* MDS 3.0 Training Agenda: Day 1

- Welcome and overview
- Review and Questions from Day 1
- Case Mix Implications
- Chapter 3 – Multi-Disciplinary Areas
- Sections A, S, B, C, D, E
- Sections F, K, Q, Z, V, X
- RAI Manual Chapters 4, 5, and 6
- Questions and Wrap-up

* Questions from Day 1

* Any questions, comments, need for additional discussion related to any topics discuss on Day 1?
Case Mix Implications for MDS 3.0

Case Mix Payment Items

Certain items coded as RUG III services, conditions, diagnoses and treatments on the MDS 3.0 assessment handout. RUG IV refers to payment items for PPS services.

MaineCare Case Mix

Maine uses a modified RUG III Code for Case Mix purposes.

PPS / Medicare uses RUG IV codes

Supporting Documentation for Case Mix payment items is required.
Resident interviews will be accepted as coded on the MDS 3.0—NO additional supporting documentation is required.

Staff interviews must be documented in the resident’s record. If interviews are summarized in a narrative note, the interviewer must document the date of the interview, name of staff interviewed, and staff responses to scripted questions asked.

Follow all “Steps for Assessment” in the RAI Manual, for the interview items.

Poor Documentation could mean...

Lower payment than the facility could be receiving, OR

Overpayment which could lead to re-payment to the State (Sanctions). This is due to either overstating the care a resident received or insufficient documentation to support the care that was coded.

Visit the portal at:
Initial and periodic assessments for all their residents residing in the facility for 14 or more days.

This includes hospice, respite, and special populations such as Pediatric and Psychiatric.

Federal regulatory requirements at 42CFR483.20(d) requires NF to maintain all resident assessments completed within the previous 15 months in the resident’s active clinical record.
**Responsibilities of NF for Reproducing/Maintaining 3.0**

Nursing Homes may:

1. Use electronic signatures for the MDS
2. Maintain the MDS electronically
3. Maintain the MDS and Care Plans in a separate binder in a location that is *easily and readily accessible* to staff, Surveyors, CMS etc.

**The Alphabet Soup of MDS**

- OBRA = Omnibus Budget Reconciliation Act
- PPS = Prospective Payment System
- OMRA = Other Medicare Required Assessments (SOT, EOT, COT)
- ARD = Assessment Reference Date

**MDS 3.0**

Long Term Care Facility
Resident Assessment Instrument (RAI)
User’s Manual

Chapter 3

Effective Oct 2016
Section A

Intent: The intent of this section is to obtain key information to uniquely identify each resident, the home in which he or she resides, and the reasons for assessment.

*Identity*

Coding Section A

A0050 - Type of Record

*Code 1 for a new record that has not been previously submitted and accepted in the QIES ASAP system*

*Code 2 to modify the MDS items for a record that has been submitted and accepted in the QIES ASAP system*

*Code 3 to inactivate a record that already has been submitted and accepted in the QIES ASAP system*

Section A

A0310 Purpose

Documents the reason for completing the assessment

Identifies the required assessment content information (determines item set)

There are several subsections to A0310
MDS 3.0 Training: Day 2

* Section A

A0310A Federal OBRA Reason for Assessment

01. Admission
02. Quarterly
03. Annual
04. Significant change in status
05. Significant correction to prior comprehensive
06. Significant correction to prior quarterly
99. Not OBRA required

* Significant Change Criteria

A "significant change" is a decline or improvement in a resident's status that:
1. Will not normally resolve itself without intervention by a CN in implementing standard care-related interventions, or "self-healing" (for declines only);
2. Impacts more than one area of the resident's health status, and
3. Requires additional, timely review and/or revision of the care plan.

* A0310A Hospice Benefit

* Electing or revoking the hospice benefit requires a significant change in status assessment

A0310: Type of Assessment

- Admission assessment (required by day 14)
- Quarterly assessment
- Significant change in status assessment
- Significant correction to prior comprehensive assessment
**Significant Error**

A "significant error" is an error in data assessment that:
1. Is not accurately represented (i.e., unrecorded) in the assessment; and
2. Has not been corrected via enhancement of a more recent assessment.

