

Importance of Section O

- Treatments, programs, & procedures can have a profound effect on an individual's:
 - Health status
 - Self-image
 - Dignity
 - Quality of Life



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O0100 Guidelines to Conduct Assessment

- Review resident's medical record
- Determine if resident received any of the special treatments & programs listed in O0100
- **Do not code services provided solely in conjunction with a surgical procedure (including routine pre -&- post-operative procedures) or diagnostic procedure**
- The look-back period is **14 days**

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Criteria for Treatments, Procedures, Programs

- Check all that apply
- Check Z = no items apply in last 14 days
- Two columns to record information
 - **Column 1** – for tx, programs or procedures received **prior** to **admission/reentry** to NH (Not a resident)
 - **Column 2** - for tx, programs or procedures received **after** admission /reentry to NH (While a resident)

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O0100 – Special Treatments & Programs, cont.

- **Cancer Treatments**
 - O0100A – Chemotherapy
 - O0100B – Radiation
- **Respiratory Treatments**
 - O0100C – Oxygen
 - O0100D – Suctioning
 - O0100E – Tracheostomy Care
 - O0100F – Ventilator or Respirator
 - O0100G – BIPAP/CPAP



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Section O: Therapy & Treatment Reminders



- **O0100C: Oxygen therapy**
 - Continuous or intermittent via mask, cannula, etc to relieve hypoxia
 - If BiPAP/CPAP hooked up to oxygen, ok to code
 - **Do not code** hyperbaric oxygen for wound therapy
- **O0100D: Suctioning**
 - Only tracheal and/or nasopharyngeal suctioning
 - **Do not code** oral suctioning here

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Section O: Reminders

- **O0100E: Tracheostomy care**
 - Code cleansing of tracheostomy and/or cannula
- **O0100F: Ventilator or respirator**
 - Any type of electrically or pneumatically powered closed-system mechanical ventilator support systems
- **O0100G; BiPAP/CPAP (New)**
 - If ventilator or respirator is used as a substitute for BiPAP or CPAP may code here

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O0100 – Special Treatments & Programs, cont.

- **Other:**
 - O0100H – IV Medications
 - O0100I – Transfusions
 - O0100J – Dialysis
 - O0100K – Hospice Care
 - O0100L – Respite Care
 - O0100M – Isolation or quarantine for active, infectious disease (not just standard body fluid precautions)
 - O0100Z – NONE of the Above



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O0100 – Special Reminders



- **O0100H – IV Medications**
 - any Rx/ biological given IV push, epidural pump, by central or peripheral port, & Epidural, intrathecal, & baclofen pumps = coded. **Do not code** flushes to keep IV open, or IV without meds., or Sub-Q pumps, IV meds given during dialysis or chemotherapy, or Dextrose 50% and/or Lactated Ringers given IV"contrast material" – Deleted
- **O0100M – Isolation or quarantine for active, infectious disease – alone in a room** - not just standard body fluid precautions
 - **Additional info related to types of precautions: See page O-4**

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O0250A, B, C - Influenza Vaccine



- **O0250A** - Did Resident receive Flu Vaccine, in this Facility, for this Year's Flu Season?
 - Code 0 = No: Did NOT receive. SKIP to- 0250C
 - Code 1 = Yes: Did receive Flu vaccine
- **O0250B, Date Vaccine Received**
 - mm/dd/yyyy (enters in the MDS database differently –Vendors must program)
 - If unknown, enter dashes

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O0250: Influenza Vaccine, cont.

- **O0250C = Reason why Flu Vaccine Not rec'd**
 - 1 = not in facility during flu season
 - 2 = received outside of this facility
 - 3 = not eligible- medical contraindication
 - 4 = offered & declined
 - 5 = not offered
 - 6 = inability to obtain vaccine due to a declared shortage
 - 9 = none of above = reasons not listed or, the answer is unknown

Coding example #3 –“Mrs.T” corrected in manual, O-7

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O0300A & B: Pneumococcal Vaccine



- **O0300A = Is Resident's PPV Up to Date?**
 - 0 = No: Not up to date or status unknown
 - 1 = Yes: Status is up to date. Skip to O0400
- **O0300B = If PPV Not Received, State Reason:**
 - 1 = Not eligible
 - 2 = Offered & declined
 - 3 = Not offered

PPV given once in a lifetime with certain exceptions - See page O-9

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O0400: Therapies 7-day look back



- Medically necessary therapies given after admission/readmission & given inside/outside facility
- **All Therapies must be:**
 - Ordered by a physician (or approved extender)
 - Performed by a qualified therapist
 - Based on a therapist's assessment & treatment plan,
 - Documented in resident's medical record, &
 - Care planned & periodically evaluated to ensure resident receives needed therapies & that current treatment plans are effective

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O0400: What constitutes group therapy?

