Nursing Facility Forum Call

Case Mix Team / Office of MaineCare Services

February 4, 2016

MaineCare Services
An Office of the
Department of Health and Human Services

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Welcome to the 1st Quarter Nursing Facility Forum call

Agenda

- Welcome
- HIPAA Reminders
- Review of MDS 3.0 Questions and Answers
- Snippet Training
- Announcements
- Questions

Nursing Facility Forum Call 2/4/16

HIPAA Reminder:

When sending email, please do not include **any** identifying information. This table developed by the Federal Department of Health and Human Services gives definitions of 18 examples of identifying information.

<table>
<tr><td colspan="2">(A) Names</td></tr>
<tr><td colspan="2">(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</td></tr>
<tr><td colspan="2">(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</td></tr>
<tr><td>(D) Telephone numbers</td><td>(L) Vehicle identifiers and serial numbers, including license plate numbers</td></tr>
<tr><td>(E) Fax numbers</td><td>(M) Device identifiers and serial numbers</td></tr>
<tr><td>(F) Email addresses</td><td>(N) Web Universal Resource Locators (URLs)</td></tr>
<tr><td>(G) Social security numbers</td><td>(O) Internet Protocol (IP) addresses</td></tr>
<tr><td>(H) Medical record numbers</td><td>(P) Biometric identifiers, including finger and voice prints</td></tr>
<tr><td>(I) Health plan beneficiary numbers</td><td>(Q) Full-face photographs and any comparable images</td></tr>
<tr><td>(J) Account numbers</td><td rowspan="2">(R) Any other unique identifying number, characteristic, or code, except as permitted by paragraph (c) of this section; and</td></tr>
<tr><td>(K) Certificate/license numbers</td></tr>
</table>

If you need to send a portion of an MDS record:

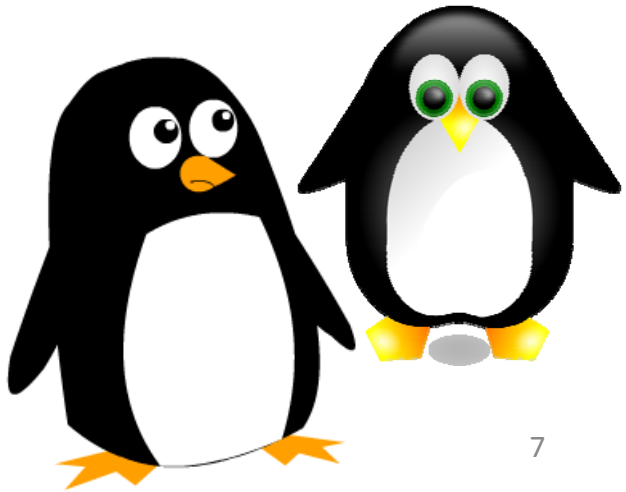
- Fax is preferred over email
- If you must email, paste the document into an word document and **apply a password**. Do NOT send the password in the same email as the attached MDS document, **OR**

- Black out all identifying information, such as name, social security number, DOB, etc. It is acceptable to refer to a resident as #1, #2, according to a list of residents left during a case mix review.