*Significant error* differs from a *significant change* because it reflects incorrect coding of the MDS and ADS and initial significant change in the resident's health status.

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**Assessment Scheduling**

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**Section A A0310B PPS Assessment**

Includes scheduled and unscheduled assessments:

- PPS Assessment
- PPS Scheduled Assessments for a Medicare Part A Stay
  - 90-day scheduled assessment
  - 140-day scheduled assessment
  - 180-day scheduled assessment
  - 220-day scheduled assessment
  - 260-day scheduled assessment
- PPS Unscheduled Assessments for a Medicare Part A Stay
  - Unscheduled assessment used for PPS (CMSA), significant medical event
  - No PPS Assessment
  - None of the above
*Scheduled Medicare PPS Assessments*

The SNF provider must complete the Medicare required assessments according to the following schedule in accordance with the SNF PPS requirements.

<table>
<thead>
<tr>
<th>Medicare Required Assessment Type</th>
<th>Time for Assessment after ARD (Weeks)</th>
<th>Assessment Reference Date</th>
<th>Assessment Medicare Related</th>
<th>Applicable Medicare PPS Forward Days</th>
<th>Start and End of Therapy</th>
<th>Change of Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 day</td>
<td>1</td>
<td>Days 1-3</td>
<td>6, 9, 11 through 14</td>
<td>6, 9, 11 through 14</td>
<td>Both Start and End of Therapy</td>
<td>Change of Therapy</td>
</tr>
<tr>
<td>14 day</td>
<td>67</td>
<td>Days 1-14</td>
<td>17, 28</td>
<td>17, 28, 35</td>
<td>Both Start and End of Therapy</td>
<td>Change of Therapy</td>
</tr>
<tr>
<td>30 day</td>
<td>60</td>
<td>Days 2-6</td>
<td>30</td>
<td>30, 35, 42</td>
<td>Both Start and End of Therapy</td>
<td>Change of Therapy</td>
</tr>
<tr>
<td>60 day</td>
<td>60</td>
<td>Days 3-6</td>
<td>45</td>
<td>45, 52, 59</td>
<td>Both Start and End of Therapy</td>
<td>Change of Therapy</td>
</tr>
<tr>
<td>90 day</td>
<td>60</td>
<td>Days 5-8</td>
<td>60</td>
<td>60, 67, 74</td>
<td>Both Start and End of Therapy</td>
<td>Change of Therapy</td>
</tr>
</tbody>
</table>

Grace days are specific to facilities that can be added to the ARD schedule within 3 days.

See RAI Manual page 2-43 for more information about use of grace days and Medicare payment days.

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*Medicare PPS Assessments*

<table>
<thead>
<tr>
<th>5 day</th>
<th>14 day</th>
<th>30 day</th>
<th>60 day</th>
<th>90 day</th>
<th>Readmission/Return</th>
<th>SCSC</th>
<th>SCPA</th>
</tr>
</thead>
</table>

PPS Scheduled Assessments for Medicare Part A Stay

RAI Manual, pages 2-49 to 2-50

PPS Unscheduled: OMRA used for a Medicare Part A Stay; RAI Manual, page 2-58

PPS Unscheduled Assessments: Other Medicare Required Assessment (OMRA)

RAI Manual, pages 2-50 to 2-58

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*Coding Section A*

A0310C PPS Other Medicare Required Assessment (OMRA)

Indicates whether the assessment is related to therapy services

Complete this item for all assessments:

0. Not an OMRA assessment
1. Start of Therapy
2. End of Therapy when ARD is 1 - 3 days after last day of therapy services
3. Start and End of Therapy
4. Change of Therapy Assessment
Section A
A0310E Type of Assessment

Is This Assessment the First Assessment (OBRA, PPS, or Discharge) since the Most Recent Admission/Entry or Reentry?

Complete this item for all assessments

Coding Section A
A0310F Entry/Discharge Reporting

01. Entry tracking record
10. Discharge assessment - return not anticipated
11. Discharge assessment - return anticipated
12. Death in facility tracking record
99. None of the above

Coding Section A
A0310G Type of Discharge

Discharge refers to the date a resident leaves the facility for anything other than a temporary LOA.