- **Q:** ... for OT, PT, ST, etc.? How many residents can be in a group to capture group minutes?
- **A:** Definitions for group therapy under Medicare Part A & B, (pg. O-18 -MDS 3.0 manual), as follows:
 - **Medicare Part A-** Tx. of 2 to 4 residents, regardless of payer source, performing similar activities, & supervised by a therapist or assistant who is not supervising any others.
 - **Medicare Part B-** Tx. of 2 or more individuals simultaneously, who may or may not be performing the same activity.

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O0400: Therapies—Coding Days & Minutes for Speech, OT & PT

- **1. Individual Minutes**
 - Total number of minutes of therapy provided by 1 therapist / assistant to 1 resident at a time
- **2. Concurrent Minutes (New)**
 - Total number of minutes of therapy provided, with line-of-sight supervision by therapist or assistant, to 2 residents at the same time, both residents performing different activities
 - Medicare Part B residents cannot be treated concurrently

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O0400: Therapies - Coding Days & Minutes for Speech, OT, & PT

- **3. Group Minutes (New)**
 - Total number of minutes of therapy provided in a group setting
 - Medicare Part A = treatment of 2-4 residents performing similar activities and supervised by a therapist or assistant who is not supervising anyone else
 - Medicare Part B = treatment of 2 residents at the same time

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O0400: Therapies—Coding Days & Minutes for Speech, OT, & PT

- **4. Days**
 - Number of days therapy services were provided in the past 7 days (a day = 15 minutes or more)
- **5. Therapy Start Date (New)**
 - Record date most recent therapy regimen (since last assessment) started
- **6. Therapy End Date (New)**
 - Record date most recent therapy regimen (since last assessment) ended.
 - If therapy is ongoing, enter dashes

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O0400: Therapies—Coding Days & Minutes for Respiratory, Psychological & Recreational

■ 1. Total Minutes

- Enter the actual number of minutes therapy services were provided in the last 7 days

■ 2. Days

- Enter the number of days therapy services were provided in the last 7 days
- A day of therapy is defined as treatment for 15 minutes or more in a day

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O0400: Therapies



■ Respiratory Therapy

- Services provided by a qualified professional (respiratory therapist, respiratory nurse)
- Services include coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds & mechanical ventilation, etc.
- A respiratory nurse = received special training on the administration of respiratory treatments & procedures, when permitted by the state Nurse Practice Act.

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O0400: Therapies

■ Psychological Therapy

- Provided only by licensed mental health professional such as a psychiatrist, psychologist, psychiatric nurse or psychiatric social worker

■ Recreational Therapy

- Services provided or directly supervised by a qualified recreational therapist who holds a national certification in therapeutic recreation = Certified Therapeutic Recreation Specialist

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O0400: Therapies -Coding Tips



- Include only therapies provided after resident admitted to the facility
- If a resident returns from a hospital stay, an initial evaluation must be done again after reentry & only those therapies that occurred since reentry can be coded on the MDS
- If Part A resident receives & meets criteria for “concurrent” therapy, then ok to code, regardless of the payer source of the 2nd resident (Pg. O-15)

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O0400: Therapies -Coding Tips



■ Therapist time

- **Do not count** initial evaluation/ documentation time
- **Can count** subsequent re-evaluation time if part of the treatment process

■ Aug. 2010 - Updates to Section O–Therapy

- **Instructions for O0400 Therapy Start Date now state:** “This is the date the initial therapy evaluation is conducted, regardless if treatment was rendered or not.” (Pg. O-15)

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O0400: Therapies -Coding Tips



- Tx. time starts when the 1st tx. activity or task, begins, & ends when resident finishes last task or last apparatus
- Time required to adjust equipment or prepare for individualized therapy is set-up time & can be included in counting minutes
- COTA & PTA services for OT & PT only count as long as they function under the direction of the therapist
- **Do not round up minutes; record actual minutes not units**

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O0500: Restorative Nursing Programs



■ 10 specific programs on MDS

- **Nursing interventions** that promote resident's ability to adapt & adjust to living as independently & safely as possible.
- **Focus** — achieve or maintain optimal physical, mental & psychosocial functioning

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O0500: Restorative Nursing Programs

■ Techniques* provided by restorative nursing staff

- **O0500A:** Range of Motion (Passive)
- **O0500B:** Range of Motion (Active)
- **O0500C:** Splint or Brace Assistance

***All techniques must be individualized to the resident's needs, planned, monitored, evaluated & documented in the medical record**

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O0500: Restorative Nursing Programs

