





Agenda

- Welcome
- HIPAA Reminder
- Review of Questions/Answers for MDS 3.0
- Questions
- Announcements



Welcome to the Summer web-based forum call!

In the lower right hand corner of the screen, you will see a box called "files." These are documents that can be downloaded, and they will also be sent out via email.

There is a Q + A box where you can type in questions if you would prefer to submit a written question rather than ask a question

HIPAA
Reminder:

When
sending
email, please
do not
include any
identifying
information

(A) Names	
(B) All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes, except for the initial three digits of the ZIP code if, according to the current publicly available data from the Bureau of the Census: (1) The geographic unit formed by combining all ZIP codes with the same three initial digits contains more than 20,000 people; and (2) The initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people is changed to 000	
(C) All elements of dates (except year) for dates that are directly related to an individual, including birth date, admission date, discharge date, death date, and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older	
(D) Telephone numbers	(L) Vehicle identifiers and serial numbers, including license plate numbers
(E) Fax numbers	(M) Device identifiers and serial numbers
(F) Email addresses	(N) Web Universal Resource Locators (URLs)
(G) Social security numbers	(O) Internet Protocol (IP) addresses
(H) Medical record numbers	(P) Biometric identifiers, including finger and voice prints
(I) Health plan beneficiary numbers	(Q) Full-face photographs and any comparable images
(J) Account numbers	(R) Any other unique identifying number, characteristic, or code, except as permitted by paragraph (c) of this section; and
(K) Certificate/license numbers	

Protected Health Information (PHI)

Information in any format that identifies the individual, including demographic information collected from an individual that can reasonably be used to identify the individual. Additionally, PHI is information created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of an individual.

De-identified

Information that has certain identifiers (see “identifiers” below) removed in accordance with 45 CFR 164.514; no longer considered to be Protected Health Information.

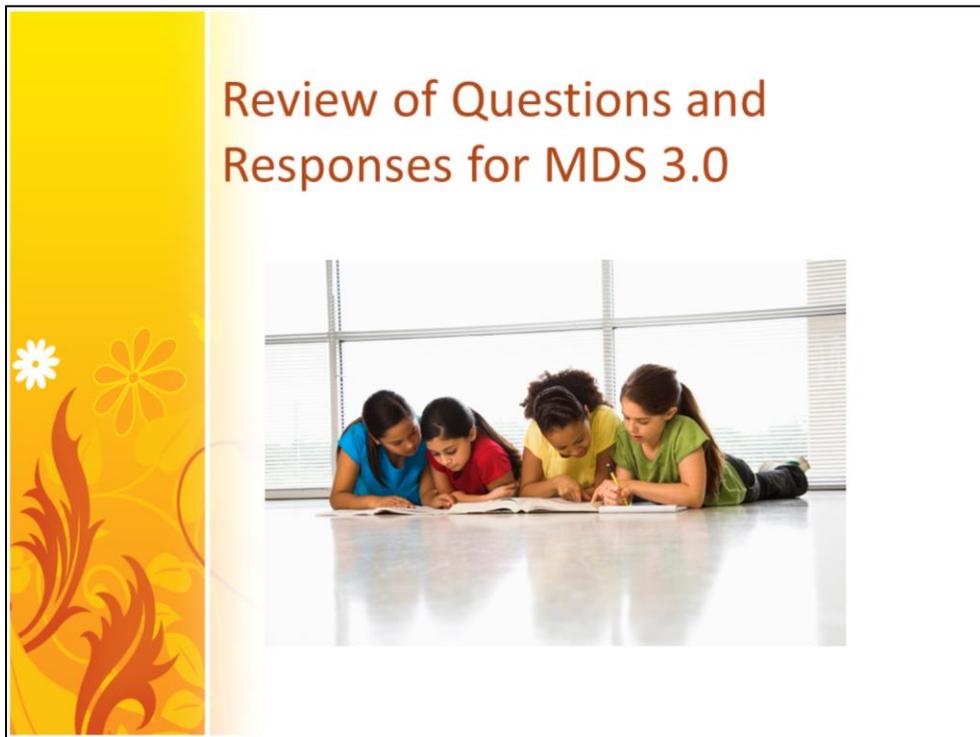
(Note: Please be aware that individual participants may be identifiable by combing other items in the data even when none of the following 18 identifiers are present. Thus, a study may still contain personally identifiable data (PID) even after removing or never acquiring the identifiers listed below, and the investigator may still need to provide complete answers for the data security questions (Items 8-10) in the protocol.)

