RAI Spotlight

MDS 3.0 Update April 1, 2012

Beginning with MDS 3.0 records that have a target date (A1600 Entry Date, A2000 Discharge Date or A2300 Assessment Reference Date) of April 1, 2012 or later, nursing facilities must use MDS 3.0 version 1.10.4. There are significant changes to the Item Subset Codes (ISCs):

- The type of Discharge – planned or unplanned – is reported at A0310G. For an unplanned discharge, the resident interviews may be skipped, e.g., BIMS, Mood and Pain.
- The Discharge assessment has been shortened.
- An additional item – Long Term Care Hospital – has been added to the choices for A1800 Entered From and A2100 Discharge Status.
- IV/Parenteral Feeding and Feeding Tube, previously K0500A and B, have been restructured at K0510A and B to require reporting separately in Column 1 While NOT a resident and in Column 2 While a Resident.
- N0400 Medications Received, previously a checkmark list, has been renumbered as N0410 and requires a reporting of the number of days these medications were received.
- Section Q items regarding resident preferences for return to the community have been reworked.

These and many other changes will be discussed in the teleconference on April 12, 2012. In preparation for the transition, the ISC’s may be found at www.cms.gov/NursingHomeQuality-Initiatives/30_NHQIMDS30TechnicalInformation.asp#TopOfPage. The coordinating RAI Manual is available at www.cms.gov/NursingHomeQuality-Initiatives/45_NHQIMDS30TrainingMaterials.asp#TopOfPage. Contact your vendor to assure that your software will be upgraded in time for this update. jRAVEN 1.1.4 will be available after March 27th at www.qtso.com/ravendownload.html.

April MDS 3.0 Revisions Teleconference

Date: April 12, 2012
Time: 1:30 – 2:30 pm EDT (Dial-in 10 minutes earlier)
Topic: April MDS 3.0 Revisions
Handouts: Power Point slides will be available about April 9 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: 5111229
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 and the Bulletins section of the CMS MDS Welcome Page.
Additional questions: qa-mds@pa.gov
Quality Measures Q & As

On January 12, 2012, a training teleconference was provided on the Quality Measures. The following questions were received:

Q. How are the QMs actually calculated?

A. Once the population is identified for both the numerator and denominator including exclusions, simply divide the numerator by the denominator and multiply by 100 to identify the Facility Observed Percent. The Facility Adjusted Percent uses the covariates in the calculation. In addition, a Comparison Group State Average, Comparison Group National Average and a Comparison Group National Percentile will be calculated and reported.

Q. Should quarter side rails be coded at P0100 Physical Restraints?

A. First, they must meet the definition of a restraint. If they do not restrict freedom of movement or normal access to one’s body, they should not be coded at P0100. This item is not used in the Physical Restraints QM.

Q. So many QMs deal with flu vaccination. How do we identify “this year’s flu season”?

A. The flu season is generally considered to begin when the vaccine becomes available. Monitor the CDC Seasonal Influenza (Flu) website at www.cdc.gov/flu for additional information. Also check www.cdc.gov/flu/weekly/usmap.htm for a map of current flu activity. The influenza season ends when influenza is no longer active in your geographic area.

With MDS 2.0, there were instructions to skip this item during the summer months. The data specifications for MDS 3.0 require that O0250A Did the resident receive the influenza vaccine in this facility for this year’s influenza season? always be completed with one of the following responses:

0 No which requires completion of O0250C If influenza vaccine not received, state reason
1 Yes which requires completion of O0250B Date vaccine received OR
Dash (-) Not assessed/no information
A skip response (^{}) is not acceptable for this item and will result in rejection of the record.

Q. QMs are scheduled to be available in April. From what time period will assessments be drawn?

A. CMS usually uses a previous time period to assure that all needed MDS data has been submitted. If they use the last quarter of FY 2011 ending September 30, this would include a full year of MDS 3.0 data.