- **Training & Skill practice** = repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under supervision of LPN or RN
- Does not need a physician's order
 - O0500D: Bed Mobility
 - O0500E: Transfer
 - O0500F: Walking
 - O0500G: Dressing and/or Grooming
 - O0500H: Eating and/or Swallowing
 - O0500I: Amputation/Prosthesis Care
 - O0500J: Communication



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O0500: Restorative Nursing Programs

- Must meet specific criteria prior to coding:
 - Documented measurable objectives/ interventions in care plan & medical record
 - Documented periodic evaluation by RN or LPN
 - RN or LPN must supervise activities
 - Nursing staff must be skilled in techniques
 - Groups no larger than 4 residents per staff
- Time coded in time blocks of 15 minutes or more
- Cannot claim techniques a therapist claimed under **O0400A, B or C**

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O0600: Physician Examinations

- **Enter # of days** physician has examined the resident in the past 14 days (or since admit if less than 14 days ago)
- Includes MD, DO, podiatrists, DDS, & authorized PAs, Nurse Practitioners or CNS working in collaboration with physician
- Examination (full or partial) can occur in facility or in physician's office



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O0700: Physician orders

- **Enter # of days** in past 14 days (or since admission if less than 14 days ago) the physician has **changed medical orders**
- Include: written, phone, fax or consultation orders for new or altered treatment
- **Excludes:** routine admission /re-admission, renewal, & clarification orders without changes
- Admission day orders as a result of an injury, unexpected change, or deterioration are new /or altered orders and do count



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Section P: Restraints



- **Intent:** Record frequency the resident was restrained by any of the listed devices, at any time, day or night over the last 7 days
- **Definition critical:** “Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident’s body the resident cannot remove easily which restricts freedom of movement or normal access to one’s body”

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Section P: Restraints



- **Removes easily**
 - Resident intentionally removes, in the same manner as they were applied by staff
- **Freedom of movement**
 - Any change in place or position for the body or any part of the body the person is able to control or access
- **Medical symptom/diagnoses**
 - Must have clear link between restraint use & how it benefits resident by addressing specific medical symptom

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P0100: Physical Restraints

- **Restraints used for fall prevention**
 - Falls are not considered self-injurious behavior nor a medical symptom that supports the use of restraints
- **Request for restraints**
 - Resident has the right to refuse treatment, but not to demand use of a restraint when the facility has determined the use is not appropriate
- **Emergency use of restraints**
 - Even if one of the listed devices was used in an emergency 1 time, code it the MDS if it meets the definition of a restraint

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Section P: Restraints

- Assess each resident to determine need for device, then evaluate the **effect** device has on the resident, not the type, intent or reason for use
- Evaluate whether resident can easily & voluntarily remove the device, material or equipment
- If resident cannot easily & voluntarily remove the restraint, continue with assessment to determine whether it restricts freedom of movement or access to his/her body

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P0100: Physical Restraints

■ Importance

- Restraints play limited role in medical care
- Restraints limit mobility & increase the risk of adverse outcomes
- Cognitively impaired residents are at higher risk of entrapment, injury & death when physical restraints are used
- Must do assessment to determine risk

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P0100: Restraints

■ Used in Bed

- P0100A: Bed rail
- P0100B: Trunk Restraint
- P0100C: Limb Restraint
- P0100D: Other

■ Used in Chair or Out of Bed

- P0100E: Trunk Restraint
- P0100F: Limb Restraint
- P0100G: Chair Prevents Rising
- P0100H: Other



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P0100: Physical Restraints

■ Bed Rails

- Any combination of partial or full rails
- If bed rails used for positioning, but meet definition of a restraint, must be coded as such

■ Trunk Restraint

- Examples include, but not limited to, vest or waist restraints, belts used in wheelchairs

■ Limb Restraints

- Include: devices, materials, or equipment that restrict movement of any part of upper or lower extremity, including mittens



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P0100: Physical Restraints

■ Chair prevents rising

- Any type of chair with: a locked lap board, places resident in a recumbent position, a soft chair, low to the floor.
- Also included are chairs with cushion placed in seat prohibiting resident from getting up

■ Other

- Any device that does not fit into listed categories but meets definition of a restraint & has not been excluded from this section

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P0100: Physical Restraints

- After determining whether or not listed device is a restraint used during 7 day look-back period, code frequency of use:
 - 0 = not used, or device used but did not meet definition of a restraint
 - 1 = device met definition & was used, but less than daily
 - 2 = device met definition & was used on a daily basis

