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ACRONYMS:

Assessment Reference Date (ARD)

Care Area Assessment (CAA)

Centers for Medicare and Medicaid Services (CMS)

CMS Long Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 (RAIM3)

Minimum Data Set (MDS)

Omnibus Budget Reconciliation Act (OBRA)

INSIDE THIS ISSUE:

Maintenance of 15 Months of MDS	1
Medicare 5-day or Readmission/Return	2
Discharge MDS or Death in Facility Record	2
MDS News in Review	3
Read a Validation Report	3
Read a Validation Report Cont'	4
Sign Up a Second QIES User	4
Contact Us/ Websites	5

The MDS Mentor

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Maintenance of 15 Months of MDS

One of the many MDS decisions that facility staff must make is choosing the method that will be used to maintain 15 months of MDS assessments and records in the resident's active clinical record.

First, you must know that the timeframe for the maintenance of MDS begins with the resident's admission to the facility. When a resident is discharged return anticipated and returns within 30 days, according to page 2-6 of the RAIM3, "the facility must copy the previous RAI and transfer that copy to the new record. The 15-month requirement for maintenance of the RAI data must be adhered to." However, when a resident is discharged return anticipated and does not return within 30 days or when a resident is discharged return not anticipated, then "facilities may develop their own specific policies regarding ... whether or not to copy the previous RAI to the new record."

The RAIM3, page 2-6, notes that after 15 months, "RAI information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff, State agency surveyors, CMS, or others as authorized by law. The **exception** is that demographic information (Items A0500-A1600) must be maintained in the active clinical record until the resident is discharged return not anticipated."

Now, let's move on to how the MDS may be maintained. The RAIM3, page 2-6, offers 3 options:

1. Maintain the MDS entirely electronically with the use of electronic signatures. "Nursing homes may use electronic signatures for clinical record documentation, including the MDS, when permitted to do so by state and local law and when authorized by the long-term care facility's policy ... Facilities must have written policies in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs." The State of Texas does allow for the use of electronic signatures within CMS guidelines.

2. Another option is to maintain the MDS electronically without the use of electronic signatures. In this case, "nursing homes must maintain, at a minimum, hard copies of signed and dated CAA(s) completion (Items V0200B-C), correction completion (Items X1100A-E), and assessment completion (Items Z0400-Z0500) data that is resident-identifiable in the resident's active clinical record."



3. Maintain the entire MDS in hard copy in the active clinical record. Be aware that facility staff determine what charts/binders/storage devices make up a resident's active clinical record. "Nursing homes must also ensure that clinical records, regardless of form, are maintained in a centralized location as deemed by facility policy and procedure (e.g., a facility with five units may maintain all records in one location or by unit or a facility may maintain the MDS assessments and care plans in a separate binder). Nursing homes must also ensure that clinical records, regardless of form, are easily and readily accessible to staff (including consultants), State agencies (including surveyors), CMS, and others who are authorized by law and need to review the information in order to provide care to the resident." Furthermore, Medicaid certified facilities need to be aware of **HHSC Rule 371.214(p)(2)** "In order to receive Medicaid reimbursement, a nursing facility that utilizes a clinical record system which is entirely electronic must maintain a hard copy of all MDS assessments in the recipient's clinical record. The hard copy of an MDS assessment must include the signatures, title, and date of all individuals completing the MDS."

A HAPPY
NEW YEAR



Medicare 5-Day or Medicare Readmission/Return

A synopsis of the instructions on page 2-46 of the RAIM3 is that a Medicare 5-Day (A0310B=01) assessment is the first Medicare-required assessment completed on a resident admitted to a Skilled Nursing Facility (SNF) for a Medicare Part A stay. Yes, an Entry Record is required for new or returning Medicare Part A stays but an Entry Record is not an assessment. In addition, a Medicare 5-Day is also “the first Medicare-required assessment to be completed when the resident is re-admitted to the facility following a discharge assessment - return not anticipated or if the resident returns more than 30 days after a discharge assessment - return anticipated”

On the other hand, a Medicare Readmission/Return assessment (A0310B=06) is “completed when a resident whose SNF stay was being reimbursed by Medi-

care Part A is hospitalized, discharged return anticipated, and then returns to the SNF from the hospital within 30 days and continues to require and receive Part A SNF-level care services. Under these conditions, the entry tracking record completed upon return to the SNF will be coded as a reentry with Item A1700 = 2. (RAIM3, page 2-47).”

When not combined with other reasons for assessment, both the Medicare 5-Day and the Medicare Readmission/Return assessment “must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).” If either assessment is combined with the OBRA Admission assessment, the assessment must be completed by the end of day 14 of admission (admission date plus 13 calendar days). Source: RAIM3, pages 2-45 and 2-47, respectively.



Wishes

May your holidays
be happy,
May your New
Year be grand,
And may MDS 3.0
coding,
Become easier to
understand.

