

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

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)

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The MDS Mentor

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00400D Respiratory Therapy

From the RAIM3, page 0-18: “For purposes of the MDS, providers should record services for respiratory, psychological, and recreational therapies (Item 00400D, E, and F) when the following criteria are met:

1. the physician orders the therapy;
2. the physician’s order includes a statement of frequency, duration, and scope of treatment;
3. the services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by qualified personnel (See Glossary in Appendix A for definitions of respiratory, psychological and recreational therapies);
4. the services are required and provided by qualified personnel (See Glossary in Appendix A for definitions of respiratory, psychological and recreational therapies);
5. the services must be reasonable and necessary for treatment of the resident’s condition. “

CMS recently clarified that scope of treatment (item 2 above) refers to indicating the condition or disease being treated by the therapy as a part of the physician’s order. Some examples that can be used, but only if they apply to the reason for the respiratory therapy for the resident, are “for Asthma” or “for Chronic Obstructive Pulmonary Disease.”

Qualified personnel for delivering respiratory therapy are respiratory therapists or trained nurses following the state nurse practice act. Some methods of developing trained nurses are to have them trained

by a respiratory therapist or by a RN who was trained by a respiratory therapist or a by a RN who has advanced academic training in respiratory therapy.

Ensure your training covers the respiratory therapy services offered in your facility and is titled as respiratory therapy training. Don't call it nebulizer training -- there is more to respiratory therapy than just one piece of equipment. When the requirement is for respiratory therapy training, that is exactly the title they expect to find in your documentation of the training. In addition, keep all your training materials! 00100D is a payment item and auditors can request that you provide evidence that training was conducted. A sign-in sheet is not evidence that training was conducted, but it is evidence that staff attended a training session. Course scripts or outlines, reference materials, and handouts are evidence that training was conducted.

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00400D Respiratory Therapy

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Ensure that there is documentation in the nurse's files that they were trained by staff qualified to provide the training and that they are competent to provide respiratory therapy services prior to coding any respiratory services on the MDS. Competency is established by having documentation (for one example, a checklist that is initialed by trainee and trainer after successful return demonstration) that shows nurses who were trained were evaluated to ensure they learned and possess the skills to provide respiratory services.

Finally, ensure that the number of days claimed for respiratory therapy in 00400D includes only those days where the resident received at least 15 minutes of set up time and 1 to 1 treatment time of respiratory therapy in one 24 hour day. Also, only the time a therapist or trained nurse remains with the resident during treatment may be counted. Finally, "The time spent on documentation or on initial evaluation is not included." (RAIM3, page 0-16).



Can a LVN Conduct Respiratory Training?

When the title question was asked, CMS wrote "It is a facility responsibility to ensure that staff that conduct respiratory therapy follow their state practice act." A challenge has been that many facility staff are not familiar with the requirements of their state practice act, including the Nursing Practice Act, available on the Texas Board of Nursing (BON) website at <http://www.bon.state.tx.us/index.html>.

However, to assist in clarifying this question and to avoid 1245 facilities in Texas contacting the BON all at once, DADS staff met with BON staff and developed the following clarification, congruent with both agencies' guidelines.

The BON does not maintain a comprehensive list of tasks that LVNs may perform. Each nurse has a different background, knowledge and level of competence and must use their judgment in deciding to accept an assignment. A LVN who has demonstrated competency in providing respiratory therapy services may train other LVNs to provide respiratory therapy, using the following guidelines:

- The curriculum used to train other LVNs must be developed and approved by a certified respiratory therapist, registered nurse, or physician trained to provide respiratory therapy services.
- A LVN may participate in developing the training curriculum to train other LVNs, but cannot develop the curriculum and training materials independently.
- The LVN must demonstrate competency in training other LVNs. This includes having a system in place to document the competency of the LVN to both provide respiratory therapy services and train other LVNs in respiratory therapy services.
- There must be a system in place to periodically establish continued nursing competence – at least annually or at some other specified interval.

MDS News in Review

On January 11, 2011, CMS released new technical specifications that will take effect April 1, 2011. This mostly affects MDS software vendors but includes a change to the Modification/Inactivation policy. Starting April 1, 2011, the reason for assessment items, assessment reference date (ARD), discharge date and entry date can no longer be changed with a modification record on MDS 3.0 records. Instead, these items must be corrected by inactivating the old record and submitting a new record. The April 1, 2011, start date refers to the date that the MDS 3.0 correction record is submitted, not the ARD of the record.