Bullet #5 on page P-3 is new

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Restraint Scenario



- Mr. C has a ½ rail for bed mobility.
- However, before the ½ rail was raised, he could get out of bed by himself. Now it's up each night, & he must ask for help to get out of bed & go to the BR. Mr. C also uses an enclosed frame wheeled walker daily with posterior seat to increase mobility. Arthritis in his hands prevent him from opening the walker's gate & stepping away on his own. He must ask for assistance any time he needs to go to the BR or sit in a chair. **How will you code Section P0100?**
- **Would you code any other section?**

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Restraint Scenario -Answers



- P0100A = 2
- P0100B = 0
- P0100C = 0
- P0100D = 0
- P0100E = 0
- P0100F = 0
- P0100G = 2
- P0100H = 0

MDS 3.0 deleted
"Bedrails used for mobility"

- G0600B = check for use of merry walker

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2 Restraint Q&As

- 1) **What is the KEY factor** in determining if a device, material or equipment is a restraint?
 - A. Type of Device
 - B. Intent or reason for using the device
 - C. How often device is used
 - D. Effect of the device on the resident's normal function.

Answer: D - the effect on the resident
- 2) If devices meet the definition of a physical restraint, but increase mobility for the resident, do not code as a restraint.

Answer: False

True or False?

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Section Q Participation in assessment & goal setting

- **Section Q revised** - legislative changes - enhance resident's voice in expressing expectations for care & explore potential for returning to the community
- Identify residents not previously considered as candidates for community living
- Triggers further assessment of their situation, including referrals for more information
- Expanded traditional definition of d/c planning
- New opportunities & requirements for d/c collaboration

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Section Q: Participation in Assessment & Goal Setting

■ Q0100A: Resident participated in assessment

- Definition: Resident actively engages in interviews & conversations as necessary to meaningfully contribute to the completion of MDS 3.0

Code 0 = No

Code 1 = Yes

Care plan should be individualized & resident driven



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Section Q: Participation in Assessment & Goal Setting

- **Q0100B:** Family /Significant Other participated in
0 = No
1 = Yes
9 = No family or significant other
- **Q0100C:** Guardian/ authorized rep participated
0 = No
1 = Yes
9 = No guardian/legally authorized rep

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Q0300: Resident's Overall Expectation

- Complete only if MDS is the first assessment since most recent admission = **A0310E = 1**
- Ask about overall expectations after the assessment is complete & there's a better understanding of the current situation & implications of alternative choices
- If Resident unable to communicate preferences, obtain information from family or significant others

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Q0300: Resident's Overall Expectation

- **Q0300A: Resident's overall goal**
 - 1 = expects to be discharged to community
 - 2 = expects to remain in facility
 - 3 = expects to be d/cd to another facility/institution
 - 9 = unknown or uncertain
- **Q0300B: Indicate information source for item A**
 - 1 = resident
 - 2 = family or significant
 - 3 = guardian or legally authorized representative
 - 9 = none of the above

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Q0400 Discharge Plan

- **Determine if active discharge plan is in place - check:**
 - Care plan
 - Medical record
 - Nurses' notes
 - Social services notes
 - Physician progress notes

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Q0400: Discharge Plan

- **Q0400A:** An active d/c plan in place for resident to return to the community?
 - 0 = No
 - 1 = Yes = Skip to Q0600
- **Q0400B:** What determination made by resident & care planning team for d/c to community?
 - 0 = determination not made by resident & care planning team regarding d/c to community
 - 1 = d/c to community is feasible
 - 2 = d/c to community is not feasible

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Q0500: Return to Community Living



- Identifies resident's desire to speak with someone re: returning to community
- Goal = obtain expressed interest of the resident & focus on resident's preferences
- Complete on Admission, Quarterly & Annual OBRA assessments
- Q0400B, Q0500B, & Q0600 all trigger CATs
 - Highly recommended to do CAAs re: Quarterly

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Q0500: Return to Community

- Let resident know this is a routine question
- A “Yes” = request for more information & doesn't ensure they're able to move back to community
- A “Yes” does not commit resident to leave NH, & a “No” is not a permanent commitment
- Resident can change their choice any time
- Opportunity for facility, resident & family to all sit down and have that hard conversation

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Q0500: Return to Community

- **Q0500A:** Resident previously asked about returning to the community?
 - 0 = **No**, if resident or family, et al, have not been asked
 - 1 = **Yes**, resident or family, et al, asked, previous response was “no”
 - 2 = **Yes**, resident or family, et al, asked previous response was yes - **skip to Q0600**
 - 3 = **Yes**, resident or family, et al, asked, but previous response is unknown

