# The MDS Mentor

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The MDS Mentor is published in March, June, September, and December each year.

ACRONYMS:

Assessment Reference Date (ARD)

Centers for Medicare and Medicaid Services (CMS)

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

Leave of Absence (LOA)

Minimum Data Set (MDS)

Omnibus Budget Reconciliation Act (OBRA)

Prospective Payment System (PPS)

Resource Utilization Group (RUG)

Skilled Nursing Facility/ Nursing Facility (SNF/NF)

## Key Coding Tips To Know about Section O

This article highlights some key coding tips for the items in O0100 Special Treatments, Procedures and Programs. However, only excerpts and clarification of items commonly overlooked or questioned are provided. Please read the RAIM3 for each item for complete coding instructions. As a reminder, all O0100 items can be performed by the resident themselves, independently or after set-up by facility staff (RAIM3, page O-1). In addition, all O0100 items do **not** include services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures (RAIM3, page O-1).

**O0100A** Chemotherapy — The drugs coded here are those actually used for cancer treatment. Do **not** code drugs that are given for cancer prevention, to shrink benign tumors that are not cancerous or to stimulate the appetite. Also, do **not** record IV fluids, IV medications or blood transfusions administered during chemotherapy in items K0500A (Parenteral/IV), O0100H (IV Medications) or O01001 (Transfusions). "During chemotherapy" includes the entire time at the chemotherapy location during the chemotherapy process, including immediately prior to and after the chemotherapy treatment (RAIM3, page O-2).

**O0100C Oxygen therapy** — Code continuous or intermittent oxygen administered via mask, cannula, etc., to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do **not** code hyperbaric oxygen for wound therapy in this item (RAIM3, page O-3).

**O0100D Suctioning** — Code only tracheal and/or nasopharyngeal suctioning in this item. Do **not** code oral suctioning here(RAIM3, page O-3).

**O0100E Tracheostomy care** — Code cleansing of the tracheostomy **and/or** cannula in this item(RAIM3, page O-3).

**O0100F Ventilator or respirator** — A resident who is being weaned off of a respirator or ventilator in the last 14 days still has the usage of the device coded here. Do **not** code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP (RAIM3, page O-3).

**O0100G BiPAP/CPAP** — If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code it in this item (RAIM3, page O-3).

**O0100H IV medications —** Code any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Do **not** code flushes to keep an IV access port patent or IV fluids without medication here. Epidural, intrathecal, and baclofen pumps are coded in this item. Subcutaneous pumps are **not** coded here. Do **not** include IV medications of any kind that were administered during dialysis or chemotherapy. Normal Saline, Dextrose 50% and/or Lactated Ringers given IV are **not** considered medications and are **not** coded in this item (RAIM3, page O-3).

## Key Coding Tips to Know About Section O

If a resident receives special treatments, procedures and/or programs during the look-back period but while on an authorized Leave of Absence (LOA) from the nursing home, those services are coded as received under the "While a Resident" column.

**O0100I Transfusions** — Code transfusions of blood **or** any blood products (e.g., platelets, synthetic blood products), which are administered directly into the bloodstream here. Do **not** include transfusions that were administered during dialysis or chemotherapy (RAIM3, page O-4).

**O0100J Dialysis** — Code peritoneal or renal dialysis that occurs at the nursing home or at another facility in this item. IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are **not** to be coded under items K0500A (Parenteral/IV), O0100H (IV medications), or O0100I (transfusions).

**O0100K Hospice care —** The hospice **must** be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider (RAIM3, page O-4).

**O0100M Isolation or quarantine for active infectious disease** — Do **not** code this item if the resident only has a history of infectious disease (e.g., s/p MRSA or s/p C-Diff - no active symptoms). Do **not** code this item if the precautions are standard precautions. The isolation criterion would **not** apply to residents with urinary tract infections, encapsulated pneumonia, and/or wound infections (RAIM3, page O-4).

## Coding Item O0600 Correctly

Physician examinations that occurred during the 14-day look-back period based on the ARD are captured in Item O0600 on the MDS. As always, it is important that the coding instructions in the RAIM3 be followed to ensure MDS accuracy and correct reimbursement.

First, ensure staff are counting and coding the number of **days** that the physician examined the resident, not the number of times. From page O-39 "Record the **number of days** that physician progress notes reflect that a physician examined the resident (or since admission if less than 14 days ago)."

