

Transition Process MDS 2.0 to MDS 3.0

(revised December 9, 2010)

Item AO310E: Policy Change for Correcting Transition Coding

Corrections will not be required for any assessments that have already been completed. Please follow the guidance in the manual.

CMS has re-evaluated the guidance outlined in the October 2010 "MDS 2.0 to MDS 3.0 Transition Document" for the coding of item A0310E. The transition document indicated that the item should be coded as "1" for the initial MDS 3.0 assessment for all existing residents; however, this guidance was overlooked on many of the assessments that were submitted.

During the November 9, 2010 National Provider Call direction was provided indicating that assessments that were coded as a "0" would need to be corrected and resubmitted.

CMS has reconsidered the matter and has concluded that providers Do Not need to submit corrected assessments where item A0310E may have been miscoded. Providers should follow the directions outlined in Chapter 3 Section A of the MDS 3.0 RAI Manual for the coding of A0310E from this point further.

TRANSITION DOCUMENT DEFINED

The transition document is a user friendly (i.e., non-programmer's) description of the transition from completing the MDS 2.0 assessment to the MDS 3.0 assessment. The information below provides a reference for the clinician in terms of transitioning and completing the MDS 3.0 assessment for the first time. The transition document especially facilitates completing the MDS 3.0 assessment in instances (item or section related) where there has been a change on the MDS 3.0 assessment (compared to the MDS 2.0 assessment) and in understanding look back periods/dates. The transition document is presented by section and by item with a brief process description specific to that section and item.

Item-Specific Notes

Section A. Identification information

In transitioning from the MDS 2.0 assessment to the first MDS 3.0 assessment some general instructions regarding Section A are outlined below.

If the target date is on or before 09/30/2010, then an MDS 2.0 assessment must be completed. If the target date for an MDS assessment is on or after 10/01/2010, an MDS 3.0 assessment must be completed. The target date is the assessment reference date (ARD) for an assessment, the entry date for an entry record, or the discharge date for a discharge or death in facility tracking record. The specific definitions of the target date for MDS 2.0 assessment and MDS 3.0 assessment are as follows:

MDS 2.0 Assessment Target Date Definition

- a. If AA8a is equal to 06, 07, or 08 (indicating a discharge tracking form), then the target date is equal to R4 (discharge date).
- b. If AA8a is equal to 09 (indicating a reentry assessment), then the target date is equal to A4a (date of reentry).
- c. Otherwise, the target date is equal to A3a (the ARD).

MDS 3.0 Assessment Target Date Definition

- a. If A0310F is equal to 01 (indicating an entry record), then the target date is equal to A1600 (entry date).
- b. If A0310F is equal to 10, 11, or 12 (indicating a discharge or death in facility tracking record), then the target date is equal to A2000 (discharge date).
- c. If A0310F is equal to 99 (indicating that this is not an entry or discharge record), then the target date is equal to A2300 (the ARD).

If, after 10/01/2010 a previously-submitted MDS 2.0 assessment needs to be modified or inactivated, this would be done using the currently existing MDS 2.0 assessment procedures and submission system.

When submitting records 10/01/2010 and forward, providers will have two choices: 1) a link to submit only MDS 2.0 records to the MDS 2.0 submission site and 2) a link to submit only MDS 3.0 records to the MDS 3.0 submission site. Records submitted to the wrong submission site will be rejected.

A0310 Type of Assessment

A0310E Is this assessment the first assessment (OBRA, PPS, or Discharge) since the most recent admission?

Providers should follow the directions outlined in Chapter 3 Section A of the MDS 3.0 RAI Manual for the coding of A0310E. Code 0, No, if the assessment is not the first assessment since the most recent entry of any kind (admission or reentry) and for any tracking record (not considered an assessment). Code 1, Yes, if this assessment is the first assessment since the most recent entry of any kind (admission or reentry). The first MDS 3.0

assessment should code A0310E as 1, Yes, (indicating that this is the first MDS 3.0 assessment), whether or not there was a prior MDS 2.0 assessment before 10/01/2010.

A0310F Entry /discharge reporting

If the entry date is 10/01/2010 or later, complete the MDS 3.0 entry tracking record. If the discharge date is 10/01/2010 or later, complete the MDS 3.0 discharge assessment or death in facility tracking record (not an MDS 2.0 tracking form).

For MDS 2.0 the admission is not reported on a separate tracking record (the admission date only being reported on the admission assessment or a discharge prior to completing the admission assessment). For MDS 3.0 the admission is reported on a separate entry tracking record. There is no difference with regard to reentry reporting (both MDS 2.0 and MDS 3.0 require a separate tracking record).

New with the MDS 3.0, a discharge return anticipated and a discharge return not anticipated now involve a clinical assessment of the resident status upon discharge in addition to discharge tracking reporting. For these discharge assessments, the ARD (A2300) must be the same as the discharge date (A2000).

A1700 Type of Entry

Swing bed facilities will always code the resident's entry as an admission, '1', since an OBRA Admission assessment must have been completed to code as a reentry. OBRA Admission assessments are not completed for swing bed residents.

