For Washington State Nursing Home staff

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

Volume 4, Issue 3
June 2011

Inside this issue:

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

MDS 3.0 Manual Updates

Marge

Judy

CMS posted the first set of updates to the MDS 3.0 User's Manual on June 1. Many of the changes involved editing and formatting, but there are several important clarifications and additions. Listed below are some of the more significant items included in the update:

1. Chapter 1: The Privacy Act Statement-Health Care Records has been updated to the 7/14/2005 edition
2. Chapter 2: Clarifications provided on the requirements for entry and discharge reporting r/t change of ownership
3. Chapter 2: Clarification r/t completing an admission assessment vs. a significant change of status for residents admitted on Hospice (do the admission assessment)
4. Chapter 3: Section D-Mood. Change in what constitutes a successful interview for the PHQ-9 (it was 7 out of 10 responses, now it is 8 out of 10).
5. Chapter 3: Section G-ADL. Clarification on "who" were not considered facility staff for coding ADL assistance (nurse aide or nursing students, family, hospice staff, EMT/Paramedic, etc.)
6. Chapter 3: Section J-Health Conditions. Change in the definition for coding J1440-Prognosis from requiring a physician to document a life expectancy of less than 6 months to having documentation that the resident is "terminally ill". Medicare Hospice still requires the physician to have documentation in the record that reflects that the resident has a life expectancy of less than 6 months however.
7. Chapter 3: Section K-Nutritional Status. Clarified the definition of therapeutic diet and provided two additional coding tips.
8. Chapter 3: Section M-Skin Condition:
   - Clarified when to code a healed ulcer for M0210;
   - Identified when to use a dash for coding M0700-the most severe tissue type in a pressure ulcer wound bed (Stage 1 pressure ulcer, Stage 2 pressure ulcer with intact blister, unstageable pressure ulcer r/t non-removable dressing/device, and unstageable pressure ulcer r/t suspected deep tissue injury);
   - Clarified M0800 r/t worsened ulcer (if a previously staged pressure ulcer becomes unstageable due to slough or eschar, do not code as worsened);
   - M1040 Other skin condition had 2 clarifications about open lesions on the foot and added the word "healed" to the description of surgical wound as it relates to stomas
9. Chapter 3: Section O-Special Treatments, Procedures and Programs:
   - Item O0100 some of the identified treatments, programs and procedures that a resident does themselves can now be coded, including putting on, adjusting or removing their own oxygen cannula, self suctioning, self tracheostomy care, placing or removing own BiPAP/CPAP mask, or self dialysis. The facility, however, will have to educate the resident on the proper procedures, safety, and use of equipment and monitor the resident for appropriate use and continued ability to self perform the procedures.
   - Item O0100M-Isolation, the definition has changed and additional guidance and resource lists were added
   - Item O0250C, Influenza Vaccine. The words "in this facility" were removed since this item asks the reason that the resident did not receive the vaccine and not all reasons relate back to the resident "being in this facility."

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3.0 Manual Updates

10. Chapter 3: Section Q-Participation in Assessment and Goal Setting. There are some new examples and ex panded Coding Tips .
11. In Appendix A (the glossary) several items were changed/added.
12. Appendix B (the list of state RAI and automation coordinators and Regional coordinators) was removed and re placed with the website address where this list will now be maintained.
13. Appendix C (the CAA list) A signature line and date line was added to all of the CAA example forms. The CAA for community referral also had a couple of minor additions.
14. Appendix E (The CPS chart was removed along with references to it being used to identify levels of cognitive per formance).
15. Chapter 5 (submission and error correction) was rewritten to reflect changes in what can be modified and inacti vated. Language was added that instructs facilities NOT to submit Managed Care Medicare assessments to the CMS data base, only OBRA required and PPS Medicare Part A assessments.
16. Chapter 6 (Medicare SNF PPS) added information related to EOT OMRA and SOT OMRA including coding ex amples and payment situation examples.

No changes were made to Chapter 4, Chapter 3 sections C, E, H, L and P, Appendices F and G.

The updates can be found at the following website:

https://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage

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Q2IT Treasure Trove Tips

1.Question: *Can functional quadriplegia be coded on the MDS?*
Answer: Yes, it can be coded in I8000, additional Active Diagnoses. Write the name and the ICD code. It cannot be coded under I5100: Quadriplegia, however.

2. Question: *For D0200I-Resident Mood Interview, if a resident states they would rather be dead (they have outlived their friends and family), but they have no thoughts of hurting themselves, how would this be coded and what follow-up is required?*
Answer: Code the symptom presence as "Yes", then the symptom frequency. The facility will need to gather additional information and assess the resident further following their policies and procedures. In addition, item D0350: Safety Notification will need to be completed.

3. Question: *Can antibiotic creams be coded in N0400F?*
Answer: Yes; page N-6 of the manual says to include any of these medications given to the resident by any route while a resident of the nursing home.

4. Question*: For M0100: Determination of Pressure Ulcer Risk, does the formal assessment instrument/tool (Braden or Norton scale for example) have to be conducted during the look-back period in order to check this item*
Answer: Yes, the skin assessment tool would need to have been done during the 7 day look-back period in order to check M0100B on the MDS.