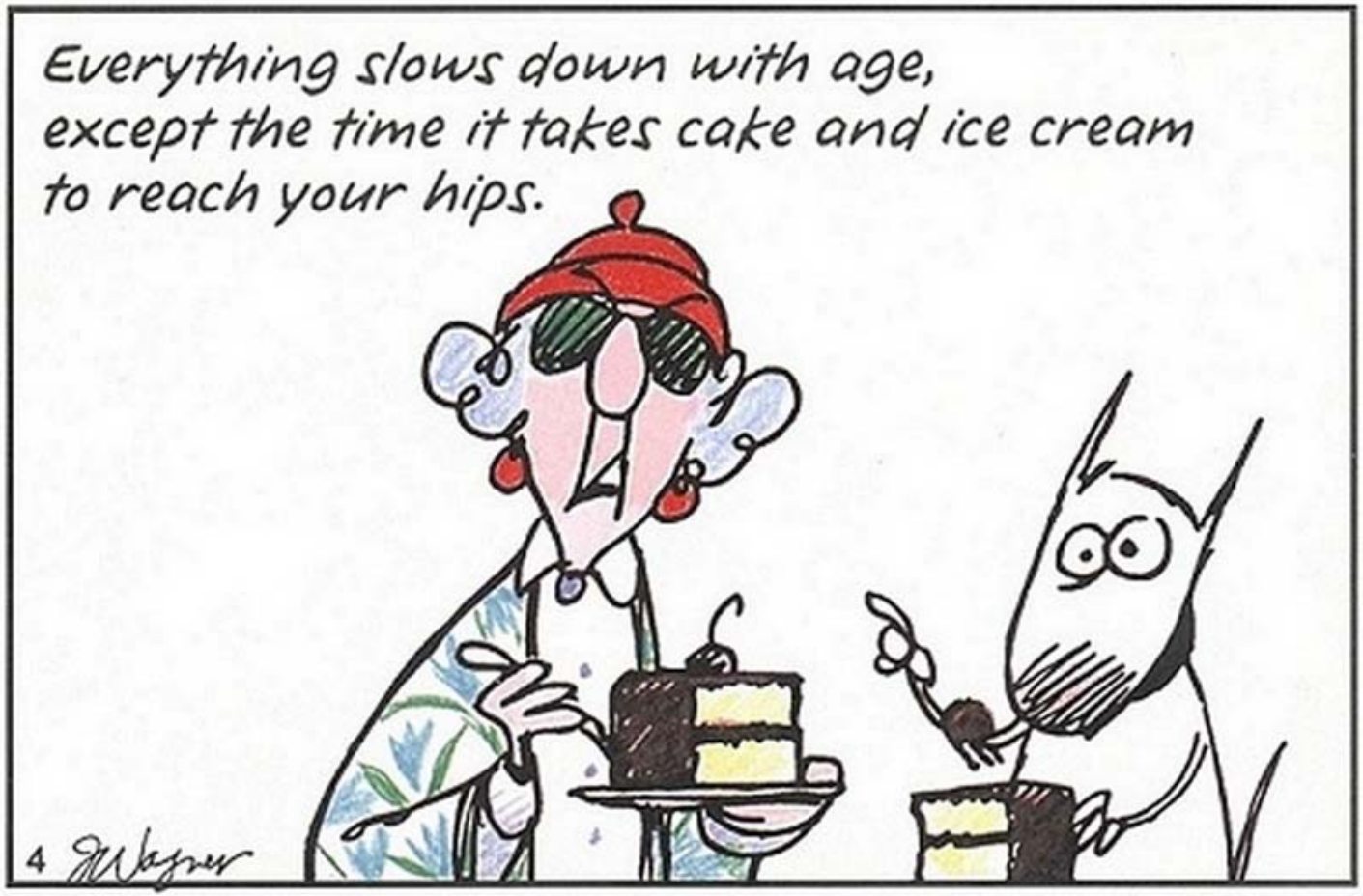
- If you mail information, please label as confidential and identify the person to whom it is being sent.

For more information:

http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/De-identification/guidance.html

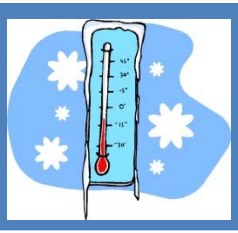


Nursing Facility Forum Call 2/4/16



Questions, Questions, Questions …

and Answers



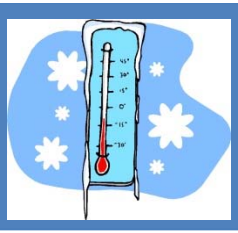
Chapter 2

A facility completed two significant change assessments on the same resident with no documentation to support decline or improvement in two areas or documentation of recommendations from the IDT. The only note in the clinical record was "therapy in, sig change." The documentation from previous comprehensive was reviewed and there was no evidence of a decline or improvement in the resident's status. Is this the correct use of a significant change assessment?