Discharge MDS or Death in Facility Record

It does not matter if the timeframe since admission to the facility is measured in minutes, hours, days or years; when a resident dies after admission to and while physically present in a facility, a Death in Facility record is required. A discharge assessment is not required. In addition, a Death in Facility record cannot be combined with any other MDS assessment.

But what if a resident is not in the facility at the time of death? If a resident is only on a leave of absence (LOA) and not discharged, a Death in Facility record is still required. The RAIM3, page 2-12, defines a LOA as:

- A temporary home visit; or
- temporary therapeutic leave; or
- hospital observation stay less than 24 hours and the hospital does not admit the resident.

The following list provides some examples of when this rule would apply:

If a resident is on a LOA with family or facility staff (i.e., dinner, movie, appointment, shopping) and dies without being admitted to a hospital.

If a resident dies in an ambulance on the way to the hospital and is pronounced dead on arrival.

If a resident dies while away from the facility for less than 24 hours in the emergency department (ED) for treatment and is not admitted to the hospital.

When required, a Death in Facility record (RAIM3, page 2-36):

- Must be completed within 7 days after the resident’s death, which is the discharge date (Item A2000) (i.e., discharge date (A2000) + 7 calendar days).
- Must be submitted within 14 days after the resident’s death, which is the discharge date (A2000) (i.e., discharge date (A2000) + 14 calendar days).

Conversely, if a resident is sent to the ED and is out of the facility for 24 hours or more when death occurs, then a discharge assessment is required. Note that it is not the length of the hospital-generated observational stay orders that matter, it is the length of time that the resident is away from the facility. For example, a resident leaves a facility at 9:00 AM with MD orders to send to the ED. At 10:30 AM in the ED, the MD orders a 23 hour observational stay but no admission. At 9:15 AM the following morning, the resident dies in the ED. The resident was out of the facility for a hospital stay that was greater than 24 hours, counting from the time the resident left until death, but was never admitted. A discharge assessment is required.

If a resident is sent to the ED and is admitted to the hospital and then passes away, a discharge assessment is always required.



MDS News in Review

1. Appendix F – MDS 3.0 Item Matrix has been added to the RAIM3 on the CMS website (website link on page 5).
2. CMS reevaluated MDS 3.0 item A0310E and announced on December 9, 2010 that facilities only need to follow the RAIM3 instructions for coding this item. Also, CMS is not requiring facilities to go back and correct this item if it was coded according to the initial MDS Transition Document instructions.
3. The CMS Automated Submission and Processing System (ASAP) experienced multiple RUG calculation issues in October and November. All RUG calculation issues have now been resolved and RUG values calculated by CMS for MDS submitted since October 1, 2010 should be correct.
4. CMS posted training videos on YouTube that address most of the MDS Sections and VIVE - Video on Interviewing Vulnerable Elders. Links to those videos can be found on the CMS MDS 3.0 Training Materials webpage.



DO NOT transmit Medicare MDS completed for Medicare Replacement Policies. Also, DO NOT combine with OBRA MDS that must be transmitted.

For A0410 on these MDS, code a “1” for neither federal nor state required submission.

For A2400A on these MDS, code a “0” for no.

How to Read a Validation Report

If you are unsure of how to read an MDS final validation report in CASPER, you are not alone. Many MDS Coordinators have had difficulty understanding the validation reports. This article will provide the basics of how to read a validation report message and determine the appropriate action to take. Below is an example of a final validation report message:

```
MDS 3.0 Item(s):          Z0250B, RECALCULATED_Z0250B
Invalid Data Submitted:   08, 1.0048
Message Number:          -3616b          WARNING
Message:                  Incorrect RUG Logic Version: The
                           submitted value of the RUG version code
                           does not match the value calculated by
                           the QIES ASAP System.
```

MDS 3.0 Item(s) are labels. They can be labels for MDS items that a facility submitted (A0100A, Z0250B), labels for MDS items that CMS calculated based on the MDS submitted (RECALCULATED_Z0250B) or labels for facility or record information that are stored in the CMS database (Existing record MDS_ASMT_ID, Current Value).

Invalid Data Submitted are data values that match the corresponding labels listed above them on the validation report. NOT ALL data values are invalid - “Invalid Data Submitted” is an inaccurate name. Data values are separated by commas, even if the data value is blank. The first “Invalid Data Submitted” data value corresponds to the first label (Z0250B = 08), the second data value corresponds to the second label (RECALCULATED_Z0250B = 1.0048), etc.

In the validation message above, the provider submitted a value of 08 in MDS 3.0 Item Z0250B and CMS calculated that Z0250B should be 1.0048 because that is the correct value for Z0250 in Texas. Now that you know how to read the labels and data values, you can address the issue in the “Message”. In the example above, the facility needs to set up their software properly or have their software fixed so that the correct data is submitted in MDS 3.0 Item Z0250B and matches the CMS calculated value.