Identifiers

- Under the HIPAA Privacy Rule “identifiers” include the following:
1. Names
 2. Geographic subdivisions smaller than a state (except the first three digits of a zip code if the geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people and the initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000).
 3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, and date of death and all ages over 89 and all elements of dates (including year) indicative of such age (except that such ages and elements may be aggregated into a single category of age 90 or older)
 4. Telephone numbers
 5. Fax numbers
 6. Electronic mail addresses
 7. Social security numbers
 8. Medical record numbers
 9. Health plan beneficiary numbers
 10. Account numbers
 11. Certificate/license numbers
 12. Vehicle identifiers and serial numbers, including license plate numbers
 13. Device identifiers and serial numbers
 14. Web Universal Resource Locators (URLs)
 15. Internet Protocol (IP) address numbers
 16. Biometric identifiers, including finger and voice prints
 17. Full face photographic images and any comparable images
 18. Any other unique identifying number, characteristic, or code (excluding a random identifier code for the subject that is not related to or derived from any existing identifier)



For more information:
<http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/De-identification/guidance.html>



While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS.

Section A

I have a skilled resident admitted private pay using Medicare B services as she did not have a qualifying hospital stay. She was only seen in the ED. Someone once told me that it is an entry from the community and not from an acute hospital because she was only in the ED, not observation and not inpatient. Should I code A1800 as 01 or 99? I can't seem to find reference in the manual



Response:
Entry from community. The resident is being admitted from home as she was not admitted to or discharged from an acute care facility.

Section D – Staff Interviews

My facility's policy is that staff interviews for mood need to be completed by 5 days after the ARD.

Is this correct?





Chapter 3, Section D, page 4:
Steps for Assessment (resident interview)
Look-back period for this item is 14 days.

1. Conduct the interview preferably the day before or day of the ARD.
2. Interview any resident when D0100 = 1.

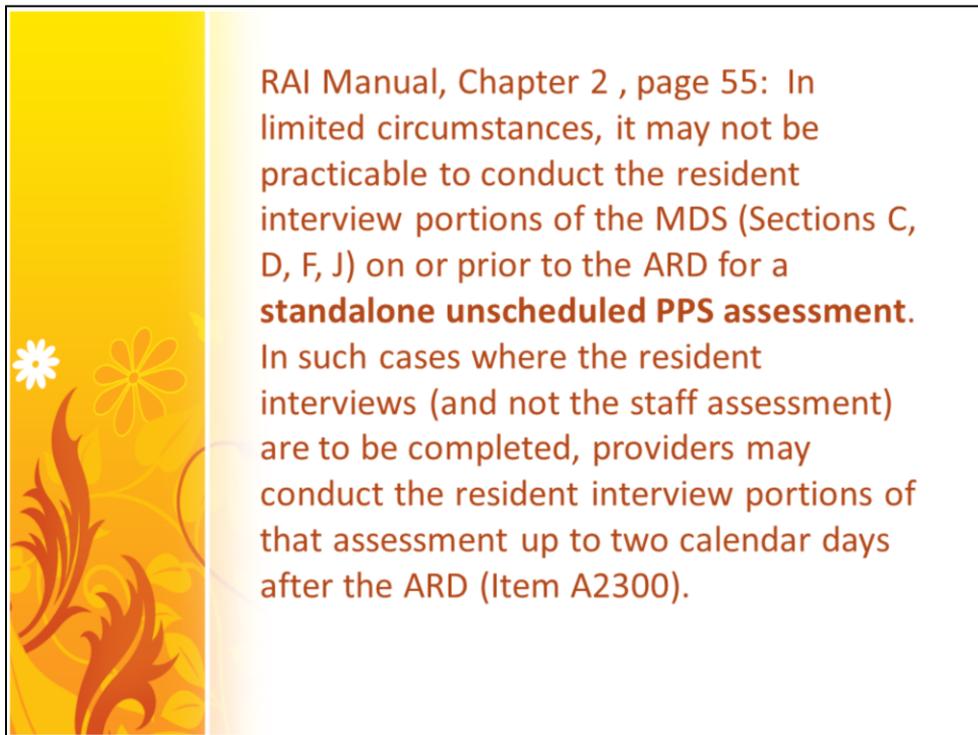


Chapter 3, Section D, page 12:

Steps for Assessment (staff interviews)

Look-back period for this item is 14 days.

