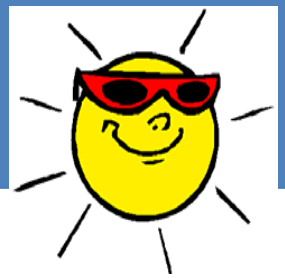
Nursing Facility Forum Call

Case Mix Team / Office of MaineCare Services

August 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 3rd Quarter Nursing Facility Forum call

Agenda

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

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

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"My memory really sucks Mildred, so I changed my password to "incorrect." That way when I log in with the wrong password, the computer will tell me... "Your password is incorrect"

Questions, Questions, Questions …

and Answers

Section N

I have a question about coding anticoagulants in section N. The wording on page N-8 of the RAI manual confuses me about the requirement of laboratory/PT/INR monitoring to code an anticoagulant. For example, eliquis and xarelto are newer medications classified as anticoagulants, but they do not require PT/INR or the degree of lab monitoring that warfarin requires. Do we code these newer anticoagulants in section N?

RAI Manual, Chapter 3, N-6:

- **N0410E, Anticoagulant (e.g., warfarin, heparin, or low- molecular weight heparin):**

Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). *Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here.*

- Code medications in Item N0410 according to the *medication's therapeutic category and/or pharmacological classification*, not how it is used. For example, although oxazepam may be prescribed for use as a hypnotic, it is categorized as an antianxiety medication. Therefore, in this section, it would be coded as an antianxiety medication and not as a hypnotic.

- **Anticoagulants must be monitored with dosage frequency determined by clinical**

circumstances, duration of use, and stability of monitoring results (e.g., Prothrombin Time [PT]/International Normalization Ratio [INR]).

Section C, D, F, and J

Interviews

if the interviews are completed on or before the ARD date and the data is enter within a week of the ARD, is that an acceptable time frame?

RAI Manual, Chapter 3, page D-3:

1. Conduct the interview preferably the day before or day of the ARD.

RAI Manual, Chapter 3, page J-7:

3. The look-back period on these items is 5 days. Because this item asks the resident to recall pain during the past 5 days, this assessment should be conducted close to the end of the 5-day look-back period; preferably on the day before, or the day of the ARD. This should more accurately capture pain episodes that occur during the 5-day look-back period.

RAI Manual, Chapter 3, Pages Z-6 and Z-7:

To obtain the signature of all persons who completed any part of the MDS. Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. Each person completing a section or portion of a section of the MDS is required to sign the Attestation Statement.

All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed

If a staff member cannot sign Z0400 on the same day that he or she completed a section or portion of a section, when the staff member signs, use the date the item originally was completed.

Section A

Are there any requirements for coding Discharge Return Anticipated / Not Anticipated when the resident has MaineCare as a funding source and there is a bed hold. For example: If a resident goes to the hospital and is expected to return within 30 days, the RAI Manual directs to code the discharge as Return Anticipated. Is there any state regulation or guidance stating that it should be coded as Return Not Anticipated if the resident is on a bed hold?

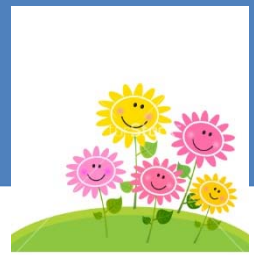
If a NF resident goes to the hospital and is expected to return within 30 days, the facility must complete a discharge return anticipated. MDS has nothing to do with the bed hold. A nursing facility may or may not choose to discharge a resident from their system if the hospital stay exceeds the allowed bed hold days

Section O - Restorative Nursing

Examples of Goals:

"I want to be well-groomed and look presentable at all times along with good oral care".

1. Is this an appropriate goal for a resident with advanced dementia?
2. Is it a measurable objective and/or intervention?



RAI Manual, Page O-39:

O0500G, Dressing and/or Grooming

Code activities provided to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks. *These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.*

Section O – Restorative Nursing

Example of Goal:

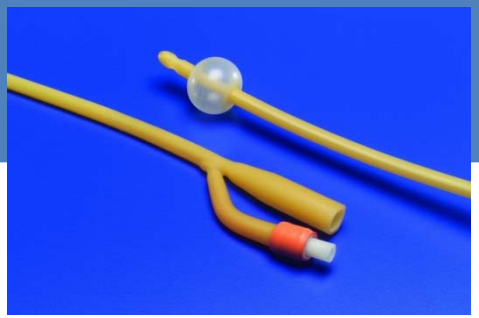
Eating/swallowing: Increase level of functioning, prevent decline in level of functioning, self-feed, increase dining independence, promote good nutrition and hydration and emotional well-being.

Is this a measureable goal?

O0500H, Eating and/or Swallowing

Code activities provided to improve or maintain the resident's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth. *These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.*

Section H



What do I code at Item H0300 for a resident who had an indwelling catheter for the entire look-back period?

What if the resident had leaking from his/her catheter during the look back period?

