

# Operational Overview of the new Long-Term Care Survey and Changes to the MDS 3.0 Database

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## PRESENTED BY

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## New focus on Data by CMS and Regulatory Agencies

- ▶ ORGANIZED APPROACHES TO FRAUD PREVENTION -
- ▶ MDS ACCURACY OVERSIGHT - RESULT OF AUDITS AND PAYMENT RETURNS
- ▶ INTERAGENCY REPORTING - NOW VERY ACTIVE PROCESS
- ▶ NEGATIVE OUTCOMES FOR PROVIDERS CAN BE REGULATORY, FINANCIAL AND LEGAL
- ▶ COMPLIANCE IS FOUNDATIONAL - PROVIDERS MUST KNOW THE RULES AND CHANGE BAD HABITS - WHO KNOWS THE RULES FOR FEDERAL PROGRAMS AND REGULATIONS?
- ▶ Data Base content - Who monitors this?

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### FOCUS OF GOVERNMENTAL AGENCIES

- ▶ COMPLIANCE - LINK POLICIES AND PROCESSES TO THE COVERAGE GUIDELINES
- ▶ REGULATORY STRUCTURE OF FEDERAL AND STATE PROGRAMS - MEDICARE AND MEDICAID
- ▶ NEW SURVEY TAGS ON MDS REQUIREMENTS - FITS INTO THE CURRENT CMS FOCUS.
- ▶ PAYMENT - WHAT ARE YOU BEING PAID FOR AND THE INTEGRITY OF YOUR SUBSTANTIATING DATA AS WELL AS THE BILLING PROCESS?
- ▶ NEW ANALYTICS - CMS & GAO REPORTS

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▶ PROVIDERS CAN NOT ELIMINATE ALL RISK BUT NEGATIVE OUTCOMES CAN BE MINIMAL OR ELIMINATED WITH PROACTIVE APPROACHES, TRAINING AND POLICY DEVELOPMENT. THE INDUSTRY IS NOT READY FOR THIS ORGANIZED OVERSIGHT AND MORE AUDITS OF THE DATA BASE AND RELATED DOCUMENTS.

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### COMPLIANCE

- ▶ COMPLIANCE IS A BIG PICTURE FOR THE ENTIRE ORGANIZATION
- ▶ MUST BE HONEST AND OPEN - REVIEW WHERE INVESTMENT IS BEING MADE.
- ▶ CAN NOT COVER UP BAD PRACTICE - VERY DANGEROUS
- ▶ INTERNAL COMPLIANCE REQUIRES AUDITS TO CONFIRM PRACTICE
- ▶ EXCELLENT OPPORTUNITY FOR QAPI PROGRAMS
- ▶ HIPAA IS A NEW FEDERAL FOCUS - IMPLICATIONS FOR THE MDS BECAUSE OF DATA USE AND SHARING
- ▶ START WITH COMPLIANCE RELATED TO PAYMENT - AND ELIGIBILITY
- ▶ REVIEW PROVIDER AGREEMENTS - PART A MEDICARE - INSURANCE & OTHER CONTRACTS

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**Your CMS Provider Agreement**

**The Agreement Says *WHAT?***

Medicare & Medicaid  
*(Reading Between the Lines)*  
Conditions of Participation

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- ▶ Basic Provider Commitments
- ▶ Admission for Care and Treatment
- ▶ Services Under Arrangements
- ▶ SNF-Specific Requirements
  - ▶ Transmittals Matter
- ▶ Provider Responsibilities
  - ▶ Termination (Voluntary & Involuntary)
  - ▶ Change of Ownership
- ▶ State Operations Manual: Enforcement

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**Basic Provider Commitments: Part A**

- ▶ Limit Beneficiary Charges to:
  - ▶ Deductible & Coinsurance
  - ▶ Non-covered Services Requested by Beneficiary
- ▶ Return any Amounts Incorrectly Collected
  - ▶ Repay Medicare within 60 Days
- ▶ System: ID during Admission Process ANY OTHER Primary Payers
  - ▶ Bill Them Before Submitting to CMS

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### Admission for Care and Treatment

Provider Agrees to:

1. Admit Eligible Beneficiaries
2. Provide Care & Treatment  
*"...ordinarily furnished to its patients, generally."*

3. 1 & 2 with Restrictions:  
Limit Scope of Services (as long as applied to ALL residents)

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### Services Under Arrangement

Third-Party Covered Services

EX: Therapies

- ▶ Receipt of Pmt by Provider = Beneficiary has No Further Duty
- ▶ Provider Responsible for Supervising Arranged Service
  - ▶ "As If" services provided by Provider's staff
  - ▶ Complete & timely resident/client records
  - ▶ Communication with Provider staff and MD
  - ▶ Medicare: Medical Necessity Determinations

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### SNF-Specific Requirements

- ▶ 12-Months with Fixed Expiration Date

- ▶ Renewal at Survey/Inspection:

- ▶ Deficiency-Free: Renew
- ▶ Plan of Correction: Extend for Up to 60 Days for Compliance  
IF
  - 1) Health and Safety of Residents Not Jeopardized
  - 2) Hardship to Beneficiaries Furnished Care, or
  - 3) Impracticable to Determine Compliance Sooner