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Q0500: Return to Community

- **Q0500B:** Ask resident, (or others if unable to respond) “Do you want to talk to someone about possibility of returning to the community?”
 - 0 = **No**, resident or others, do not want to talk to someone about return to community
 - 1 = **Yes**, resident or others, want to talk to someone
 - 9 = **Unknown** or uncertain, resident cannot respond & others, not available to respond/ no guardian has been appointed

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Q0600 Importance

- Facilities will continue to do d/c planning & meet regulatory requirements
- Opportunity for residents to voice their choices & get information about available LTC options & supports in the community
- Local contact agencies can assist resident & facility in transition planning to secure/locate housing, home modifications, personal care, & community integration
- **Q0600 = triggers CAA #20**

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Q0600: Referral

- Has referral been made to local contact agency?
 - If Q0400A = 1, Yes, complete this item
 - If Q0400B = 1, Yes, complete this item
 - If Q0500A = 2, Yes, complete this item

Coding choices

- 0 = No - determination made by resident (or others) & care planning IDT - no contact required
- 1 = No -contact needed, but referral not made
- 2 = Yes - Referral made

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Section V- Care Area Assessment (CAA)

- MDS alone does not provide a comprehensive assessment
 - It is a preliminary screening to identify potential resident issues/conditions strengths and preferences
- Care Areas - triggered by MDS item responses indicating a need for more in-depth evaluation
- Triggered care areas form a critical link between the MDS & care planning decisions

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Section V: CAA Summary

- 20 Care Areas with MDS 3.0
 - 18 areas present with MDS 2.0, 2 new areas were added: Pain & Return to Community Referral
- After MDS completion, use CAA process to identify care areas needing further assessment, focusing on areas triggered by the MDS
- Summary form lists “triggered” items from the MDS requiring further assessment & identifies where further information is found

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V0100: Items from most recent Prior OBRA or PPS Assessment

- 2 care areas require information from most recent prior MDS 3.0 -allows evaluation of resident decline.
- 6 items in this section are recorded based on the coding of most recent prior OBRA or PPS MDS, if available
- Complete these items only if prior MDS has been completed since the most recent Admission
- **Do not include /consider prior discharge or entry records**

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V0100: Items from most recent Prior OBRA or PPS Assessment

- **V0100A** – OBRA reason for assessment most recent prior MDS
- **V0100B** – PPS reason for assessment from most recent prior MDS
- **V0100C** – **ARD (A2300)** from the most recent prior OBRA or PPS assessment

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V0100: Items from most recent Prior OBRA or PPS Assessment

- **V0100D** – C0500 BIMS summary score from most recent prior OBRA or PPS MDS
- **V0100E** – D0300 (PHQ-9 total severity score) from most recent prior OBRA or PPS MDS
- **V0100F** – D0600 PHQ-9-OV total severity score (staff assessment) from most recent prior OBRA or PPS MDS

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V0200: CAA & Care Planning

- Summarizes “triggered” items from MDS requiring further assessment
- **V0200A: CAA Results**
 - **Column A:** records CAAS “triggered”
 - **Column B:** records if addressed in care plan
 - **Last column:** records location & date of documentation about the CAA
- Most software generate a report with triggered items checked, based on MDS responses

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V0200: CAA & Care Planning

- **V0200B1 & 2:** Signature of RN Coordinator for CAA process & date process complete
 - CAA review no later than the 14th day of stay for Admission MDS, &
 - Within 14 days of ARD for Annual, Significant change or Significant correction assessments
 - **This is the “Completion Date” of the RAI**
- **V0200C:** Signature of person facilitating care planning decision-making process & date this column was completed
 - **Care plan required within 7 days of V0200B date**

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Section X

- The first item in Section X identifies if MDS is new & needs to be added to the MDS repository, or
- if this is a request to correct an MDS already accepted into the system
- X0100: Type of Record
 - Code 1 = add a new record - every MDS
 - Code 2 = Modify existing record
 - Code 3 = Inactivate existing record

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Error Corrections



- May correct MDS, data entry or software errors
- May not change a previously completed MDS when a resident's status changes during the course of their stay (do a SCSA MDS)
- If assessment has **not been transmitted successfully (accepted) do not use electronic correction process**
 - Correct problem in software (& on paper copy) then submit or re-submit

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Error Corrections



- **“Major” error** = MDS & the Care Plan does not match or meet the needs of a resident's condition
- **If MDS assessment not transmitted yet:**
 - Correct in your vendor system, re-do the CAAs, & update plan of care
 - Then submit correct assessment
- Minor errors would be all other errors & are corrected through the MDS electronic correction process & form

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Error Corrections – Section X



- Data **already accepted** in database can **only** be corrected using the electronic MDS Section X correction process
- There are **2 types of correction** possible
 - **Modification**
 - **Inactivation**
- If an error is identified in the MDS **after** it's been submitted & accepted by QIES ASAP, the MDS must be corrected by the facility