1. Interview staff from all shifts who know the resident best. Conduct interview in a location that protects resident privacy.
2. The same administration techniques outlined above for the PHQ-9© Resident Mood Interview (pages D-4–D-6) and Interviewing Tips & Techniques (pages D-6–D-8) should also be followed when staff are interviewed.

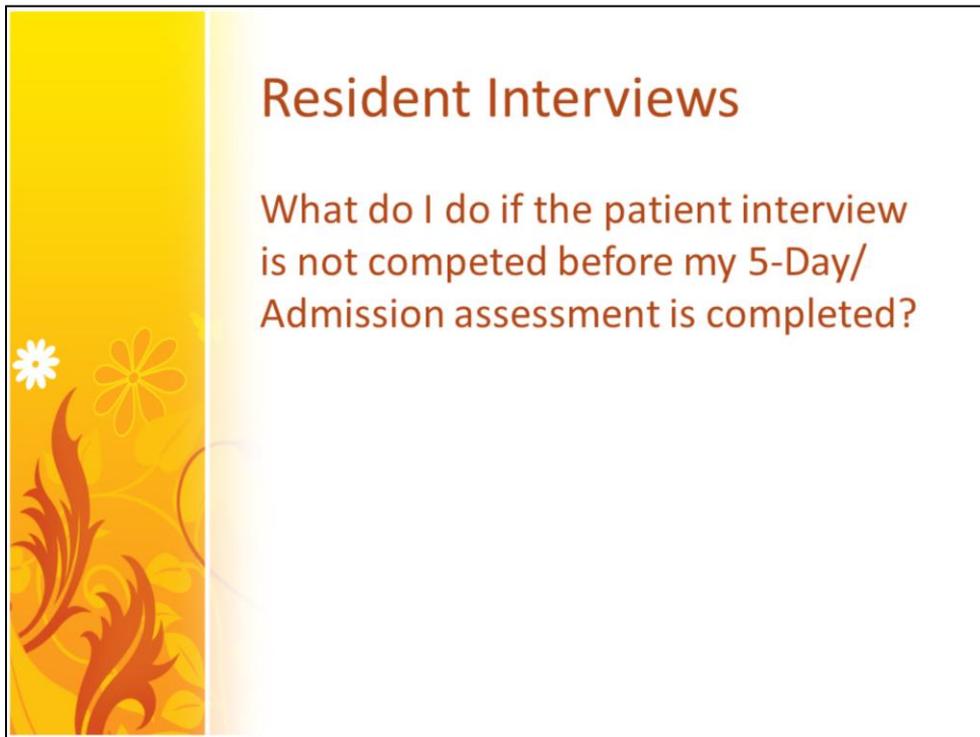


In such cases where the resident interviews (and not the staff assessment) are to be completed and the assessment is a standalone unscheduled assessment, providers may conduct the resident interview portions of that assessment up to two calendar days after the ARD (Item A2300).

This passage allows for up to two calendar days for a standalone unscheduled PPS assessment only. This would not apply to a scheduled OBRA assessment of any type or a scheduled PPS assessment. Unscheduled standalone PPS assessments are COT, EOT, and SOT.

It is not acceptable to complete the staff interviews 5 days after the ARD. The recommendations are to complete the interviews before or on the day of the ARD. Case Mix nurses are willing to accept a nurses note dated *the day after* the ARD, provided that the note clearly references the specific dates of the look back period.

This was sent to the RAI panel who agreed with the State's response.



Resident Interviews

What do I do if the patient interview is not completed before my 5-Day/ Admission assessment is completed?

RAI, chapter 6, page 7: The provider must ensure that all Medicare assessment requirements are met. When the provider fails to meet the Medicare assessment requirements, such as when the assessment is late (as evidenced by a late ARD), the provider may be required to bill the default code. In these situations, the provider is responsible to ensure that the default code and not the RUG group validated by CMS in Items Z0100A and Z01050A is billed for the applicable number of days. See Section 6.8 of this chapter for greater detail.



Response:

Without the information from the resident, this assessment is NOT complete, so you cannot sign at Z0500 until all until all Sections are done in the assessment. If you cannot get the interviews done and the assessment completed (at Item Z0500B) by the admission date + 13 days (& submitted by the date at Z0500B + 14 days), then your facility will receive the PPS Default Rate for the first 14 days of the resident's stay.

RAI, chapter 6, page 7: The provider must ensure that all Medicare assessment requirements are met. When the provider fails to meet the Medicare assessment requirements, such as when the assessment is late (as evidenced by a late ARD), the provider may be required to bill the default code. In these situations, the provider is responsible to ensure that the default code and not the RUG group validated by CMS in Items Z0100A and Z01050A is billed for the applicable number of days. See Section 6.8 of this chapter for greater detail.