Providers may optionally implement the new correction procedure prior to April 1, 2011. CMS will update chapter 5 of the MDS 3.0 RAI Manual in Spring 2011 to reflect this policy.



On March 29th, 2011, www.QTSO.com made jRAVEN version 1.1.0 available. jRAVEN users should update to the newest version if they have not already.

Discharge Assessments in Detail

We understand that the MDS 3.0 discharge assessment has become the bane of existence for many Swing Bed/Nursing Facility MDS Coordinators. However, it is required by CMS and must be completed correctly. Based on the questions that the Texas DADS MDS program gets related to discharge assessments, there is still confusion over how and when to perform them. Included below are some important details about the often misunderstood discharge assessment.

“A discharge assessment ...

- Must be completed when the resident is discharged from the facility.
- Must be completed when the resident is admitted to an acute care hospital.
- Must be completed when the resident has a hospital observation stay greater than 24 hours.
- Must be completed on a respite resident every time the resident is discharged from the facility.” (RAIM3, page 2-34)

For example, a discharge assessment would be required if a resident was out of the building for a hospital observation stay of 48 hours, because this is clearly more than 24 hours, but a discharge assessment would not be required when the resident goes on a leave of absence (or out on pass). If the resident dies while admitted to your swing bed or nursing facility, dies at the hospital during a 24 hour observation when not admitted, or dies while out on leave of absence, then a death in facility tracking record is required and a discharge assessment is NOT performed. If the resident dies after your facility has discharged him or her, perform a discharge assessment and NOT a death in facility tracking record.

“For unplanned discharges, the facility should complete the discharge assessment to the best of its abilities. The use of the dash, “-”, is appropriate when the staff are unable to determine the response to an item, including the interview items. In some cases, the facility may have already completed some items of the assessment and should record those responses or may be in the process of completing an assessment” (RAIM3, page 2-34). Please note that if the resident interview was dashed because the discharge was unplanned, then the staff assessment for that interview must also be dashed. You cannot perform the staff assessment if the resident is not available (in the building) to perform the resident interview.

Every section of the MDS specifies the look back period for the items in that section. Always report data from the entire look back period. Even though the resident’s status may have changed dramatically just before discharge, the entire look back period for each section must still be observed. The assessment reference date (ARD) of the discharge assessment is always the date of discharge.

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Discharge Assessments in Detail

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When a resident is “discharge - return anticipated,” and does not return within 30 days, Texas does not require facilities to correct the discharge assessment to “discharge - return not anticipated.” This is true if the resident goes to the hospital and then goes to a different nursing facility, goes straight home, dies, etc. In other words, a “discharge - return anticipated” never needs to be updated to “discharge - return not anticipated.” However, if facility or corporate policy is to correct a “discharge - return anticipated” to “discharge - return not anticipated” once it is determined the resident will not return, Texas does allow it to be completed. Last but not least, when a resident returns to the facility over 30 days after a “discharge - return anticipated,” it is considered a new admission and a new OBRA Admission assessment must be completed.



MDS Modification Secrets

When a mistake is discovered in an MDS that has been submitted to CMS, a correction is required. Chapter 5 of the RAIM3 goes into great detail concerning corrections. Modifications are particularly tricky but a few simple secrets can help you perform them correctly.

The least known secret of modifications involves item Z0400 Signatures of Persons Completing the Assessment or Entry/Death Reporting. When any section of an MDS is modified or inactivated, Z0400 must be signed and dated by facility staff who certify the accuracy of the **corrected** data. The facility staff certifying the corrected data may be different from the facility staff who certified prior data. Each signature certifying the accuracy of the corrected data is accompanied by the date that the corrected data was collected or confirmed. Once Z0400 is appropriately signed and dated for the corrected data, the RN Assessment Coordinator can complete item X1100 for the corrected MDS. Never change Z0500 unless that is one of the items that you are modifying because the RN did not sign the assessment on the date indicated; Z0500 is always the signature and date that the RN signed the original MDS assessment.

