

For Washington State Nursing Home staff

From Residential Care Services, Aging and Disability Services
Department of Social & Health Services

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**our mascot
Cousin IT**

“This is I.T.” Newsletter

**Info and Tips from the MDS-WA Office—*Clinical stuff,
Computer stuff, Reports ‘n stuff, and other STUFF!***

By Marge Ray and Judy Bennett, State of WA, DSHS

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OMRA: EOT & SOT

No, this is not a foreign language; it is MDS speak! OMRA stands for Other Medicare Required Assessment; EOT is the acronym for End of Therapy while SOT refers to Start of Therapy. Both of these assessments are types of OMRA's completed for Medicare Part A payment purposes.

The SOT OMRA is a new assessment type with MDS 3.0 and it is optional in most situations. It cannot replace a scheduled PPS assessment (5 day, 14 day, etc.) and is done only if the resident is not already in a RUG-IV Rehabilitation plus Extensive Services or Rehabilitation Group. The purpose is to classify a resident into one of these two RUG classifications in order to receive payment at the Rehab level and is effective on the day that therapy was started.

The ARD (assessment reference date) must be set on days 5, 6, or 7 after the start of any of the 3 therapies (PT, OT, SPL). The day that therapy starts is considered the date of the earliest therapy evaluation. Please note that if you have a non-therapy RUG that has a higher case mix index weight than the Rehab RUG that could be assigned with the SOT, the system will not assign the Rehab RUG and will reject the assessment.

Another situation where a SOT assessment is completed is when a facility wishes to do a Medicare Short Stay Assessment. Chapter 6 of the RAI manual describes the 8 criteria needing to be met, including completion of a SOT assessment, in order to do the short stay assessment.

The EOT OMRA is not a new requirement and was required with MDS 2.0 but was only called an OMRA then. This assessment type is required when a resident who was classified in a RUG-IV Rehabilitation plus Extensive Services category or a Rehabilitation category has had all of their therapy services discontinued but remains in the nursing home with skilled care continuing. Once completed, this assessment will produce a non-therapy based RUG for payment purposes. The ARD must be set on day 1, 2, or 3 after all rehabilitation therapies have been discontinued. Day #1 is considered to be the first day that therapy would normally have been provided after the last therapy treatment was given. For example, if a resident had their last therapy provided on Wednesday and the facility normally provides therapy Mon-Saturday then Thursday would be considered day #1 as it is the first day after therapy was last provided and therapy is normally provided on that day. For a facility that provides therapy Mon-Fri, if the last therapy provided was on Friday and then discontinued, the first day that therapy would normally be provided again would be Monday, thus Monday would be day #1.



Marge

Judy

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OMRA:EOT & SOT

When a resident has had all therapy discontinued but no longer requires skilled care, no EOT is required because Medicare Part A benefits will have stopped with the end of therapy. In situations where therapy is not provided for 3 or more treatment days (these are the days that therapy is provided to residents in the facility, not just a particular resident's therapy schedule), an EOT must also be completed. If therapy wishes to resume services, then a SOT assessment will need to be completed in order to obtain a new therapy based RUG for payment purposes. A new therapy evaluation will also be required for each of the therapies that will resume as the resident may have new deficits or regressed during the time that he/she was not receiving therapy. This assessment is not a re-evaluation, but a new evaluation.

There must be a clinical determination if the current plan of care and goals need to be changed based on the resident's current condition. Whether or not new physician orders will be needed is determined on a case-by-case basis. If the plan of care or treatment regime needs to be modified, new orders may be needed. If not, the state practice act and your own facility policy will determine the need.