Update 8/18/15

The question above did not indicate if the ARD was timely.

The facility would receive the default rate for the first 14 days (the assessment in the question was a 5 day/admission) only if the ARD (item A2300) was late. In the question above, it is not clear if the ARD was late or just the interview. The facility would not have to bill a default rate if the ARD was timely and the interview was late. The staff completing the interview would sign at Z0400 with the date the interview was complete. The completion date at Z0500 would reflect the date the MDS was completed.

Item A2300 would be considered to be late if the admission/5 day assessment was not set by day 8 after admission (5 days plus up to 3 grace days). If the lateness of the interview changes the look back period, facility might consider changing the ARD.

Section H

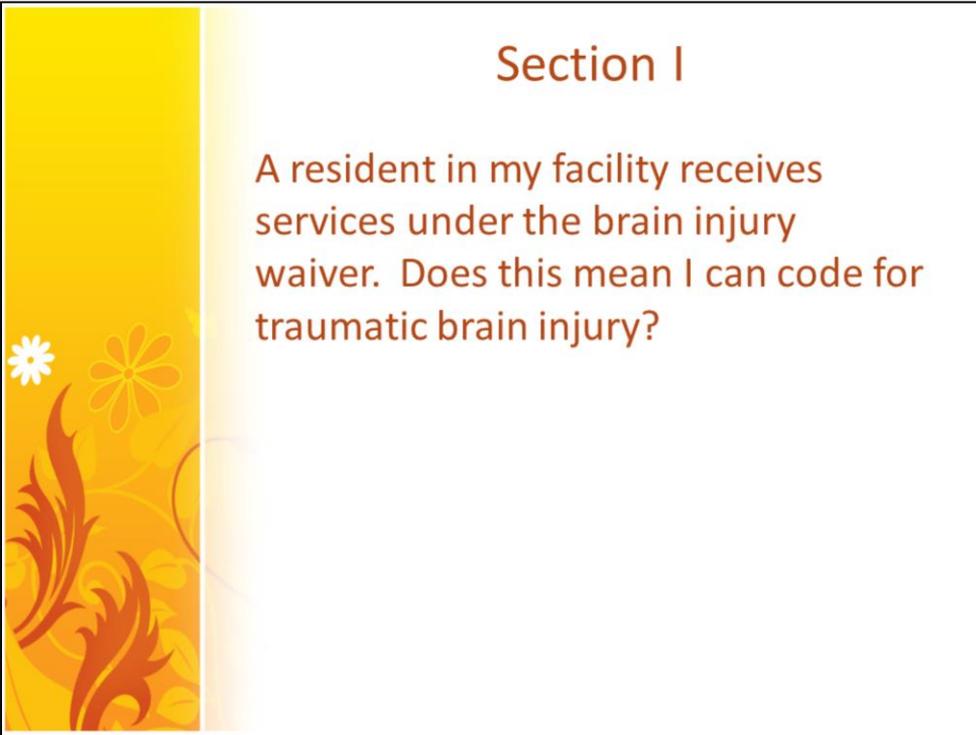
A resident has end-stage dementia and can no longer communicate or sense the urge to defecate or urinate. Staff administer a suppository every 3 days if no bowel movement. Staff are able to anticipate when resident will need to go to the toilet after receiving the suppository. Usually this resident is incontinent of BM. Occasionally after giving the suppository and getting the resident to the toilet after the suppository has had time to work, the resident will be continent. It seems as though when coded on the MDS as an episode of continence it is not really a true picture of the residents' continence.

Response:

From the description, it sounds as though the resident could be coded with a “2,” meaning frequently incontinent if he/she received a suppository and had a continent episode during the look back period. It also sounds as though the staff have implemented a bowel program to manage incontinence. The resident’s care plan could include information on how staff are able to determine if the resident needs to be taken to the toilet.

Section I

A resident in my facility receives services under the brain injury waiver. Does this mean I can code for traumatic brain injury?





RAI Manual, Section I, page 3:

ACTIVE DIAGNOSIS: Physician-documented diagnosis in the last 60 days that has a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.



