Conversion from AT&T to Verizon for MDS 3.0 Submissions

A major change in the way nursing facilities submit MDS 3.0 records is scheduled to take place in June.

In the meantime, continue to connect as normal until further instructions are posted.”

An additional link was posted on May 19 at https://www.qtso.com/submissions/submissions.html to provide state-specific information but it is not active yet.

As of the date of this newsletter’s release, little more information has been provided concerning the specifics of the changeover from AT&T to Verizon for submission of MDS 3.0 records. According to earlier announcements, once the Verizon system is activated, the AT&T system will no longer be functional. Monitor the Department of Health Message Board as well as the CMS links to identify changes that may have to be made to your facility’s MDS submission system.

RAI Manual Revisions Teleconference

Date: July 14, 2011
Time: 1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)
Topic: RAI Manual Revisions
Handouts: Power Point slides will be available about July 11 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: 71162846
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
MDS 3.0 Update Q & As

On April 14, 2011, a training teleconference was provided on MDS 3.0 Update. The following questions were received. Responses are based on the RAI Manual released in December.

Q: Is it all right to do the interviews after the ARD? Personnel may not be available if the ARD is set, e.g., on a Sunday.

A: Any data gathered after the ARD may not be recorded on the MDS. The resident interviews must be done during the look-back period. It is strongly recommended that some be done on the ARD or the day before, but this is not an absolute requirement. In this situation, the interviews could be done on the Friday prior to the ARD. Even better, personnel who are working on the weekend could do the interviews. It is not required that they be done by the RNAC.

Q. Previously, assessments created only for Medicare HMO or insurance payments could be submitted to the MDS database. Some insurers even require proof, e.g., Validation Report, that they have been submitted and accepted. Is it true that these cannot be submitted any more?

A. The only MDS records that may be submitted to the QIES ASAP system are those that fulfill OBRA requirements (A0310A) for all residents in Medicare and/or Medicaid certified beds and those required for residents in a Medicare Part A covered stay (A0310B). The definition of a Medicare-covered stay on page A-25 defines this as a SNF stay billable to Medicare Part A. It does not include stays billable to Medicare Advantage HMO plans or other insurers.

The directions on the MDS for coding A0310B state: PPS Scheduled/Unscheduled Assessments for a Medicare Part A Stay. This section may not be used to create assessments for other payer sources; this is incorrect coding of the MDS and will provide CMS with wrong information. Do not even use this section in combination with an OBRA assessment unless the resident is truly in a Medicare Part A covered stay; code A0310B = 99.

You will need to work with the various payers for residents in your facility to help them understand this new CMS requirement. Work with your vendor to devise a system that will allow you to create and save these additional assessments without submission. CMS has provided a free Validation Utility Tool (VUT) available at https://www.qtso.com/vendormds.html. This is a software utility that can be used to validate MDS 3.0 submission files in XML format. The tool enforces the edits that are mapped to the MDS 3.0 items, as published in the MDS 3.0 specifications. Perhaps this would be sufficient proof of MDS accuracy for the various insurers.

Q. Must there be q shift documentation for a Turning/Repositioning program (M1200C)?

A. There are several requirements to support a turning/repositioning program in the RAI Manual on page M-33: “Includes a consistent program for changing the resident’s position and realigning the body. “Program” is defined as a specific approach that is organized, planned, documented, monitored and evaluated based on an assessment of the resident’s needs.” The program must be specific as to the approaches for changing the resident’s position and realigning the body including the specific intervention and frequency. Progress notes, assessments, and other documentation should support that the program is monitored and reassessed to determine the effectiveness of the intervention. In addition, the same federal regulation (42 CFR 483.25(c)) that was discussed on the teleconference in relation to pressure-reducing devices also applies to this item: There must be evidence that the intervention was implemented and monitored consistently over time and across all shifts.

In short, through documentation of every shift, there are many other pieces that must be put in place to support a turning/positioning program.

Q. How should the interview items be handled on the discharge assessment when the resident is sent to the hospital in an emergency situation?

A. The various resident interview items should be dash-filled. Do not do the staff interviews as a substitute.

Q. What MDS records need to be completed on the resident’s return if the resident was hospitalized after a 5-day/Return anticipated discharge were completed? What should the response be in A1700 on her reentry?

