Nursing Facility Forum Call

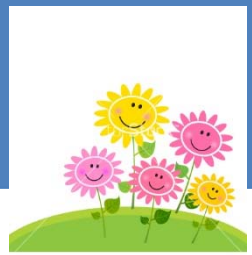
Case Mix Team / Office of MaineCare Services

May 5, 2016

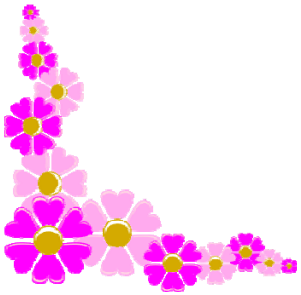
MaineCare Services
An Office of the
Department of Health and Human Services

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

Nursing Facility
Forum Call
5/5/16



Welcome to the 1st Quarter Nursing Facility Forum call



Department of Health and Human Services

Agenda

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

Nursing Facility Forum Call 5/5/16

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.

(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	

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.

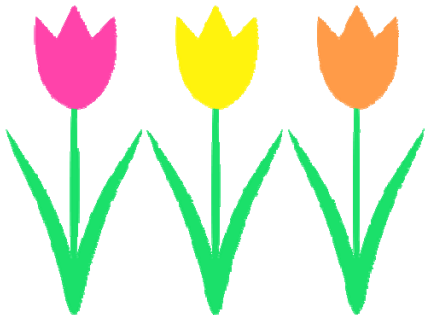
- If you mail information, please label as confidential and identify the person to whom it is being sent.

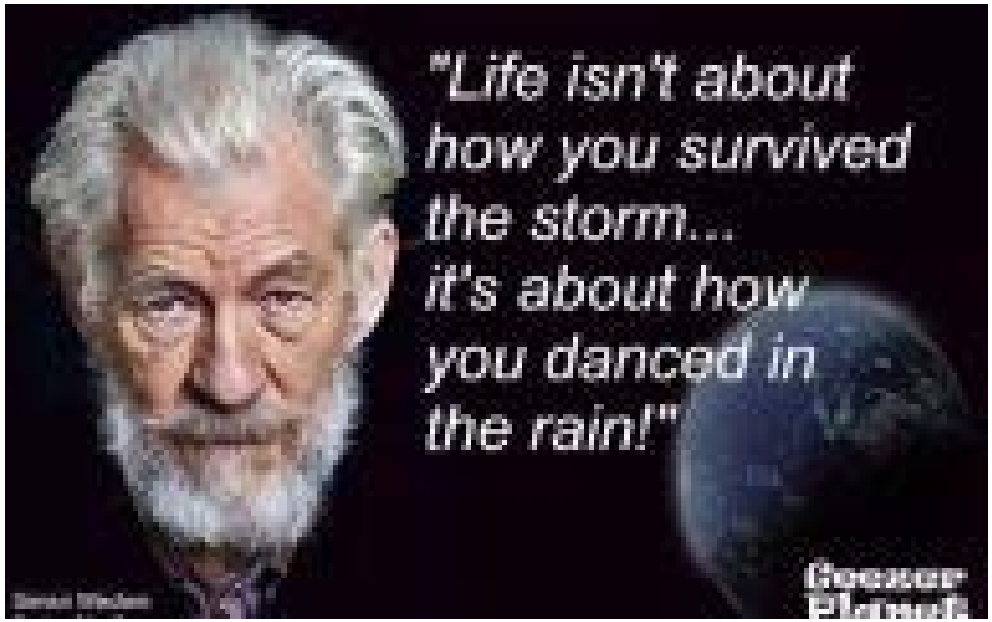
For more information:

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

HIPAA
Health Insurance Portability and Accountability Act

Nursing Facility Forum Call 5/5/16



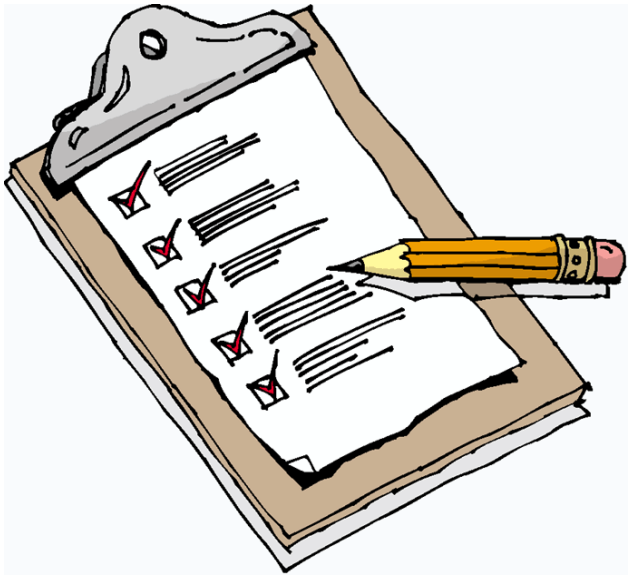


Questions, Questions, Questions …

and Answers

Section A

Am I allowed to submit extra quarterly assessments and when should I do a significant change assessment?



OBRA Assessment is the assessment defined by CMS as a schedule of assessments **performed for a nursing facility resident at admission, quarterly, and annually, whenever the resident experiences a significant change in status, and whenever the facility identifies a significant error in a prior assessment**. This assessment is the active assessment instrument used for evaluating members during their stay in a nursing facility. Reimbursement is based on these assessment outcomes. With the exception of the admission assessment, the active OBRA assessment sets the payment from the Assessment Reference Date (ARD) until the day before the ARD on the next required OBRA assessment. The admission assessment sets payment from the admission date until the next required OBRA assessment.

16.2.1 **Schedule for MDS submissions**

(1) An Admission Assessment (Comprehensive) must be completed and submitted (VB2) by the fourteenth (14th) day of the resident's stay.

(2) An Annual Reassessment (Comprehensive) must be completed and submitted (VB2) within three hundred-sixty-six (366) days of the most recent comprehensive assessment.

(3) A Significant Change in Status Reassessment (Comprehensive) must be completed and submitted (VB2) by the end of the fourteenth (14th) calendar day following determination that a significant change has occurred.

(4) A Quarterly Assessment must be completed and submitted every ninety-two (92) days.

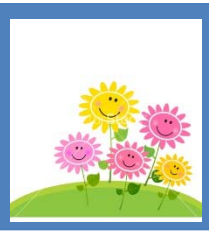
Significant Change:

A Significant Change in Status Reassessment (Comprehensive) must be completed and submitted (VB2) by the end of the fourteenth (14th) calendar day **following determination that a significant change has occurred**. (MBM, chapter III, Section 67)

After the IDT has determined that a resident meets the significant change guidelines, the nursing home should document the initial identification of a significant change in the resident's status in the clinical record (RAI, page 2-20)

The ARD must be less than or equal to 14 days after the IDT's determination that the criteria for a SCSA are met (determination date + 14 calendar days).

The final decision regarding what constitutes a significant change in status must be based upon the judgment of the IDT. MDS assessments are not required for minor or temporary variations in resident status - in these cases, the resident's condition is expected to return to baseline within 2 weeks. However, staff must note these transient changes in the resident's status in the resident's record and implement necessary assessment, care planning, and clinical interventions, even though an MDS assessment is not required.



A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement.

A condition is defined as “self-limiting” when the condition will normally resolve itself without further intervention or by staff implementing standard disease-related clinical interventions. If the condition has not resolved within 2 weeks, staff should begin a SCSA.

If there is only one change, staff may still decide that the resident would benefit from a SCSA. Nursing homes must document a rationale, in the resident’s medical record, for completing a SCSA that does not meet the criteria for completion.

