DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 13-56-NH

DATE: **August 23, 2013**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Minimum Data Set (MDS) 3.0 Discharge Assessments that Have Not Been Completed and/or Submitted

Memorandum Summary

MDS 3.0 Discharge Assessments: The Centers for Medicare & Medicaid Services (CMS) is clarifying steps to take to address Minimum Data Set (MDS) 3.0 discharge assessments that have not been completed and/or submitted as required under 42 CFR §483.20(g) and 42 CFR §483.20(f)(1). The memo is intended to help surveyors understand both (a) what nursing homes should do to address inactive residents remaining on their resident roster due to incomplete and/or unsubmitted discharge assessments and (b) how nursing homes can ensure compliance with discharge assessment requirements.

Action by September 30, 2013: We are providing this information in order to promote nursing home completion of discharge assessments for inactive residents by September 30, 2013.

Background

CMS regulations at 42 CFR §483.20(g) Accuracy of Assessment require that Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs) provide that assessments "accurately reflect the resident's status." Further, 42 CFR §483.20 (f) requires facilities to encode the following information for each resident in the facility within seven (7) days after completing a resident's assessment: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. A "subset of items upon…discharge…" means discharge assessment. See State Operations Manual (SOM), Appendix PP, Interpretive Guidance for F287: "Background (face-sheet) information refers to the MDS Entry tracking record, while the discharge subset of items refers to the MDS discharge assessment."

In addition, within 14 days after a facility completes a resident's assessment, it must electronically transmit to the CMS system the encoded data and ensure that it is accurate and complete.

The failure to submit or complete MDS 3.0 discharge assessment records leads to inaccurate MDS 3.0 Quality Measures (QMs) data, potentially affecting the resident, the facility's payment, and facility liabilities. For example, failure to submit or complete MDS 3.0 discharge assessment records can also lead to citation of a facility under 42 CFR §483.20(f) and 42 CFR §483.20(g).

Discharge assessments capture a resident's clinical condition at discharge. When discharge assessments are not completed or submitted as required, the true length of stays and episodes are difficult to construct. Lack of completion and/or submission of discharge assessments causes errors on several reports, such as a facility's MDS 3.0 Roster report, the MDS 3.0 Facility Characteristics Report, and MDS 3.0 Missing Assessment report. For example, in the case of the current MDS 3.0 Roster, the lack of discharge assessments in the Quality Improvement and Evaluation System Assessment Submission and Processing (QIES ASAP) system results in more residents appearing on the Roster than the facility has residents and/or beds.

Facility Procedures

Beginning October 1, 2013, MDS assessments older than 3 years will no longer be accepted. Also, to minimize impact on QM data, CMS has selected a reference date of October 1, 2012. The CMS is requiring facilities to take the following steps when facilities have not completed discharge assessments and/or have not submitted discharge assessments prior to September 30, 2013:

1. Identify any residents appearing on the facility's current MDS 3.0 Roster report who are no longer active residents.

2. If the resident was discharged prior to October 1, 2012, a discharge assessment must be completed for the resident indicating the actual date of discharge in Item A2000, Discharge Date. This assessment must have demographic information completed in Section A. Clinical information in Sections B through Z must be dash-filled. Items Z0400, Signatures of Persons Completing the Assessment or Entry/Death Reporting, and Z0500, Signature of RN Assessment Coordinator Verifying Assessment Completion, must reflect the actual completion date of this assessment.

3. If the resident was discharged on or after October 1, 2012, a discharge assessment must be completed for the resident indicating the actual date of discharge in Item A2000, Discharge Date. This assessment must have demographic information completed in Section A. Clinical information in Sections B through Z must be completed as much as possible to reflect the actual status of the resident at the time of discharge. The following coding instruction is applicable for

coding BIMS, PHQ-9 and Pain interviews for these late discharge assessments: In lieu of the interviews, the staff assessments should be completed if appropriate based on the clinical record information that is available. In this case the gateway questions (Items C0100, D0100 and/or J0200) should be coded No (0) and the staff assessment should be completed. Z0400, Signatures of Persons Completing the Assessment or Entry/Death Reporting, and Z0500, Signature of RN Assessment Coordinator Verifying Assessment Completion, must reflect the actual completion date of this assessment.

CMS is providing this opportunity to rectify the current situation related to missing and incomplete discharge assessments. Facilities must complete the above steps to address the completion and submission of discharge assessments as soon as possible, but no later than September 30, 2013.

Importance and CMS Policy

The CMS emphasized the importance of meeting requirements related to discharge assessments in the March 2012 MDS Provider Training. QM data integrity is heavily dependent on Discharge assessments. Therefore, facilities should have policies and procedures that ensure timely and accurate completion and submission of these assessments. Details about the timing requirements for Discharge assessments are available in Chapter 2 of the Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0 accessible via the following link: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.

The previous steps listed under facility procedures above address any currently incomplete and/or unsubmitted discharge assessments in existence from the date of the release of this memo through September 30, 2013. The following is CMS policy for the completion and submission of stand-alone discharge assessments:

- A discharge assessment must be completed when the resident is discharged from the facility (whether or not return is expected).
- A discharge assessment must be completed (Item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days).
- Submission of the discharge assessment must occur within 14 days after the MDS completion date (Z0500B + 14 calendar days).

Please note that for a discharge assessment, the Assessment Reference Date (ARD) is not set prospectively, as with other assessments. The ARD for a discharge assessment is always the discharge date.

In situations where the resident is discharged prior to the end of the prescribed ARD window, including grace days when appropriate, for a required assessment (e.g., PPS, OBRA) where the discharge assessment is to be combined with the required assessment, the ARD of that required assessment must have been set in order for the facility to adjust the ARD to equal the discharge

date. In the event the ARD has not been set to allow for adjustment of the ARD of the PPS- or OBRA-required assessment, the stand-alone discharge assessment must be completed and the other PPS- or OBRA-required assessment is considered a missed assessment.

Contact: Please direct any additional questions or concerns regarding this memorandum to your State Resident Assessment Instrument (RAI) Coordinator.

Effective Date: Immediately. This information should be communicated with all survey and certification staff, their managers, and the State/Regional Office training coordinators within 14 days of this memorandum.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management