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### Administrator Responsibilities: State Operations Manual

Documentation

- ▶ MDS & POC
- ▶ Workflow
- ▶ Incident/Accident
- ▶ HIPAA
- ▶ QAPI
- ▶ HR: Performance, Requirements, Time/Schedule & Payroll
- ▶ Contracts: Vendors & Other

Policies & Procedures

- ▶ Operations
  - ▶ Clinical & Business
  - ▶ Form Follows Function (Who-Do)
  - ▶ Board Approval & Renewal
  - ▶ Conflict of Interest
  - ▶ Corporate Compliance
- ▶ Staff Development
- ▶ Emergency Preparedness
- ▶ Volunteers

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### Plaintiffs' Pathways

Target

Physician  
&  
Staff  
&  
Contractors

Cause for Action / Allegation

- Medical Negligence**
  - ▶ Applicable Standards of Care NOT MET
  - ▶ POC Not
    - ▶ Updated (*timely or accurately*)
    - ▶ Followed

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### Plaintiffs' Pathways

Shortfall Claimed:

- ▶ Staffing Level
- ▶ Competence/Qualified
- ▶ Info: Timely & Accurate
- ▶ P & P's: Insufficient/Ignored
- ▶ Communication: Ineffective

Terms of Endearment:

- ▶ Wrongful Death
- ▶ Accelerated Deterioration
- ▶ Loss of Dignity
- ▶ Extreme Pain & Suffering
- ▶ Acted with:
  - ▶ Oppression
  - ▶ Fraud
  - ▶ Malice
  - ▶ Wanton or Reckless Regard

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### Short-Term "Can Do" List:

**Review:**

- ✓ Original CMS Provider Application
- ✓ Certification Renewal Letter (Most Recent)
- ✓ P&P's - Relevant and Current?
  - ▶ Clinical & Business



**Update:**

- ✓ Renewal Date of P&P's by Governing Body / Ownership
- ✓ In-Service Logs

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## PART A MEDICARE

- ▶ Medicare Provider Agreement must be in place for you to admit and bill for Medicare Benefits in the SNF
- ▶ What document tells you the federal rules and coverage guidelines for Part A Medicare?
- ▶ Who needs to have the specific guidelines for admission, coverage of services, documentation, and certification?
- ▶ MEDICARE BENEFIT POLICY MANUAL - CHAPTER 8 is the reference - the only reference - Who has copies and knows content?
- ▶ All claims denials and audit denials need to be justified from this document - have been for many years.
- ▶ WHO HAS THIS DOCUMENT IN YOUR CORPORATE COMPLIANCE OFFICE AND ON SITE IN THE FACILITIES WHERE ADMISSION AND COVERAGE DECISIONS ARE MADE?
- ▶ YOU MUST DOCUMENT THAT ADMISSIONS & SERVICES ARE COVERED

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## LET'S TAKE A LOOK.....

- ▶ The current document was updated in October 2016 with many pages of coverage guidance and also significant information about claims review requirements for documentation.
- ▶ The new guideline for Maintenance Therapy is also included as well as expanded guidelines for Skilled Nursing and Skilled Therapy services.
- ▶ Certification rules and signature guidelines
- ▶ All administrators should have this document and use it when questions come up to define the covered services and documentation requirements.
- ▶ Many facilities use outdated coverage guidance - bad idea - terrible idea!

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▶ USE THE MEDICARE BENEFIT POLICY MANUAL (CHAPTER 8) FOR ORIENTATION, INSERVICES, DOCUMENTATION GUIDELINES AND COVERAGE DECISIONS.

▶ DOCUMENT THE SECTIONS OF CHAPTER 8 IN YOUR DOCUMENTATION NOTES OR UTILIZATION MINUTES TO CONFIRM COVERAGE.

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### COMPLIANCE AUDITS - ESSENTIAL

▶ ARE YOU ACTIVE WITH AUDITS :

- ▶ ADMISSION CRITERIA - DOCUMENTATION IN THE CHART - WHY WAS THIS PERSON ADMITTED UNDER Part A?
- ▶ Admission primary diagnosis - very important - MDS & Billing - MUST MATCH!
- ▶ Certification documents - signed and dated on time - original documents must be available if outside audit is done. No cert no payment.
- ▶ Treatment records, orders and documentation of interventions for skilled nursing or skilled therapy - specific documentation - resident specific plans & interventions are required.
- ▶ Outcomes and documentation of changes in coverage.
- ▶ This is the facility responsibility - not the therapy contractor - The facility owns the record.
- ▶ Document the audits and outcomes as well as actions to improve compliance.

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## Chances are .....

- ▶ Based on my experience...
  - ▶ Admissions department has not seen the MBPM chapter 8
  - ▶ Updated definitions and coverage guidelines are not being used
  - ▶ Audits on Part A cases have not been done for Compliance
  - ▶ Documentation guidelines are not being used
  - ▶ Certifications are not signed and dated properly and stored carefully - originals?
  - ▶ Doctors orders for services do not match the first day of service you are billing for.
  - ▶ Coverage of skilled service does not match the requirements - for example: supervision of PTAs and COTAs giving therapy .....
- ▶ Use this list for a quick audit - then take action

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### SO HOW DOES THIS CONNECT.....