Second, ensure the source for all physician examinations coded on the MDS is the physician progress notes. It is not acceptable for a nurse to document that the physician examined the resident in the nurse's notes and have that be the only source for coding item O0600.

Third, ensure staff understand the RAIM3 definition of physician, from page O-39 "Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law." For example, an Ophthalmologist is a medical doctor but an Optometrist is not. Likewise, a Psychiatrist is a medical doctor but a Psychologist (PhD) is not. Licensed psychological therapy by a Psychologist should be recorded in O0400E, Psychological Therapy.

Next, continuing on page O-39 of the RAIM3, ensure staff understand that the "Examination (partial or full) can occur in the facility or in the physician's office." Telehealth visits may even be counted as long as the requirements for physician/practitioner type are met and it qualifies as a telehealth billable visit. Furthermore, "if a resident is evaluated by a physician off-site (e.g., while undergoing dialysis or radiation therapy), it can be coded as a physician examination as long as documentation of the physician's evaluation is include in the medical record." Just ensure that when staff include the documentation in the medical record, it is placed in the physician progress notes.

Finally, do **not** include visits made by Medicine Men (RAIM3, page O-39).

## When Were MDS Assessments Dated as Complete in Z0500B?

MDS assessments were dated as complete in Z0500B an average of 4 days after the assessment reference date (ARD+4), according to an analysis of all Texas assessments with an ARD between October 2011 and March 2012. Almost 90% of MDS assessments were dated as complete within 10 days after the ARD, plenty of time before the 14 day requirement for signing a comprehensive, quarterly or Medicare PPS assessment as complete. These figures are presented as a statewide comparison for individual facility practice.

All 5-day Medicare PPS assessments, alone and combined, were dated as complete 1 day earlier than most other assessments (ARD+3), even though they had the same 14 day period in which they had to be completed. Admission/14-day combined assessments were dated as complete an average of 1 day after ARD (ARD+1), as would be expected since Admission assessments must be completed by entry+13 days. Discharge assessments, alone and combined, took 2 days longer to complete than average (ARD+6).

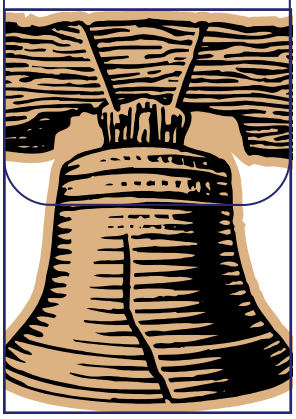
More MDS assessments are dated as complete on ARD+1 than any other day. ARD and ARD+2 are also popular days to date the completion. Some types of assessments see small surges of completion dates on days ARD+6 or ARD+14.

According to this information, Texas MDS coordinators are to be commended for exceeding state and federal requirements for MDS assessment completion. Congratulations! Please continue to pay close attention to completion timeframes to ensure continued success.

Liberty without learning is always in peril and learning without liberty is always in vain—John Fitzgerald Kennedy

Any society that would give up a little liberty to gain a little security will deserve neither and lose both. —Benjamin Franklin

Therefore, send not to know for whom the bell tolls, it tolls for thee—John Donne



## SCSA and Quarterly after Reentry

Scenario: A resident is scheduled for an OBRA Quarterly assessment with an Assessment Reference Date (ARD) of 4/17, the last possible day that the Quarterly assessment can scheduled. The resident is discharged return anticipated from the nursing home on 4/15, is admitted to the hospital, and returns to the nursing home as a reentry on 4/16. On 4/18, the nursing home staff determines that a Significant Change of Status Assessment (SCSA) is required. How does the nursing home staff address the Quarterly and SCSA assessments that are due?

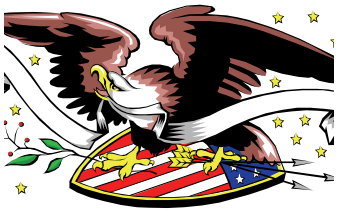
Try to answer the question yourself, and then read the correct solution below.

Solution: The Quarterly assessment must be changed to a SCSA. The SCSA must have the same ARD as the original Quarterly. The nursing home must have documentation that the Quarterly was started on or before the ARD. From page 2-29 RAIM3, "If a significant change in status is identified in the process of completing any assessment except Admission and SCSAs, code and complete the assessment as a comprehensive SCSA instead."