**MaineCare Benefits Manual,
Chapter II, Section 18**

18.03-2 General Eligibility Criteria

B. Has a diagnosis of **acquired brain injury**. Acquired Brain Injury means an insult to the brain resulting directly or indirectly from trauma, anoxia, or vascular lesions, or infection, which is not of a degenerative or congenital nature, can produce a diminished or altered state of consciousness resulting in impairment of cognitive abilities and/or physical functioning, can result in the disturbance of behavioral or emotional functioning, can be either temporary or permanent, and can cause partial or total functional disability or psychosocial maladjustment. (Title 22 §3086);

- A. Is age eighteen (18) or older; and
- B. Has a diagnosis of acquired brain injury. Acquired Brain Injury means an insult to the brain resulting directly or indirectly from trauma, anoxia, or vascular lesions, or infection, which is not of a degenerative or congenital nature, can produce a diminished or altered state of consciousness resulting in impairment of cognitive abilities and/or physical functioning, can result in the disturbance of behavioral or emotional functioning, can be either temporary or permanent, and can cause partial or total functional disability or psychosocial maladjustment. (Title 22 §3086); and
- C. The individual has received an assessment by a qualified neuropsychologist (as defined in the *MaineCare Benefits Manual*, Rehabilitative Services, Section 102.08-5 B) and/or a licensed physician who is Board certified or Board eligible in Physical Medicine and Rehabilitation, which:
 - 1. positively indicates the individual: is not in a persistent vegetative state; is able to demonstrate potential for physical and/or behavioral and/or cognitive rehabilitation; shows evidence of moderate to severe behavioral and/or cognitive and/or functional disabilities; and

2. results in specific rehabilitation goals, based upon the findings of the assessment, describing types and frequencies of therapies and expected outcomes and timeframes; and

D. Has a completed Department-approved Health and Safety Assessment administered by the Department with an overall score of 0.1 or higher. The Department approved Health and Safety Assessment evaluates cognitive, physical, and behavioral needs related to a person's brain injury. It assesses whether a person needs support for the three areas. Additionally, it assesses if the person needs cueing, direct support, or a behavioral support. Scores range from 0-1. The assessment can be found at the Department's Brain Injury Services website: <http://www.maine.gov/dhhs/oads/disability/bi/index.shtml> The assessment was last revised: 02/25/14. The Department will only accept assessments conducted no more than three months prior to application; and

E. Has completed Mayo-Portland Adaptability Inventory – 4 (or current Department approved version of the MPAI) with an item score of 3 or higher for two of the following items:

- a. Novel Problem Solving
- b. Impaired Self-Awareness
- c. Irritability, Anger, Aggression
- d. Inappropriate Social Interaction
- e. Fund of Information or Attention/Concentration or Memory

The Department will only accept assessments conducted no more than three months prior to application; and

F. Does not receive services under any other federally-approved MaineCare home and community-based waiver program; and

G. Meets all MaineCare eligibility requirements as set forth in the *MaineCare Eligibility Manual*; and

H. The estimated annual cost of the member's services under the waiver is equal to or less than one hundred percent (100%) of a blended rate of the statewide average annual cost of care for individuals in Intermediate Care

Facilities for Individuals with Intellectual Disabilities (ICFs/IID) and Nursing Facility Brain Injury units, as determined by DHHS (the blended rate being the sum of 20% of the statewide average annual cost of care in an ICF/IID and 80% of the statewide average annual cost of care in a Nursing Facility Brain Injury unit); and

I. Can have his or her health and welfare needs assured in the community setting as stated in § 18.04-2(D).



Brain Injury Definitions

- **Traumatic Brain Injury (TBI)**
TBI is defined as an alteration in brain function, or other evidence of brain pathology, caused by an external force.
- **Acquired Brain Injury**
An acquired brain injury is an injury to the brain, which is not hereditary, congenital, degenerative, or induced by birth trauma. An acquired brain injury is an injury to the brain that has occurred after birth.

There is sometimes confusion about what is considered an acquired brain injury. By definition, any traumatic brain injury (eg, from a motor vehicle accident, or assault) could be considered an acquired brain injury. In the field of brain injury, acquired brain injuries are typically considered any injury that is non traumatic. Examples of acquired brain injury include stroke, near drowning, hypoxic or anoxic brain injury, tumor, neurotoxins, electric shock or lightning strike.