"Code 9, not rated: if during the 7-day look-back period the resident had an indwelling bladder catheter, condom catheter, ostomy, or no urine output (e.g., is on chronic dialysis with no urine output) for the entire 7 days." (RAI Manual, page H-8)

Section G

if you had 3-4's, 2-2's, and the rest 0's , could code a 3? The other question was 3-4's and 3-2's how would you code it?

0-0-0-0-0-0-4-4-0-0-0-0-2-4-0-2-0-0-0-0-0

0-0-0-0-0-0-4-4-0-0-0-0-2-4-0-2-2-0-0-0-0

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.

RAI Manual, Chapter 3, page G-8:

Rule of three Instructions:

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.

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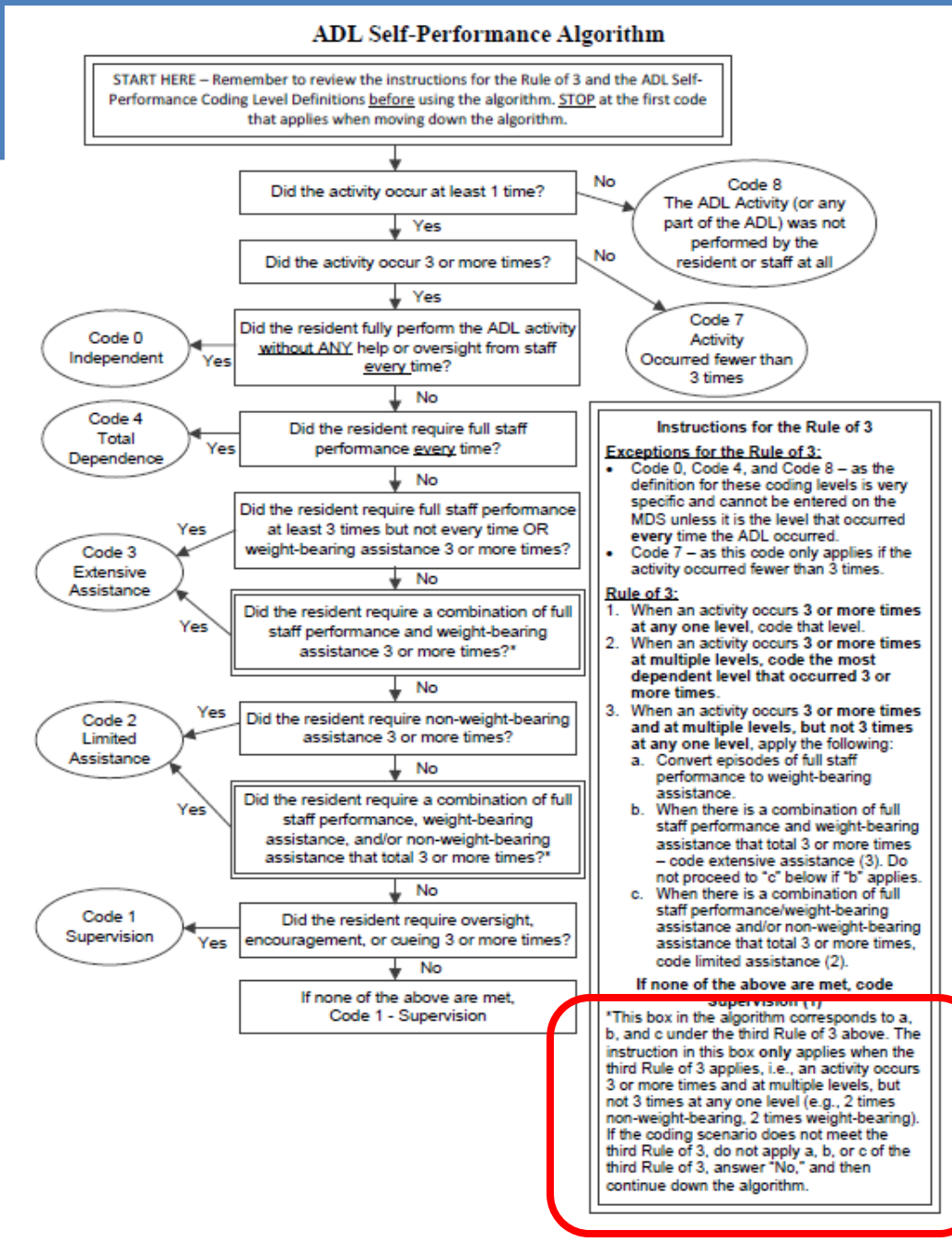


*This box in the algorithm corresponds to a, b, and c under the third Rule of 3 above. The instruction in this box **only** applies when the third Rule of 3 applies, i.e., an activity occurs 3 or more times and at multiple levels, but not 3 times at any one level (e.g., 2 times non-weight-bearing, 2 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 K