A discharge assessment is required for:
1. Discharge return not anticipated
2. Discharge return anticipated
3. Part A PPS Discharge
**Part A PPS Discharge Assessment:** The Part A PPS Discharge assessment is completed when a resident's Medicare Part A stay ends (A2400C), and the resident remains in the facility; or may be combined with an OBRA Discharge (A0310F = 10) if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000). (Page A-7)

**Discharge from facility and Part A:**

Combined OBRA/Part A discharge MDS.

If the End Date of the Most Recent Medicare Stay (A2400C) occurs on the day of or one day before the Discharge Date (A2000) of a planned discharge (A0310G=1), the OBRA Discharge assessment and Part A PPS Discharge assessment are both required and may be combined.

When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000).

**If the resident is remaining in the facility:**

- A0310F will be coded as '99', as this is not an OBRA discharge.
- Therefore, A0310G will be skipped, as this is completed only if A0310F = 10 or 11.
- A0310H will be coded ‘Yes’, for a Part A PPS discharge.
What if the resident doesn’t go home until the next day?

Complete a Medicare Part A Discharge assessment, and complete an OBRA Discharge assessment

* A0310F = 10 (discharge, return not anticipated)
* A0310H = 1 (Part A PPS Discharge)
* A2000 = A2400 +1
* A2300 = A2000  (ARD = discharge date)
* A2400 = last covered day

A0410. Unit Certification or Licensure Designation

1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State
2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State
3. Unit is Medicare and/or Medicaid certified
Section A
Resident Data

A0500 through A1300
Check and double check the accuracy of the name and all numbers - social security, Medicare and MaineCare numbers, Date of Birth

Section A
A1500 PASRR/ Medicaid

All individuals admitted to Medicaid certified NFs must complete a Level I PASRR (Federal Requirement)

If the Level I screen is positive for known or suspected mental illness, intellectual disability, developmental disability, or “other related conditions,” a Level II evaluation is performed

Section A
A1510- Level II Preadmission Screening and Resident Review (PASRR) Conditions

Completed only if admission (01), Annual (03), significant change (04), or significant correction to prior comprehensive assessment (05)

Level II Conditions:
* Serious mental illness
* Intellectual disability
* Other related condition
### MDS 3.0 Training: Day 2

#### Section A

**A1550- Level II Preadmission Screening and Resident Review (PASRR) Conditions**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Transfusion</td>
<td>A1570</td>
</tr>
<tr>
<td>B. Neurology</td>
<td>A1580</td>
</tr>
<tr>
<td>C. Splinter</td>
<td>A1590</td>
</tr>
<tr>
<td>D. Other extreme conditions related to AIDS</td>
<td>A1600</td>
</tr>
</tbody>
</table>

**A1590** Risk Organism Condition

- A1600-1800 Most Recent Admission/Entry or Reentry to the facility
- A1900 Admission Date
- A2000 Discharge Date
- A2100 Discharge Status

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**PASRR**

http://assessmaine.com

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A1600-A1800 Most Recent Admission/Entry or Reentry to the facility

A1900 Admission Date

A2000 Discharge Date

A2100 Discharge Status
Section A
A2300 Assessment Reference Date (ARD)

* Designates the end of the look-back period so that all assessment items refer to the resident’s status during the same period of time.
* Anything that happens after the ARD will not be captured on that MDS.
* The look-back period includes observations and events through the end of the day (midnight) of the ARD.

Medicare Stay End Date Algorithm RAI Manual, page A-37

RAI Manual Chapter 6
Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS)

6.2 Using the MDS in the Medicare PPS System
6.3 Resource Utilization Groups (RUG) IV
6.4 Relationship Between the Assessment and the Claim
6.5 SNF PPS Eligibility Criteria
6.6 RUG IV Calculation Worksheets
6.7 SNF PPS Policies
6.8 Non-compliance with the SNF PPS Assessment Schedule
Section S
This section is specific data requirements for the State of Maine only.

S0120 Residence Prior to Admission
Enter the zip code of the community address where the resident last resided prior to nursing facility admission.