<http://www.biausa.org/about-brain-injury.htm>



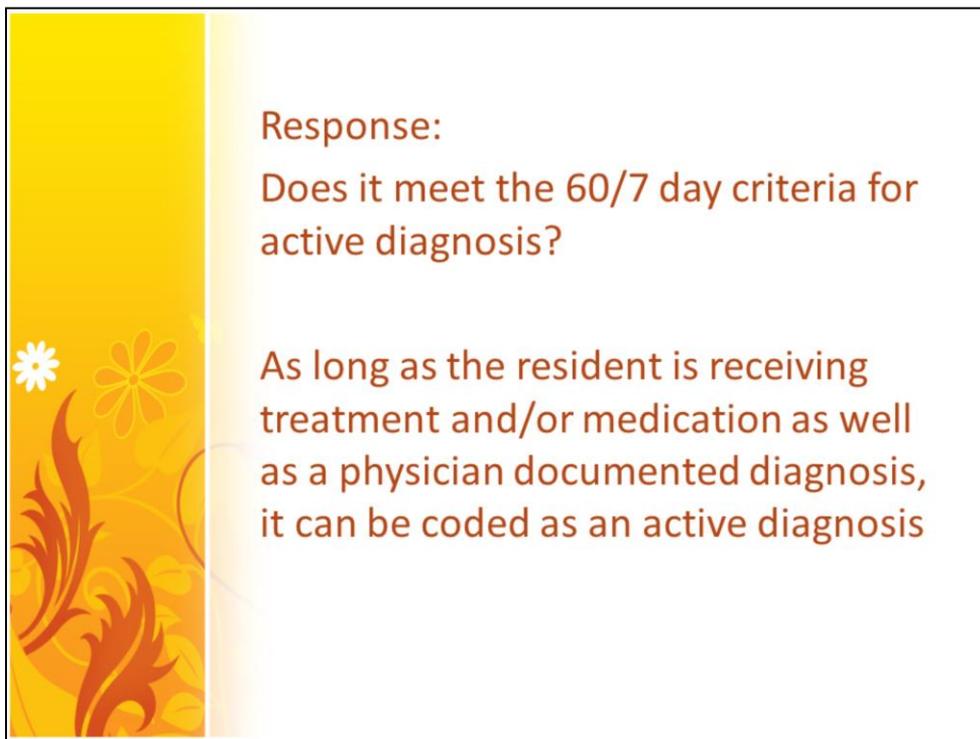
In Summary:

MDS 3.0 asks specifically for information related to a traumatic brain injury. There must be documentation to support the diagnosis within the past 60 days it must impact on the care needs in the past 7 days.

A resident with a diagnosis of an acquired brain injury related to a CVA, anoxia, hypoxia, etc. may qualify for services under Section 18, but the cause may not be related to trauma.

Section I

how long can you code a fracture on the MDS? A short term resident was admitted from another facility, she fell and fractured ribs on 3/15. I am doing her 14 day assessment and a chest x-ray reveals no evidence of acute fractures. She is on therapy for aftercare of the fx, receives anti inflammatory medications and a lido-derm patch daily



Response:
Does it meet the 60/7 day criteria for active diagnosis?

As long as the resident is receiving treatment and/or medication as well as a physician documented diagnosis, it can be coded as an active diagnosis

We had a difficult time determining a response to the question because we had no reference points. It was not clear if the 3/15 date referenced a fall in the current or previous facility, especially if a CXR done at the time of the 5 day assessment showed no evidence of acute fracture.

Section I

Would a subdural hematoma from a fall be coded on the MDS as a TBI without the physician diagnosing it as such or does it have to be documented by the physician or physician services specifically as a TBI?



Response:

Active Diagnosis:
Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/ problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered.

it is also essential that diagnoses communicated verbally be documented in the medical record by the physician to ensure follow-up.

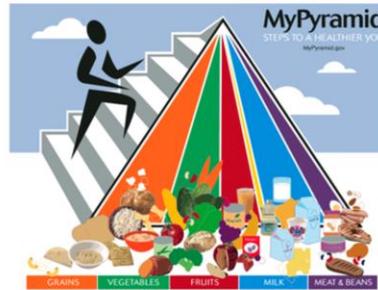
Section K

We have residents who have lost small amounts of weight and we add higher calorie foods as part of a "Fortified diet" in order to encourage small weight gains or weight maintenance. We have always considered these nursing or dietary interventions that do not need a physician's order.



Response:

This would not be considered a therapeutic diet, but could and/or should be included on the care plan.



Section K

Occasionally, however, we may have a resident who has had some weight loss or had a diagnosis of calorie malnutrition, and the physician may order a fortified diet and dietary nutritional supplements to provide additional calories with the goal of weight gain, versus maintenance. Would this be considered a therapeutic diet?



Response:

This would be considered a therapeutic diet. The diet order would not have to specify a weight goal. Specific details and interventions would be included in the care plan.



