MDS Information for DONs
MDS and DONs

• 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
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
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
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.
• 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
• 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
• **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
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.
• **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
• 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
• **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
• 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
**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
• **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
**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
• **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
• 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
• **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
**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.
• **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.
• **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
• MDS 3.0 Assessment Completion of Items
  – ADL coding tips
    • Sleeping on furniture other than 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
• **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)
• 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.
• **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
• 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
• 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
QUESTIONS???
THANK YOU!!
Your presenter has been:

Sophie A. Campbell, MSN, RN, CRRN, RAC-CT
Director, Clinical Advisory Services
Baker Tilly Virchow Krause, LLP
724-601-7873
Sophie.campbell@bakertilly.com