Learning Objectives

- Discuss updates to the RAI User’s Manual Sections M - Z
- Identify common errors made with completion of the MDS 3.0 and strategies to avoid them
- Outline the correct process for measuring and recording pressure ulcers in section M of the MDS 3.0
- Discuss Quality Measure pitfalls
M0210. Unhealed Pressure Ulcer(s)

- PrU healed during the look-back period and there is no documented pressure ulcer on the prior assessment – do not capture on current assessment

M0210. Unhealed Pressure Ulcer (s)

- PU Staging is an assessment system that describes and classifies the anatomic depth of soft tissue damage
- Tissue damage can be visible or palpable in the ulcer bed
- Pressure ulcer staging also informs expectations for healing times

\[(p. M-4)\]

M0210. Unhealed Pressure Ulcer

- Scabs and eschar are different both physically and chemically
- Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound
- A scab is made up of dried blood cells and serum, sits on the top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc.)
**M0210. Unhealed Pressure Ulcer**
- A scab is evidence of wound healing
- A pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2 and therefore, staging should not change
- Eschar characteristics and the level of damage it causes to tissues is what makes it easy to distinguish from a scab
- It is extremely important to have staff who are trained in wound assessment and who are able to distinguish scabs from eschar" (p. M-5)

**M0210. Unhealed Pressure Ulcer (s)**
- Oral Mucosal ulcers caused by pressure should not be coded in Section M
- Code these ulcers in item L0200C, Abnormal mouth tissue
- Mucosal ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made (p. M-5)

**M0300A-G. Steps for Completion**

**Step 1: Determine Deepest Anatomical Stage**
- Observe and **palpate** the base of any pressure ulcers to determine the **anatomic depth of soft tissue** damage involved
- Ulcer staging should be based on the ulcer’s **deepest anatomic soft tissue damage that is visible or palpable**
M0300A-G. Steps for Completion

**Step 1: Determine Deepest Anatomical Stage**

- A pressure ulcer is unstageable if the tissues are obscured so that the depth of soft tissue damage cannot be observed.
- A pressure is always classified at the highest numerical stage that it has ever reached, even if it appears now to be a lower stage.
- To increase accuracy, carefully document and track pressure ulcers.

**Step 2: Identify Unstageable Pressure Ulcers**

- Visualization of the wound bed is necessary for accurate staging.
- Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed, should be classified as unstageable.

M0300B. Stage 2 Pressure Ulcers

**Planning for Care**

- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the patient’s overall clinical condition should be reassessed. (p. M-9)

**Coding Tip**

- Do not code skin tears, tape burns, moisture associated skin damage, or excoriation here. (p. M-10)
M0300C. Stage 3 Pressure Ulcers

- Accurately observe and palpate the pressure ulcer to determine its depth
- Bones, tendons, and muscle will not be visible or directly palpable in a Stage 3 pressure ulcer (p. M-12)
- The wound bed may have the presence of granulation tissue

M0300D. Stage 4 Pressure Ulcers

**Coding Tip**
- Cartilage serves the same anatomical function as bone
- Pressure ulcers that have exposed cartilage should be classified as a Stage 4 (p. M-15)

M0300F. Unstageable Pressure Ulcers

**Slough and/or Eschar Coding Tip:**
- Pressure ulcers that are covered with slough and/or eschar should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined
- Only until enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, can the stage of the wound be determined (p. M-17)
M0610. Dimensions of Unhealed Pressure Ulcer

Measurement for each applicable ulcer:
• Length: Measure longest portion of the ulcer along the same line as an imaginary line running from the resident’s head to his/her toes
• Width: Measure widest portion of the ulcer along a line perpendicular (at right angles) to the head-to-toe line
• Multiply length × width (total surface area)

M0610 = the one with the largest surface area
• Also measure depth of the one with largest surface area

M0610. Dimensions of Unhealed Stage 3 or 4 PrU or Unstageable (Due to Slough/Eschar)