- Therapeutic diets are not defined by the content of what is provided or when it is served, but **why** the diet is required.
- Food elimination diets related to food allergies (e.g. peanut allergy) can be coded as a therapeutic diet
- A nutritional supplement given as part of the treatment for an altered nutrition status, does not constitute a therapeutic diet, but may be **part** of a therapeutic diet.

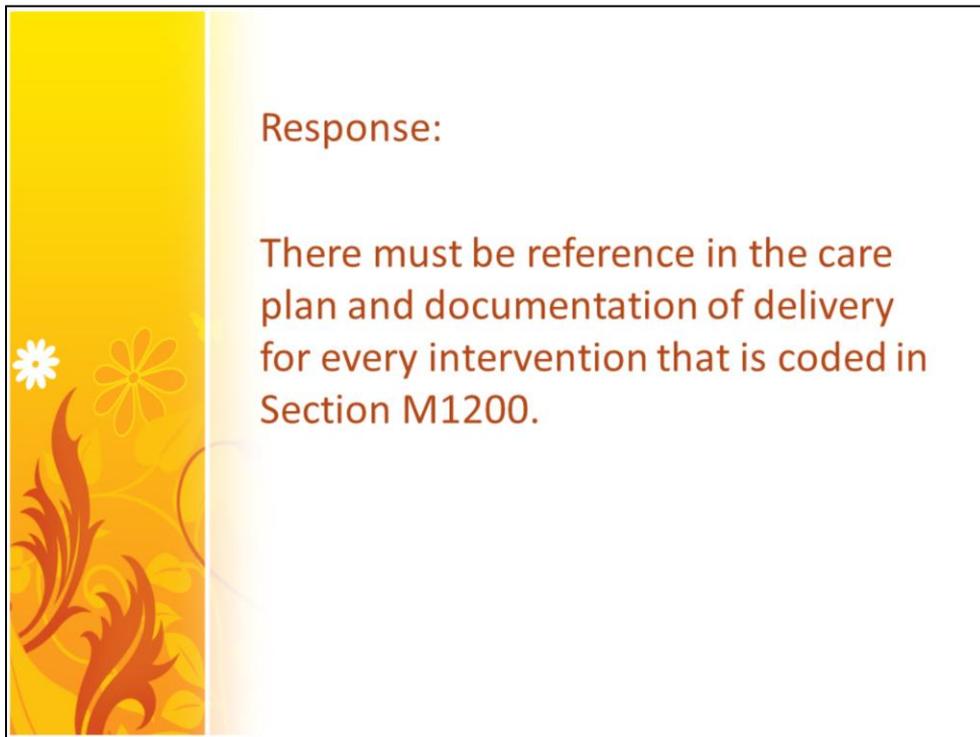
Coding Tips for K0510D (RAI Manual, Section K, page 12)

supplements (whether given with, in-between, or instead of meals) are only coded in K0510D, Therapeutic Diet when they are being administered as part of a therapeutic diet to manage problematic health conditions (e.g. supplement for protein-calorie malnutrition).

Section M

Our facility has a “skin care protocol” that includes several components. Is it okay to sign off on the “protocol” every day as proof of pressure reducing device for a chair, a turning program, and application of a moisture barrier?





Nurses are looking for physician orders for procedures, evidence of care planning to address interventions, documentation of delivery of procedures. The nurse will accept a facility policy indicating all beds have pressure relief mattresses if that is one of the interventions referenced on the care plan.

Section N

For Section N410-G (Antibiotic), do we code ophthalmic antibiotic drops as an antibiotic?





RAI Manual, Section N, page 6;

- Code medications in Item N0410 according to the medication's therapeutic category and/or pharmacological classification, not how it is used.
- Include any of these medications given to the resident by any route (e.g., PO, IM, or IV) in any setting (e.g., at the nursing home, in a hospital emergency room) while a resident of the nursing home.

Section O

When counting MD orders do you count only dosage changes of Coumadin? What if a certain dosage is ordered x2 weeks then the next order continues the same dosage x2 weeks? But the order includes a repeat PT/INR. Does this count as a new order every time it is ordered?