A2200 Previous Assessment Reference Date for a Significant Correction

It is acceptable to have a date in A2200 that precedes 10/01/2010. A significant correction of a prior comprehensive or quarterly is a new assessment. If the ARD of the new assessment is on or after 10/01/2010, then it must be an MDS 3.0 assessment, even if the prior assessment that you are correcting is an MDS 2.0 assessment.

A2300 Assessment Reference Date

If the ARD is on or before 09/30/2010, then an MDS 2.0 assessment must be completed. If the ARD is on or after 10/01/2010, then an MDS 3.0 assessment must be completed.

The yearly timing rule is not a fatal error and applies if the submitted MDS 3.0 record is a comprehensive assessment—it is applicable only to nursing homes, not swing beds:

- If the most recent prior comprehensive assessment is an MDS 3.0 assessment, then the ARD of the next MDS 3.0 comprehensive assessment must be within 366 days of the ARD of the prior assessment.
- If the most recent prior comprehensive assessment is an MDS 2.0 assessment, then the ARD of the first MDS 3.0 comprehensive assessment must be within 366 days of the VB2 date of the prior assessment.

If the yearly timing rule is violated, then the facility will receive a warning on the Final Validation Report received after submission of the MDS 3.0 comprehensive assessment.

The quarterly timing rule is not a fatal error and applies if the submitted MDS 3.0 record is a quarterly or comprehensive—applicable only to nursing homes, not swing beds:

- If the most recent prior quarterly or comprehensive assessment is an MDS 3.0 assessment, then the ARD of the next MDS 3.0 quarterly or comprehensive assessment must be within 92 days of the ARD of the prior assessment.
- If the most recent prior quarterly or comprehensive assessment is an MDS 2.0 assessment, then the ARD of the first MDS 3.0 quarterly or comprehensive assessment must be within 92 days of the R2B date of the prior assessment.

If the quarterly timing rule is violated, then the facility will receive a warning on the Final Validation Report received after submission of the MDS 3.0 comprehensive assessment or MDS 3.0 quarterly assessment.

In situations where an MDS 2.0 assessment was completed, transmitted, and accepted, with a coding error requiring a modification identified on or after 10/01/2010, the MDS 2.0 submission system will be available to process the MDS 2.0 modification request. In situations where an MDS 2.0 assessment was completed, transmitted, and accepted, with the need to inactivate that record identified on or after 10/01/2010, the MDS 2.0 submission system will be available to process the MDS 2.0 inactivation request.

At this time, there are no plans to “turn off” the MDS 2.0 submission system. If an MDS 2.0 assessment needs to be modified or inactivated, it should be modified or inactivated with an MDS 2.0 correction request submitted to the MDS 2.0 submission site. There will be sufficient notice when, or if, the MDS 2.0 system is “turned off.”

A significant correction of a prior comprehensive or quarterly assessment is a new assessment with a new ARD and observation period. If the ARD for a significant correction is on or after 10/01/2010, then that assessment must be an MDS 3.0 assessment, even when the prior assessment in error was an MDS 2.0 assessment.

A2400 Medicare Stay

The A2400 items report the most recent Medicare stay since the last entry (admission or reentry) into the facility. For the MDS 3.0, it is required that a Medicare stay must be reported if the stay start date (A2400B) is on or after 01/01/2010 (i.e., the Medicare stay began during 2010). Facilities may optionally report an earlier Medicare stay that occurred before 2010.

Section B. Hearing, Speech, and vision

No transition issues

Section C. Cognitive patterns

C1600 Acute Onset Mental Status Change

Make the determination from available medical record information.

Section D. Mood

No transition issues

Section E. Behavior

E1100 Change in Behavior or Other Symptoms

For the first MDS 3.0 assessment, code a dash (-) in item E1100.

Section F: Preferences for customary routine and activities

Section F should be completed as indicated on the assessment (i.e., either resident or staff interview). Do not carry forward information from the MDS 2.0 assessment.

Section G. functional status

No transition issues

Section H. Bladder and Bowel

No transition issues

Section I. active diagnoses

No transition issues

Section J. health conditions

J1800 Any Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), which ever is more recent.

Code making the determination from available medical records.

J1900 Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), which ever is more recent.

Code making the determination from available medical records.

Section K. Swallowing / nutritional status

No transition issues

Section L. Oral / dental status

No transition issues

Section M. Skin conditions

Code pressure ulcers using the MDS 3.0 instructions. Note that the number of pressure ulcers coded on the MDS 3.0 assessment may not necessarily match (may be less than) the ulcer counts on the MDS 2.0 assessment. On the MDS 2.0, the ulcer count items (Items M1a to M1d) include ulcers due to any cause (including arterial and venous ulcers). On the MDS 3.0, the number of arterial and venous ulcers is now coded in a separate item on the MDS 3.0 assessment. Pressure ulcer determination requires a thorough clinical assessment of the pressure ulcer and the surrounding area. Back staging or reverse staging is not allowed on the MDS 3.0 assessment (e.g., Stage 3 remains a Stage 3 until healed/closed), regardless of whether the pressure ulcer's 'worst' Stage presented on a prior MDS 2.0 assessment or the MDS 3.0 assessment.