The RAI Manual indicates a SCSA is required when the criteria (two changes, improvement or decline that will not resolve without intervention by staff or by implementing standard disease related clinical interventions and/or enrollment or revocation of hospice services) is met. The RAI Manual also indicates the IDT can choose to complete a SCSA when only one criterion is present. However, in this situation the medical record **must** include a rationale for the decision to complete the SCSA when the criteria is not met. The medical record lacked evidence to indicate the resident met the criteria for a SCSA and a rationale for the decision to complete a SCSA when the criteria was not met. Therefore, the SCSA should be inactivated because the event did not occur.

Section D

Staff interviews for mood items: Sitting in front of the computer and answering the questions in D0500 is not accepted as in interview!! Some facilities have staff fill out paper copies of the D0500 questions, with no mention of anyone performing an interview … also not acceptable.



RAI manual, Chapter 3, page D-12

When the resident is not able to complete the PHQ-9©, scripted interviews with staff who know the resident well should provide critical information for understanding mood and making care planning decisions.

1. Interview staff from all shifts who know the resident best. Conduct interview in a location that protects resident privacy.

Section G

Our facility used the following clinical record documentation/data for coding toilet use on an MDS:

- 0/0 was coded 10 times,
- 0/1 was coded 5 times,
- 1/1was coded 2 times,
- 2/2 was coded 2 times, and
- 4/2 was coded 1 time.

Using this data/documentation, the facility software coded the MDS for toilet use as 2/2.

Nursing Facility Forum Call 2/4/16

ADL Self-Performance Algorithm

START HERE – Remember to review the instructions for the Rule of 3 and the ADL Self-Performance Coding Level Definitions before using the algorithm. STOP at the first code that applies when moving down the algorithm.

- Did the activity occur at least 1 time? — No → Code 8: The ADL Activity (or any part of the ADL) was not performed by the resident or staff at all
- Yes → Did the activity occur 3 or more times? — No → Code 7: Activity Occurred fewer than 3 times
- Yes → Did the resident fully perform the ADL activity without ANY help or oversight from staff every time? — Yes → Code 0: Independent
- No → Did the resident require full staff performance every time? — Yes → Code 4: Total Dependence
- No → Did the resident require full staff performance at least 3 times but not every time OR weight-bearing assistance 3 or more times? — Yes → Code 3: Extensive Assistance
- No → Did the resident require a combination of full staff performance and weight-bearing assistance 3 or more times?* — Yes → Code 3: Extensive Assistance
- No → Did the resident require non-weight-bearing assistance 3 or more times? — Yes → Code 2: Limited Assistance
- No → Did the resident require a combination of full staff performance, weight-bearing assistance, and/or non-weight-bearing assistance that total 3 or more times?* — Yes → Code 2: Limited Assistance
- No → Did the resident require oversight, encouragement, or cueing 3 or more times? — Yes → Code 1: Supervision
- No → If none of the above are met, Code 1 - Supervision

Instructions for the Rule of 3

Exceptions for the Rule of 3:

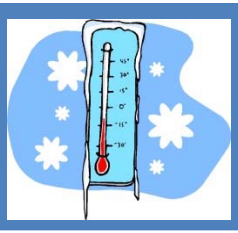
- Code 0, Code 4, and Code 8 – as the definition for these coding levels is very specific and cannot be entered on the MDS unless it is the level that occurred **every** time the ADL occurred.
- Code 7 – as this code only applies if the activity occurred fewer than 3 times.