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Correction Types

- **Modification**= process used to correct most errors
 - Use with valid assessments
 - Corrects these errors: data entry, assessment coding, transcription, & reason for assessment (RFA is New to this process)
- It is **not** used to correct the following:
 - A0200 -Type of Provider
 - A0410 -Submission Requirement
 - Facility submission ID (FAC_ID)

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Correction Types



■ Inactivation

- Used when an invalid MDS assessment submitted to the QIES ASAP system
- Event did not occur
 - Record submitted does not correspond to any actual event
 - **Example:** a discharge MDS submitted for a resident, but resident was never discharged; resident assessed was the wrong resident

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Special Manual Record Correction Request

- A few error types cannot be corrected with an automated modification or inactivation request
 - Test record submitted as production
 - Wrong submission requirement in A0410
 - Wrong facility id in control item FAC_ID
- Facility must submit a written request to the state MDS Automation coordinator to have this problem fixed

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Section X: Correction Request

- Items **X0200 through X0700** identify the existing MDS in error & function as “locators”
- Reproduce the information exactly as it appeared in the MDS that needs to be corrected, even if the information is wrong
- If the information is not 100% the same, the correction process will not work because the system will not be able to find the prior document.

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Section X: Correction Request

- **X0900: Reasons for Modification**
 - Complete this item when X0100 = 2
 - **Examples:** transcription, data entry, software product, item coding errors, etc.
- **X0150: Reasons for Inactivation**
 - Complete this item when X0100 = 3
 - **Examples:** event did not occur, etc.
- **X1100: RN Assessment Coordinator Attestation of Completion**
 - Complete entire process within 14 days of discovering error

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Section X: Correction Request, cont.

Follow your software vendor instructions

- Find assessment or tracking form to be corrected & make corrections on that document
- Submit both Section X & the corrected MDS/Tracking form
- Make a copy of correction request form & attach it to the MDS or tracking form you corrected & place in the clinical record

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Section Z: Assessment Administration

Billing info & signatures = completion the MDS

- **Z0100A - Medicare Part A HIPPS Code**
- **Z0100B - RUG Version Code**
- **Z0100C - Is This a Medicare Short Stay Assessment?**
 - **1 = No:** unless a Medicare Short Stay Assessment.
 - **2 = Yes:** this is a Medicare Short Stay Assessment

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- **Z0150: Medicare Non-Therapy Part A Billing**
 - **Z0150A,** Medicare Non-therapy Part A HIPPS Code
 - **Z0150B,** RUG Version Code
- **Z0200: State Medicaid billing if required by state**
 - **Z0200A,** RUG Case Mix Group
 - **Z0200B,** RUG Version Code
- **Z0250: Alternate State Medicaid Billing if required by state**
 - **Z0250A,** RUG Case Mix Group
 - **Z0250B,** RUG Version Code

Colorado
doesn't have
alternate
Medicaid billing

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Z0300: Insurance Billing

- Z0300A, RUG Case Mix Group
- Z0300B, RUG Version Code
- Z0100-Z0300 – all of these Billing items
 - Typically the MDS software products calculate these values

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Section Z: Assessment Administration

- Z0400: Signatures of persons completing MDS Assessment Sections
 - Same as AA9 from MDS 2.0
 - Signatures certify accuracy of sections completed
- Z0500A&B: Signature & Date of RN Assessment Coordinator
 - Same as R2a & b from MDS 2.0
 - Signature certifies completion of assessment
 - No longer the timing compliance date

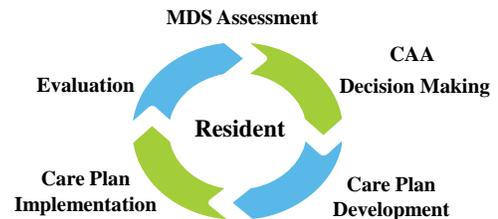
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Chapter 4 - CAAs Care Area Assessment process

- MDS information & the CAA process provide the foundation upon which the individualized care plan is formulated.
- CAA process only for OBRA comprehensive assessments (Admission, Annual, Significant change, Significant correction of full)
- **NOT** for non-comprehensive, PPS only or entry/discharge assessments

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CAA Process and Care Planning



A seamless, circular process that begins on admission & continues until discharge

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Care Area Triggers

■ CATs

- One or more pre-determined MDS items that “flag” areas for further review
- Identify residents who have or are at risk for developing specific functional conditions
- A CAT provides a starting point for care planning - use in combination with other assessment & care planning information