M0300 Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

In general, due to changes in coding pressures ulcers between the MDS 2.0 assessment and the MDS 3.0 assessment (e.g., pressure ulcers and ulcers due to circulation have been separated; code based on anatomical involvement; no back staging), comparison of the last MDS 2.0 assessment to the first MDS 3.0 assessment may not crosswalk exactly.

M0300B1 Number of Stage 2 Pressure Ulcers

Code the number of Stage 2 ulcers that were always a Stage 2 (non-healed). The ulcers included in this count were never coded as a Stage 3 or 4 on the MDS 2.0 assessment.

M0300B2 Number of these Stage 2 pressure ulcers that were present upon admission/reentry

Code the number of Stage 2 ulcers that were present upon admission/reentry.

M0300B3 Date of oldest Stage 2 pressure ulcer

If known, enter the date of oldest Stage 2 pressure ulcer; if not known, enter dashes in each box.

M0300C1 Number of Stage 3 pressure ulcers

Code the number of Stage 3 ulcers that were always a Stage 3 (non-healed). The ulcers included in the count were never coded as Stage 4 on the MDS 2.0 assessment, but may have been coded as a Stage 2.

M0300C2 Number of these Stage 3 pressure ulcers that were present upon admission/reentry

Code the number of Stage 3 ulcers that were present upon admission/reentry.

M0300D1 Number of Stage 4 pressure ulcers

Code the number of Stage 4 ulcers that were always a Stage 4 (non-healed).

M0300D2 Number of these Stage 4 pressure ulcers that were present upon admission/reentry

Refer to first paragraph above under Section M. Skin Conditions. Code all ulcers that were at a Stage 4 upon admission/re-entry.

M0300E2 Number of these unstageable pressure ulcers that were present upon admission/reentry

Refer to first paragraph above under Section M. Skin Conditions. Code this item only if the pressure ulcer is still unstageable due to a non-removable dressing and this was present upon admission

M0300F2 Number of these unstageable pressure ulcers that were present upon admission/reentry

Code the number of unstageable pressure ulcers due to slough/eschar. These ulcers would have been coded as Stage 4 on MDS 2.0 assessment.

M0300G2 Number of these unstageable pressure ulcers that were present upon admission/reentry

Refer to first paragraph above under Section M. Skin Conditions. Code unstageable-suspected deep tissue injury that was present upon admission/reentry and has not resolved.

M0800 Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)

Refer to first paragraph above under Section M. Skin Conditions. Code any ulcers that were not present or at a lesser stage on the last assessment. Do not code ulcers that were unstageable for any reason as worsening if this is the first assessment where the ulcer could be staged. For example, if a wound was covered with eschar on the previous MDS 2.0 assessment, it would have been coded as a Stage 4. If the wound bed now is visible and

the wound can be staged, code the ulcer in the appropriate item and enter zero if none of the ulcers have worsened.

On the first MDS 3.0 assessment for a resident, A0310E should be coded as 1 indicating this is the first MDS 3.0 assessment and item M0800 will be skipped.

M0900 Healed Pressure Ulcers

On the first MDS 3.0 assessment for a resident, A0310E should be coded as 1 indicating this is the first MDS 3.0 assessment and items M0900A through M0900D will be skipped.

M1040 Other Ulcers, Wounds and Skin Problems

Several skin conditions coded on the MDS 2.0 assessment are no longer coded on the MDS 3.0 assessment (e.g., rashes, skin tears; some lesions when due to fall would be accounted for in Section J).

Section N. Medications

No transition issues

Section O. Special treatments, procedures, and programs

O0100 A-Z column 1 While NOT a resident

Check column 1 if the services were received before an initial entry or between a discharge and a reentry. Column 1 should only be coded if the resident entered (admission/reentry) within 14 days of the ARD. If the resident entered 14 or more days ago then do not check column 1 blank and proceed to coding column 2.

O0250 Influenza vaccine

We are following CDC guidelines, which may change annually. The intent of the flexible 'season' will capture vaccination despite variation in influenza season and also variation in vaccine availability.

O0400A-C Minutes of Therapy

Rehabilitation staff must begin tracking/documenting the MDS 3.0 different modes of therapy (i.e., individual, concurrent, and group) beginning 09/25/2010 to accommodate MDS 3.0 assessments with an ARD 10/01/2010.

Section P. restraints

No transition issues

Section Q. Participation in assessment and goal setting

Q0300 Resident's Overall Expectation

Code this item only if this is the first assessment for this resident (OBRA, PPS, or discharge) since the most recent entry (admission or reentry) or this is the first MDS 3.0 assessment for the resident. Answer this question ONLY if A0310E is coded as '1.'

Section V. Care area assessment (CAA) summary

For the first MDS 3.0 assessment for a resident, A0310E should be set to 1 and all Items from V0100A through V0100F will be skipped.

Section X. Correction request

X0100 Type of Record

For the first and each MDS 3.0 assessment, code as '1' if adding a new record to the QIES ASAP system.

NO specific Section. pps / payment / misc issues

SNF PPS payment transition

Please refer to information located at www.cms.gov/SNFPPS