Section A

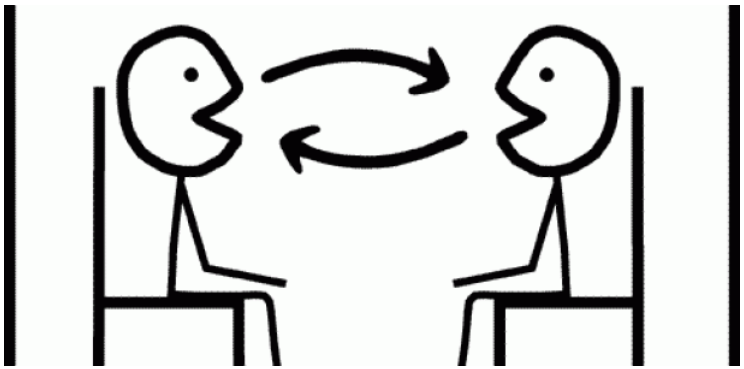
Please clarify A0310E , “Is this the first assessment since the most recent admission/entry/reentry?” if we are doing an entry assessment we would answer no to this if it is not an actual assessment but an entry tracker? Is this correct?

No, based on the information provided in the question, the send was completing an *entry tracking form*, not an assessment.

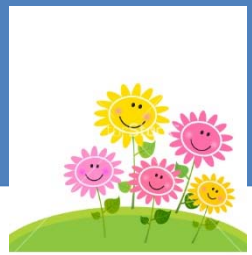
If the sender was completing an admission *assessment*, it would have been coded as the first assessment.

Section C

For a PPS assessment, what are the guidelines for using one BIMS or Mood interview for two different assessments



When coding a standalone Change of Therapy OMRA (COT), a standalone End of Therapy OMRA (EOT), or a standalone Start of Therapy OMRA (SOT), the interview items may be coded using the responses provided by the resident on a previous assessment only if the DATE of the interview responses from the previous assessment (as documented in item Z0400) were obtained no more than 14 days prior to the DATE of completion for the interview items on the unscheduled assessment (as documented in item Z0400) for which those responses will be used. RAI Manual, Chapter 2, page 55



Section G

I listened to a webinar last week by an MDS clinical coordinator about coding section G. One of the examples used was:

0 0 0 0 0 3 3 4 4 for self-performance equaled an "if none of the above are met" situation and should be coded supervision.

However, it seems like this should be a case of a combination of full staff performance and weight-bearing assistance 3 or more times and be coded extensive. Can someone explain this one to me?

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:

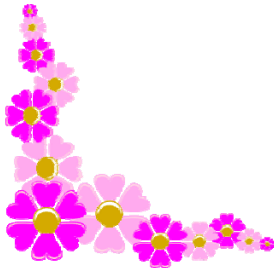
    a. Convert episodes of full staff performance to weight-bearing assistance when applying the third Rule of 3, as long as the full staff performance episodes did not occur every time the ADL was performed in the 7-day look-back period. It is only when **every** episode is full staff performance that Total 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).

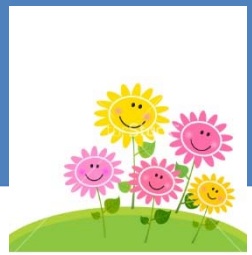
    b. When there is a combination of full staff performance and weight-bearing assistance that total three or more times—code extensive assistance (3).

    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.

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).





First rule of 3: When an activity occurs three or more times at any one level, code that level.

(Independent occurred 5 times but due to the coding level definition on G-5, "0" cannot be coded)

Second rule of 3: When an activity occurs three or more times at multiple levels, code the most dependent level that occurred three or more times.

(This rule does not apply because only Independent occurred 3 or more times and no other level occurred at least 3 times.)

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

(This rule does not apply because Independent occurred 3 or more times)

Final instructions: If none of the above are met, code supervision.

Judi Kulus, NHA, RN, MAT, RAC-MT, C-NE
Vice-President of Curriculum Development
AANAC
Denver, CO (posted 2/15/16)

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).

