PADONA 2015 Annual Convention

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MDS Information for DONs

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- **Why do DONs need information about the MDS?**
  - At least half of assessment nurses report to the DON
  - MDS coding is driven by documentation
  - MDS outcome drives facility reimbursement
  - MDS coding should impact the care plan
  - Inaccurate MDS coding may impact the survey
  - MDS coding produces the Quality Measures
  - MDS coding initiates the 802 and 672 forms
  - Increased knowledge of the issues and processes increase the opportunities to ensure compliance

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- **How will this presentation assist you?**
  - Provide you with some basic MDS information
  - Review the MDS items most impacted by nursing
  - Give you questions to ask of your teams at your facilities
  - Provide you with some answers for questions that your boards and management professionals ask of you
  - Provide guidance related to support documentation that is needed for accurate coding

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Why is the MDS completed?

- Initially developed and implemented as a comprehensive, interdisciplinary resident assessment tool
- Should be used to guide us to the care plan and plan of care
- Pennsylvania utilizes the MDS in the determination of case mix index for Medicaid reimbursement
- Federal development and implementation of the Prospective Payment System using the MDS coding to determine RUG IV classification for Medicare reimbursement in the late 90s
- Department of Health surveyors review the MDS in connection with care plan development, notation of significant changes and timeliness of assessments

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- **Why is the MDS completed?**
  - Fiscal Intermediaries and external auditors (RACs, MICs and ZPICs) utilize the MDS as one document reviewed after the claim for support of the reimbursement level
  - Utilization Management Review (UMR) team reviews the MDS annually to determine if there is support for the coding that resulted in the case mix index and Medicaid reimbursement level

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- **Which items of the MDS assessment are important?**
  - All items on the 38 page tool are important
    - Each item drives the care plan in some way
  - There are specific items that impact reimbursement
    - For Medicare Part A beneficiaries of skilled services
    - For skilled care beneficiaries of managed care plans
    - For Medicaid using the Case Mix Index (CMI) system

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- **Key Terms**
  - **RUGs: Resource Utilization Groups**

    A resident classification system that identifies various levels of care and services that are delivered to residents accounting for medical and functional levels in addition to ADLs and care delivery

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- **Case Mix Index**
  - Case Mix Index is a “weighted” score within a system
    - The higher the CMI the higher the payment or the greater the impact on the cumulative score
    - The MDS software program will automatically place a resident in the RUG level with the highest CMI (case mix adjusted)
    - You are always assigned the highest case mix score of all the scores/RUGs that the resident qualifies for

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- **Case Mix Index**
  - Case Mix Index for Medicaid: is the cumulative score that is derived from MDS assessment coding with each RUG being assigned a score that in combination with all of the RUG scores determines the Medicaid reimbursement per day for each of the facility Medicaid residents

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- **Assessment Office Operations**
  - Assure that assessment nurses have updated RAI Manual
    - Assure they have all updates and CMS survey and certification memos that refer to changes in the MDS
    - Empower assessment nurses to make decisions and request needed information for the completion of the MDS assessment items
    - Involve the interdisciplinary team in the completion of MDS assessment items (MDS, CAAs and Care Plans)
      - CMS allows interdisciplinary team members to code after education

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- **Assessment Office Operations**
  - Evaluate assessment office operations
    - Assure assessment nurses are appropriately completing items that are beyond the MDS assessment
    - Reduce clerical functions being completed by the assessment nurses
    - Should not or rarely have to complete documentation to support coding of the MDS assessment
    - Evaluate meetings attended by the assessment nurses to assure they are valuable
    - Assure involvement of the assessment nurses with other departments and the nursing team members

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- **Assessment Office Operations**
  - Assure education and training of assessment nurses through webinars and conferences
  - Assure access to CMS and OLTL websites
  - Involvement with state and national associations for networking and updates, as well as education
  - Certification for the assessment process

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- **Assessment Office Operations**
  - Determine if DON is appropriate reporting level
    - Based on financial responsibility it may be the administrator
    - Based on the staff in the office it may be the DON