Note: Determine longest length (white arrow line) head to toe and greatest width (black arrow line) of each Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar. (M-21)

M0700. Most Severe Tissue Type of Any Pressure Ulcer

• Stage 2 pressure ulcers appear as partial-thickness loss of the dermis
• Granulation tissue, slough or eschar are not present in Stage 2 pressure ulcers
• Stage 2 pressure ulcers should not be coded as having granulation, slough, or eschar tissue and should be coded as 1 [epithelial tissue] for this item

(p. M-24)
Planning for Care: The interdisciplinary care plan should be reevaluated to ensure that appropriate preventative measures and pressure ulcer management principles are being adhered to when new pressure ulcers develop or when pressure ulcers worsen (p. M-25)

Coding Tips
If a numerically staged pressure ulcer increases in numerical staging it is considered worsened.
• If two pressure ulcers merge, do not code as worsened. Although two merged pressure ulcers might increase the overall surface area of the ulcer, there would need to be an increase in numerical stage in order for it to be considered as worsened (p. M-26)

If a pressure ulcer increases in numerical stage during a hospital admission, its stage should be coded on admission and is considered as present on admission/entry or reentry.
• Do not include or code in M0800
• While not included in this item, it is important to recognize clinically on reentry that the resident’s overall skin status deteriorated while in the hospital
• If the pressure ulcer deteriorates further and increases in numerical stage on a subsequent MDS assessment, it would be considered as worsened and would be coded in this item
M0900. Healed Pressure Ulcers

- Number of pressure ulcers noted on the prior assessment that completely closed by ARD of the assessment in progress
- Do not capture on any assessment if:
  - A pressure ulcer developed after ARD of the prior assessment AND
  - Healed before look-back period of assessment in progress

If a pressure ulcer documented on the prior assessment healed between assessments but another pressure ulcer occurred at the same location by the ARD of the assessment in progress, do not consider the first one to have healed and do not record it as healed in M0900

Health-related Quality of Life:
- Pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development before they re-epithelialize
- Stage 3 and 4 pressure ulcers fill with granulation tissue
- This replacement tissue is never as strong as the tissue that was lost and hence is more prone to future breakdown

(p. M-38)
Section M: Skin Conditions

**MYTH:** If documentation for a Stage 2 wound states that there is granulation tissue present, it means the wound is healing.

**FACT:** Stage 2 pressure ulcers by definition have partial-thickness loss of the dermis. M0700, Most Severe Tissue Type for Any Pressure Ulcer, should not be coded as granulation issue. Instead, code 1, Epithelial tissue (p. M-24).

Quality Measure

**High Risk Residents with Pressure Ulcers (Long Stay)**

- Looks at high-risk residents and identifies the percentage with Stage 2-4 pressure ulcers on their latest assessment in the episode
- High-risk = any of the following:
  - Impaired bed mobility or transfer indicated, by **either** or both of the following:
    - Bed mobility self-performance (G0110A1) = [3, 4, 7, 8]
    - Transfer self-performance (G0110B1) = [3, 4, 7, 8]
  - Comatose (B0100 = [1])
  - Malnutrition or at risk of malnutrition I5600 = checked
- Admission, 5-day, Readmission/Return assessments are not included
Pitfalls

- This measure includes only pressure ulcers that are Stages 2–4
- There are a number of criteria, any one of which could qualify a resident as high risk:
  - Bed Mobility and/or Transfers in G0110 Self-Performance coded as a 3, 4, 7, or 8
  - Diagnosis of comatose in B0100
  - Malnutrition or risk of malnutrition indicated in I5600
- This QM collects data only from assessments that are not coded as an initial assessment (PPS 5-day or Admission assessment)

Quality Measure

New or Worsened Pressure Ulcers (Short Stay)

Captures any new or worsening Stage 2-4 pressure ulcers coded on any qualifying assessment since the beginning of the episode
Pitfalls

- Only Stage 2–4 pressure ulcers and does not include unstageable ulcers
- Pressure ulcers that become unstageable are NOT worsened and should not be coded in M0800
- Pressure ulcers that are “present on admission” are NOT worsened and should not be coded in M0800
- Unstageable pressure ulcers debrided for the first time are not worsened

Pitfalls (cont.)