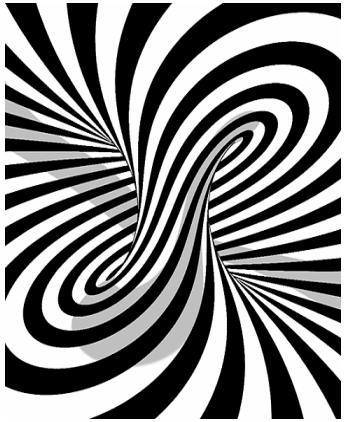
If none of the above are met, code Supervision (1)

*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.

Section J

CNA's check off if a resident has had a delusion or hallucination in their charting which automatically transfers unto the MDS. Is there a concern here for errors when I have my MDS audit?

There must be documentation in the clinical record that gives specific examples of the delusion or hallucination. What did the resident report seeing, hearing, thinking etc.



Section K

Where should I find documentation to support IV fluids being given for hydration while not a resident of my facility?

Response: Hospital documents such as transfer summary, discharge summary, medication administration records (MAR) should contain specific information about which days a resident received IV fluids and the purpose for receiving those fluids.

Refer to RAI Manual, pages K-11 and K-12

Section M

When staging pressure ulcers, do we code for how the ulcer is currently presenting itself or do we code once a 3 always a three even though it may now presents as a 2? and what does back staging mean?

RAI Manual, page M-6 Steps for completing M0300A-G

…Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage.

For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is not the primary cause, do **not** code here.

If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the resident's overall clinical condition should be reassessed. (RAI page M-11)

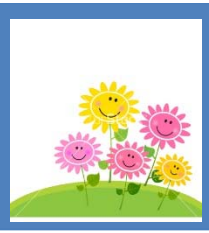
Section O

My question is related to therapy services for a client also receiving hospice care. I would like to clarify for the MDS and coding therapy minutes in those cases where therapy is providing services, but the hospice provider is the payer for therapy (i.e. therapy is billing the hospice provider, not Medicare part B). How would we code section O for therapy?

RAI Manual, page O-17 and O-21

Only skilled therapy time (i.e., requires the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met) shall be recorded on the MDS.

In situations where the ongoing performance of a safe and effective maintenance program does not require any skilled services, once the qualified therapist has designed the maintenance program and discharged the resident from a rehabilitation (i.e., skilled) therapy program, the services performed by the therapist and the assistant are not to be reported in item O0400A, B, or C Therapies. The services may be reported on the MDS assessment in item O0500 Restorative Nursing Care, provided the requirements for restorative nursing program are met.