Rule of 3:

1. When an activity occurs **3 or more times at any one level**, code that level.
2. When an activity occurs **3 or more times at multiple levels, code the most dependent level that occurred 3 or more times**.
3. When an activity occurs **3 or more times and at multiple levels, but not 3 times at any one level**, apply the following:
   a. Convert episodes of full staff performance to weight-bearing assistance.
   b. When there is a combination of full staff performance and weight-bearing assistance that total 3 or more times – code extensive assistance (3). Do not proceed to "c" below if "b" applies.
   c. When there is a combination of full staff performance/weight-bearing assistance and/or non-weight-bearing assistance that total 3 or more times, code limited assistance (2).

If none of the above are met, code Supervision (1)

*This box in the algorithm corresponds to a, b, and c under the third Rule of 3 above. The instruction in this box **only** applies when the third Rule of 3 applies, i.e., an activity occurs 3 or more times and at multiple levels, but not 3 times at any one level (e.g., 2 times non-weight-bearing, 2 times weight-bearing). If the coding scenario does not meet the third Rule of 3, do not apply a, b, or c of the third Rule of 3, answer "No," and then continue down the algorithm.



Instructions for the Rule of 3:

When an ADL activity has occurred **three or more times**, apply the steps of the Rule of 3 below **(keeping the ADL coding level definitions and the above exceptions in mind)** to determine the code to enter in Column 1, ADL Self-Performance. These steps must be used in sequence. Use the first instruction encountered that meets the coding scenario (e.g., if #1 applies, stop and code that level).

1. When an activity occurs **three or more times at any one level**, code that level.

2. When an activity occurs **three or more times at multiple levels, code the most dependent level that occurred three or more times**.

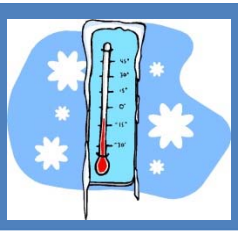
3. When an activity occurs **three or more times and at multiple levels, but not three times at any one level**, apply the following:

    a. Convert episodes of full staff performance to weight-bearing assistance when applying the third Rule of 3, as long as the full staff performance episodes did not occur every time the ADL was performed in the 7-day look-back period. It is only when **every** episode is full staff performance that Total dependence (4) can be coded. Remember, that weight-bearing episodes that occur three or more times or full staff performance that is provided three or more times during part but not all of the last 7 days are included in the ADL Self-Performance coding level definition for Extensive assistance (3).

    b. When there is a combination of full staff performance and weight-bearing assistance that total three or more times—code extensive assistance (3).

    c. When there is a combination of full staff performance/weight-bearing assistance, and/or non-weight-bearing assistance that total three or more times—code limited assistance (2).

If none of the above are met, code supervision.



For the scenario, Independent occurred at least 3 times. This means that you can't apply the sub-steps at #3. In your situation, it appears the software vendor is miscoding using these sub-steps. The final statement in this section of the manual is: **If none of the above are met, code supervision.**

Supervision is the correct code for self-performance for this scenario.

Section N

Is melatonin classified as a hypnotic?

Melatonin is a natural hormone produced by the pineal gland. Commercially, melatonin that is available and sold as a medicine is produced in a laboratory. Melatonin has been used as an alternative medicine as an aid in treating insomnia.

It cannot be coded as a hypnotic as it is not classified in that category of drugs. It is considered to be a dietary supplement.

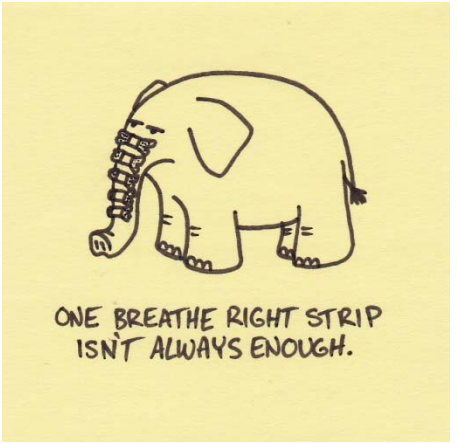
Section O

Our facility has a NP who is doing psych visits. She is not doing a physical exam, but is going over their meds with them and checking on their mental status. The RAI manual states the physician's evaluation can include partial or complete examination of the resident, monitoring the resident for response to a treatment, or adjusting the treatment as a result of the examination. So, are they allowed to code the NP visits?