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- **Medical Record Documentation to Support the Coding of the MDS 3.0 Assessment**
  - RUG classification for the claim is derived from the MDS assessment for Medicare and some managed care
  - Reimbursement is based on RUG classification
  - Cannot be coded on the MDS assessment without documentation support in the medical record
  - Audits are based on evaluation of the claim followed by review of the MDS assessment and then request for medical record documentation to ascertain documented support

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- **Documentation Process to Support MDS 3.0**
  - Identification of diagnoses that require attention with highest potential to result in hospital readmissions and/or changes in condition
  - Filtering documentation to exclude unnecessary information and focus on information for plan of care
  - Documenting to the care plan identified problems/needs/goals/approaches
  - Addressing the admission diagnosis and qualifying stay condition (when a new admission or skilled stay)
  - Narrative or flow sheet documentation system is irrelevant – information communication is critical

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- **Documentation Process to Support MDS 3.0**
  - DON has opportunity to address documentation
  - Assessment nurses must request and remind team members of areas where support documentation is needed with DON support
  - Development of forms and processes can be MDS focused and supportive of coding
  - Documentation education can be provided by the assessment nurses for the licensed nurses

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Review of MDS 3.0 Assessment Items

- Assessment Reference Date (ARD) A2300
  - Determines the common end of the assessment reference period – look back period
  - Everyone must use the same date
  - Must be within the timeframes determined by federal regulations for the type of assessment being completed (including grace days)
  - If not within the timeframes of the federal regulations, the default rate must be billed on the claim
  - Assessment nurses must have confidence, competence and authority to determine the final ARD

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- **Review of MDS 3.0 Assessment Items**
  - Reason for Assessment A0310
    - Demonstrates compliance with federal requirements for MDS assessment completion (PPS and OBRA)
    - Assessment nurses must know the regulatory requirements
    - Demonstrates type of assessment being completed
      - On cycle or scheduled assessment for Medicare/skilled and OBRA
      - Off cycle or unscheduled assessments for Medicare
      - Significant change assessments when warranted

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MDS 3.0 Assessment Completion of Items

- Types of MDS assessments
  - PPS system for skilled beneficiaries requires more assessments than OBRA system for long term care residents
    - PPS system requirements include:
      - 5 day assessment
      - 14 day assessment
      - 30 day assessment
      - 60 day assessment
      - 90 day assessment
      - Significant change in status assessment and off cycle assessments for specific criteria

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- **MDS 3.0 Assessment Completion of Items**
  - Off cycle or unscheduled PPS assessments include (OMRA-Other Medicare Required Assessments)
    - Change of Therapy (COT) when the number of minutes or days of therapy changes – up or down
    - End of Therapy (EOT) when there have been 3 days without rehabilitation therapy services provided and the resident continues to receive skilled services
    - End of Therapy – Resumption (EOT-R) when therapy was discontinued for 3 days and the resident continued to receive skilled services but was returned to therapy services within 5 days at the same level of service

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- **MDS 3.0 Assessment Completion of Items**
  - Off cycle or unscheduled PPS assessments
    - Start of Therapy (SOT) when resident was skilled for a clinical service and now has started rehabilitation therapy services (optional – can wait until next scheduled assessment)
    - Significant Correction of prior assessment
    - Death in facility when the resident dies while a resident of the facility
    - Discharge assessment when resident is discharged from the facility

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- **MDS 3.0 Assessment Completion of Items**
  - Types of assessments
    - OBRA assessments are required to include the following:
      - Admission – completed on or before the 14th day of the stay
      - Quarterly – review the changes in the resident status since the previous quarter
      - Significant change in status
      - Significant correction of prior assessment

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- **MDS 3.0 Assessment Completion of Items**
  - Section B items:
    - Item B0700 whether resident can be understood guides whether to complete resident interviews
      - Coded as a 3 (rarely/never understood) the resident is not interviewed but staff interviews are completed for the coding of interview sections
      - Coded any other number (0, 1 or 2) and resident interviews should at least be attempted