S0170. Advanced Directive
A. Guardian
B. Durable power of attorney for health care
C. Living will
D. Do not resuscitate
E. Do not hospitalize
F. Do not intubate
G. Feeding restrictions
H. Other treatment restrictions
I. None of the above
S0510. PASRR Level I Screening

Was a PASRR Level I screening completed?

0. No → Skip to S3300 Weight-based Equipment Needed
1. Yes → Continue to S0511 PASRR Date
9. Unknown → Skip to S3300 Weight-based Equipment Needed

S0511. PASRR Level I Date:
(Complete only if S0510 = 1)

- - -
Year Month Day

S0513. PASRR Level I Screening Outcome

What was the outcome of the PASRR Level I screen?

0. Screen was sent to the NP, no diagnosis, suspected diagnosis or need for specialized services
1. Screen was sent for determination of need for Level II screen due to diagnosis, suspected diagnosis or need for specialized services related to mental illness, intellectual disability, or other related conditions
S3300. Weight-based Equipment Need

Did this resident require specialized equipment based on weight since last assessment?
1. No → Skip to S6020 Specialized Needs
2. Yes → Continue to S3305 Requirements for Weight

S3305. Requirements for Care, Specifically related to Weight

A. Lifting device, stair lift assessed; is a specialized lifting device required?
B. Wheelchair or mobility device, in need of assessment; was an elevated, non-standard wheelchair or other mobility device required?
C. Bed positioning assessment, was a specialized, non-standard bed required?
D. Ventilator, was a lift assessment, and a specialized, non-standard bed required?
E. Was there a staff skill assessment, was it sufficient and was it completed with adequate MDT?
F. Other, please specify, but other equipment, non-standard equipment required?

S6020. Specialized needs specifically related to a resident’s need for a Ventilator/Respirator

A. Yes, specific, content needs curare or an Invasive ventilator/Respirator
B. O2 therapy assessed; does the resident need a specific O2 equipment?
C. Ventilator, IV/IRRI equipment, was there enough, does the resident need a specific equipment?
D. Equipment, Resident needs specific equipment
E. Other, please specify, non-standard equipment
F. Some of the above
S6022. Direct care by a Licensed Nurse

Enter a response for A, B, and C to indicate the number of days the resident required direct care described.

A. Number of days the resident required direct care by a licensed nurse on an hourly basis.
   During the last 7 days, number of times/day.

B. Number of days the resident required direct care by a licensed nurse in 15-minute intervals.
   During the last 7 days, number of times/day.

C. Number of days the resident required direct care by a licensed nurse in 5-minute intervals.
   During the last 7 days, number of times/day.

S6023. Direct Care by a CNA

A. Number of days the resident required direct care by a CNA on an hourly basis.
   During the last 7 days, number of times/day.

B. Number of days the resident required direct care by a CNA in 15-minute intervals.
   During the last 7 days, number of times/day.

C. Number of days the resident required direct care by a CNA in 5-minute intervals.
   During the last 7 days, number of times/day.

S6024. Direct Care by a Respiratory Therapist

A. Number of days the resident required direct care by a respiratory therapist on an hourly basis.
   During the last 7 days, number of times/day.

B. Number of days the resident required direct care by a respiratory therapist in 15-minute intervals.
   During the last 7 days, number of times/day.

C. Number of days the resident required direct care by a respiratory therapist in 5-minute intervals.
   During the last 7 days, number of times/day.
Resident Stays Outside of the Facility:

S6200. Hospital Stays
S6205. Observation Stays
S6210. Emergency Room (ER) Visits

Resident Stays

S6200. Hospital Stays
S6205. Observation Stays
S6210. Emergency Room (ER) Visits

S8010 Payment Source - To determine payment source that covers the daily per diem or ancillary services for the resident’s stay in the nursing facility, as of the ARD date.