**National Provider Identification (NPI)**

If your facility undergoes a Change of Ownership (CHOW), your NPI will change. All MDS with an ARD before the CHOW date must have the old NPI. All MDS with an ARD on or after the CHOW date must have the new NPI. Contact your software vendor for help changing the NPI.

# Adjusting the ARD for a Scheduled Medicare MDS



Centers for Medicare and Medicaid Services (CMS) staff have clarified that when a resident on a Medicare Part A stay is discharged, the Assessment Reference Date (ARD) of a scheduled Medicare Prospective Payment System (PPS) assessment may be adjusted to the day the resident is discharged only when the ARD for the scheduled PPS assessment was set prior to the day of discharge. From page A-26 of the MDS 3.0 RAI Manual: "When the resident dies or is discharged prior to the end of the look-back period for a required assessment, the ARD must be adjusted to equal the discharge date."

The ARD should be adjusted on the day of discharge or as soon thereafter as facility staff becomes aware the resident has been discharged. However, in all cases, the ARD must be adjusted no later than day 14 after discharge. As mandated on pages 2-44 and 2-45 of the MDS 3.0 RAI Manual, all required Medicare PPS MDS "Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days)." Beyond 14 days after discharge, the scheduled PPS assessment becomes a missed assessment.

The following three scenarios illustrate this guidance:

**Scenario One:** Facility staff set an ARD for day 8 for a PPS 5 day. On day 5, the resident was discharged. On the day of discharge or 1 to 14 days after discharge, staff can adjust the ARD to day 5, as long as the PPS MDS is completed no more than 14 days after the adjusted ARD.

**Scenario Two:** Facility staff set an ARD for day 18 for a PPS 14 day. On day 17, the resident was discharged. Fifteen or more days after discharge, staff can NOT adjust the ARD to day 17.

**Scenario Three:** Facility staff had a resident admitted for a Medicare Part A stay. Facility staff never set an ARD in the facility MDS software or on an MDS item set for a PPS 5-day. On day 3, the resident was discharged. Facility staff can NOT adjust the ARD to day 3 because there is no ARD to adjust. From page 2-72 of the MDS 3.0 RAI Manual:

> If the SNF fails to set the ARD prior to the end of the last day of the ARD window, including grace days, and the resident was already discharged from Medicare Part A when this is discovered, the provider cannot complete an assessment for SNF PPS purposes and the days cannot be billed to Part A. An existing OBRA assessment (except a stand-alone discharge assessment) in the QIES ASAP system when specific circumstances are met may be used to bill for some Part A days. See chapter 6, Section 6.8 for greater detail.

**Note:** Chapter 6, Section 6.8, which is located on pages 6-53 to 6-54 of the RAIM3, explains the exceptions and the criteria that must be met for nursing home staff to bill for Medicare Part A stays without a PPS assessment and/or with an OBRA assessment substituted for the PPS assessment. For example, on page 6-53, the RAIM3 lists "instances when the SNF may bill the default code when a Medicare-required assessment does not exist in the QIES ASAP system." The first example listed is when the Medicare Part A "stay is less than 8 days within a spell of illness."

### Importing CMI Values into jRAVEN

Texas nursing home staff who use jRAVEN to enter and submit MDS records must set up the Texas Medicaid Case Mix Index (CMI) values into a custom CMI set. Previously, Texas nursing homes had to create the custom Texas CMI set and hand enter all of the CMI values for each RUG. DADS now has the Texas custom CMI set available for import so that values do not have to be hand entered. Instructions for importing the Texas custom CMI set can be found on the DADS MDS website, under Step 2: Set up software, in the jRAVEN/RAVEN RUG Setup Instructions.

http://www.dads.state.tx.us/providers/MDS/introduction/step2.html

## MDS News in Review

- April 14, 2012 - RAI Manual Errata v3 and v4 were posted on the CMS MDS 3.0 RAI Manual website. They are critical updates that are not included in the core MDS 3.0 RAI Manual (April 2012).
- May 4, 2012 - jRAVEN 1.1.5 was posted on the QTSO website. This update fixed errors found in jRAVEN 1.1.4 that was created to include the MDS 3.0 changes implement on April 1, 2012.
- May 23, 2012 - The DADS MDS website "Step 6: Correct your data" was updated with the recent CMS inactivation policy clarification.
- June 1, 2012 - The DADS MDS website "Links and resources" was updated with additional links to other state MDS websites.
- June 2012 - CMS moved the MDS 3.0 QM User's Manual Version 5.0. to the Quality Measures web page and added an errata at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html.