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The Trigger Legend

- Worksheet that summarizes all 20 CAAS & the MDS items that triggered them
- Located in Chapter 4 of the RAI manual
- Not required to be used or in resident’s medical record
- Software products automatically review the MDS for triggered items & they appear at V0200A, Column A
- Using the Trigger Legend, you can calculate the triggers by hand

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Care Area Assessment - CAA

- **Paint a picture of resident’s status/condition**
- **Each CAA has two parts:**
 - An introduction that provides general information about the condition
 - A list of items & responses from the MDS that serve as the trigger(s) for review called **CATS (Care Area Triggers)**



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CAA Process

- Identify what Care area is triggered & why
- Determine if the Care Area is a problem for this resident
- Describe nature & impact on functioning
- Identify causative & unique risk factors:
 - Potential for improvement or decline
 - Strengths to build on



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CAA process continued



- Identify need for referral
- Document which research, resources, or assessment tools were used in completing the CAA
- What plan of care can be developed/ revised to improve status, maintain function & prevent decline?
- If determination is not to proceed with care planning, document why

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Key to writing good CAAs

- Per Chapter 4, facilities are to use current, evidence-based or expert endorsed resources for the Care Area Assessments
- Facilities must be able to prove the CAAs they used are expert endorsed or evidence-based
- This requirement is consistent with F-tag 492 – services must meet professional standards of quality

From CMS MDS 3.0 Conference in August 2010

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Key to writing good CAAs

- No additional note or summary, other than routine chart documentation, is needed for Section V, CAA Summary
- However, in some cases, it may be prudent to write a summary of the CAA information, especially if the documentation in the record is incomplete, unclear, too scattered, or unfocused

From CMS MDS 3.0 Conference in August 2010

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Key to writing good CAAs

- Assign responsibility for completing the MDS & CAAs. (OBRA statute: resident's assessment must be conducted/ coordinated by a RN with appropriate participation of health professionals)
- It is common practice for facilities to assign specific MDS items & subsequent CAAs to those of various disciplines

From CMS MDS 3.0 Conference in August 2010

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Care Planning

- Good assessment = basis for a solid care plan
- Analysis of all gathered data is the key
- CAAs = the link between MDS & the care plan
- Care plan is driven by resident problems, unique characteristics, strengths & needs
- Answer the “So what now?” question



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Care Planning Summary

- No required format or structure
- Must have measurable goals & time tables
 - Goals = a subject, verb, modifier & time frame
 - Mr. “B” will walk 50 ft 2x daily within next 3 mo.
- Approaches should identify what staff are to do & when they are to do it.
 - Ambulate Mr. “B” to & from lunch & dinner with Front wheeled-walker & stand by assist daily

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Oct 01, 2010 - Impact of MDS 3.0 on Survey & Quality Assurance

- As assessments are transitioned, some residents will have plans of care developed from MDS 2.0 while others will be based on 3.0
- Quality Measure and Quality Indicator data bases and the reports they produce will change
- Some of the tasks of the traditional survey process cannot be done as a result

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Survey Task Changes

- Offsite Prep
 - **QI/QM reports are not to be used starting 10/1/2010 – due to MDS 3.0 implementation**
 - Facility files and OSCAR data can be used
- Entrance Conference
 - The team coordinator will ask for information such as the number of residents with the types of conditions previously identified on QI/QM reports

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Temporary Changes Planned

- CMS will issue a Survey & Certification letter this summer identifying the survey tasks that will be temporarily modified
- Expectation that this will last for a year
- Providers will be notified via a “Dear Administrator” letter
- CMS plans for a satellite broadcast in August/September 2010 timeframe to explain the changes

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Survey Task Changes

- **Tour**
 - More prominent role
 - Surveyors will use a blank 802 Roster Matrix form to identify areas of concern
 - Will take longer to complete
- **Sample Selection**
 - Will occur on site, & be based on information collected during tour and from facility
 - Will still contain interviewable, non-interviewable, heavy and light care residents

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802 Roster/Sample Matrix

- There will be form changes that will be permanent and instructions will be published in the State Operations Manual
- CMS will make a crosswalk to MDS 3.0, much like the current one for MDS 2.0
- Some of the characteristics will be split apart
- Initially, some fields will need to be manually completed

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What about CASPER Reports & NH Compare after 10/01/2010?