- If a pressure ulcer was numerically staged and becomes unstageable, and is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the pressure ulcer’s current numerical stage has increased, consider this pressure ulcer as worsened. Code these pressure ulcers in M0800

Pitfalls (cont.)

- This QM also has covariates that help level the playing field for a facility that has a larger number of residents with covariate conditions
- The score for a facility with a greater number of residents in the denominator with one or more of the covariate conditions would improve on this QM
- The data collected for this QM is through a look-back scan that includes all of the assessments in the episode of care and may encompass multiple stays
N0410. Medications Received

• Only those medications required to treat the resident's condition are being used, it is important to assess the need to reduce these medications wherever possible and ensure that the medication is the most effective for the resident's assessed condition.' (p. N-4)

• Oxazepam may be used to promote sleep but it is classified as an antianxiety medication and therefore would be correctly coded as an antianxiety medication rather than a hypnotic (p. N-6)

N0410. Medications Received

MYTH: Antibiotic eye ointments are not coded in N0410F, Antibiotic.

FACT: N0410 includes medications given to the resident by any route (e.g., PO, IM, or IV) in any setting (e.g., at the facility, in a hospital emergency room).

Quality Measure

New Antipsychotic Medication Use (Short Stay)
New Antipsychotic Medication Use

- This QM identifies short-stay residents who newly started on antipsychotic medication after the initial assessment and who do not have any of the exclusion diagnoses.
- Does this by capturing the percentage of short-stay residents who received a psychoactive medication on a target assessment but not on the initial assessment.

Pitfalls

- Focuses solely on “newly” received antipsychotic medication by comparing medications on the initial assessment to all subsequent assessments
- The data collected for this QM is through a look-back scan that includes all of the assessments in the episode of care and may encompass multiple stays
- Antipsychotic medications are a major focus in surveys

Quality Measure

Antianxiety and Hypnotic Meds (Long Stay)
Antianxiety & Hypnotic Meds

Long-stay residents with a target assessment, except those with exclusions

Pitfalls

- Medications coded according to the medication’s therapeutic category and/or pharmacological classification rather than how it is used
- Generous list of exclusions consisting mostly of diagnoses that can contribute to anxiety
  - Delusions (E0100B), can be overlooked by the assessor when it is due to dementia

Pitfalls (cont.)

Anxiolytics

- Benzodiazepines, Short-acting, e.g.,
  - alprazolam
  - estazolam
  - lorazepam
  - oxazepam
  - temazepam
Pitfalls (cont.)

Anxiolytics
- Benzodiazepines, Long-acting, e.g.,
  - chlordiazepoxide
  - clonazepam
  - clorazepate
  - diazepam
  - flurazepam
  - quazepam
  - buspirone

Hypnotics
- Benzodiazepine hypnotics, e.g.,
  - estazolam
  - flurazepam
  - Quazepam

  - Sleep hygiene approaches that individualize the sleep and wake times to accommodate the resident's wishes and prior customary routine) prior to initiating pharmacologic interventions

Quality Measure

Antipsychotic Medication Use (Long Stay)
Antipsychotic Medication Use

Captures the percentage of long-stay residents who are receiving a antipsychotic medication in the target period.