- C3 - MaineCare per diem. Do not check if MaineCare is pending
- G3 MaineCare pays Medicare or insurance Co-pay
- S8099 None of the above
S8510. MaineCare Therapeutic Leave Days

- Leave of Absence, or LOA, refers to:
  - Temporary home visit
  - Temporary therapeutic leave
  - Hospital observation stay of less than 24h where resident is not admitted to hospital

S8512. MaineCare Hospital Bed-Hold Days

- MaineCare hospital bed-hold days are calculated using the number of days the resident is admitted to a hospital.
Section B
Hearing, Speech, and Vision

Intent: The intent of items in this section is to document the resident’s ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others and whether the resident experiences visual limitations or difficulties related to diseases common in aged persons.

B0100: Comatose
B0200: Ability to Hear (with hearing aid if normally used)
B0300: Hearing Aid
B0600: Speech Clarity
B0700: Makes Self Understood
B0800: Ability to Understand Others
B1000: Vision (with adequate light)
B1200: Corrective Lenses

Section C
Cognitive Patterns

Intent: The items in this section are intended to determine the resident’s attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions.
**Section C**

C0100

Should the Brief Interview for Mental Status (BIMS) be conducted???

Code 0, no: if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. Skip to C0700, Staff Assessment.

Code 1, yes: if the interview should be attempted because the resident is at least sometimes understood verbally or in writing, and if an interpreter is needed, one is available.

**IMPAIRED COGNITION CATEGORY**

B0100 - Comatose (requires supporting documentation) AND

C0200
C0300
C0400
C0500

OR

B0700
C0700
C1000

Staff Assessment

**Section C**

C0200-C0500: BIMS resident interview questions (scripted interview)
Section C

C0600: Should the staff assessment be conducted?

C0700-C1000 Staff assessment:
- C0700 Short-Term Memory
- C0800 Long-Term Memory
- C0900 Memory/Recall Ability
- C1000 Cognitive Skills for Daily Decision Making

Documentation required to confirm responses

**Definitions**

**Delirium**
A mental state that is characterized by confusion and altered awareness of the surroundings, often accompanied by disturbances in thought processes, behavior, and memory.

**Disorganized Thinking**
Exhibited by rambling, irrelevant, or incoherent speech.

**Definitions**

**Amotivation**
Reduced ability to sustain attention on a task due to reduced motivation or interest in the task.

**Delirium**
A disturbance in consciousness characterized by inattention, disorganized thinking, hallucinations, and delusions.

**Disorganized Thinking**
Exhibited by rambling, irrelevant, or incoherent speech.

**Signs and Symptoms of Delirium**

- **Confusion**
- **Disorientation**
- **Hallucinations**
- **Delusions**
- **Agitation**
- **Disorganized thinking**
- **Reduced attention**
- **Change in behavior**
- **Irritability**

Documentation required to confirm responses.
**Section D  Mood**

**Intent:** The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable.

**Section D  D0100: Should Resident Mood Interview Be Conducted?**

**If yes...**

**D0200 (Resident Interview - PHQ9°)**

Enter the frequency of symptoms for Column 2, Items A through I

Requires no further supporting documentation. Case mix nurses check for **timely completion** according to Z0400.
Section D
D0300

D0300 Total Severity Score
A summary of the frequency scores that indicates the extent of potential depression symptoms. The score does not diagnose a mood disorder, but provides a standard of communication with clinicians and mental health specialists.

Total score must be between 00 and 27

Section D
D0500

Staff Assessment of Resident Mood
Look-back period for this item is 14 days.
Interview staff from all shifts who know the resident best.

Supporting documentation is required
*Section E
Behavior

Intent: The items in this section identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment.

*BEHAVIORAL SYMPTOMS

Payment Items
- E0100A Hallucinations
- E0100B Delusions
- E0200A Physical behaviors
- E0200B Verbal behaviors
- E0200C Other behaviors
- E0800 Rejection of care
- E0900 Wandering

Section E
E0200

E0300: Overall Presence of Behavioral Symptoms
E0500: Impact on Resident
E0600: Impact on Others
**Section E**

**E0800 and E0900**

**E0800: Rejection of Care - Presence & Frequency**

**E0900: Wandering - Presence & Frequency**

- Not found in residents
- E1000: Wandering - Impact
- E1000A Risk to Self
- E1000B Intrusion on others
- E1100: Change in Behavior or Other Symptoms

---

**Section F**

**Preferences for Customary Routine and Activities**

Intent: The intent of items in this section is to obtain information regarding the resident’s preferences for his or her daily routine and activities.

