MDS 3.0 Electronic Record Storage

The Federal regulatory requirement at 42 CFR 483.20(d) requires nursing facilities to maintain all resident assessments completed within the previous 15 months in the resident’s active clinical record. This requirement applies to all MDS assessment types regardless of the form of storage (i.e., electronic or hard copy). In addition, the demographic information (Items A0500 – A1600) must be maintained in the active clinical record until the resident is discharged return not anticipated.

Maintenance of the MDS electronically does not require that the entire clinical record also be maintained electronically, nor does it require electronic signatures.

- If electronic signatures are used, there is no requirement to have any portion of the MDS in hard copy on a chart. Facilities must have written policies in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.

- If electronic signatures are not used, hard copies of signed and dated CAA(s) completion (Items V0200B – C), correction completion (Items X1100A – E), and assessment completion (Items Z0400 – Z0500) data that is resident-identifiable must be maintained in the resident’s active clinical record. Nursing facilities must ensure that clinical records, regardless of form, are easily and readily accessible to staff (including consultants), State agencies (including surveyors), CMS, and others who are authorized by law and need to review the information in order to provide care to the resident. More information is available in the MDS 3.0 RAI Manual beginning on page 2-5.

Reports Teleconference

Date: January 13, 2011
Time: 1:30 – 2:30 pm ET (Dial-in 10 minutes earlier)
Topic: Verification and CASPER Reports
Handouts: Power Point slides will be available about January 10 on the DOH Message Board at http://app2.health.state.pa.us/commonpoc/content/facilityweb/login.asp
Call in number: 1-888-694-4728 or 1-973-582-2745
Conference ID Number: 27870828

Company Name: Myers and Stauffer Moderator: Cathy Petko
A recording of this conference will be available; directions for requesting this will be posted on the DOH Message Board.

Additional questions: qa-mds@state.pa.us
New RAI Coordinator

Kiera Sanderson is a Health Facility Quality Examiner in the Division of Nursing Care Facilities. She recently became the Pennsylvania RAI Coordinator in the Division of Nursing Care Facilities in the Department of Health. Kiera has three years of experience as a long-term care surveyor. Prior to coming to the Department of Health, she practiced nursing for sixteen years in the clinical setting. Jane Hepner, the former RAI Coordinator, is now serving as the Assistant Director of the Division of Nursing Care Facilities.

Additional Section Q Guidance.

According to CMS (https://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp), Section Q Participation in Assessment and Goal Setting will be administered to all SNF/NF residents. The resident will be referred to a local contact agency (LCA) if the resident has transition needs that the SNF/NF cannot plan for or provide.

Every resident, particularly a resident in a short term rehabilitation stay, does not need a referral to a Local Contact Agency. For this short term resident, you would probably indicate that there was an active discharge plan in place (Q0400 = 1) and then indicate in Q0600 that it had been decided that referral to the LCA was not necessary (Q0600 = 0).

Only one contact with the LCA is needed, as long as the local contact agency has communicated with the nursing facility that they will be working with the individual and his/her family to determine if returning to the community is a feasible option. Initiate a second contact only if there has been no response from the LCA after 10 days.
November 2010 CMI Reports

November 2010 CMI Reports will be unique in that both MDS 2.0 and MDS 3.0 records will be included. Many factors have to be considered in the programming for these reports.

Latest Classifiable Assessment
The latest classifiable assessment will be selected for inclusion:
- MDS 2.0: OBRA assessments (AA8a = 1 – 5, 10) and PPS assessments (AA8b = 1 – 5, 7 and 8)
- MDS 3.0: OBRA assessments (A0310A = 01 – 06) and Scheduled PPS assessments (A0310B = 01 – 06)

MDS 3.0 uses Item Subset Codes to identify the types of assessments based on the responses to A0310. Only Comprehensive (NC), Quarterly (NQ) and Scheduled PPS (NP) Item Subsets contain all the information necessary to do RUG classification. MDS 3.0 allows you to combine many types of assessments together; as long as the assessment has one of the designated responses in A0310A and/or B, it may be selected for the CMI Report.

Validity
An assessment is considered valid if the Assessment Reference Date is within four months of the Picture Date. For November 1, the ARD must be no earlier than July 1.

RUG Classification
Pennsylvania continues to use the RUG-III v. 5.12 44 group system as has been true since the beginning of the rate-setting year on July 1, 2010. With MDS 3.0, CMS has provided a crosswalk (also known as Mapping Specifications) which allows use of MDS 3.0 item responses in the RUG-III v. 5.12 system (also identified as the 5.20 system by CMS). The crosswalk is available at http://www.cms.gov/NursingHomeQuality-Initiatives/30_NHQI.MDS30TechnicalInformation.asp and the worksheet is available in the Resident Data Reporting Manual.

Case Mix Indices (CMIs)
The PA Normalized Nursing Only CMIs calculated from the nursing facility population of 2/1/10 will continue to be used.

Obtaining the CMI Report
From the MDS Welcome Page, access the MDS 2.0 Submission system. Select Obtain Validation Reports. CMI Reports are designated as CMI-Nov2010 followed by your PROMISe number and the date/time of creation.