Pitfalls

- Exclusion list that is limited to a small number of diagnoses in section I of the MDS
- Diagnoses listed in item I8000 are not considered as exclusions
- Antipsychotic medications are a major focus in surveys

O0100F. Ventilator or Respirator

- Include closed-system mechanical ventilation via tracheostomy or endotracheal tube (nasal or oral ventilation)
- Do not include BiPAP or CPAP
O0100M. Isolation

Four Criteria:
• Active infection, highly contagious, acquired by physical contact, airborne, or droplet transmission
• Precautions must be over and above standard precautions: transmission-based (contact, droplet, and/or airborne)
• In a room alone because of active infection and cannot have a roommate (single room isolation required)
• Resident must remain in his/her room because of the high level of contagion

O0100. Isolation

• Choosing when and how to isolate a resident with a communicable disease requires coordination by the interdisciplinary team
• Determine the best way to contain and prevent transmission
• Based on type of infection and clinical presentation of the specific communicable disease
• Utilize the CDC guidelines:
  • 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings
  • SHEA/APIC Guideline: Infection Prevention and Control in the Long-Term Care Facility

O0100. Isolation

MYTH: A resident is in isolation related to MRSA in his sputum. He is actively coughing and occasionally requires oral suctioning to help clear his secretions. As long as the resident wears a mask, he can attend therapy in the rehab room. This isolation can be coded on the MDS.

FACT: To code isolation on the MDS, the resident must be in a separate room alone and remain in his or her room. This requires that all services be brought to the resident (e.g., rehabilitation, activities, dining).
O0250. Influenza Vaccine

- Info about current flu season can be obtained at www.cdc.gov/flu
- Flu season essentially starts when vaccine is available in your area and continues until flu is no longer active in your area
- Once flu vaccine has been administered to a resident for current flu season, carry this forward on MDS assessments until the next flu season begins

Quality Measure

Vaccination Quality Measures

Influenza Vaccinations – Short Stay

Assessed and appropriately given the vaccine, –
Looks at all short-stay residents with a qualifying target assessment during the most recent six months
- Except residents who were not in the facility during the most recent influenza season
- This measure is only calculated once a year with a target period of October 1 of the prior year to June 30 of the current year and reports for the October 1 through March 31 influenza vaccination season.
Influenza Vaccinations – Short Stay

Assessed and appropriately given the vaccine
Computes the percentage who:
• Received the influenza vaccine for most recent flu season either in this facility or outside of this facility
• Declined the vaccine when offered
• Were ineligible due to medical contraindications

Influenza Vaccinations – Short Stay

Three additional flu vaccine QMs break out:
1. Residents who received the flu vaccine during the most recent flu season, either in or outside of the facility
2. Residents who were offered and declined the flu vaccine
3. Residents who were ineligible due to medical contraindications
Residents not in facility during the most recent flu season are excluded for all three.

Influenza Vaccinations – Short Stay

Exclusions for all four flu vaccine QMs:
1. O0250C = [1] (resident not in facility during the most recent influenza season)
2. Resident’s age on target date of selected target assessment is 179 days or less

Note:
This measure is only calculated once a year with a target period of October 1 of the prior year to June 30 of the current year and reports for the October 1 through March 31 influenza vaccination season.
Pneumococcal Vaccine – Short Stay

Assessed and Appropriately Given the Vaccine
- Looks at short-stay residents with a target assessment
- Computes the percentage:
  - With PPV status up to date
  - Declined the vaccine when offered
  - Were ineligible due to medical contraindications

3 additional QMs break out separately
- PPV status up to date
- Were offered and declined
- Were ineligible due to medical contraindications

Exclusion for all 4 PPV QMs
- Resident’s age on target date of selected target assessment is less than 5 years (i.e., resident has not yet reached 5th birthday on target date
Influenza Vaccine – Long Stay

Looks at all long-stay residents with a qualifying target assessment during the most recent three months.

- Except residents who were not in the facility during the most recent influenza season
- This measure is only calculated once a year with a target period of October 1 of the prior year to June 30 of the current year and reports for the October 1 through March 31 influenza vaccination season.