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- **MDS 3.0 Assessment Completion of Items**
  - Section C: BIMS (Brief Interview for Mental Status)
    - Resident interview section
    - Need documentation of the date completed because there are requirements
    - Questions should be asked as they appear in the section
    - Generally completed by Social Services but other IDT members can complete after education
    - Gateway question is critical as to whether the resident should be completed
    - Assessment nurses need to check

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- **MDS 3.0 Assessment Completion of Items**
  - Section D: PHQ-9 Assessment of Mood Indicators
    - Resident interview section
    - Need documentation of the date completed because there are requirements
    - Questions should be asked as they appear in the section
    - Generally completed by Social services but other IDT members can complete after education
    - Gateway question is critical to determine if resident will be interviewed
    - Assessment nurses should check

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- **MDS 3.0 Assessment Completion of Items**
  - Section G Functional Status
    - ADL coding section – Activities of Daily Living
    - Every RUG classification requires/includes ADLs
    - Accuracy of documentation by team members is critical for follow up: RUG outcome, care planning, resident referrals and reimbursement
    - Where and how documented is not critical – accuracy is
    - Assessment nurses are experts in the coding of the ADLs and the MDS language and can assist with education of team members

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- **MDS 3.0 Assessment Completion of Items**
  - Activities of Daily Living (ADL) Assistance (G0110)
    - ADL: tasks related to personal care.
    - ADL Aspects: Components of the ADL activity. Each activity has multiple components that must be considered.
    - ADL Self-performance: measures what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last 7 days according to a performance-based scale.
    - ADL Support Provided: Measures the highest level of support provided by staff, even if it only occurred once in the 7 day look-back period.

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- **MDS 3.0 Assessment Completion of Items**
- ADLs
  - Coding:
    - Must consider each component of the ADL activity.
    - Review the medical record, interview staff and observe resident.
    - Code based on the resident's level of assistance when using adaptive devices.
    - Self performance may vary from day to day; shift to shift, or within shifts.
    - ADL coding is a 2 part evaluation.

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- **MDS 3.0 Assessment Completion of Items**
  - ADL documentation (last 7 days)
    - Code for the most support provided during the shift.
    - Ideally documented when the event occurs.
    - Should be coded for what the resident actually does rather than what the resident could do
    - Must account for physician orders for weight bearing
    - Potential for variation between shifts and between nursing and therapy

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- **MDS 3.0 Assessment Completion of Items**
  - ADL coding tips
    - Sleeping on furniture other then bed. Consider when coding bed mobility.
    - Differentiating between guided maneuvering and weight bearing assist: determine who is supporting the weight of the residents extremity or body.
    - Do not include assistance provided by the family or other visitors.

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MDS 3.0 Assessment Completion of Items

- Section H: Bladder and Bowel
  - H0200 urinary toileting programs require documentation of the programs that follow requirements
    - At least a 3 day/72 hour voiding pattern determination
    - Documentation of results of toileting programs
    - Evaluation of effectiveness of toileting programs
    - Determination of potential of another schedule
    - Check and change is not a toileting program
    - Habit training, scheduled voiding, bladder retraining are toileting programs

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- **MDS 3.0 Assessment Completion of Items**
  - Section I: Active Diagnosis (I0100)
    - Code diseases that have a direct relationship to the resident's:
      - Current functional status;
      - Cognitive status;
      - Mood or behavior status;
      - Medical treatments;
      - Nursing monitoring; or
      - Risk of death during the 7 day look back period.

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- **MDS 3.0 Assessment Completion of Items**
  - Active Diagnosis
    - Requires a documented diagnosis by physician.
      - Use a 60 day look-back period.
    - Determine diagnosis status.
      - Determine if diagnosis is active or inactive.
        - Listing of diagnosis on the resident's medical record is not enough to determine if active.
        - Should also be included in care plan and meet criteria
      - Use a 7 day look-back period.
        - Except Urinary Tract Infection (30 days)

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- **MDS 3.0 Assessment Completion of Items**
  - Active Diagnosis
    - Coding tips:
      - A medication indicates active disease if that medication is prescribed to manage an ongoing condition that requires monitoring or is prescribed to decrease active symptoms associated with a condition.
      - It is expected that nurses monitor all medications for adverse effects as part of usual nursing practice.
      - Administration of medications does not necessarily indicate active disease.