A. The first record would be an Entry tracker (A0310F =01) with A1700 = 1 Admission. This is required because the Admission assessment was not completed during the resident’s prior stay. If the resident was continuing in a Medicare Part A stay, a Medicare Return/Readmission (A0310B = 06) would need to be completed, probably best done in combination with the Admission assessment. Even if the resident’s condition seems to indicate that she might need a Significant Change assessment, the Admission assessment must be done first since no comprehensive assessment has been completed.

Q. What is the appropriate entry in A2400C End Date of Most Recent Medicare Stay if a resident in a Part A stay must return to the hospital?

A. The Discharge Date (A2000) would be entered in A2400C on the Discharge Return Anticipated assessment. If the resident returned in a Part A stay, the date of reentry would be coded at A2400B Start Date of Most Recent Medicare Stay. (p. A-25-27)

Q. Documentation is required for every shift to support a positive entry at M1200A Pressure Reducing Device – chair. How should this be handled for shifts when the resident is not in the chair, e.g., 11 – 7?

A. Documentation in the record should be complete and consistent. Use your facility policy for charting that an event did not occur, e.g., enter NA for Not Applicable, circled initials, etc.
Revised MDS 3.0 Forms and RAI Manual

CMS has updated the MDS 3.0 forms available at www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage to version 1.00.4 to include the following legal notice on the last page after Z0500: “Legal Notice Regarding MDS 3.0 - Copyright 2011 United States of America and InterRAI. This work may be freely used and distributed solely within the United States. Portions of the MDS 3.0 are under separate copyright protections: Pfizer Inc. holds the copyright for the PHQ-9 and the Annals of Internal Medicine holds the copyright for the CAM. Both Pfizer Inc. and the Annals of Internal Medicine have granted permission to freely use these instruments in association with the MDS 3.0.” In the future, printed copies of any MDS 3.0 assessments should include this notice.

CMS is also releasing a revised version of the RAI Manual at the same site to clarify any issues that have arisen since the December 2010 update, e.g., changes in correction policy, and to clarify material that has caused confusion. The manual, with an associated change document, will be released at the end of May or the beginning of June. These revisions will be the topic of the teleconference on July 14.

Medicare PPS Proposed Rule

CMS released the annual Medicare PPS Proposed Rule in the Federal Register (http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10555.pdf) on May 6, 2011. It is a complex proposal with many proposed changes in MDS completion and Medicare PPS payment calculations. There is a 60-day comment period open until 5 p.m. on June 27, 2011. The final regulation that will be effective October 1, 2011 (FY 2012) will be published in late July. The regulation is undergoing a great deal of scrutiny and discussion by the industry but until the regulation is final, it is uncertain which parts will actually be implemented.

Revised MDS forms – version 1.00.4 – have been posted at www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage incorporating proposed new items A0310C4 Change of Therapy, O0450 Resumption of Therapy, X0600C4 Change of therapy, and X0900E End of Therapy – Resumption (EOT-R) date.

National Quality Forum Endorsed QIs

The National Quality Forum has released their endorsed Quality Indicators (QIs) which will be used in the Centers for Medicare and Medicaid Services Nursing Home Compare website. (www.qualityforum.org/News_and_Resources/Press_Releases/2011/NQF_Endorses_21_Measures_for_Nursing_Homes.aspx) The details of their calculation have not been released, and CMS has stated that they do not expect to have sufficient MDS 3.0 data to implement these until 2012. However, it is of interest to know what will be emphasized in evaluating the quality of care in nursing facilities.

- Physical therapy or nursing rehabilitation/restorative care for long-stay residents with new balance problem
- Percent of residents experiencing one or more falls with major injury (long stay)
- Percent of residents on a scheduled pain medication regimen on admission who report a decrease in pain intensity or frequency (short stay)
- Percent of residents who self-report moderate to severe pain (short stay)
- Percent of residents who self-report moderate to severe pain (long stay)
- Percent of residents with pressure ulcers that are new or worsened (short stay)
- Percent of residents with pressure ulcers that are new or worsened (long stay)
- Percent of high-risk residents with pressure ulcers (long stay)
- Percent of residents assessed and appropriately given the seasonal influenza vaccine during the flu season (short stay)
- Percent of residents assessed and appropriately given the seasonal influenza vaccine (long stay)
- Percent of residents assessed and appropriately given the pneumococcal vaccine (short stay)
- Percent of residents assessed and appropriately given the pneumococcal vaccine (long stay)
- Percent of residents with a urinary tract infection (long stay)
- Percent of low-risk residents who lose control of their bowels or bladder (long stay)
- Percent of residents who have/had a catheter inserted and left in their bladder (long stay)
- Percent of residents who were physically restrained (long stay)
- Percent of residents whose need for help with activities of daily living has increased (long stay)
- Percent of residents who lose too much weight (long stay)
- Percent of residents who have depressive symptoms (long stay)
Important Number:

With the conversion to MDS 3.0 on October 1, 2010, other CMS requirements also changed. One was the new requirement that assessments and tracking forms be submitted within 14 days of their completion date. Since most MDS assessments are completed within electronic systems, it was felt that this should not be an onerous standard and would provide CMS with more timely data.

Submitting assessments late can have several repercussions. The most immediate is that you will receive Warning -3789 Record Submitted Late. Completion dates vary depending on the type of record, but if the submission date is more than 14 days after the applicable completion date, this warning will appear.

Section PP of the State Operations Manual at F287 details the transmittal requirements mandated in the Code of Federal Regulations at §483.20(f)(3): “Within 14 days after a facility completes a resident’s assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System.” You could be cited for late submission by the Department of Health.

In addition, Title 55 §1187.72 of the Pennsylvania Code dealing with Ongoing responsibilities of nursing facilities states: (18) Submit the initial Federally-approved PA Specific MDS record for each resident admitted to the nursing facility to the Department within 7 calendar days of the date the record is completed. MDS 3.0 requires that an Entry Tracking Form (A0310F = 01) be submitted whenever a resident enters or reenters the nursing facility. It must be completed within 7 days of the Entry Date (A1600 + 7) and submitted within 14 days of the Entry Date (A1600 + 14). The Office of Long Term Living has decided that timely completion and submission of the Entry Tracking Form will meet the requirement at §1187.72.

Avoid Warnings! Avoid F287 citations! Avoid errors on the 7-Day Submission Report! Submit all records within 14 days of completion!

Summer Review 2011

Field Operations (FO) representatives (reps) are visiting every nursing facility (NF) this summer to perform the Summer Review. This review is different than that conducted as a Baseline Review in previous years because of the October implementation of MDS 3.0.

There are four goals of this review:
Verify that the positive MDS item responses used to determine a RUG-III classification that appear in the facility are the same that were submitted.
Verify that there is sufficient documentation in a resident’s record to support the MDS item response.
Verify that the CMI Report of 2/1/11 accurately reflects the resident population and the MA for MA Case Mix status on that PD.
Provide technical assistance to aid the NF in coming into compliance with these requirements.

The FO reps will be reviewing 20 recently completed classifiable assessments with an emphasis on those completed for MA residents. Only positive items – those where the response indicates that the resident had the condition or received the service – will appear on the profiles to be reviewed.

In addition, the reps will begin using the Section Q Report. This report contains a list of the residents currently in the facility for whom the last assessment had a response of Yes (2) to Q0600 Has a referral been made to the local contact agency (LCA)? The reps will be reviewing whether the NF made the referral in a timely fashion, and the LCA responded in a timely fashion.

Avoid Warnings! Avoid F287 citations! Avoid errors on the 7-Day Submission Report! Submit all records within 14 days of completion!

Transferring a Resident to Another Nursing Facility

A question was received as to whether the sending facility should include a copy of the most recent MDS along with the rest of the paperwork when transferring the resident to another nursing facility. Page 2-5 of the RAI Manual states as the first point under Resident Transfers: “When transferring a resident, the transferring facility must provide the new facility with necessary medical records, including appropriate MDS assessments, to support the continuity of care.” It’s not only a good idea to include a copy of the most recent MDS, it’s a requirement!

On the same page, it states “The admitting facility should look at the previous facility’s assessment in the same way they would review other incoming documentation about the resident for the purpose of understanding the resident’s history and promoting continuity of care. However, the admitting facility must perform a new Admission assessment for the purpose of planning care within that facility to which the resident has been transferred.”