Computes the percentage who:

- Received the influenza vaccine during most recent flu season either in this facility or outside of this facility
- Declined the vaccine when offered
- Were ineligible due to medical contraindications

Three additional flu vaccine QMs break out:

- Residents who received the flu vaccine during the most recent flu season, either in or outside of the facility
- Residents who were offered and declined the flu vaccine
- Residents who were ineligible due to medical contraindications

Residents not in facility during the most recent flu season are excluded for all three.

Pitfalls. Influenza Vaccine

- Influenza QMs are calculated once a year, with a target period of October 1 of the prior year to June 30 of the current year, and they report for the October 1 through March 31 influenza vaccination season
- Do not confuse with the coding rules in O0250 where influenza season is defined as beginning when the vaccine is available and continuing until influenza is no longer active in the geographical area
Pitfalls. Pneumococcal Vaccine

- Vaccine is most often given only once in a lifetime
- Some circumstances require a second dose be administered
- Algorithm p. O-12 of the RAI can assist

Pneumococcal Vaccine Algorithm

O0400. Therapies

<table>
<thead>
<tr>
<th>Therapy minutes defined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual minutes – 1 therapist treating 1 resident (also includes co-treatment minutes)</td>
</tr>
<tr>
<td>Concurrent minutes (Part A)</td>
</tr>
<tr>
<td>- Treatment of two residents at the same time with residents performing two different activities</td>
</tr>
<tr>
<td>- Both must be in line-of-sight of treating therapist or assistant</td>
</tr>
<tr>
<td>- The residents may have different payer sources</td>
</tr>
<tr>
<td>- Concurrent therapy provided to a Part B resident is considered group therapy</td>
</tr>
<tr>
<td>- When the definition of concurrent therapy is not met, those minutes may not be coded on the MDS as group therapy</td>
</tr>
</tbody>
</table>
O0400. Therapies

Group minutes (Part A)

• **Exactly four** residents performing similar activities supervised by a therapist or assistant who is not supervising anyone else
• If one or more of the four participants are unexpectedly absent from the group session or if they cannot finish participating in the entire session, the session will meet the definition of group therapy as long as the therapy program originally had been planned for four residents.

(continued)

• When the definition of group therapy is not met, those minutes may not be coded on the MDS as group therapy
• Group therapy may be no more than 25% of total reimbursable minutes per therapy discipline (discussed in more detail in PPS module)
• The 25% limitation does not apply for non-Medicare participants.

Therapy start date (O0400A5, O0400B5, and O0400C5) is equal to the date of the earliest therapy evaluation since most recent entry whether minutes were provided or not

• Determine if resident had skilled rehab at any time from A1600 date of the current assessment through current ARD
• If resident had more than one regimen of therapy during current stay, use the most recent
O0400. Therapies

- When an EOT-R is completed, the Therapy Start Date (O0400A5, O0400B5, and O0400C5) on the next PPS assessment is the same as the Therapy Start Date on the EOT-R. (p. 2-49, O-27)
- No longer based on resumption date at O0450
- Since the EOT-R represents a continuation of a previous therapy regimen, the EOT-R does not establish a new therapy start date. Continue the original "therapy start date" on subsequent assessments until or unless another therapy event changes the start date.

Therapy Documentation

“When therapy is provided staff need to document the different modes of therapy and set-up minutes that are being included on the MDS. It is important to keep records of time included for each”

(p. O-19)

O0420. Distinct Calendar Days

- Added: Distinct Calendar Days of Therapy, item O0420
O0450. Resumption of Therapy

Applies to EOT OMRA required when 3 or more consecutive days of therapy are missed:
- Previously, only option for obtaining therapy RUG when therapy resumed was to complete a SOT OMRA
- Policy updates offer another option – the End of Therapy-Resumption (EOT-R)

• EOT-R option available only if therapy resumes
  - Within 5 days AND
  - At same RUG in effect prior to missed therapy
  - The same disciplines resume treatment (May, 2013)
• Accomplished by completing item O0450 on the EOT OMRA
• EOT-R results in picking up therapy RUG from assessment in effect prior to missed therapy