Yes. It is a mental health exam by a qualified professional. Even for a physical exam, if documentation supports that the resident "was seen by" a physician (i.e. the physician either did hands-on or had a health-related conversation *with* the resident), it can be coded, and there is actually a qualifier for "telehealth" in the Manual now (page O-43). If a physician comes into the facility, discusses the resident's condition with the nurses, reviews lab results, and/or writes orders, but never "examines" the resident, then it cannot be coded as a physician visit.

Section O

I have a patient that is using the AVAPs non-invasive ventilator at all times that she is asleep (not used while awake). It is delivered via a non-invasive nasal mask. I spoke with the respiratory therapist and it is definitely not used in place of BiPAP/CPAP. Would I code this on section O as a ventilator, BiPAP or neither?

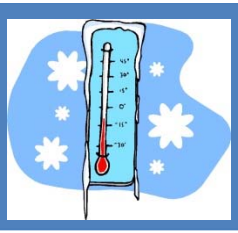


RAI Manual, page O-3:

O0100F, Ventilator or respirator

… Residents receiving closed-system ventilation includes those residents receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) as well as those residents with a tracheostomy. A resident who is being weaned off of a respirator or ventilator in the last 14 days should also be coded here.

The system that was described does not meet the definition in Section O as ventilation is not being delivered via endotracheal tube or trach, and cannot be coded on the MDS.



Section O

Can we count minutes performed by CNA staff who have been trained by a music therapist under Recreational therapy.

Appendix A, page A-18:

Recreational Therapy: Services that are provided or directly supervised by a qualified recreational therapist who holds a national certification in recreational therapy, also referred to as a Certified Therapeutic Recreation Specialist." Recreational therapy includes, but is not limited to, providing treatment services and recreation activities to individuals using a variety of techniques, including arts and crafts, animals, sports, games, dance and movement, drama, music, and community outings. Recreation therapists treat and help maintain the physical, mental, and emotional well-being of their clients by seeking to reduce depression, stress, and anxiety; recover basic motor functioning and reasoning abilities; build confidence; and socialize effectively. Recreational therapists should not be confused with recreation workers, who organize recreational activities primarily for enjoyment.

The following criteria must be met for coding recreational therapy:

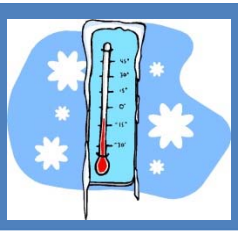
— the physician orders the therapy;

— 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.



Final answer…

Minutes of care provided by a CNA who was trained by a qualified recreational therapist cannot be counted on the MDS as treatment minutes.

MaineCare Benefits Manual, Chapter III, §16.2.3.1 Definitions"

Describes two forms of corrections: modification and deletion.

Unverified Case Mix Group Record

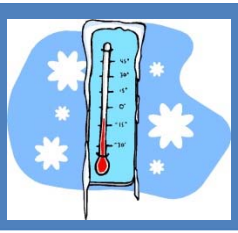
Unverified MDS Record

Both types of errors must be corrected

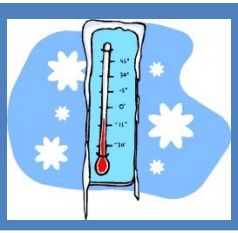
Short Stay

I have a patient who was admitted on Wednesday the 9th and left on Friday the 11th to go back to a residential care facility can I do a short stay and is it considered a short stay if completed as SOT and EOT?

I have another patient who came in on 11/1 after an MVA, he went back to the hospital on 11/5. I have completed his MDS but billing wants me to change his ARD to a short stay. Can I do that?