- ▶ LET'S START WITH MEDICARE PART A -
  - ▶ HOW MUCH DO YOU BILL MEDICARE PART A EACH MONTH - PER FACILITY? - Total \$
  - ▶ THAT IS YOUR RISK FOR POOR DATA - THERAPISTS NOT KNOWING THE COVERAGE GUIDELINES - POOR DOCUMENTATION - BAD COVERAGE DECISIONS
  - ▶ DO NOT TRUST CONTRACTORS - "WE HAVE TRAINING!!!!!!" WRONG !!! AUDITS?
  - ▶ THIS IS THE FACILITY RESPONSIBILITY - THEY CAN RUN.
  - ▶ WE HAVE OUR OWN THERAPY - NOT MUCH BETTER - TRAINING - POLICIES - AUDITS
  - ▶ MOST OF WHAT YOU BILL IS FOR REHAB SERVICES - TAKE A GOOD LOOK AT WHAT IS HAPPENING - REHAB AUDITS ARE NECESSARY - VERY INFORMATIVE AND GOOD COMPLIANCE ACTIVITY.
  - ▶ ASK YOURSELF - WHO HAS A COPY OF THE COVERAGE GUIDELINES AND THE RULES - FRONT LINE THERAPY STAFF? THEY NEED IT. They are billing the minutes that create the \$ groups.

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### MOVING TO THE DATA BASE.....

- ▶ THIS IS THE MDS PROCESS -
- ▶ YOUR MDS DATA SETS CREATE THE PAYMENT - THEY MUST BE PERFECT.. PERFECT!!
- ▶ CMS EXPECTS THAT ALL THE DATA ON THE MDS IS "COMPREHENSIVE, ACCURATE, STANDARDIZED AND REPRODUCIBLE"
- ▶ MDS MUST MATCH THE UNIVERSAL BILL EXACTLY - WHERE DOES THE DATA COME FROM..THIS IS COMPLICATED AND MISTAKES CAN CREATE VERY DANGEROUS RISK.
- ▶ BILLING & MDS MUST BE ON THE SAME PAGE! THIS IS NOT A REALITY IN MOST ORGANIZATIONS AND COMPANIES.

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### PAY CLOSE ATTENTION TO THE MDS PROCESS

- ▶ MAKE SURE ALL PEOPLE CODING ON THE MDS HAVE UPDATED MANUALS AND DIRECTIONS FOR THE CODING INSTRUCTIONS.
- ▶ THERAPY - ONLY SKILLED THERAPY MINUTES GO ON TO THE MDS IN SECTION O
- ▶ IF YOU CODE NON SKILLED MINUTES OR MINUTES THAT ARE NOT COVERED THAT IS FRAUD....WHO DECIDES WHAT MINUTES ARE CODED....VERY INTERESTING QUESTION! EACH TREATING PERSON IN THERAPY?
- ▶ TYPES OF MINUTES - A BIT CONFUSING - Not really if you read the definitions.
- ▶ THERAPY CODING MUST BE CHECKED - THERAPY SERVICES MUST BE AUDITED BY THE FACILITY - NOT THE THERAPISTS.
- ▶ DATES ON THE MDS MUST BE CORRECT - SUBSTANTIATED BY THE RECORD
- ▶ The coding of therapy minutes section of the RAI Manual was updated in October 2016. WHO HAS READ THIS UPDATE? - Keep records of training.

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- ▶ THE LAST MANUAL UPDATE IS DECEMBER 2017
  - ▶ NEW ITEMS WILL BE INTRODUCED IN OCTOBER 2018
- ▶ MDS DATA MUST BE LOGICAL... RESIDENT GETTING INSULIN BUT DOES NOT HAVE A DIABETES DIAGNOSIS ON THE MDS.
- ▶ THIS IS A VERY DETAILED TECHNICAL DOCUMENT - USE OF ANALYTICS IS VERY HELPFUL AND CAN BE SAVE MANY PROBLEMS WITH DATA ERRORS.
- ▶ MDS IS THE FOUNDATION FOR PAYMENT - MEDICARE, MEDICAID IN CASE MIX STATES, INSURANCE
- ▶ MDS CREATES THE QUALITY MEASURES - 5 STAR AND SURVEY ACTIVITY - BE CAREFUL
- ▶ CREATES THE CARE PLAN FOR THE RESIDENT
- ▶ CREATES THE DEMOGRAPHICS FOR FEDERAL REPORTS ABOUT THE FACILITY, PEPPER AND CASPER REPORTS AND INTERNAL CMS DATA ABOUT YOUR FACILITY.

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WHO IS RESPONSIBLE FOR:

- ▶ THE MDS CODING AND ACCURACY IN THE FACILITIES?
- ▶ TRAINING?
- ▶ AUDITS?
- ▶ DATA BASE ACCURACY FOR INTERNAL AND EXTERNAL REVIEW?

