MDS 3.0 and RUG-IV

Updates and Current Status

November 9, 2010

Agenda

- Resource Sites

- MDS 3.0 Submission and Validation

- Survey & Certification

- SNF Part A

- MDS 3.0

Resource Sites

Resource Sites

- https://www.qtso.com/

- www.cms.gov/NursingHomeQualityInits/30_NHQIMDS30TechnicalInformation.asp

- www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp

- http://www.cms.gov/Manuals/IOM/list.asp

- http://www.cms.gov/CMSForms/

- www.cms.gov/snfpps/

- www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp

MDS 3.0 Submission and Validation

MDS 3.0 Welcome Page Links

QTSO MDS 3.0 Links

Helpful Hints[1]

- Login to the MDS 3.0 Submission system and CASPER Reporting application with your *individual* user ID, e.g. MDSxxxxxxx

- "Upload Completed" response to a submitted file indicates that the ASAP system merely *received* the file – not that the records of the file were error-free and *accepted*

- "Submission received" response includes Submission ID, Submission Date, and File Name. Print and retain for future reference so that you may verify that the records were accepted

Helpful Hints$_2$

- Select the <u>Submission Status</u> link on the MDS 3.0 File Submission system menu bar to access the **List of Submissions** page and view the processing status and record count of your submitted file

Helpful Hints$_3$

- When the status is "Completed" and the record count is *zero* (0)

  - o The ASAP system cannot produce the generated MDS 3.0 NH (or SB) Final Validation report

  - o There is **no** final validation report for this file in your facility's CASPER validation report (VR) folder

  - o One of two severe errors occurred:

    - ▪ Error -1001 Invalid Zip File: **Unable to unzip submitted file**

    - ▪ Error -1002 Invalid Zip File: **Zip file contained no files**

    - ▪ Contact your vendor

Helpful Hints[4]

- When the status is "Completed" and the record count is *greater than zero*:

  - View the generated MDS 3.0 NH (or SB) Final Validation report to verify that **all** records processed without error

- The generated MDS 3.0 NH (or SB) Final Validation report is found in your facility's CASPER shared validation report (VR) folder

Helpful Hints$_5$

- When **all** records in the submission are **not** displayed on the generated Final Validation Report, run the MDS 3.0 Submitter Validation report to identify the errors associated with records that are missing from the generated report

- The MDS 3.0 Submitter Validation report **must** be requested by the same user who submitted the file

Most Common Fatal Errors[1]

- **-1030** Missing Item: Based upon the Item Subset Code (ISC) submitted in this record, this item is required.

- **-1007** Duplicate Assessment: The submitted record is a duplicate of a previously submitted record.

- **-3676** Invalid Value: The value submitted for this item is not an acceptable value.

- **-3693a** Invalid FAC_ID: The FAC_ID submitted in this file does not identify a valid provider in the QIES ASAP System.

- **-3704a** Invalid Skip Pattern: If D0300 equals 00-27, then all active items from D0500A1 through D0600 must equal blank (^).

Most Common Fatal Errors$_2$

- **-3746** Invalid Skip Pattern: If X0100 equals 1, then all active items from X0150 through X1100E must equal blank (^).

- **-3668a** Inconsistent O Items: If A2300 minus A1600 is greater than or equal to 14 days, then items O0100A1 through O0100Z1 in Column 1 must equal blank (^).

- **-1004** Invalid XML File Format: The submitted file is not structured properly or contains tags longer than 30 characters and cannot be processed.

- **-3704b** Invalid Skip Pattern: If D0300 equals 99 or dash (-), then all active items from D0500A1 through D0600 must not equal blank (^).

- **-3612a** Invalid Skip Pattern: If M0210 equals 0, then all active items from M0300A through M0800C must equal blank (^).

Most Common Warnings[1]

- **-1057** Medicare RUG III Transition RUG Calculated: A Medicare Transition RUG III was calculated for this assessment.