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- **MDS 3.0 Assessment Completion of Items**
  - Section J: Health Conditions
    - Pain Assessment Interview (J0200)
      - Resident interview items related to pain
      - Questions should be asked as they are in the section
      - Can be completed by anyone trained to do so
    - Many items that impact the RUG classification
    - Documentation support is critical to assure accuracy

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- **MDS 3.0 Assessment Completion of Items**
  - Section K: Swallowing/Nutritional Status
    - K0100 swallowing problems must be documented but can be something that you use as an alert
    - Some areas can be coded by the dietician but nursing documentation and involvement is critical
      - Documentation of height and weight
      - Documentation of intake and output
      - Documentation of intake of supplemental fluids

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- **MDS 3.0 Assessment Completion of Items**
  - Section M: Skin Conditions
    - Significant nursing involvement
    - Need for documentation support
    - Accurate measurement and staging of pressure ulcers
    - Accurate determination of type of skin area
    - Assessment of skin close to admission to determine community acquire or facility acquired
    - Knowing when and how to combine wounds and how to measure

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- **MDS 3.0 Assessment Completion of Items**
  - Section M: Skin Conditions
    - Documentation of all treatments is required
    - Knowing where the foot begins may change coding
    - Always refer to and use guidelines from NPUAP (National Pressure Ulcer Advisory Panel)
    - Physician documentation support is needed for some items such as arterial and venous ulcers

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- **MDS 3.0 Assessment Completion of Items**
  - Section N: Medications
    - Correctly identify medications by their classifications and not what they are used for
    - Impacts the quality measures and CMS antipsychotic medication use reduction goals

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- **MDS 3.0 Assessment Completion of Items**
  - Section O : Special Treatments
    - O0100 section is nursing care and treatment
    - Requires documentation support
    - Has two columns – while a resident and while not a resident
      - While not a resident must be coded and comes from hospital documents
      - While a resident is all that impacts RUG classification
      - Both can impact the need for a care plan
    - O0250 section requires that we know when the flu season is for our area per the local health department

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- **MDS 3.0 Assessment Completion of Items**
  - Section O
    - Therapy days, minutes and start and end dates are best entered by therapy
    - Restorative nursing requires that we follow RAI guidelines for a restorative nursing program to code
      - Periodic evaluation
      - Oversight by a licensed nurse
      - Documentation of delivery of services
      - Goals addressing resident needs and delivery of services
      - Services delivered by educated team members
      - 15 minutes of service in 24 hours is equal to a day of service

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- **MDS 3.0 Assessment Completion of Items**
  - Section O
    - Counting physician orders and visits have specific guidelines on what can/cannot be counted
    - Clarification orders are not counted
  - Section P : Restraints
    - Follow RAI instructions when determining a restraint
    - Same definition as F Tags
    - Assure that restraints are documented and care planned

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- **MDS 3.0 Assessment Completion of Items**
  - Section V : Care Area Assessments (CAAs)
    - Requires documented investigation of the triggered MDS items
    - Requires citation of where documentation was found in the medical record to code the items that triggered
    - Often more than one discipline will be involved in the CAA for one MDS item
    - Can use the CAA guidelines provided by CMS or can document using freestyle narrative or something that has been provided by software vendor
      - Content is important not format

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- **MDS 3.0 Assessment Completion of Items**
  - Connecting the MDS to the care plan
    - CMS developed the MDS as an independent, comprehensive, interdisciplinary resident assessment that would “drive” the care plan
    - Care plan is expected to “drive” resident care
    - Care plans can be completed by IDT members completing their MDS sections and CAAs
    - Department of Health survey teams review the MDS coding in connection with resident care plan development

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QUESTIONS???

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THANK YOU!!

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Your presenter has been:

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