More details and examples later in this course

Section P. Restraints

Definition
Proper interpretation of the physical restraint definition is necessary to understand if nursing homes are accurately assessing manual methods or physical or mechanical devices, materials or equipment as physical restraints and meeting the federal requirement for restraint use (see Centers for Medicare & Medicaid Services. [2007, June 22]. (p. P-1)
Section P. Restraints

Chair Prevents Rising:
Chairs that prevent rising include any type of chair with a locked lap board, that places the resident in a recumbent position that restricts rising, chairs that are soft and low to the floor, chairs that have a cushion placed in the seat that prohibit the resident from rising, geriatric chairs, and enclosed-frame wheeled walkers.

(p. P-6)

Section P. Restraints

MYTH: Half-bedrails are automatically coded as enablers, since they always help with positioning residents in bed.

FACT: The decision to code a device as a restraint should always be specific to each resident. An interdisciplinary assessment must be the basis for such a judgment. Looking at the resident as a whole person—considering his or her functional, psychological, and psychosocial strengths and limitations—can help prevent drawing inappropriate conclusions about what the resident's needs are.

Quality Measure

Physically Restrained (Long Stay)
Physically Restrained

Of all long-stay residents with qualifying assessment in the reporting period, the QM computes the proportion with daily physical restraints

• Trunk restraint used in bed (P0100B = [2]), OR
• Limb restraint used in bed (P0100C = [2]), OR
• Trunk restraint used in chair or out of bed (P0100E = [2]), OR
• Limb restraint used in chair or out of bed (P0100F = [2]), OR
• Chair prevents rising used in chair or out of bed (P0100G) = [2])

Pitfalls. Additional Tips

• Geri-chair does not meet definition and should not be coded in P0100 for resident with no voluntary or involuntary movement
• Chair with unlocked lap board could be included as chair prevents rising if resident cannot easily remove lap board
• Side rails are not restraints for resident who has no movement; this resident probably should not have side rails up
• Merry Walker may be a restraint if resident is unable to open the gate and exit, via opening a gate, bar, strap, latch, removing a tray, etc.

THE QUALITY MEASURES
CASPER REPORTS
CASPER QM Reports

Made possible by the national analytic reporting system, the Certification and Survey Provider Enhance Reporting (CASPER) system

CASPER QM Reports

Access via CMS Welcome screen – same screen through which assessments are transmitted to QIES ASAP national database

- Click MDS link, then
- Click CASPER Reporting Online Reports link

CASPER QM Reports

Three reports
- Facility Characteristics Report
- Facility Quality Measure Report
- Resident Level Quality Measure Report

Reports default to a 6-month reporting period ending with the most recently ended month
- User’s may change the dates of the reporting period manually
Facility Characteristics Report

See sample report in handouts

Facility Quality Measure Report

See sample report in handouts

Facility Quality Measure Report

See sample report in handouts
STRATEGIES FOR SUCCESS

Promote Standards of Clinical Practice

- QMs are changing the way care is delivered in nursing homes
- Example: Have you ever heard? “We have a lot of residents with terminal conditions. It is expected that we would have a lot of pain reporting.”
- This rationalization is not acceptable, because a goal for all residents with pain should be to achieve consistent pain relief at a level acceptable to the resident, regardless of diagnosis or prognosis.
- Evidence-based Clinical Studies show that all residents can and should be managed for pain
Designate a Point Person

- Select a point person to serve as a Quality Measures coordinator and facility expert
- Point person can be tasked to understanding the nuances of what the QM scores mean
- Point person can monitor QM scores, quality-improvement activities, and coordinate training staff about QMs