- **-3808** Missing/Invalid Data: This required Section S item is either missing or contains invalid data. Number fields must be unsigned.

- **-3806** Inconsistent A0100C: The value submitted for A0100C (State Provider Number) does not match the State Provider Number in the QIES ASAP System for the provider identified by the FAC_ID in the file.

- **-3616b** Incorrect RUG Logic Version: The submitted value of the RUG version code does not match the value calculated by the QIES ASAP System.

- **-1018** Inconsistent Record Sequence: Under CMS sequencing guidelines, the type of assessment in this record does not logically follow the type of assessment in the record received prior to this one.

Most Common Warnings$_2$

- **-3616a** Incorrect HIPPS/RUG Value: The submitted value of the HIPPS/RUG code does not match the value calculated by the QIES ASAP System.

- **-1055** No Medicaid RUG Value Calculated: If the Value in Error begins with MDCD RUG CLCTN 2 (Z0250A), then this message should be ignored. If the Value in Error begins with MDCD RUG CLCTN 1 (Z0200A), then the submitted Assessment Reference Date (ARD) is not within the date parameters set up by the state in the RUG options table. Verify the A2300 date is accurate; otherwise contact your State Coordinator.

- **-1056** HIPPS/RUG Value Calculated: The submitted value of the Medicare Part A HIPPS code is blank. The QIES ASAP system calculated the HIPPS code and the value displayed. IF the assessment is to be used for Part A payment, please use this code for billing.   If the assessment is not to be used for Part A billing, please ignore this warning.

CMS

Centers for Medicare & Medicaid Services

Medicare RUG IV Items

- Submitted in Z0100 and Z0150

- ASAP system recalculates the Medicare RUG IV values for all assessments with the exception of records where A0310A = 99 and A0310B = 99

- The recalculated values are compared to the submitted items Z0100 and Z0150

- If the value of a submitted item does not equal the recalculated value, the ASAP system sends a warning message -3616 that includes the item id, the submitted value, and the recalculated value

- If the submitted value matches the recalculated value, then **no message is sent**

Medicare Transition RUG III

- Is calculated by the ASAP system

- Is displayed on the Final Validation Report in warning message -1057 for MDS 3.0 assessments with an Assessment Reference Date (ARD) between October 1 – October 31, 2010, inclusive

- Provides the RUG-III value for Medicare billing for days of service before 10/1/2010. An MDS 3.0 assessment with an ARD in October can cover days of service before 10/1/2010, and in that event, RUG-III must be billed for the September days

Medicaid RUGs

- Submitted in Z0200 and Z0250

- If requested by the state, the ASAP system recalculates the Medicaid RUG values for NC, NQ, and NP assessments using the parameters set by the state

- The recalculated values are compared to the submitted items Z0200 and Z0250.

- If the value of a submitted item does not equal the recalculated value, the ASAP system sends a warning message -3616 that includes the item id, the submitted value and the recalculated value

- If the submitted value matches the recalculated value, then **no message is sent**

Medicaid RUG Items

- Z0200A, Z0200B, Z0250A and Z0250B are always active on NC, NQ, and NP assessments

- As active items, these items must be included in your XML file with valid values

- Per the MDS 3.0 Data Specifications, the valid values for these items are "TEXT" or "^"

- If the state requires the Medicaid RUG item to be submitted, then the item value should be the appropriate RUG TEXT value

- If the state does not require the Medicaid RUG item to be submitted, then the item value should be a "^" (skip)

ASAP RUG Update

- Issues are resolved

- Submission files with Submission IDs from 1 through 33,291 were reprocessed on 10/21/2010

- New MDS 3.0 Final Validation reports were created and are located in the provider's shared validation report (VR) folder

- Accepted assessments in these files are available in the MDS 3.0 Viewer and QIES Workbench