Q. What are the Continuous Days in the Facility (CDIF) to identify a short-stay (SS) and a long-stay (LS) resident?

A. A resident is selected for inclusion in a sample if they are discharged within the target period (usually a quarter) or are still present in the facility on the last day of the target period. This is the conclusion of an episode. The continuous days in the facility are calculated for all the stays in this episode. If the total is 100 or less, the resident is included in the short-stay sample. If the total is 101 or more, the resident is included in the long-stay sample.

Q. Our facility is a post-acute short-stay facility. We do not have any residents who stay 101 days or longer. Will we be penalized on the QM report?

A. If you have no residents to populate the long-stay sample, these QMs cannot be calculated. Exactly how this will be reported on the QM report is unknown currently.

Q. How many short-stay QMs are there?

A. There are four for each type of vaccination for a total of eight. Only three other QMs are short-stay: Percentage of short-stay residents who can self-report pain, are on a scheduled pain medication regimen at their initial assessment, and who report lowered levels of pain on their target assessment; Percent of short-stay residents, with at least one episode of moderate/severe pain or horrible/excruciating pain of any frequency in the last five days; and Percent of short-stay residents with new or worsening Stage 2-4 pressure ulcers. There is a total of 18 long-stay QMs.

Q. How will the QMs be used in the Five Star calculations?

A. CMS has not released this information for MDS 3.0.

Q. How many QMs use a look-back scan?

A. Only two QMs use a look-back scan, reviewing all the assessments available for the target period: Percentage of short-stay residents with new or worsening Stage 2-4 pressure ulcers and Percentage of long-stay residents who have experienced one or more falls with major injury reported in the target period.
Independent Informal Dispute Resolution

If nursing facilities disagree with deficiencies identified during a survey by the Department of Health Division of Nursing Care Facilities (DNCF), they may request an Informal Dispute Resolution. This process allows the facility to present additional information to DNCF to clarify issues identified on the survey.

CMS is adding an additional appeal process for nursing facilities: Independent Informal Dispute Resolution (IIDR). Under certain circumstances, the NF is given the opportunity to dispute cited deficiencies through a process independent from the State survey agency.
- Only applies to all standard and/or complaint surveys begun on or after January 1, 2012.
- Survey must initiate an enforcement action for which a civil money penalty is imposed and is subject to being placed in escrow.
- CMS will send a letter indicating that the facility is eligible for an IIDR.
- Facility must request an IIDR within 10 calendar days of receipt of the offer.

The reviewer will be a qualified healthcare professional within the Department of Health, Quality Assurance Deputate, but will not be an employee of DNCF. The review will be completed within 60 calendar days of the facility’s request.

Further information may be found in the Survey and Certification letter 12-08-NH found at www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter12_08.pdf.

Reporting Suspicion of a Crime

The Patient Protection and Affordable Care Act of 2010 added Section 1150B to the Social Security Act requiring covered individuals in long-term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility. A covered individual is defined as each individual who is an owner, operator, employee, manager, agent or contractor of a long-term care facility.

Reports about the suspicion of a crime must be submitted to at least one law enforcement agency of the jurisdiction and the State Survey Agency within two hours if there is serious bodily injury. Otherwise, the report must be made no later than 24 hours after forming the suspicion.

The LTC facility must annually notify each covered individual of their obligation to report “any reasonable suspicion of a crime” as defined by local law, committed against an individual who is a resident of, or is receiving care from, the facility. Penalties are defined for failure to report, as well as for any retaliatory actions taken against an employee who makes a lawful report.

Further information can be found in the revised (1/20/12) Survey and Certification Memorandum “Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility (LTC): Section 1150B of the Social Security Act” at http://www.cms.gov/SurveyCertificationGenInfo/Downloads/PMST/List.asp?filter-Type=none&filterByDID=0&sortByDID=3&sortOrder=ascending&intNumPerPage=10.

DOH Message Board Changes

The rules for posting material on the DOH Message Board have been changed. As of February 1, 2012, all old postings prior to November 1, 2011, were removed. Any new postings will remain for only 60 days, after which they will be automatically deleted.