Establish a Quality Assurance Process

Strong programs of Continuous Quality Improvement (CQI)
- Utilize QAPI principles for CQI improvement
- Continuous monitoring of key aspects of key systems
- Correlate related QM scores with each other for clues to causative factors
- Identify and correct problems before they become trends
- Individual accountability for key systems – put someone in charge of the system

Utilize QI Organization Resources

- Work to achieve sustainable system change by implementation of proven resident-care systems adapted to the individual facility
- Utilize QIO resources to improve care systems
- Leadership and supervision are the keys to success
Manage Consumer Interest

- Be prepared to discuss QMs with residents, families, visitors, and others who have an interest in nursing home quality of care
- Share appropriate details of quality improvement efforts.
- Make QMs a regular agenda item for the resident and family council
- Inform stakeholders about what the QMs are and what they are not
- Showcase areas of excellence and positive outcomes

Ensure MDS Data Accuracy

Misunderstandings about coding definitions can be disastrous

- QM scores are derived from MDS data
- Inaccurate coding can result in misleading Quality Measure scores
- Inaccurate MDS coding can result in inappropriate resident care

Ensure MDS Data Accuracy

- Use the most current version of the RAI User’s Manual
  - Use it thoroughly
  - Use it OFTEN
- Check AANAC website at least weekly for updates from CMS
Shore Up Supporting Documentation

• Other problems that contribute to inaccurate MDS coding are poor chart documentation and ineffective communication among interdisciplinary team (IDT) members
• It is essential that all clinical staff, including certified nursing assistants, charge nurses, and medication and treatment nurses, be well trained with regard to the kind of information IDT members need to ensure accuracy of the MDS.

Establish MDS Accuracy Checks

• Facility staff should have a monitoring system in place that provides for auditing by a clinician who has expertise in MDS coding and documentation but who is not a part of the facility’s MDS process.
  – Interrater reliability audits
  – Surveillance of documentation to support MDS responses

Section Q. Participation in Assessment and Goal Setting

• Resident participation in the assessment is critical to the assessment’s accuracy
• Resident participation (as well as that of the family/significant other or guardian or legally authorized representative) is captured in Q0100
• Q0600 addresses the need for referral to the local contact agency (LCA)
  • Referral is needed if discharge needs are present that the nursing facility staff cannot arrange
Section Q. Participation in Assessment and Goal Setting

**MYTH:** A resident who is being discharged back to home with home health services needs a referral to the LCA.

**FACT:** If the facility staff can coordinate the nursing services needed in the home, and the resident's discharge can be safely planned by the IDT, resident, and family, then it will not be necessary to make a referral.

Section V. Care Area Assessment (CAA) Summary

- Quality CAA assessment is not only helpful to support compliance with federal regulations, it is also vital to ensure excellent care for the residents entrusted to the facility staff.
- Each of the 20 CAAs has specific criteria that need to be met in order to be "triggered"; these items are called the Care Area Triggers (CATs).
- RAI User's Manual does not mandate any specific tool for completing the further assessment of the triggered care areas but does require use of tools grounded in clinical practice standards.

**MYTH:** The dietitian is in the facility only once a week. When she is there, she can complete needed MDS information as well as any CAAs at the same time, even though the MDS is not finished.

**FACT:** This practice can lead to poor-quality CAA documentation, as not all CATs will have been filtered either to trigger the CAAs or to be identified as part of the CAA analysis. The MDS coordinator should review the CAA clinical practice guidelines and add any needed additional information, then review this with the dietitian to ensure integrity of the information.
Section X. Inactivation

- If an assessment is inactivated for any reason, any replacement assessment must have a current ARD and completion dates.
- If inactivation results in SNF PPS assessments being late, the late or missed assessment policy applies.
- See chapter 5 of the RAI User’s Manual for details of the MDS Correction Policy.