In order to bill for short stay, you would have had to complete a 5-day and a SOT assessment, the resident had to have received therapy services 1-4 days during the Part A stay in your facility, the resident had to have received therapy on the last day of the Part A stay, and the RUG assigned to the SOT must have been a Rehab Plus Extensive or a Rehab group. If the RUG does not meet the requirements, the assessment will be rejected.



Section S

My understanding with S8010, is that you mark “co-pay only” if MaineCare is, at the time of the ARD, paying the co-pay for a skilled stay. But the per diem benefit – is that the routine MaineCare long term stay?

You are correct. In S8010, choice C3 (MaineCare per diem) is routine MaineCare long term stay & Item G3 (MaineCare covers other insurance co-pay) is usually for a skilled stay & only starts when they reach day 21.

Section X

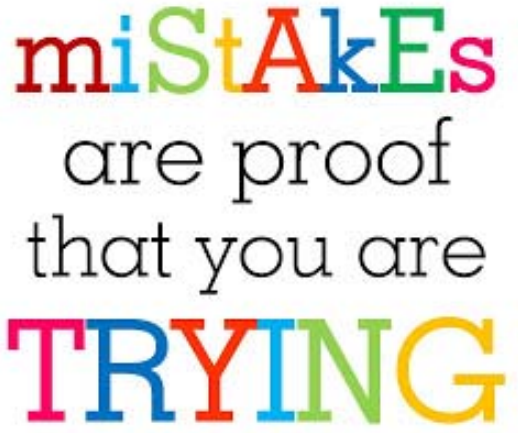
I'm having trouble submitting my corrections, they're getting rejected.

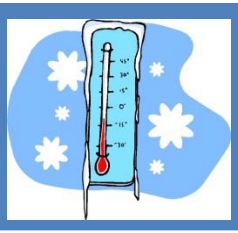
Check X0800 Correction Number

This item is not asking how many ***items*** you are correcting on this assessment. It's asking how many ***times*** have submitted a correction for this assessment

Corrections

Corrections must be done for *documentation* as well as *payment* errors.





16.2.3.5 Failure to complete MDS corrections by the nursing facility staff within fourteen (14) days of a written request by staff of the Office of MaineCare Services may result in the imposition of the deficiency per diem as specified in Principle 37 of these Principles of Reimbursement.

Failures to correct MDS, as requested in writing, and submit within the specified time outlined in Principle 16.2.1 of these Principles of Reimbursement. A reduction in rate because of deficiencies shall remain in effect until the deficiencies have been corrected, as verified by representatives of the Department, following written notification by the provider that the deficiencies no longer exist.

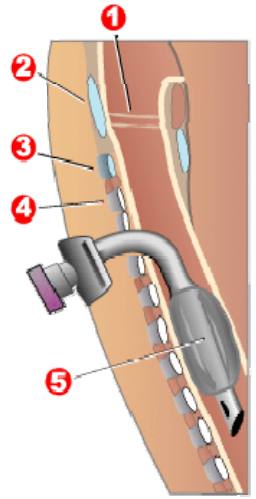
Mr. V. is able to eat by himself. Staff must set up the tray, cut the meat, open containers, and hand him the utensils. Each day during the 7-day look-back period, Mr. V. required more help during the evening meal, as he was tired and less interested in completing his meal. In the evening, in addition to encouraging the resident to eat and handing him his utensils and cups, staff must also guide the resident's hand so he will get the utensil to his mouth.

G0110H1 would be **coded 2, limited assistance**. G0110H2 would be **coded 2, one person physical assist**.

Mr. F. begins eating each meal daily by himself. During the 7-day look-back period, after he had eaten only his bread, he stated he was tired and unable to complete the meal. One staff member physically supported his hand to bring the food to his mouth and provided verbal cues to swallow the food. The resident was then able to complete the meal.