1. Determine whether or not resident is rarely/never understood and if family/significant other is available. If resident is rarely/never understood and family is not available, skip to item F0800, Staff Assessment of Daily and Activity Preferences.
2. Conduct the interview during the observation period.
3. Review Language item (A1100) to determine whether or not the resident needs or wants an interpreter.
   - If the resident needs or wants an interpreter, complete the interview with an interpreter.
4. The resident interview should be conducted if the resident can respond:
   - verbally,
   - by pointing to their answers on the cue card, OR
   - by writing out their answers.
Intent: The items in this section are intended to assess the many conditions that could affect the resident’s ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches. The assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately.

Section K - Nutritional Approaches
K0510: Approaches
A. Parenteral / IV Feeding
B. Feeding Tube
C. Mechanically Altered Diet
D. Therapeutic Diet
Z. None of the above
* K0510 Assessment Guidelines

The following items are NOT coded in K0510A:

- IV medications
- IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay
- IV fluids administered solely as flushes
- Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis

RAI Manual pages K-10 through K-12

* K0710 Percent Intake by Artificial Route

A. Proportion of total calories the resident received through parenteral or tube feeding
   1. 25% or less
   2. 26-50%
   3. 51% or more

B. Average fluid intake per day by IV or tube feeding
   1. 500 cc/day or less
   2. 501 cc/day or more

K0710B.3 is a payment item

If the resident took no food or fluids by mouth (NPO) or took just sips of fluid, stop here and code 3, 51% or more.

If the resident had more substantial oral intake than this, consult with the dietician.

* K0710B Average Fluid Intake per Day by IV or Tube Feeding

Code for the average number of cc per day of fluid the resident received via IV or tube feeding. Record what was actually received by the resident, not what was ordered.

- Code 1: 500 cc/day or less
- Code 2: 501 cc/day or more

K0710A and B (column 3) are payment items for Residents receiving nutrition via IV or Tube Feeding
Section Q - Participation in Assessment and Goal Setting

Intent: The items in this section are intended to record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals. Discharge planning follow-up is already a regulatory requirement (CFR 483.20 (i)(3)). Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.

Q0100 Participation in Assessment:
Who participated??

Whenever possible, the resident should be actively involved—except in unusual circumstances such as if the individual is unable to understand the proceedings or is comatose.

Q0300 Residents Overall Expectation
*Overall expectations
*Information source
Q0400 Discharge Plan
Q0490 Preference to Avoid Being Asked Question Q0500B
The goal of follow-up action is to initiate and maintain collaboration between the nursing home and the local contact agency to support the resident’s expressed interest in being transitioned to community living.

Q0550B, what is the source of the information?

A. Indicate information source for Q0550A
   1. Resident
   2. Another resident, their family or significant other
   3. Staff member, a friend or significant other, a family member, or legally authorized representative
   4. None of the above

Who is the Local Contact Agency for Maine?

Long Term Care Ombudsman Program
Section Z
Assessment Administration

Intent: The intent of the items in this section is to provide billing information and signatures of persons completing the assessment.

The majority of this section is completed by your software.

Z0100 Medicare Part A Billing (RUG IV)
Z0150 Medicare Part A Non-Therapy (RUG IV)
Z0200 State Medicaid Billing (RUG III)
Z0250 Alternate State Medicaid Billing
Z0300 Insurance Billing

To check your final validation report: https://sms.muskie.usm.maine.edu/

Section Z
Assessment Administration

Z0400 Attestation Statement

Z0500 Signature of RN Assessment Coordinator
Verifying Assessment Completion
*Section Z
Assessment Administration

Z0400 Signature of Persons Completing the Assessment or Entry/Death Reporting.

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

*Z0400 Attestation Statement

Coding Instructions

• 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.
• Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident’s status. Penalties may be applied for submitting false information.

