight.asp)

## 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

109

## 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

110

## 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

111

## 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

112

## 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

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## 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**

114

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



115

## 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

116

## 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)

MDS 3.0 Section A

117

## 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**

MDS 3.0 Section A

118

## 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** New

119

## 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

120

## 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**

121

## MDS Assessment Types - Review

- **Swing Bed Assessment**
  - Same subset as SNF/PPS
- **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**

122

## 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
  - If no information available, dash fill all boxes
  - **HMO – DO NOT use HMO number in place of Medicare number**
- **A0700: Medicaid Number**

123

## 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**

124

### 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

125

### 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)**

126

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

- 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

127

### 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

128

### 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-** (1<sup>st</sup> MDS 3.0 skip pattern)
  - **1 = YES**

129

### 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**

130

### 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

131