- Accepted assessments are in the State Assessment Extract file dated 10/22/2010

Survey and Certification

Survey & Certification

- Changes to Traditional Survey Process

  o SOM Appendix P: S&C memo 10-27-NH on 7/30/2010

- Changes to Interpretive Guidance for LTC Surveyors

  o SOM Appendix PP: S&C memo 10-33-NH on 9/24/2010

  o Survey forms (672, 802, & 805): S&C memo 10-33-NH on 9/24/2010

MDS Submissions

- Changes to Regulation

  o CFR 483.20(f)(3)

  o Monthly submissions → 14 days

- Compliance with Regulation

  o S&C memo 11-02-NH on 10/29/2010

SNF Part A

SNF Part A$_1$

- ## Hybrid RUG-III and RUG-IV update

  o Section 10325 of the Affordable Care Act mandates:

  - Delay of RUG-IV by one year

  - Implementation of the allocation of concurrent therapy and lookback period components of RUG-IV effective 10/1/10 (the system implementing these policies is hereafter referred to as Hybrid RUG-III or HR-III)

  - Use of MDS 3.0 effective 10/1/10

SNF Part A$_2$

- ## Hybrid RUG-III and RUG-IV update (cont.)

  o Implementation of HR-III and RUG-IV

    - HR-III Grouper not available in time for 10/1/10

    - RUG-IV Grouper being used to determine payments in the interim until HR-III is implementable. Payments based on RUG-IV beginning 10/1/10.

    - Once the HR-III system is in place, retroactive adjustments will be made back to 10/1/10. Current focus is on getting the HR-III Grouper ready, details about the adjustment process will be determined later.

    - Aggregate payments from RUG-III to RUG-IV, from RUG-IV to HR-III and from HR-III back to RUG-IV are budget neutral.

SNF Part A$_3$

- ## Non-Therapy Ancillary (NTA) Research

  o NTA services (labs, diagnostics and pharmacy) currently reimbursed as part of the nursing component

  o Previous research done by Abt Associates, Urban Institute, and MedPAC

  o Potential criteria for prospective payments for NTA costs include:

    ▪ Information from available administrative data, i.e., data currently required on claims or MDS

    ▪ Costs would be based on an add-on NTA index to RUG case-mix groups

    ▪ Minimal number of payment groups to limit complexity

    ▪ Utilizes clinically intuitive and readily understandable payment groups

SNF Part A$_4$

- **Other Medicare Required Assessment (OMRA)**

    - Two types
        - Start of Therapy (SOT)
        - End of Therapy (EOT)

    - Shortened assessments

    - May not replace a scheduled PPS assessment

    - New RUG **will** be established, payment change according to rules

SNF Part A$_5$

- **SOT OMRA**

    o New assessment type, OPTIONAL

    - To obtain therapy RUG* any time during stay (Z0100A)
        - Not to increase or decrease therapy RUG

    - ARD 5-7 days after start of first therapy (day 1 = day therapy started)

    - Payment starts first day of therapy

    o Only complete if therapy RUG (index maximized), otherwise rejected

    o Be attentive when combining

    - No need to combine w/ 5-day except for short stay

*Rehabilitation or Extensive Services Plus Rehabilitation

SNF Part A$_6$

- **EOT OMRA**

  - Not new; not optional

  - Complete only when skilled care continues
    - When there is a break in the furnishing of therapy for 3 or more treatment days, an EOT OMRA is required

  - To obtain a non-therapy RUG (Z0150A)

  - ARD 1-3 days after last day of therapy provided (day 1= the next day therapy normally available)
    - Normally provided = if provide some w/e coverage, then provide therapy

  - Payment changes day after last day of therapy

  - No penalty for early ARD when set on day therapy not normally available

SNF Part A[7]

Thurs	Fri	Sat	Sun	Mon	Tues
Therapy end	Therapy available	Therapy not available	Therapy not available	Therapy available	Therapy available
EOT OMRA ARD ----→	Day 1			Day 2	Day 3

When a facility does not provide therapy 7 days/week, the days therapy is not provided are not applied to the 3 day count. The facility may set the ARD on a non-therapy day and the early assessment rule is not applied

SNF Part A$_8$

Thurs	Fri	Sat	Sun	Mon
Therapy end	Therapy available	Therapy not available	Therapy not available	Resident is discharged
EOT OMRA ARD ----→	Day 1			

An EOT OMRA is required when the resident has any Medicare Part A days after the last day of therapy if the facility wants to receive payment for those days.