Response:

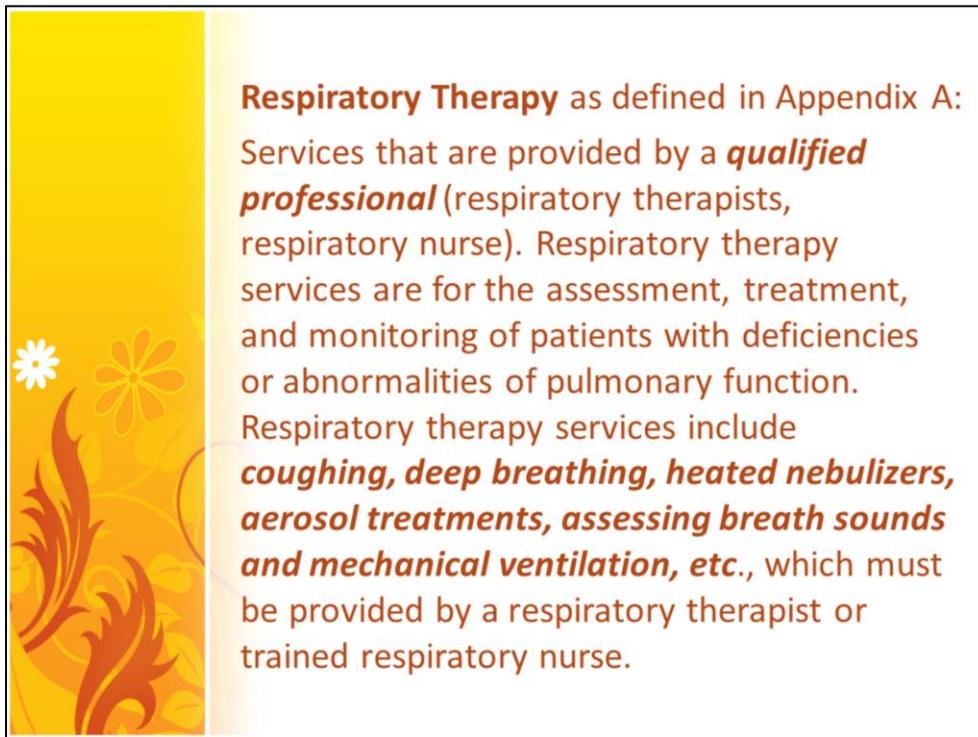
If it is a renewal of the same drug, dose, and frequency, then it is not an order change. But if it is a new order for a PT/INR, then that is a new order. (If you have an order to repeat the PT/INR at specified times or intervals, then it is not a new order when you implement that order, only when you received that order.)

Section O

Can CPAP/BIPAP be coded on the MDS as respiratory therapy?

Are there any requirements, especially wording, that are required when coding respiratory therapy?

Is there a reference in the RAI or the MDS forums that I can use?



RAI manual, Appendix A, page 19

A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws.



BiPAP/CPAP would be coded at O0100G. (RAI manual, page O-3)

Respiratory therapy, would be coded at O0400D (RAI manual, page O-21): enter the total number of minutes in the 7 day look back period and the number of days the resident received at least 15 minutes of respiratory therapy in the past 7 days.

CPAP or BiPAP is a respiratory support device that prevents airways from closing by delivering slightly pressurized air through a mask continuously or via electronic cycling throughout the breathing cycle, unlike ventilators that “breathe” for the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes his/her own BiPAP/CPAP mask. (RAI, page O-3)

Providers should code services for respiratory, psychological, and recreational therapies (Item O0400D, E, and F) when the following criteria are met:

- the physician orders the therapy;
- the physician’s order includes a statement of frequency, duration, and scope of treatment;
- the services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by qualified personnel;
- the services are required and provided by qualified personnel;
- the services must be reasonable and necessary for treatment of the resident’s condition.

Special Care RUG:

**Resp therapy at least 15 minutes per day x 7 days during look back and
ADL score of at least seven = SSA**

ADL 15-16 = SSB

ADL 17-18 = SSC



In the age of EHR, can you tell me if the regulation still requires a paper bound book for referrals, or if an electronic record will meet regulations?

Response:
This would be a licensing issue (regulatory) rather than MDS related.
287-9300

This might even be related to Residential Care rather than NF.

Section O

Can a therapist (PT, OT, or ST) accept a telephone order for therapy services from a physician?

Response:

Yes, a nurse is not required to contact the physician or accept orders for therapy services.



Snippet suggestions for future calls?



Announcements and Reminders:

- New Toll Free Help Desk number:
1-844-288-1612
- Please do NOT send protected health information (PHI) via email unless the email is encrypted.
- Upcoming MDS 3.0 Training:
8/18/15 Caribou
9/14/15 Seaport Village Health Care
9/23/15 Biddeford
October TBD - Augusta
- Next call: November 5, 2015

Contact Information

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