Chapter 2 of the RAI User's Manual, September 2010, has the information for coding these assessment types as well as several examples. In addition, CMS held several provider educational webinars on SNF PPS and RUG-IV issues in the summer and fall of 2010. Printed information as well as the audio portions of the trainings is available at the following site:



http://www.cms.gov/SNFPPS/03_RUGIVedu.asp#TopOfPage. (please note that between the "03 and RUGIVedu." Is an underscore, not a space)

NH web sites in WA

Info for NH Professionals

<http://www.aasa.dshs.wa.gov/professional/nh.htm>

MDS Automation web page

<http://www.adsa.dshs.wa.gov/Professional/MDS/Automation/>

MDS Clinical web page

<http://www.adsa.dshs.wa.gov/Professional/MDS/Clinical/>

NH Rates web page

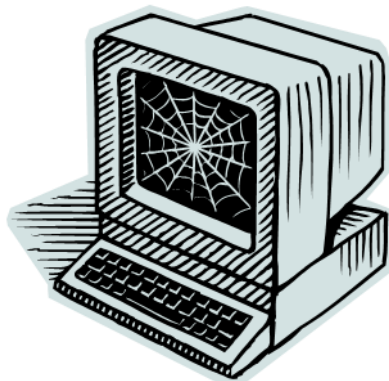
<http://www.adsa.dshs.wa.gov/professional/rates/>

NH Rates and Reports

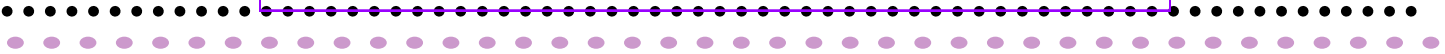
<http://www.adsa.dshs.wa.gov/professional/rates/reports/>

Case Mix web page

<http://www.adsa.dshs.wa.gov/professional/CaseMix/>



The MDS-WA newsletter publishes info that you can **really use** in your work with the MDS: tips and hints, new stuff from CMS, clinical info, technical help, notices about RUG reports, and more.
Sign up for the MDS-WA Listserv Newsletter by emailing
LISTSERV@LISTSERV.WA.GOV
In the subject line put: **SUBSCRIBE MDS-WA**



MDS Accuracy Technical Assistance visits

The accuracy of the MDS is essential for good care planning, care delivery and helping to assure positive resident outcome; it is also a key component in determining appropriate payment for services provided. With MDS 2.0 the Quality Assurance Nurses (QAN) from RCS visited each Medicaid certified nursing home once every 12-15 months to conduct MDS accuracy reviews related to the RUG-III case mix payment system. With the implementation of MDS 3.0 on October 1, 2010 an interim process for evaluating the accuracy of MDS items was developed and will be in use for up to a year. Since mid to late October, the QANs have been making visits to their facilities to look at how the new MDS 3.0 process is going. The visits have taken on more of a technical assistance flavor and the results of these visits are not used in the current payment process. An approximate 10% sample of resident MDS 3.0 assessments are reviewed and the results are shared with the facility DNS and/or Administrator both verbally and in writing. Our goal is for each Medicaid facility to receive at least one accuracy check visit by October of 2011.

To date, 41 visits have occurred and the most problematic areas are:

- Section I-Active Diagnoses. Either there is no physician documented diagnosis in the clinical record in the last 60 days or there is no evidence that the disease was “active” during the last 7 days.
- Item J0600 A & B-Pain Intensity. Facilities are coding both the use of the Numeric Rating Scale and the Verbal Descriptor Scale. Only one of these two should be coded, not both. If the resident has a problem with one, then the other scale is to be attempted and the scale that is successful is coded.
- O0500-Restorative Nursing Programs. Time is not being consistently recorded for each program when it is provided and not all of the established criteria as listed in the RAI manual for coding these programs are being met.
- G0110-Functional Status. The ADL coding rules are not being correctly applied (e.g., incorrect use of the code of “8”, not capturing each time the ADL is provided, conflicting information in the record when compared to the MDS coding and no explanation of why there is a difference).
- Section M-Skin Conditions. Pressure ulcers not correctly staged as being present on admission; coding formal skin assessments having been done when they were not completed within the 7-day look-back period; not recording ulcer depth; incorrect identification of the most severe tissue type in a wound bed.
- O0400-Therapies. Incorrect calculation of therapy minutes and/or days.