## Common MDS Mistakes 2012

The MDS is complicated. There is a lot to learn and remember. The DADS MDS staff recommends that MDS Coordinators read the entire MDS 3.0 RAI Manual (RAIM3) at least once a year, cover to cover. Now is a great time to confirm and update your knowledge of MDS by reading the April 2012 version of the RAIM3 in its entirety, errata documents, and Medicare clarifications that are available on the CMS website. Do not skim the manual; read it critically, looking for any information you forgot, you learned differently, or CMS changed since the last time you read it thoroughly. Some MDS Coordinators made the following mistakes in past months because they were unfamiliar with MDS 3.0 requirements.

- A0310F. An Entry tracking record is required EVERY time a resident admits to a facility or reenters after a discharge return anticipated. (Page 2-32) CMS says that all missed entry tracking records are required to be completed for any records with an entry date of December 2010 or later. The Entry tracking record is not an assessment, and does not have an ARD, so there are no limitations on how late it can be sent. A wrong entry date in A1600 on an Entry record requires that the record be inactivated to correct the date per Chapter 5 of the RAIM3. However, incorrect entry dates on MDS assessments do NOT require inactivation to correct and may be corrected by the modification process.
- A0600B. If no social security number is available for the resident (e.g., if the resident is a recent immigrant or a child) the item may be left blank. Do not enter a number that is not the resident's valid social security number. (Page A-7) A0600B can be corrected with a modification according to Chapter 5 of the RAIM3.
- A0700. The OBRA assessment must have a "+" or a valid resident Texas Medicaid number for the record to be loaded into the TMHP Portal for Texas Medicaid. If the MDS is not in the Texas Medicaid Portal, the first step is to review the electronic record in your MDS data entry software and ensure that A0700 has the correct value; even if you have a paper printout of the MDS (the electronic version may be different). A0700 can be corrected with a modification according to Chapter 5 of the RAIM3.
- Medicare HMO/Medicare replacement/Medicare Part C might require assessments resembling MDS PPS or OMRA assessments to be completed but those assessments are NOT to be submitted to CMS and may not be combined with OBRA assessments that are submitted to CMS. Please reference the MDS Mentor September 2011 article *Private Pay and Medicare Part C MDS* for more details.
- Any time an MDS record is rejected on the MDS 3.0 Final Validation Report due to a skip pattern error, contact your software vendor for assistance; it is usually a user error or software glitch.

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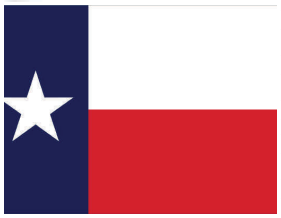

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## Useful Web Links

**DADS MDS Web Site**: Texas MDS site for MDS policy, procedures, and 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" emails 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 3.0 website**: MDS 3.0 RAI Manual, Item Sets (forms), related MDS 3.0 materials and left-side table links to MDS technical information and MDS 2.0.
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

**Centers for Medicare & Medicaid Services (CMS) FY 2012 RUG-IV Education & Training**: Clarification and follow-up documents related to Medicare MDS.
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/RUGIVEdu12.html

**QIES TECHNICAL SUPPORT OFFICE (QTSO)**: MDS 3.0/2.0, jRAVEN/RAVEN and CMSNet (Verizon) information. Validation Report Messages, Guides, Training and DAVE/DAVE 2 Tip sheets.
https://www.qtso.com/

**Quality Reporting System (QRS)**: DADS information site on Texas nursing homes.
http://facilityquality.dads.state.tx.us/qrs/public/qrs.do

**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/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html

This guidance is being provided on the published date of The MDS Mentor. The reader should be aware that guidance regarding topics in The MDS Mentor may be time-limited and may be superseded by guidance published by CMS or DADS at a later date. It is each provider's responsibility to stay current with the latest CMS and DADS guidance.