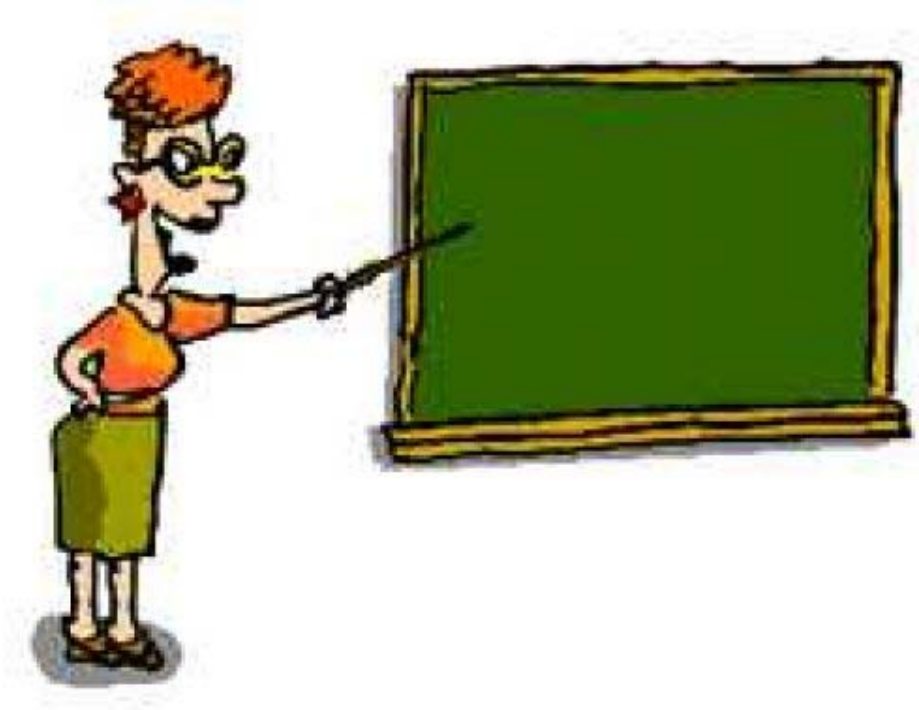
Section S

When Section S asks for hospital stays since last assessment (or since admission if less than 90 days), if the resident just came from the hospital on the admission assessment would we code this a “yes”?

You would not count the hospital stay if the resident is a **new** admission to your facility from the hospital. The facility needs to enter a response as a two-digit number.

Questions???

Snippet Training



Restorative Nursing

Restorative Nursing Programs

- **"refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible."**

CMS, Long-Term Care Facility

Resident Assessment Instrument (RAI) User's Manual, page O-32

Who is a candidate for RNP?

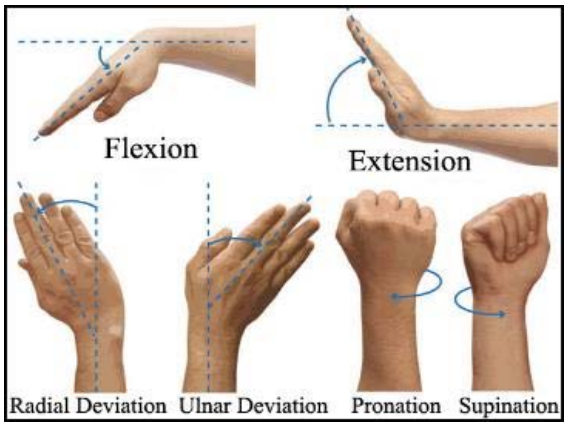
- A resident who is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy
- When restorative needs arise during the course of a longer-term stay

  in conjunction with formalized rehabilitation therapy

  when the resident is discharged from formalized therapy (PT, OT, or ST)

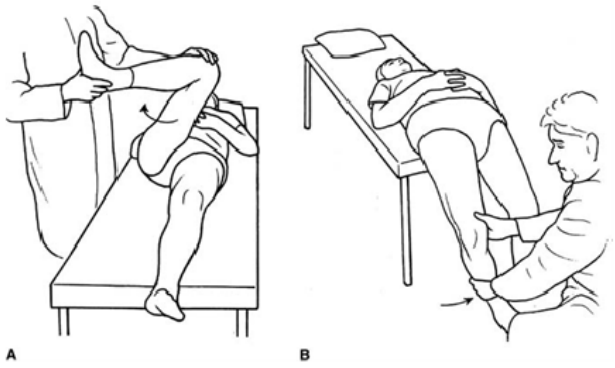
RAI User's Manual, pg. O-36

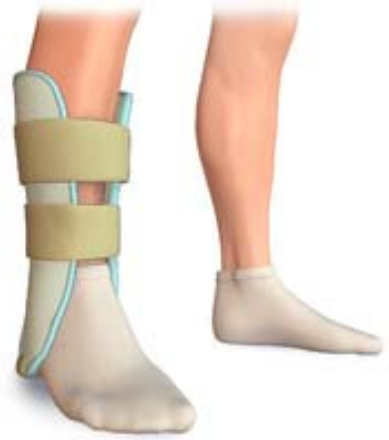
Restorative Programs



Technique

- Range of Motion (Passive)
- Range of Motion (Active)
- Splint or Brace Assistance





Ankle Stirrup Splint

Restorative Nursing Programs

Training & Skill **Practice in**:

- Bed Mobility
- Transfer
- Walking
- Dressing & Grooming
- Eating and/or Swallowing
- Amputation/Prosthesis Care
- Communication

Restorative Nursing Programs

- Measureable objectives and interventions
- Evidence of periodic evaluation by a licensed nurse
- CNA must be trained
- Licensed nurse must supervise all activities
- Does not require a physician's order