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**MDS ACCURACY SURVEY  
NEW AND VERY PROBLEMATIC**

- ▶ First time the survey process has looked at MDS data base accuracy as part of the basic process
- ▶ In the past if the data base was not accurate it was only cited if it was related to the outcome of the resident care or another citation
- ▶ Accuracy of the MDS data base has been the concern of the audits or charges of fraud and payment abuse.
- ▶ This has allowed a lot of inaccurate data to be present and not identified
- ▶ Data errors usually cost facilities reimbursement
- ▶ Historically there are very few MDS accuracy tags cited. Now significant number of accuracy tags.

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TAG - 636

- ▶ The facility must initially and periodically do a comprehensive, accurate, standardized, reproducible assessment of the resident's functional status.

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WHERE IS THE ACCURACY STANDARD FOR THE DATA COLLECTION AND TRANSMISSION PROCESS?

- ▶ First is the regulatory process - Federal tags 636 and following
- ▶ Next is the issue of the data collection process and the selection of the proper assessment types and timing. - RAI Manual
- ▶ Chapter 1 of the RAI Manual - Privacy statement and interdisciplinary process
- ▶ Coordination of the RAI Manual and federal regulations and policy statements - Medicare Benefit Policy Manual etc.
- ▶ Directions, definitions and statements in the RAI Manual updated for the ARD of the assessment being completed - this is very important!

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- ▶ SENIOR MANAGEMENT MUST DEMAND COMPLIANCE WITH THE RAI MANUAL.
- ▶ MANY OF THESE SOURCES ARE NOT USED BY THE R.N. ASSESSMENT COORDINATORS TO SCHEDULE AND COMPLETE ASSESSMENTS.
- ▶ THE SURVEYORS AND AUDITORS HAVE ALL THESE REFERENCES.
- ▶ BEFORE AN MDS NURSE COMPLETES OR CODES AN ASSESSMENT THEY MUST READ THE REGULATORY MATERIALS AND THE REQUIREMENTS FOR THE ASSESSMENT DATA.
- ▶ THE INDUSTRY HAS A LOT OF HOMEWORK TO DO AS THE SURVEY PROCESS BEGINS SO THEY ARE READY TO RESPOND TO REQUESTS AND INQUIRY ABOUT THE PROCESS. THIS IS HAPPENING NOW IN MOST STATES.
- ▶ MDS ACCURACY IS A FOCAL POINT OF THE NEW SURVEY TASKS AND CITATIONS

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### WHERE TO BEGIN ??????????

- ▶ AN HONEST ASSESSMENT OF THE CURRENT DATA COLLECTION PROCESS IS ESSENTIAL
- ▶ INCLUDES CURRENT MANUALS AND REGULATORY MATERIALS
- ▶ A WRITTEN REPRESENTATION OF THE FLOW OF THE DATA - WHO FILLS OUT THE SECTIONS OF THE DATA SET .
- ▶ THE ASSESSMENT PROCESS IS THE RESPONSIBILITY OF THE ADMINISTRATOR OF THE FACILITY - " THE FACILITY MUST....."
- ▶ THE ADMINISTRATOR WILL BE ASKED QUESTIONS DURING THE SURVEY - THEY NEED TO BE READY AND AWARE OF THE PROCESS IN THE FACILITY.
- ▶ WHAT ARE THE REQUIREMENTS IN THE PROCESS?
- ▶ WHO IS THE R.N. ASSESSMENT COORDINATOR? - THIS IS REQUIRED FOR EACH FACILITY.

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### R.N. Assessment Coordinator

- ▶ Is required
- ▶ Person must be aware and able to identify how they manage the assessment process
- ▶ Signature on section Z that the assessment is complete - What does this mean?
- ▶ Know the practice guidelines for nurses in your state
- ▶ LPN/LVN can not assess in most states - they gather information and report
- ▶ Should not be writing assessment notes in the chart - document observations and report facts

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- ▶ Tag 636 says - "standardized assessment" - You need to have a policy and procedure so that all assessments are done the same according to the structure in the RAI Manual.
- ▶ Remember you are collecting Data not information or stuff. Definitions are important!
- ▶ Data collection needs to be part of orientation for all staff expected to be part of the data collection process. This is currently not being done in most facilities.
- ▶ Surveyors will ask for a list of all personnel with responsibility for any data entered on to the assessments and their assigned sections or items. Do not forget Section A. - RN Assessment coordinator should have this.
- ▶ Surveyors will ask for the name and contact information for the quality assessment and assurance coordinator. Have information about the QA process in the facility and the frequency of the review of the QM reports.

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### LET'S GO BACK TO THE REGULATORY LANGUAGE...

- ▶ COMPREHENSIVE
- ▶ ACCURATE
- ▶ STANDARDIZED
- ▶ REPRODUCIBLE ASSESSMENT
- ▶ THE ASSESSMENT MUST ACCURATELY REFLECT THE RESIDENT'S STATUS.
- ▶ SCHEDULED ACCORDING TO THE DIRECTIONS IN CHAPTER 2 OF THE RAI MANUAL
- ▶ COMPLETED ACCORDING TO THE RULES IN CHAPTER 2 AND CHAPTER 5 INCLUDING TRANSMISSION AND VALIDATION.
- ▶ BE SURE MDS MANAGER HAS UPDATED MANUAL & POLICIES TO COVER ALL DATA COLLECTION AND TRANSMISSION.