- The delay (blackout) is secondary to transition from 2.0 to 3.0 & need for data to support the reports - typically allow 6 mos. to "stabilize" data
- After a 6 mo. period CMS will begin analyzing data for QM reports (data needs to map to new QMs)
- Although facilities won't have reports, still have MDS source data to continue monitoring QM/QIs during the transition
- CMS feels providers should already have an internal QM/QI system in place

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What about Quality Indicators & Quality Measures

- **At this time, 3 QIs will be retained**
 - Falls, Behavioral Symptoms & Psychoactive Medications
- **New Nursing Home Quality Measures will include both post acute & chronic care & will replace or modify existing measures**
 - 18 potential measures have been recommended
 - 4 measures were recommended for retirement or replacement

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Measures for Possible Retirement

MDS 2.0 Quality Measures Recommended for Retirement/Replacement

	PAC	Chronic	Potential Replacement
Delirium	X		Delirium (new PAC measure)
Mobility decline		X	'Ambulation' (PAC and Chronic)
Pressure ulcers (low risk)		X	
Bedfast		X	

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Candidate Measures Submitted to NQF

Summary Table of 18 Measures Submitted for Endorsement

	PAC	Chronic	Five Star Item
Percent of Residents with Pain	X	X	X
Delirium (replacement measure)	X		X
Percent of Short-Stay Residents with Pressure Ulcers That Are New or Have Not Improved	X		X
Percent of Residents Who Were Assessed and Given Pneumococcal Vaccination	X	X	

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Candidate Measures Submitted to NQF

Summary Table of 18 Measures Submitted for Endorsement

	PAC	Chronic	Five Star Item
Percent of Residents Who Were Assessed and Given Influenza Vaccination	X	X	
ADL decline (replacement measure)		X	X
Mobility decline (replacement w/ focus on ambulation)		X	X
Percent of Long-Stay, High-Risk Residents with Pressure Ulcers		X	X

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CMS Centers for Medicare & Medicaid Services

Candidate Measures Submitted to NQF

Summary Table of 18 Measures Submitted for Endorsement

	PAC	Chronic	Five Star Item
Percent of Long-Stay Residents Who Were Physically Restrained		X	X
Percent of Long-Stay Residents Who Have/Had a Catheter Inserted and Left in Their Bladder		X	X
Percent of Long-Stay Residents with a Urinary Tract Infection		X	X

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CMS Centers for Medicare & Medicaid Services

Candidate Measures Submitted to NQF

Summary Table of 18 Measures Submitted for Endorsement

	PAC	Chronic	Five-Star Item
Percent of Long-Stay, Low-Risk Residents Who Lose Control of their Bowels or Bladder		X	
Percent of Long-Stay Residents Who Lose Too Much Weight		X	
Percent of Long-Stay Residents Who Have Become More Depressed or Anxious		X	

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- ### Colorado Survey Process Impact with QIS & MDS 3.0
- **QIS (Quality Indicator Survey) – CO, July 2010**
 - Sixteen currently participating QIS States
 - CT, FL, KS, MN, NM, LA, OH, NC, WV, WA, MD, DE, ME, VT, GA, AZ
 - **QIS = Continuous Quality Improvement**
 - MDS data an integral part, but “behind the scenes”
 - transition to MDS 3.0 will not be apparent
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- ### Colorado Survey Process Impact with QIS
- **July – August, 2010 - QIS Training**
 - 8 surveyors – 4 to be permanent CO QIS Trainers
 - Mock Surveys during this time of training
 - Actual QIS process will begin Aug
 - November – begin QIS training for all surveyors
 - As surveyors (State & Fed) are trained in QIS process they will switch to doing QIS surveys
 - Surveys = will be a mixture of Traditional & QIS conducted, until all CO surveyors are trained
 - Could take up to 2 yrs for this to be fully implemented
- 100

Colorado Survey Process Impact with QIS

■ Traditional process

- Survey tasks impacted include off-site prep, entrance, facility tour, sample selection & resident review

■ QIS process

- Uses customized software on tablet PCs to guide surveyors through a two-staged systematic review of the regulatory requirements
- Approved Federal NH survey process to increase consistency, reliability and accuracy

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What Does the QIS Provide?

- Structured approach to achieve more accurate and consistent results
- Larger & more diverse randomly selected samples to obtain a more accurate picture of the residents
- Automation to systematically review regulatory areas, synthesize surveyor findings, enhance investigative protocols, and organize surveyor documentation

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What QIS Is Not

■ QIS Does Not Represent:

- Change in Social Security Act
- Change in the Regulations
- Change in Interpretive Guidance
- Change in enforcement process

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Additional QIS Information

QIS Satellite Broadcast:

<http://surveyortraining.cms.hhs.gov/pubs/VideoInformation.aspx?cid=1082>

QIS Resource Manual:

http://www.uchsc.edu/hcpr/qis_manual.php

QIS Electronic Forms and Worksheets:

http://www.uchsc.edu/hcpr/qis_forms.php

QIS Brochure:

<http://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter08-21.pdf>

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*Thank you for
coming...*

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