Modifications Requests

Modification Requests are used when clinical or demographic errors are noted on MDS record in the QIES ASAP system:

- Clinical Items (B0100 – V0200C) can be modified.
- Typographical or Data Entry Errors on can be modified on the following assessment types:
  1. Entry Date on an Entry tracking record (A1600)
  2. Discharge Date on a Discharge/Death in Facility record (A2000)
  3. ARD on OBRA or PPS assessments (A2300)
  4. Type of Assessment (A0310) when the Item Set Code (ISC) is not changed.

Inactivation Requirement

When a record has been accepted into the QIES ASAP system but the corresponding event did not occur. The following items must be inactivated:

1. Type of Provider (A0200)
2. Type of Assessment (A0310) when the ISC would change if the MDS is modified.

Inactivate if the modification would change the MDS look-back or clinical assessment information on the following:

1. Entry Date (A1600) on an entry tracking record
2. Discharge Date (A2000) on a discharge record
3. Assessment Reference Date (A2300)
Chapter 5. Correction Request

- Errors identified in records in the database must be corrected via modification or inactivation within 14 days of identifying the error(s).
- Inactivation, modification and corrections request must be submitted within 3 years of the target date.
- If a facility is terminated, then corrections must be submitted within 2 years of the facility termination date.
- See chapter 5 of RAI User’s Manual for more information about the correction requirements.

Chapter 5: Correction Request

**MYTH:** A resident who was skilled under Medicare had a 30-day assessment due. Facility staff completed the assessment but accidentally coded it as 60-day assessment. The facility will have to bill default days for the days not covered by the missed 30-day assessment.

**FACT:** The facility staff can complete a correction assessment and modify the reason code in A0310B, as since the Item Set Code (ISC) and look-back information did not change.

Section Z. Assessment Administration

When a clinician completes a portion of the MDS is not available to sign it (e.g. no longer employed at facility):
- Current assessor can sign attestation after verifying the information for accuracy.
- Verify the portions of the MDS with the medical record and/or through resident/staff/family interview.
- Use the date the review was conducted.
- For resident interviews, current assessor can sign the attestation for completion of that section after interviewing the resident to ensure the accuracy of information and sign on the date this verification occurred (p. Z-7).
Z0400. Signatures

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

• For items with a standard look-back period that requires observing the resident through the end of the ARD, the date at Z0400 should be no earlier than the day after the ARD

• For items that do not have a standard look-back period, such as the resident's name and demographic information, the items may be completed at any time during the completion process

• For resident interviews, the MDS items should be completed prior to the end of the ARD, except standalone unscheduled PPS assessments, which may be conducted up to two days after the ARD

The Scripted Interviews

• Resident interviews for cognition, mood, preferences, and pain must be completed prior to end of ARD

• Standalone unscheduled PPS assessments (OMRAs) are an exception if it was not predictable that they would be required
  - Interviews may be completed up to 2 days after ARD
  - Provision of therapy should be monitored day-to-day to identify missed therapy in order to be able to reschedule the missed session when possible
Z0500. Signature of RN Assessment Coordinator

Verifying Assessment Completion

- Z0500A is the location for the RN assessment coordinator’s signature, signifying that the assessment is complete for assessments that do not require section V, “CAA Summary.”
- Item Z0500B is the date that the RN assessment coordinator signed at Z0500A. This is the actual date the pen touched the paper or the electronic signature was applied.
- The date at Z0500B must be no later than 14 days after the assessment reference date (A2300) for all assessments except the Admission assessment (which must be completed within 14 days of admission), the Significant Change of Status Assessment, and Significant Correction to Prior assessments, which must be completed within 14 days of identification of a significant change in status or need for correction.

Z0500 RN Signature

**MYTH:** If the MDS coordinator is not an RN, another RN can sign Z0500 and will be attesting to accuracy of every completed item on the MDS.

**FACT:** Signing at Z0500 indicates completion of non-comprehensive MDS assessments. The RN signing should understand the guidance in the RAI User’s Manual surrounding Z0500, but is not attesting to accuracy of the MDS.

**THANK YOU!**

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