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### COMMON CODING PROBLEMS

- ▶ NUMERICAL CODING IS VERY EASY FOR AUDIT CHECK
- ▶ SCORES FOR BIMS, MOOD SEVERITY INTERVIEW, LEVELS OF PAIN, ADL SCORES, HEIGHT, WEIGHT, SPECIFIC TREATMENTS, DAYS OF THERAPY OR MEDICATIONS
- ▶ DIAGNOSIS CODING MUST BE SPECIFIC AND CONFIRMED BY THE PHYSICIAN
- ▶ LOOK AT SPECIFIC CODING INSTRUCTIONS - EXAMPLE - DEHYDRATION, UTI, PRESSURE ULCER CODING ETC. SPECIAL DEFINITIONS IN RAI MANUAL.
- ▶ REMEMBER ALL DATA ON THE MDS NEEDS TO BE REPRODUCIBLE IN THE MEDICAL RECORD DURING THE TIME FRAMES DICTATED BY THE DIRECTIONS IN THE RAI MANUAL. SAME WORDS!
- ▶ INTERVIEWS MUST BE DOCUMENTED IN THE RECORD - WHEN THEY WERE DONE AND BY WHOM - REMEMBER THERE ARE 6 INTERVIEWS ON THE ADMISSION ASSESSMENT.

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### BE VERY CAREFUL WITH REHAB CODING

- ▶ MINUTES OF THERAPY HAVE A VERY SPECIFIC DEFINITION IN SECTION O OF THE RAI MANUAL
- ▶ THERAPY MINUTES MUST BE JUSTIFIED WITH NOTES AND THEN CAREFULLY CODED IN THE RECORD TO THE MINUTE - NO ROUNDING OF MINUTES
- ▶ THERAPY MINUTES IN SECTION O 400 A, B, C SHOULD BE SIGNED FOR BY THE THERAPY MANAGER OR THE INDIVIDUAL THERAPISTS IN SECTION Z FOR ACCURACY.
- ▶ ALL THERAPY MINUTES ON THE MDS MUST BE FOR SKILLED THERAPY SERVICES ONLY AND BE IDENTIFIED BY THE TYPES OF MINUTES DEFINED IN SECTION O.
- ▶ CO-TREATMENT AND INDIVIDUAL MINUTES ARE DOUBLE CODED SINCE THE LAST RAI MANUAL REVISION. - THIS IS A PROBLEM TODAY.

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### SO WHAT DO WE DO NOW?

START NOW WITH DOCUMENTATION OF YOUR ASSESSMENT PROCESS WITH A POLICY AND PROCEDURE THAT IS ACCURATE AND OPERATIONALLY CORRECT.

CHECK THAT ALL MEMBERS OF THE TEAM COMPLETING ITEMS ON THE MDS HAVE THE CORRECT, UPDATED DIRECTIONS FROM THE MANUAL.

REVIEW THE SUBSTANTIATING DATA IN THE MEDICAL RECORD - THE CRITERIA IS REPRODUCIBLE - EXACT DOCUMENTATION.

ALL INTERVIEWS NEED TO BE DOCUMENTED IN THE RECORD - ALL 6 INTERVIEWS !!!!!!!

ATTESTATION SIGNATURES AND DATES NEED TO BE COMPLIANT WITH THE DIRECTIONS.

NO ONE SHOULD TAKE CREDIT FOR ACCURACY OF DATA IN SECTION Z THAT THEY DID NOT CREATE OR SECURE FROM THE RECORD.

SINCE THERAPY MINUTES AND DAYS PRODUCE SIGNIFICANT PAYMENT RISK THEY SHOULD BE ATTESTED TO BY THE THERAPY MANAGER OR A THERAPIST.

DO YOU HAVE A LIST OF ALL THE STAFF INVOLVED WITH THE SCHEDULING AND COMPLETION OF THE MDS PROCESS - THAT INCLUDES TRANSMISSION AND VALIDATION AS WELL AS CORRECTIONS.

WHERE ARE THE MANUALS AND ARE THEY UPDATED TO OCTOBER 2016.

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### AND NOW.....

- ▶ SHOULD WE AUDIT ? GOOD IDEA!!!!!!!!!!!!
- ▶ Audit activities should focus on areas identified in the survey process
- ▶ CHECK ON TRAINING
- ▶ DO NOT ASSUME STAFF HAVE READ MATERIALS FROM THE MANUAL - CHECK ON THEIR UNDERSTANDING AND COMPLIANCE.
- ▶ NO ONE SHOULD EVER SIGN FOR ACCURACY OF DATA THAT THEY ARE NOT COMPLETING OR CREATING.
- ▶ THIS NEW SURVEY TASK IS VERY PROBLEMATIC AND RISKY - BE CAREFUL.
- ▶ CHECK THAT ALL STAFF DOING DATA ENTRY ON THE MDS HAVE MANUAL INSTRUCTIONS AND DEFINITIONS.
- ▶ READ THE REGULATORY TAGS RELATED TO THE ASSESSMENT PROCESS - PAY SPECIAL ATTENTION TO THE PROBES AND SURVEYOR GUIDANCE SECTIONS.