This will affect the availability of the RAI Spotlight, teleconference materials and the CD Teleconference Request form. These will only be posted on the Message Board for 60 days.

To assure longer availability of these items, the last four issues of the RAI Spotlight as well as a generic CD Teleconference Request form will be posted in the Bulletins section of the CMS MDS Welcome Page. Any teleconference materials, e.g., handouts, will be included on the requested CD.
Hospital Reserved Bed Day Payment

Effective July 1, 2010, in order to qualify for a hospital reserved bed day payment, a facility’s overall occupancy rate for the associated rate quarter has to equal or exceed 85% according to either 55 Pa. Code § 1187.104(b)(1)(ii)(B) or 55 Pa. Code § 1189.103(b)(1)(ii)(B). The nursing facility’s occupancy rate for a quarter is determined according to either 55 Pa. Code § 1187.104(b)(1)(iii) or 55 Pa. Code § 1189.103(b)(1)(ii). Data is used from the three most recent Picture Dates; the maximum occupancy percentage of these three dates determines whether or not the NF can receive hospital reserved bed day payments for the associated rate quarter.

Beginning with the February 1, 2012 Picture Date, these occupancy rates will be summarized on the last page of the CMI Report and the NF will be informed whether or not they may receive these payments for the specified rate quarter. If they may not, instruction is provided concerning the proper billing procedures. An example of these pages is provided on the CMS Welcome Page Bulletins section.

In the past, bed size information and occupancy calculations for the latest four (4) Picture Dates were located at the end of the CMI Report. This information was provided primarily as an aid to reviewing your CMI Report and was not a required calculation. As continuing to provide this same information may be confusing when viewed with the new CMI Report page described above, the old calculations will be discontinued effective with the February 1, 2012 Picture Date.

Resident Data Reporting Manual

The Resident Data Reporting Manual is being updated to coordinate with the April 1, 2012 changes to the MDS 3.0 Item Subset Codes and the revised RAI Manual. The RUG Worksheet and Documentation Guidelines in particular have been adjusted to coordinate with the changes. This revised manual should be available on the MDS Welcome Page Bulletins Section as well as the PA Department of Aging Long Term Care Case Mix Information Page at www.portal.state.pa.us/portal/server.pt/community/long-term_care_case_mix_information/19342 by the end of March.

Analysis of FY 2012 SNF PPS RUG Distributions

For FY 2012, CMS instituted several policy changes for SNF PPS. Specifically, the Nursing CMI portion of the various Rehabilitation categories was recalculated, group therapy time was allocated in the RUG calculation, and the Change of Therapy OMRA was instituted. They have released a report at www.cms.gov/SNFPPS/02_Spotlight.asp that reviews some of the changes that have resulted by comparing first quarter data from FY 2012 with the full year of data from FY 2011.

They compared the SNF Case-Mix Distributions by Major RUG-IV Category revealing some shifts to the nursing categories:

<table>
<thead>
<tr>
<th>Category</th>
<th>FY 2011</th>
<th>FY 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Plus Extensive Services</td>
<td>2.38%</td>
<td>1.78%</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>89.5%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Extensive Services</td>
<td>0.6%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Special Care</td>
<td>4.0%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Clinically Complex</td>
<td>2.1%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Behavioral Symptoms and Cognitive Performance</td>
<td>0.3%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Reduced Physical Function</td>
<td>1.2%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

They also analyzed the Modes of Therapy being provided. This revealed that providers have significantly changed the modes of therapy being provided. Facilities are providing individual therapy almost exclusively in FY 2012.

<table>
<thead>
<tr>
<th>Mode</th>
<th>FY 2011</th>
<th>FY 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>91%</td>
<td>99%</td>
</tr>
<tr>
<td>Concurrent</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Group</td>
<td>8%</td>
<td>0%</td>
</tr>
</tbody>
</table>