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

To dash or not to dash…that is the question!

Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to the MDS QIES ASAP system. A dash value indicates that an item was not assessed and most often occurs when a resident is discharged before the item could be evaluated and accurately coded.

Early CMS instructions last summer advised that, for planned discharges, all items on the discharge assessment, including resident interviews, were to be completed. However, for unplanned emergent discharges, facilities could just dash fill the interview items. These were the instructions that were shared with providers during the initial MDS 3.0 training sessions in Washington last summer.

Recent CMS analysis of the first 5 months of MDS 3.0 data for the discharge assessments showed a large number of dashes (up to 40%) especially for Quality Measure items such as pain and pressure ulcers. CMS is very concerned about the excessive use of the dash in any assessment because of the potential impacts related to quality monitoring, quality measure calculations, and communication of resident status at discharge to support coordination and continuity of care.

Using a dash may reduce the size of the facility's quality measure resident sample and result in an inaccurate representation of the facility's actual resident population. Important clinical information regarding resident condition may be absent and missing data will skew quality measure rates both positively and negatively.

Several of the quality measures use data from the sections of the MDS 3.0 that assess mental status, depression and pain. These measures also use data from the discharge assessment under certain circumstances. In all cases, these measures will use data from resident interviews, if those sections are complete. When resident interviews are not complete, the measure will use data from staff assessments.

If neither is present, for one of these three sections, the resident may be excluded from the measure, thereby reducing the sample size when calculating the measure and potentially impacting the accuracy of the measure. Thus, it is important on all assessments, including discharges, that every effort is made to complete the resident interviews, and, if this is not feasible, to complete the staff assessments.

As a result of the data analysis, CMS has provided the following assessment guidance for resident interviews on unplanned discharges:

- For the BIMS, PHQ-9 and Pain interviews, if the resident is discharged unexpectedly and the resident interview has not yet been completed the staff assessment should be completed if appropriate clinical record information is available.
- When completing the staff assessment, facility staff should complete the discharge assessment to the best of their ability and dash fill only those items for which they have no information

Using the dash for all of the resident interview items for the particular item being assessed should allow the staff assessment items to become active so that you can code them. If you are not able to access the staff assessment items, you will need to contact your software vendor for assistance.

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.**

RAI Coordinator 360-725-2487 Marge Ray marjorie.ray@dshs.wa.gov

MDS Automation Coordinator 360-725-2620 Judy Bennett Bennej@dshs.wa.gov

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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/

MDS 3.0 Training

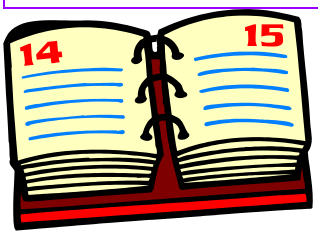
Two additional MDS 3.0 training classes have been scheduled for 2011. The course entitled, "MDS 3.0: The Basics-Blueprint for Success" is intended for nursing home staff new to the MDS assessment process or for those who would like a refresher. Each session is 2 days in length, from 8 am to 4 pm, and covers entry and discharge reporting, coding instructions for select items, interviewing, significant change in status, care area assessments and correction of errors, among other topics.

There is no charge for the course and space is limited to 25 attendees per class. Both classes will be held at Residential Care Services Headquarters building , 4500 10th Ave SE, Lacey, WA 98503 in the Rose Room.

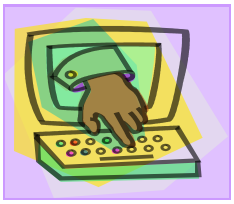
Dates:

- August 30 and 31
- November 15 and 16

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



Computer Corner



Entry Dates : MDS 3.0 Item A1600

Currently, A1600 errors cause the most Defaults and Excluded Residents on RUG reports. The Washington State Case Mix system looks at ALL entry dates, not just the Entry Trackers. Therefore, to avoid defaults and excluded residents, please be sure all Entry Dates (A1600) are correct.

Per the RAI Manual, May 2011, page A-18 Coding Instructions for A1600: Enter the most recent date of entry to this nursing home. If your software pre-populates this date or gives you a drop-down menu of dates to choose from – please check for accuracy. The federal MDS System (ASAP) **will accept** assessments with incorrect A1600 dates. The current error messages available for A1600 are all comparisons **within** the assessment, they are not comparisons with **other** assessments. Examples:

-3573a - Inconsistent Dates: The first date listed must be prior to or the same as the second date.
A0900 (Birth Date) must precede or be the same as A1600 (Entry Date)
A1600 (Entry Date) must precede or be the same as A2200 (Previous ARD for Significant Correction)

-3749d - Assessment Completed Late: For this Admission assessment (A0310A equals 01), Z0500B (completion date) is more than 13 days after A1600 (entry date).

--3789e - Record Submitted Late: The submission date is more than 14 days after A1600 on this new (X0100 equals 1) entry tracking record (A0310F equals 01).

Please note: there is **not** an error message for A1600 not matching previous assessment entry dates!

If you have an A1600 error on an Entry Tracker you will need to do an inactivation and submit a new Entry Tracker. If you have an A1600 error on any other type of MDS document, you can do a modification.