Coding: G0110H1 would be **coded 3, extensive assistance**. G0110H2 would be **coded 2, one person physical assist**.

Mrs. D. receives all of her nourishment via a gastrostomy tube. She did not consume any food or fluid by mouth. During the 7-day look-back period, she did not participate in the gastrostomy nourishment process.



Coding: G0110H1 would be **coded 4, total dependence**. G0110H2 would be **coded 2, one person physical assist**.

Chocolate for everyone!


Announcements

Announcements

Any evidence of back dating, which may be falsifying MDS records, will be referred to program integrity for review.

AANAC / RAC training is good training, and it is not a substitute for attending State training.

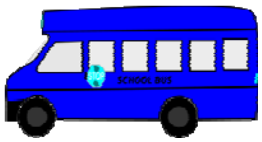
OMS is not required by policy to give advance notice of a case mix review. There may be unannounced visits coming. Facilities, according to policy, are required to give access to all records used to code the MDS.

Non-Emergency Transportation

Non-emergency transportation requests must be sent to the Non-Emergency Transportation (NET) Unit.

Letters of request may be sent via fax at 207-287-2675 or via e-mail at NetUnit.DHHS@maine.gov The facilities must password-protect letters sent via email in order to be compliant with HIPAA.

Password can always be **Member**

Slide Title
Over Two Lines

10-144 Ch. 101
MAINECARE BENEFITS MANUAL
CHAPTER II

SECTION 113 **NON-EMERGENCY TRANSPORTATION (NET) SERVICES** ESTABLISHED 10/1/1985
LAST UPDATED 4/5/2015

INTRODUCTION

MaineCare's Non-Emergency Transportation (NET) Services provide transportation for eligible MaineCare Members to and from covered, non-emergency MaineCare service when no other means of transportation is available. The State is divided into eight regions for the purposes of providing this transportation. Broker(s) have contracts with the State to provide NET services in one or more regions.

MaineCare Benefits Manual, Chapter II, Section 67.05-14

A. … NF's must use their agency vehicle to transport members whenever possible. Each time a member is transported by someone other than a family member/friend, or the NF's agency vehicle, and for which MaineCare reimbursement will be sought, the member's record must document why the NF vehicle was not used.

B. … NF staffing shortages should not be an ongoing reason for NET services. It is the expectation that the NF is fully staffed and a need to use a transportation agency due to unavailable staff would not occur frequently.

The first line of information is the RAI manual for the MDS 3.0. If you have a situation that you are unsure of how to code, call your case mix nurse or the MDS help desk for more guidance.

The web site to obtain copies of the *training calendar*, the training power point and handouts, etc. is:
http://www.maine.gov/dhhs/oms/provider/case_mix_manuals.html

Don't forget the training portal:
http://www.maine.gov/dhhs/dlrs/mds/training/index.shtml

Upcoming MDS 3.0 training:

February 19, 2016 - Augusta

March 16, 2016 – Lewiston

April, TBA – Bangor

May, TBA - Portland

Call or email to register:
MDS3.0.DHHS@maine.gov

Next call: May 5, 2016

Contact Information:

- MDS Help Desk: 624-4019, or
  1-844-288-1612 (toll free)
  MDS3.0.DHHS@maine.gov
- Lois Bourque RN: 592-5909
  Lois.Bourque@maine.gov
- Darlene Scott-Rairdon RN: 215-4797
  Darlene.Scott@maine.gov
- Maxima Corriveau RN: 215-3589
  Maxima.Corriveau@maine.gov
- Heidi Coombe RN: 441-6754
  Heidi.L.Coombe@maine.gov
- Sue Pinette RN: 287-3933 or 215-4504 (cell)
  Suzanne.Pinette@maine.gov

Questions?

Thanks for spending time with the case mix team!

Join us again in May

Department of Health and Human Services

Maine People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor *Mary C. Mayhew, Commissioner*