Some of the factors that impact the accuracy of MDS coding include the following:

- *Not having the most current version of the RAI User's manual.* The MDS 3.0 manual was released several sections/chapters at a time in 2010. As a result, there are a variety of dates that appear on the bottom left side of each page even in the most current version. If any of the sections, chapters, appendices, are dated **prior to July 2010** those portions are not current and need to be updated. The current version of the manual is available on line at: www.qtso.com Select MDS 3.0 from the menu on the left and then click on RAI manual.
- *Not reading the definitions and coding instructions in the RAI User's Manual and coding only from what is on the MDS item set forms or from memory.* There is not enough detail to be able to accurately code the MDS by using only the form and you do not have the benefit of the examples provided in the manual that illustrate different scenarios.
- *Software issues.* Be aware of fields that may be pre-populated from previous MDS assessments. If information has changed, or if it was incorrect in a previous assessment it will be carried forward to the new assessment and will continue to be problematic. Frequent examples of this include old diagnoses, previous ADL scores, wrong dates.

Our goal... Our goal is to help you accurately assess, code, and transmit the MDS. Accurate assessment forms a solid foundation for individualized care to help residents achieve their highest level of well-being.

MDS 3.0 Training

Q2IT Treasure Trove Tips



1. Question: *If a resident has C-Diff, is in a private room with their own bathroom, has a red bag for linen and we use body substance and contact precautions but the resident is not confined to their room (goes to the dining room for meals, goes to the therapy room and wheels around the halls), can we code the MDS as a "Yes" for item O0100M-Isolation or quarantine for active infectious disease?*

Answer: No. This item does not include standard body/fluid precautions and, the resident must not be out of their room. All services such as therapy, activities, dining, etc. must be provided in the resident's room.

2. Question: *If a resident who has a diagnosis of quadriplegia, for example, is routinely given suppositories to stimulate bowel activity and the individual can tell staff that the suppository has worked, would this be coded as continence (H0400)?*

Answer: No. Continence is defined in the RAI Manual as the capacity to hold urine or stool until it can be eliminated in a socially appropriate manner and location (e.g., commode, urinal, bedpan).

Question: *Would this routine use of suppositories be considered a bowel toileting program (H0500)?*

Answer: Not unless all of the criteria listed in the RAI Manual for a bowel toileting program are met. If the only intervention is the use of suppositories, the answer would be "No".

3. Question: *If a resident has a hematoma, would J1550D: Internal Bleeding be coded?*

Answer: No. If the hematoma occurred as a result from a fall and the fall was coded in J1800, then the hematoma would be assessed and recorded in J1900 at either item B. Injury or C. Major Injury (subdural hematoma only).

Several MDS 3.0 training classes have been scheduled for Spring 2011. The course entitled, "MDS 3.0: The Basics-Blueprint for Success" is intended for nursing home staff new to the MDS assessment process or for those who would like a refresher. Each session is 2 days in length from 8 am to 4 pm and covers item-by-item coding instructions, interviewing, significant change of status, care area assessments and error correction among other topics. Openings are available for the following dates and locations:

- April 26-27 in Burien at the Criminal Justice Center main auditorium
- May 3-4 in Yakima at the Yakima Community College Parker Room of the Deccio Building
- June 8-9 in Spokane at Sacred Heart Hospital in the Providence Auditorium

Details can be found at: <http://www.adsa.dshs.wa.gov/professional/MDS/MDS3.0/>

If you are interested, please contact Marge Ray RN, WA State RAI Coordinator at (360) 725-2487 or e-mail rayma@dshs.wa.gov

You must call or e-mail to reserve a spot as some locations have limited space.

Computer Corner

Upcoming Modification Change to MDS 3.0



Currently you can modify any item on an MDS record except for A0200 Type of Provider, A0410 Submission Requirement, and the control item containing the FAC ID.

Effective April 1, 2011, besides A0200, A0410 and the FAC ID, you will also no longer be able to modify A0310 A,B,C,D,F Type of Assessment, A1600 Entry Date, A2000 Discharge Date, and A2300 Assessment Reference Date. If there is an error in any of these items you will need to inactivate the record and submit, as a new record, a whole new MDS with the correct information.

The new edit is -3811 and will apply to all records submitted on or after 4/1/2011, regardless of the target date. So—if you have any of these MDS items that need correcting, you might want to get them done before April 1st.