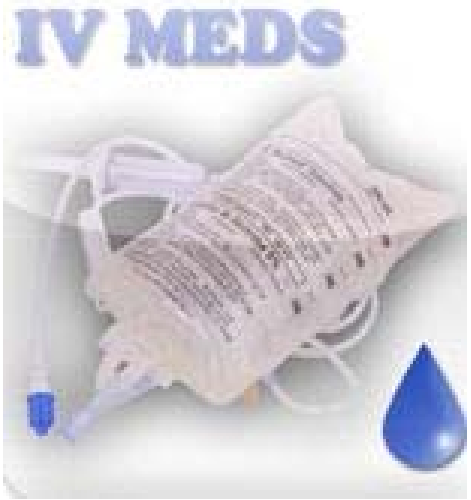
Can IV fluids be coded at Item K0510A when administered during ECT, as this is not a surgical or diagnostic procedure?

Response: No, IV fluids during ECT are no different than IV fluids given during chemotherapy or dialysis. It's part of that procedure.

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

Section O

Can IV meds be coded at Item O0100H when administered during ECT, as this is not a surgical or diagnostic procedure?



The RAI Manual on page O-3 state the following:

O0100H, IV medications

Do **not** include IV medications of any kind that were administered during dialysis or chemotherapy.

Response: There are no specific instructions with relation to ECT, however, it is a procedure performed outside of the facility, and similar to dialysis or chemotherapy, the medication must be used in order to perform the procedure, therefore, it is our opinion that this should not be coded on the MDS."

Section O

O0600

The Manual states not to code here for counseling by a Ph.D.—what about other providers who are not licensed physicians (e.g. LCSW)?

RAI Manual, Chapter 3, page O-43:

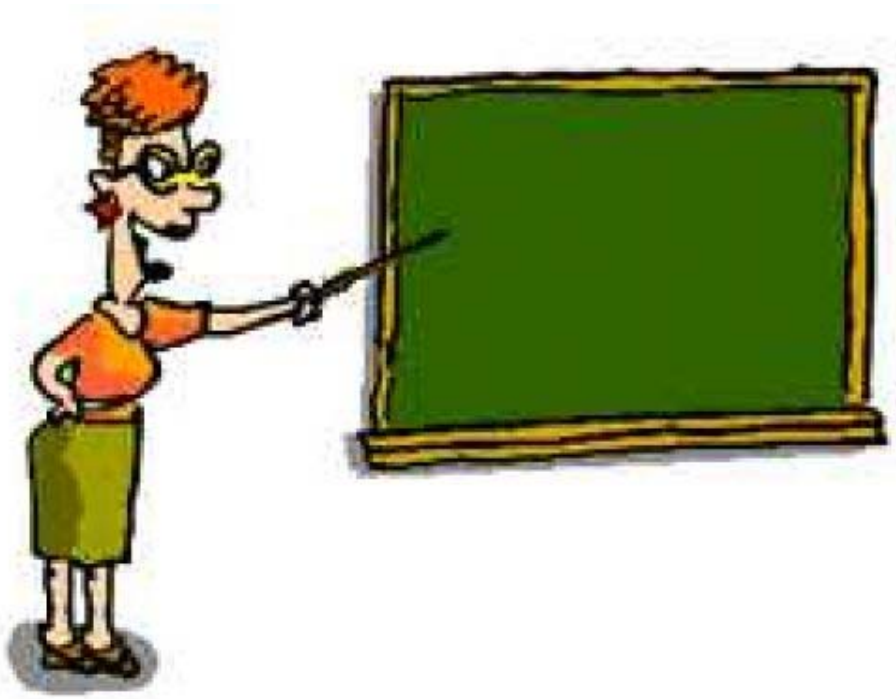
The licensed psychological therapy by a Psychologist (PhD) should be recorded in O0400E, **Psychological Therapy.**

RAI Manual, Chapter 3, page O-19:

Psychological Therapy is provided by any licensed mental health professional, such as psychiatrists, psychologists, clinical social workers, and clinical nurse specialists in mental health as allowable under applicable state laws. Psychiatric technicians are not considered to be licensed mental health professionals and their services may not be counted in this item.

Questions???

Snippet Training



RAI

Changes

Effective 10/1/16

Objectives for training to be done in September

- Identify major changes to item sets
- Identify major manual changes
- Understand changes to delirium assessment and scoring
- Understand clarifications for falls and pressure ulcers

I will be planning 4 webinar training sessions to review expected MDS 3.0 changes with an update on Section Q and Money Follows the Person (MFP).

What will be covered:

- SNF Part A PPS Discharge Assessment
- Updates to delirium assessment
- Section GG
- Fall-related injuries
- Pressure ulcers present on admission
- Item set wording changes
- No changes to Section S this year

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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:

August 9, 2016 - Caribou

September 22, 2016 - Biddeford

October 14, 2016 - Augusta

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

Next Forum call: November 3, 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
- 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 September for MDS changes

Department of Health and Human Services

Maine People Living Safe, Healthy and Productive Lives

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

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