Measureable, Functional Goals

Examples:

1. Resident will **maintain** ability to raise hands over head for donning & removing upper body clothing.

2. Resident will **improve** ambulation from 100 feet, 3 times per day to 200 feet, 3 times per day.

3. Resident will **maintain** ability to take food by mouth.

4. Resident will **maintain** ability to feed self finger foods.

Restorative Nursing Programs

Restorative Nursing Programs

Mr. V. has lost range of motion in his right arm, wrist, and hand due to a cerebrovascular accident (CVA) experienced several years ago. He has moderate to severe loss of cognitive decision-making skills and memory. To avoid further ROM loss and contractures to his right arm, the occupational therapist fabricated a right resting hand splint and instructions for its application and removal. The nursing coordinator developed instructions for providing passive range of motion exercises to his right arm, wrist, and hand three times per day. The nurse's aides and Mr. V.'s wife have been instructed in how and when to apply and remove the hand splint and how to do the passive ROM exercises. These plans are documented in Mr. V.'s care plan. The total amount of time involved each day in removing and applying the hand splint and completing the ROM exercises is 30 minutes (15 minutes to perform ROM exercises and 15 minutes to apply/remove the splint). The nurse's aides report that there is less resistance in Mr. V.'s affected extremity when bathing and dressing him.

Restorative Nursing Programs

What are you going to code on the MDS?

Does it meet the qualifications?

- **Splint or Brace Assistance item (O0500C), and**
- **Range of Motion (Passive) item (O0500A),**
- **coded 7** (this was the number of days these restorative nursing techniques
- were provided.)

Will it contribute to a RUG group?

Restorative Nursing Programs

Mrs. D. is receiving training and skill practice in walking using a quad cane. Together, Mrs. D. and the nursing staff have set progressive walking distance goals. The nursing staff has received instruction on how to provide Mrs. D. with the instruction and guidance she needs to achieve the goals. She has three scheduled times each day where she learns how to walk with her quad cane. Each teaching and practice episode for walking, supervised by a nursing assistant, takes approximately 15 minutes.

Restorative Nursing Programs

What are you going to code on the MDS?

Does it meet the qualifications?

- **Walking (O0500F), and**
- **coded 7** (this was the number of days these restorative nursing techniques were provided.)

Will it contribute to a RUG group?

Restorative Nursing Programs

Mr. W.'s cognitive status has been deteriorating progressively over the past several months. Despite deliberate nursing restoration attempts to promote his independence in feeding himself, he will not eat unless he is fed.

Restorative Nursing Programs

What are you going to code on the MDS?

- **Eating and/or Swallowing (O0500F), and**
- **coded 7** (this was the number of days these restorative nursing techniques were provided.)

Does it meet the qualifications?

Mrs. K. was admitted to the nursing facility 7 days ago following repair to a fractured hip, but physical therapy was delayed due a weakened condition. She had difficulty moving herself in bed and required total assistance for transfers. The nursing staff implemented a plan on the second day following admission to teach her how to move herself in bed and transfer from bed to chair using a trapeze, the bed rails, and a transfer board. The plan was documented in Mrs. K.'s medical record and communicated to all staff at the change of shift. The charge nurse documented in the nurse's notes that in the 5 days Mrs. K. has been receiving training and skill practice for bed mobility for 20 minutes a day and transferring for 25 minutes a day, her endurance and strength have improved, and she requires only extensive assistance for transferring.

Restorative Nursing Programs

What are you going to code on the MDS?

Does it meet the qualifications?

- **Bed Mobility (O0500D), and**
- **Transfer (O0500E),**
- **coded 5** (this was the number of days that restorative nursing training and skill practice for bed mobility and transfer were provided.)

Will it contribute to a RUG group?

Ice Cream for everyone!

Nursing Facility Forum Call 5/5/16

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.

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:

May 18, 2016 - Biddeford

June 17, 2016 – Augusta

July, TBA – Lewiston

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

Next call: August 4, 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 August

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

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