FYI...
Chapter 110, Regulations Governing the Licensing and Function of Skilled Nursing Facilities and Nursing Facilities
http://www.maine.gov/sos/cec/rules/10/ch110.htm

Chapter 2.B.1.b Comprehensive Assessment (page 2)

b. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.
Section V
Care Area Assessment Summary
CAAs

Intent: The MDS does not constitute a comprehensive assessment. Rather, it is a preliminary assessment to identify potential resident problems, strengths, and preferences. and CATS

CAAs are not required for Medicare PPS assessments. They are required only for OBRA comprehensive assessments (Admission, Annual, Significant Change in Status, or Significant Correction of a Prior Comprehensive). However, when a Medicare PPS assessment is combined with an OBRA comprehensive assessment, the CAAs must be completed in order to meet the requirements of the OBRA comprehensive assessment.

*Section V
Care Area Assessment Summary

V0100 Items from Most Recent Prior OBRA or PPS Assessment

*Reason for assessment (A0310A and/or A0310B)
*Prior ARD (A2300)
*Prior BIMS score (C0500)
*Prior PHQ-9 (C0300 or C0600)

V0200: CAAs and Care Planning
Section V
Care Area Assessment Summary

This chapter provides information about the Care Area Assessments (CAAs), Care Area Triggers (CATs), and the process for care plan development for nursing home residents.

Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident’s functional capacity and needs, in relation to a number of specified areas (e.g., customary routine, vision, and continence). The results of the assessment, which must accurately reflect the resident’s status and needs, are to be used to develop, review, and revise each resident’s comprehensive plan of care.

RAI Manual Chapter 4
Care Area Assessment and Care Planning

This chapter provides information about the Care Area Assessments (CAAs), Care Area Triggers (CATs), and the process for care plan development for nursing home residents.

Section X
Correction Request

Intent: The purpose of Section X is to identify an MDS record to be modified or inactivated. Section X is only completed if Item A0050, Type of Record, is coded a 2 (Modify existing record) or a 3 (Inactivate existing record).

In Section X, the facility must reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.
Section X
Correction Request

A modification request is used to correct a QIES ASAP record containing incorrect MDS item values due to:
- transcription errors,
- data entry errors,
- software product errors,
- item coding errors, and/or
- other error requiring modification.

Section X
Correction Request

An inactivation request is used to move an existing record in the QIES ASAP database from the active file to an archive (history file) so that it will not be used for reporting purposes.

Section X
Correction Request: Manual Deletion

A Manual Deletion Request is required only in the following three cases:
1. Item A0410 Submission Requirement is incorrect.
2. Inappropriate submission of a test record as a production record.
3. Record was submitted for the wrong facility.
Section X
Correction Request

X0150 Type of Provider
X0200 Name of Resident
X0300 Gender
X0400 Date of Birth
X0500 Social Security Number
X0600 Type of Assessment
X0700 Date on existing record

Section X
Correction Request

X0800 Correction number
X0900 Reasons for Modification
X1050 Reasons for Inactivation
X1100 Name, Title, Signature, Attestation Date

RAI Manual Chapter 5
Submission and Correction of MDS

5.1 Transmitting MDS Data:
The provider indicates the submission authority for a record in item A0410, Submission Requirement.

5.2 Timeliness Criteria
5.3 Validation Edits
5.4 Additional Medicare Submission Requirements that Impact Billing Under SNF PPS
* RAI Manual Chapter 6
Medicare Skilled Nursing Facility
Prospective Payment System (SNF PPS)

6.2 Using the MDS in the Medicare PPS System
6.3 Resource Utilization Groups (RUG) IV
6.4 Relationship Between the Assessment and the Claim
6.5 SNF PPS Eligibility Criteria
6.6 RUG IV Calculation Worksheets
6.7 SNF PPS Policies
6.8 Non-compliance with the SNF PPS Assessment Schedule
Forum call for Nursing Facilities
1st Thursday of the month in February, May, August and November, 1:00-2:00
Call the MDS Help Desk to register!

Reminder!
ASK questions!
ASK more questions!
Attend training as needed
Call the MDS help desk to inquire or register for training.
Please complete your evaluations to help us to continually improve training to best meet your needs.

Contact Information:
MDS Help Desk: 624-4019 or toll-free: 1-844-288-1612
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
Training Portal: www.maine.gov/dhhs/dlrs/mds/training/