Reporting a Change in MA Status for the CMI Report:
- MDS 2.0: If there is no MDS 3.0 assessment for the resident, submit an MA Change Tracking Form to the MDS 2.0 Submission system. October dates may be used. The Final Validation Report will indicate that the record has been Ignored as always.
- MDS 3.0: If there is an MDS 3.0 record completed on this resident, modify Section S to report the change in MA status and submit to the MDS 3.0 system. At S9080B, enter the first date the resident changed status even if there were discharges or other records intervening. The database will use this information to identify the resident’s status on any particular date.

Discharge Return Anticipated
CMS has stated that if a resident is out of the facility more than 30 days after a Discharge Return Anticipated (DRA) assessment, the resident must be treated as a new admission when they return. Similarly, if more than 30 days have elapsed since the DRA assessment, the resident will not be included on the CMI Report.

If less than 30 days have elapsed since the Discharge Date, the resident will appear in the non-MA section of the CMI Report. The facility may have knowledge that the resident is not returning, e.g., died, went to another nursing facility. The DRA assessment (A0310F = 11) should be modified to a Discharge Return Not Anticipated assessment (A0310F = 10). There is no need to do a new assessment, simply modify the Type of Assessment. Directions for the modification process can be found in Chapter 5 of the RAI Manual.

New CMI Reports
When MDS 2.0 data was submitted to the state server, data was received in NIS within a few minutes and a new CMI Report could be generated quickly. MDS 3.0 data is submitted to a national server, and data is received in the state server only once a day usually early in the morning. It is immediately transferred to NIS and creation of new CMI Reports begun. However, there may easily be a delay of 24 hours before a new CMI Report is available. The last data accepted for automatic generation of a CMI Report must be submitted no later than the 21st of the month following the Picture Date. This should lead to a CMI Report on the 22nd and the facility can meet the mailing deadline for the Certification Page.

Having trouble with your software? jRAVEN is a free software available at https://www.qtso.com/ravendownload.html that will allow you to data enter, edit and submit MDS 3.0 records. Once your software is functioning well, the records in jRAVEN can be transferred to your proprietary software.
Website Updates

DPW Long Term Care Case Mix Information has moved to a new site: [www.portal.state.pa.us/portal/server.pt/community/long-term_care_case_mix_information/19342](http://www.portal.state.pa.us/portal/server.pt/community/long-term_care_case_mix_information/19342). In addition to all the previously available information, the latest release of the Resident Data Reporting Manual dated 12/01/2010 is posted on this site.

[www.cms.gov/SNFPPS/03_RUGIVEdu.asp#TopOfPage](http://www.cms.gov/SNFPPS/03_RUGIVEdu.asp#TopOfPage) CMS presented a conference call on November 9 on MDS 3.0 and RUG-IV: Updates and Current Status. These slides provide useful information about errors, end of therapy assessments, etc.

[www.qtso.com/download/mds/MDS_3.0_Helpful_Hints.pdf](http://www.qtso.com/download/mds/MDS_3.0_Helpful_Hints.pdf) Dealing with new systems for MDS submission and obtaining reports can be very challenging. This document provides screen shots and specific details about submitting MDS 3.0 files, verifying the file’s submission status and obtaining an FVR.

[www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter11_02.pdf](http://www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter11_02.pdf) Due to the difficulties with submission of MDS 3.0 records, facilities are concerned about how delayed submission will be handled by the Survey and Certification agency. This letter gives directions as to how Survey and Certification will deal with late submissions.


The CASPER Reporting Manual is available at [https://www.qtso.com/mds30.html](http://www.qtso.com/mds30.html) and on the MDS Submission Page with more detail about MDS 3.0 reports. Chapters updated in November 2010 are indicated on the Dropdown menu.


Manual Record Correction Request

Usually if errors are found in an MDS 3.0 record, the nursing facility can use either a modification (X0100 = 2) to correct data errors or an inactivation (X0100 = 3) to remove a record reporting an event that did not occur. However, there are some errors that are so serious that the records must be manually removed from the database so that no trace remains. The following errors require manual record correction:

- The record is a test record inadvertently submitted as production.
- The record has the wrong submission requirement in item A0410.
- The record has the wrong facility ID in the control item FAC_ID.

If one of these errors has occurred, contact the RAI Coordinator at 717-787-1816. If the situation does re-

Don’t Forget S9080B!

On all Comprehensive (NC), Quarterly (NQ), PPS (NP), Discharge (ND) and Tracking (NT) MDS 3.0 records/assessments, the MA for MA Case-Mix status of the resident must be reported in S9080A reflecting the resident’s status on the Assessment Reference Date, or the effective date. S9080B Date of Change to/from MA for MA Case-Mix must also be completed; it cannot be skipped. Record the date the resident first was identified at the MA for MA Case-Mix status identified in S9080A.

Report the same MA for MA Case-Mix status and Date of Change on all future records until the resident’s status changes. If there is no date reported in S9080B, the information in S9080A will not be considered in identifying the resident’s MA for MA Case Mix status.