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### Tracking the RAI Process

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| Pre admission information                  |
| Set the Assessment Reference information   |
| Unit procedures to collect data            |
| Team meeting                               |
| Master schedule                            |
| MDS coordinator becomes P.P.S./MDS Manager |
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### Data Collection

- Driven from RAI Definition
- Tools - Interdisciplinary
- Treat data as valuable document
- Change current staffing documentation habits
- Create a support document for assessment and reimbursement

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### ADL Coding to ADL Score

- ▶ Use coding from G 0110 - Bed Mobility, Transfer, and Toilet Use for Self Performance and Support Provided to get an ADL point value for each ADL.
- ▶ Use coding for Eating Self Performance score only
- ▶ Add the points for the four ADLs together and that gives you the ADL score from the RUG IV system calculator
- ▶ ADL score ranges have changed from RUG III to RUG IV
- ▶ Now ADL range is 0-16
- ▶ ADL scoring still only uses the four late loss ADLs for the payment process even though other ADL activity must be considered in the care planning process.

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### New Items October 2016 - Section GG

- ▶ Draft of Data Set Available GG0130-Self Care
- ▶ Assessments for Admission (Start of PPS Stay)
- ▶ Admission Assessments - Assessment Period days 1 through 3
- ▶ Code residents usual performance at the start of the SNF PPS day for each activity using 6 point scale.
- ▶ If activity was not attempted at the start of the SNF PPS stay code the reason
- ▶ Code the patients end of SNF PPS goals using 6 point scale.

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### 6 Point Scale Safety & Quality Performance

If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.*

- 06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
- 05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity.
- 04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.

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### 6 Point Scale Safety & Quality Performance (con't.)

- ▶ 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts or holds trunk or supports trunk or limb, but provides less than half the effort.
- ▶ 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- ▶ 01. **Dependent** - Helper does ALL the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.

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### Activity Not Attempted Codes

If activity was not attempted, code reason:

- 07. Resident refused.
- 09. Not applicable.
- 88. Not attempted due to medical condition or safety concerns.

VERY IMPORTANT CODING

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### Self-Care Activities

- A. **Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
- B. **Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
- C. **Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing or ostomy, include wiping the opening but not managing the equipment.

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### Section GG Item GG0170 - Mobility

- ▶ Admission assessment
- ▶ Assessment Period days 1 through 3
- ▶ Use of Usual Performance terminology
- ▶ Code if activity was not attempted
- ▶ Code admission performance and end of SNF PPS stay goal

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### Mobility Assessment Items

- B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
- C. **Lying to sitting on side of bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
- D. **Sit to stand:** The ability to safely come to a standing position from sitting in a chair or on the side of the bed.
- E. **Chair/bed-to-chair transfer:** The ability to safely transfer to and from a bed to a chair (or wheelchair).
- F. **Toilet transfer:** The ability to safely get on and off a toilet or commode.

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### Mobility Assessment Items (con't.)

H1. Does the resident walk?

0. No, and walking goal is not clinically indicated ➡ Skip to GG0170Q1, Does the resident use a wheelchair/scooter?

1. No, and walking goal is clinically indicated ➡ Code the resident's discharge goal(s) for items GG0170J and GG0170K

2. Yes ➡ Continue to GG0170J, Walk 50 feet with two turns

J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.

K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

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### Mobility Assessment Items (con't.)

Q1. Does the resident use a wheelchair/scooter?

➡ 0. No Skip to GG0130, Self Care

➡ 1. Yes Continue to GG0170R, Wheel 50 feet with two runs

R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.

RR1. Indicate the type of wheelchair/scooter used.

1. Manual

2. Motorized

S. Wheel 150 feet: Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.

SS1. Indicate the type of wheelchair/scooter used.

1. Manual

2. Motorized

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### Section GG Functional Ability & Goals - Discharge (End of PPS Stay)

▶ Item GG0130 -self Care

▶ Last 3 days of SNF PPS Stay ending on A2400-C

▶(C. End Date of most recent Medicare stay)

▶ Complete only if A0310G Is not 2-Unplanned Discharge and A0310H - SNF PPS part A Discharge (end of stay)

▶ And the length of the Part A Stay is greater than 2 days.

▶ And the discharge is not to an acute care hospital A2100 discharge Status

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### Coding of Self Care Items

- ▶ Same as an Admission
- ▶ 6 Point Scale
- ▶ Activity not attempted code
- ▶ Code only discharge performance
- ▶ "Usual Performance" definition - Record the patient's usual ability to perform each activity. Do not record the patient's best performance and do not record the patient's worst performance, but rather record the patient's usual performance during the assessment period.