Now let us practice with another validation report message. Try to figure out yourself which values the facility sent in which MDS items, and which values came from CMS. Can you guess what needs to happen based on the information below?

```
MDS 3.0 Item(s):          A0100B, Current Value, A0100C, Current Value
Invalid Data Submitted:   ^ , 7799999999, 001015999, 102999
```

Go to page 4 to check your answer.



An Entry Tracking Record must be submitted for EVERY Admission and Reentry. A return from LOA does not require an Entry Tracking Record.



How to Read a Validation Report Cont'

MDS 3.0 Item(s): A0100B, Current Value, A0100C, Current Value
Invalid Data Submitted: ^ , 779999999, 001015999, 102999

In the example above, the facility submitted a blank in MDS 3.0 item A0100B (CCN) and CMS calculated that the correct value should be 779999999. Also, the facility submitted 001015999 in MDS 3.0 item A0100C (State Provider Number) and CMS calculated that the correct value should be 102999. The facility needs to update the CCN to 779999999 and the State Provider Number to 102999 in their software's facility information screen. Getting the hang of it? Now let's try something different.

MDS 3.0 Item(s): A0310F, Submission Date, X0100, Z0500B
Invalid Data Submitted: 11, 20101103, 1, 20101018

In the example above, all of the labels and data values come from the facility's MDS record. What is wrong with this MDS? The issue is not obvious from the labels and data values so now look at the validation description.

Message Number: -3789d WARNING
Message: Record Submitted Late: The submission date is more than 14 days after Z0500B on this new (X0100 equals 1) discharge assessment(A0310F equals 10 or 11).

All of the "MDS 3.0 Item(s)" labels (A0310F, Submission Date, etc.) are listed because validation edit -3789d checked them and determined there was an issue (note that they are all mentioned in the "Message"). We can tell from the labels and data values that the discharge assessment was originally signed by the RN on October 18th and submitted on November 3rd. Are any of the data values invalid or incorrect? Possibly. If you double-check the MDS in your software and find incorrect information, such as an incorrectly entered Z0500B, the MDS can be corrected and a modification submitted. If all of the data values are correct and valid then the MDS was definitely submitted late, there is nothing to change and the facility should take steps to avoid late MDS in the future.

For more information on what the validation messages mean and how to respond to them, go to www.QTSO.com, click on the "MDS 3.0" link, and refer to Chapter 5 of the "MDS 3.0 Provider User's Guide." If the MDS 3.0 Provider User's Guide does not help resolve the issue then contact your MDS Automation Coordinator (contact information on back page).



"I have had a holiday,
and I'd like to take it
up professionally."

Kylie Minogue

"If there is no joyous
way to give a festive
gift, give love away."

Unknown

Sign Up a Second QIES User

One out of six providers in Texas have only one user signed up with a QIES user account and that could spell trouble if you are one of those providers. The QIES user account allows MDS and Swing Bed Coordinators to submit MDS data using the CMS MDS website and to view provider reports in CASPER. If only one person at a provider has QIES access and that person leaves, it may take a while for someone else to request and be given access. While waiting for QIES access, a provider might fall behind on submitting MDS records and be forced to submit MDS late.

CMS recommends that all providers have at least two people signed up with QIES user accounts so that the primary Coordinator has a back-up in case they become unavailable for whatever reason. Sign up a second QIES user by completing the MDS Individual User Account Request on the QIES Technical Support Office website at:

<https://www.qtso.com/accessmids.html>.

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Useful Web Links



DADS MDS Web Site: Texas MDS site for MDS policy, procedures, clinical and technical information (including The MDS Mentor).

<http://www.dads.state.tx.us/providers/MDS/>



Sign up for MDS Resource E-mail updates: Go to <http://www.dads.state.tx.us/>, click on the “E-mail updates” tab and follow the directions. The “DADS Texas Minimum Data Set (MDS) Resources” E-mails are the key line of communication for MDS updates and alerts to nursing home and swing bed facilities from the DADS MDS staff.



Centers for Medicare & Medicaid Services (CMS) MDS Web Site for MDS 3.0: MDS 3.0 Highlights, RAI Manual, Item Sets (forms), related MDS 3.0 materials, and a link to MDS 2.0.

http://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp



QIES TECHNICAL SUPPORT OFFICE (QTSO): MDS 3.0/2.0, jRAVEN/RAVEN and AT&T Client Software information. Validation Report Messages, Guides, Training and DAVE/DAVE 2 Tip sheets.

<https://www.qtso.com/>



CMS MDS Training Web Site: MDS 2.0 computer-based training (CBT).

<http://www.mdstraining.org/upfront/ul.asp>



Quality Reporting System (QRS): DADS information site on Texas nursing homes.

<http://facilityquality.dads.state.tx.us/>



Nursing Home Compare: CMS site that compares nursing homes in a given area.

<http://www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteria.asp>



5 Star Technical Manual: Explains data used to create the 5 Star Report.

http://www.cms.gov/CertificationandCompliance/13_FSQRS.asp#TopOfPage