For example, an assessment needs to be modified because A0700 does not contain a “+” necessary to indicate that Medicaid is pending. To modify the assessment, follow these steps:

1. Complete Section X (except for X1100).
2. Modify A0700 to contain a “+”.
3. To Z0400, add the staff member who completed, and is accountable for, the completion of Section X.
4. To Z0400, add the staff member who completed, and is accountable for, the change to item A0700.
5. The RN Assessment Coordinator signs X1100.

Always remember to complete Section X first before modifying the data in the MDS since this will help to avoid the validation error stating that the original MDS cannot be found. When an incorrect assessment meets the qualifications for a significant correction of a prior quarterly/comprehensive assessment, you must complete a modification of the original incorrect assessment **in addition to** completing a significant correction. You are allowed to submit and modify MDS 2.0 assessments using the MDS 2.0 format up to three years after the ARD of any assessment where the ARD is earlier than October 1, 2010.

“In gratitude, we thank Nurses, their willingness to serve, we find so appealing, bringing to us, their comfort, wisdom, compassion and healing.”

- Written by Richard G. Shuster

A2400C and the Medicare MDS

A difficult task for new MDS coordinators is figuring out the last day of the Medicare stay. This is not only important for filling out item A2400C “End Date of Most Recent Medicare Stay” correctly for a Part A Medicare stay, but also important for ensuring that the Assessment Reference Date (ARD) in item A2300 is always a date when the resident was still receiving Medicare services and a date allowed by the RAIM3 for that type of assessment.

From the coding instructions for A2400C on page A-25 of the RAIM3:

- Code the date of last day of this Medicare stay if A2400A is coded 1, yes.
- If the Medicare Part A stay is ongoing there will be no end date to report. Enter dashes to indicate that the stay is ongoing.
- The end of Medicare date is coded as follows, **whichever occurs first:**

Date SNF benefit exhausts (i.e., the 100th day of the benefit); or

Date of last day covered as recorded on the effective date from the Generic Notice or

The last paid day of Medicare A when payer source changes to another payer (regardless if the resident was moved to another bed or not); or

Date the resident was discharged from the facility (see Item A2000, Discharge Date).

It is essential, when the resident does not exhaust 100 benefit days, that MDS coordinators are aware of any notices provided to a Medicare Part A recipient in the facility. Many times, facility staff will mention that they were unaware that a Generic Notice, listing the last day of Medicare Part A coverage, was provided to the resident.

Next, it is crucial to understand that when a payer source changes, for example from Medicare to Medicaid, that the payment source at midnight is considered the payment source for the entire day. The last day of the Medicare Part A stay would have been the day before the payer source changed.

Finally, the day of discharge can be the ARD of a Medicare Part A assessment, especially when the resident is discharged unexpectedly, when none of the earlier rules for setting the end date of the Medicare stay apply and it is a valid date for that type of MDS. It is suggested that staff review and keep as a reference, the excellent algorithm on page A-26 of the RAIM3.

Incorrect Resident Information

The Texas DADS MDS program has recently received numerous calls related to incorrect resident information. Facilities are not receiving Medicare or Medicaid money because the resident’s name, social security number, etc. are incorrect. Take steps to avoid this issue in the first place and to correct it when it occurs.

Please read the article “Resident Legal Name” on page 4 of the September 2010 *MDS Mentor* (available on the DADS MDS website). Wherever you see a reference to the resident name in the article, you should also consider social security number, Medicare/

Medicaid number, and date of birth.

Implement procedures at your facility, based on what you learn from the “Resident Legal Name” article, to ensure that correct resident information is collected during resident admission. Confirmation up front can help you avoid the issues that arise from incorrect resident information later. If you encounter resident information inconsistencies during admission, or discover an MDS with incorrect resident information, then correct the resident information, whether that correction needs to be made with Medicare, Medicaid, or the MDS itself.



Congratulations to DADS MDS RN Cheryl Shiffer. On February 10, 2011, Cheryl was appointed as the newest member of the RAI Panel, a select group of eight state MDS RAI Coordinators who help all state MDS RAI coordinators with MDS issues. Cheryl’s expertise will now benefit swing bed and nursing facilities across the nation.

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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/u1.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/CertificationandComplianc/13_FSQRS.asp#TopOfPage