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### ANALYTICS

- ▶ ARE VERY HELPFUL
- ▶ CAN LOOK AT ALL SEGMENTS OF THE DATA
- ▶ ADDITIONAL RISK MANAGEMENT DATA CAN TRACK FALLS, SKIN AND OTHER CLINICAL AND OUTCOME RISK AREAS
- ▶ REHOSPITALIZATIONS CAN BE TRACKED AND EVALUATED
- ▶ MDS AND BILLING DOCUMENTS CAN BE SCRUBBED PRIOR TO TRANSMISSION TO ELIMINATE ERRORS
- ▶ ANALYSIS OF ALL ASPECTS OF THE CARE PROCESS CAN ASSIST STAFF TO EVALUATE OUTCOMES AN PATTERNS OF CARE

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### Section O Therapy Services

- ▶ First look at criteria for therapy and that includes the active doctor's order at the beginning of the therapy treatment.
- ▶ Now we have requirements for four types of minutes to be documented :
  - ▶ Individual Minutes
  - ▶ Concurrent Minutes
  - ▶ Group Minutes
  - ▶ Co-Treatment

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### Section O Therapy Services

- ▶ Therapy start and stop dates are on each form
- ▶ Days of therapy remain the same
- ▶ Concurrent minutes mean therapy delivered to two residents at the same time - no more - big issue!!!!!!
- ▶ Respiratory therapy remains the same - looking for manual revision for this- Nurse can deliver therapy and code minutes. Glossary reference for definition pg. Appendix A-19.
- ▶ Coding minutes of therapy p.015-29

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### NEW ITEMS FOR THE MDS 3.0 October 2017

- ▶ The MDS data set will change in October 2017 with the addition of new items in Section N and Section P.
- ▶ The RAI Manual supporting these changes has not been released.
- ▶ The items and coding directions for the form have been released
- ▶ The new MDS will be version 1.15.0 and will begin use October 1, 2017.
- ▶ Section N will add 5 new items
- ▶ Section P will have a new title and add 7 new items

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### Section N - new items

- ▶ Item N0410H - Opioid - will be coded with other medications received in the last 7 days
- ▶ Item N0450 Antipsychotic Medication Review - item title
- ▶ Item N0450A - Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment , whichever is more recent?
  - ▶ Four options for answers
  - ▶ No
  - ▶ Yes routine
  - ▶ Yes PRN
  - ▶ Yes routine and PRN

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- ▶ Item N0450B - Has gradual dose reduction (GDR) been attempted?
- ▶ Options No - Yes
- ▶ If Yes then go to item N0450C
- ▶ Item N0450C - Date of last attempted GDR
- ▶ Item N0450D - Physician documented GDR as clinically contraindicated - options yes or no
- ▶ Item N0450E - Date physician documented GDR as clinically contraindicated.

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### Section P - new items

- ▶ Section P - P200 has a new title - Restraints and Alarms
- ▶ New Item Alarms - Instructions: An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected
- ▶ Item P200A - Bed alarm
- ▶ Item P200B - Chair alarm
- ▶ Item P200C - Floor mat alarm
- ▶ Item P200D - Motion sensor alarm
- ▶ Item P200E - Wander /elopement alarm
- ▶ Item P200F - Other alarm

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- ▶ The corresponding definitions for the various types of alarms listed on the assessment have not been released at this time and will stimulate a lot of discussion.
- ▶ The entire team must focus on alarm use and proper documentation as well as evaluation of the utility of the alarm and alternatives.
- ▶ All of these additional items will have RAI Manual directions and definitions for coding. Look for that information in the summer with an implementation of coding October 1, 2017.
- ▶ The content of the MDS 3.0 will change as of that date as well.

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### Section Z Assessment Administration

- ▶ Very important section
- ▶ Totally reorganized
- ▶ Legal definitions are all expanded - Attestation Statement
- ▶ Must be reviewed by the MDS manager and the administrator.
- ▶ RN Assessment Coordinator is a person identified by the rules - not just any RN

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### Section Z Assessment Administration

- ▶ Only sign the assessment when it is complete - be careful of dates here.
- ▶ The rules for electronic signatures must be in line with state and local laws for the same - You must have specific security in the system to prevent use of electronic signatures by other than the individual.
- ▶ Item Z0400 is very important -everyone who codes items on the form needs to sign - and date and identify the items they have completed - very important

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### Section Z Assessment Administration

- ▶ The attestation is a legal responsibility document - It was written to assure accuracy and make MDS documents available for external audit.
- ▶ Should be in HR records - "I certify.."

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### Impact of Accurate Data on Quality Measures

- ▶ First, lets look at the three sets of Quality statistics that the MDS data base reports.
- ▶ Gone are the days of CASPER Quality Measures - only viewed by the facility - state agencies and federal agencies.
- ▶ Now we have Quality Measures reported:
  - ▶ CASPER Quality Measures
  - ▶ Quality Measures reported in and calculating 5-Star rankings for all facilities
  - ▶ Quality Measures reported on the Nursing Home Compare Website
  - ▶ MDS data is also combined with Claims Data to impact Readmission calculations
  - ▶ New Quality Measures that reflect functional improvement or decline are also being calculated and reported

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### Your Team Must Understand the Data that Creates the Quality Measures

- ▶ #1 recommendation - Use the color coded MDS documents for training and discussion.
- ▶ These tools show the flow of the data to the Quality Measures and identify which Quality Measures are triggered.
- ▶ Who is coding the Items? - Who is gathering the data? - Professionals with training - direct care staff with oversight - Do you have current manual instructions?
- ▶ Manual instructions change every year - How do you update your team with resources, training and policy development? This requires operational oversight and regular communication between the MDS office and administration.

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### Overview of Claims-Based Measures

- ▶ Measures use Medicare claims, although the MDS is used in building stays and for some risk-adjustment variables.
- ▶ Measures only include Medicare fee-for-service beneficiaries.
  - ▶ Eventually, encounter data may allow us to include Medicare Advantage enrollees.
- ▶ All are short-stay measures that only include those who were admitted to the nursing home following an inpatient hospitalization.
- ▶ Measures are risk-adjusted, using items from claims, the enrollment database and the MDS

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### Percentage of Short-Stay Residents Who Were Re-hospitalized After a Nursing Home Admission

- ▶ Development of readmission measures is a high priority for CMS:
  - ▶ The Protecting Access to Medicare Act calls for public reporting of readmission measures on Nursing Home Compare.
  - ▶ SNF Value-Based Purchasing (VBP) will use a claims-based readmission measure.
- ▶ Includes hospitalizations that occur after nursing home discharge but within 30-days of stay start date.
  - ▶ Includes observation stays.
  - ▶ Excludes planned readmissions and hospice patients.
- ▶ A 'stay-based' measure that includes both those who were previously in a nursing home and those who are new admits.

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### Percentage of Short-Stay Residents Who Were Successfully Discharged to the Community

- ▶ For many short-stay patients, return to the community is the most important outcome associated with SNF care.
- ▶ Measure uses MDS assessments to identify community discharges and claims to determine whether the discharge was successful.
  - ▶ An episode-based measure that looks at whether resident is successfully discharged within 100 days of admission
  - ▶ Successful discharge defined as those for which the beneficiary was not hospitalized, was not readmitted to a nursing home, and did not die in the 30 days after discharge.

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### Percentage of Short-Stay Residents Who Have Had an Outpatient Emergency Department Visit

- ▶ Better preventative care and access to physicians and nurse practitioners in an emergency may reduce rates of emergency department (ED) visits.
- ▶ Outpatient ED visit measure has same 30-day timeframe as the re-hospitalization measure and considers all outpatient ED visits except those that lead to an inpatient admission (which are captured by the re-hospitalization measure).

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### Percentage of Short-Stay Residents Who Made Improvements in Function

- ▶ Measures the percentage of short-stay residents who made functional improvements during their complete episode of care.
  - ▶ Based on self-performance in three mid-loss activities in daily living (ADLs): transfer, locomotion on unit, walk in corridor
  - ▶ Calculated as the percent of short-stay residents with improved mid-loss ADL functioning from the 5-day assessment to the Discharge assessment
  - ▶ Based on Discharge assessment at which return to the nursing home is not anticipated
  - ▶ Excludes residents receiving hospice care or who have a life expectancy of less than six months

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### Percentage of Long-Stay Residents Whose Ability to Move Independently Worsened

- ▶ Measures the percentage of long-stay nursing residents who experienced a decline in their ability to move around their room and in adjacent corridors over time.
  - ▶ Defined based on "locomotion on unit: self-performance" item.
  - ▶ Includes the ability to move about independently, whether a person's typical mode of movement is by walking or by using a wheelchair.
  - ▶ Risk adjustment based on ADLs from prior assessment.
- ▶ Decline is measured by an increase of one or more points between the target assessment and prior assessment.
- ▶ Look at the data in Section G.G. to be used in October 2016.

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### Percentage of Long-Stay Residents Who Received an Antianxiety or Hypnotic Medication THIS IS CURRENTLY ON HOLD

- ▶ Measures the percentage of long-stay residents in a nursing facility who receive antianxiety or hypnotic medications.
  - ▶ Purpose of the measure is to prompt nursing facilities to re-examine their prescribing patterns in order to encourage practice consistent with clinical recommendations and guidelines.
  - ▶ No risk adjustment
- ▶ Excludes residents who are receiving hospice care or have a life expectancy of less than 6 months at the time of target assessment.
- ▶ This QM will have a delay.

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YOU CAN MANAGE YOUR RISKS AND HAVE BETTER FISCAL, CLINICAL AND OPERATIONAL OUTCOMES BY FOCUSING ON:

- ▶ COMPLIANCE
- ▶ DATA BASE CONTENT
- ▶ USING ANALYTICS AS A TOOL

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- ▶ RISK MANAGEMENT - THE NAME OF THE GAME
- ▶ PROACTIVE APPROACHES TO MITIGATE OR ELIMINATE RISK
- ▶ HIGH RISK DATA RELATED AREAS ARE VERY DANGEROUS
- ▶ MANAGERS MUST BE AWARE OF DATA & MONITOR BUILDING DATA PROFILE.
- ▶ RISKS ARE GROWING FAST THIS YEAR WITH DATA CHANGES IN OCTOBER AND QM CHANGES IN APRIL.

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QUESTIONS??????

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