In this example, the EOT OMRA could have an ARD of Fri, Sat, Sun or Mon.

SNF Part A$_9$

- ## EOT OMRA followed by SOT OMRA

  o New therapy evaluation(s) required

    - Resident may have new deficits and/or regressed

    - Clinically must determine if plan of care and/or goals need to be modified

  o Establish new/current start of therapy date(s)

    - Allows SOT OMRA to be completed if requirements met (still optional)

  o New physician orders – determined case-by-case

    - Plan of care/treatment regimen modified – may require new orders

    - Plan of care/treatment regimen not modified – dependent on State practice act and facility policy

SNF Part A$_{10}$

- ## Medicare Short Stay

  - Must be discharged from Part A on or before day 8 of Part A stay

  - Payment policy only based on optional SOT OMRA

  - To obtain a therapy RUG

  - Therapy is prorated based on **average** daily therapy minutes – see chapter 6 for therapy minute calculation

  - Requirements and payment implications - chapter 6

  - A2400C has coding algorithm – please reference

  - Medicare stay end date may or may not = D/C date

  - Know your CMIs

SNF Part A$_{11}$

- **Late and Early Assessments**

  o Not new

  o Default payment

  o Outlined in chapter 6

  o Based on ARD and if it is set within allowed ARD window (including grace days)

- **Missed Assessments**

  o Not new

  o Outlined in chapter 6

MDS 3.0

MDS 3.0 Items to be Addressed

- General Comments from the 1st Month

- Interview Frequency

- Discharge Assessment

- Coding Questions

- Quality Measures

- Next Steps

1st Month Experience

- Anecdotal comments have been mixed:

  o More valuable information elicited from residents

  o Interviews take less time than chart abstraction

  o Residents seem to appreciate the increased interaction

  o Adjusting to discharge assessment

  o Offering suggestions to decrease/eliminate duplication

Frequency of Interviews

- At this time, interview frequency will remain unchanged

- The intent of the interviews is to ensure patient needs are not inadvertently overlooked – the status of a resident can change abruptly – thus what may appear as a "redundant" interview is actually a "safety valve" for each resident

- CMS will re-evaluate the frequency of the interviews and provide updates as deemed appropriate

Discharge Assessment

- Discharge assessments are to be completed for all resident discharges as indicated in the RAI manual

- Discharge assessments should be completed to the extent feasible (e.g. planned discharge – complete assessment; unplanned discharge – complete using information that is readily available)

- Discharge to home or back to the community is a "good thing" and the planned discharge assessments will provide data to support "good or positive outcomes"

- CMS will re-evaluate the items included in the discharge assessments and provide updates as deemed appropriate

Coding Questions[1]

Pressure Ulcers Present on Admission

- For each pressure ulcer, determine if the pressure ulcer was **present at the time of admission and not acquired while the resident was in the care of the nursing home**.

- Review for location and stage at the time of admission or reentry. If the pressure ulcer was present on admission and subsequently worsened to a higher stage during the resident's stay, the pressure ulcer is coded at that higher stage, and that higher stage **should not be considered as "present on admission."**

- If the pressure ulcer was unstageable on admission, but becomes stageable later, it should be considered as "present on admission" at the stage at which it first becomes stageable. If it subsequently worsens to a higher stage, that higher stage **should not be considered "present on admission."**

Coding Questions$_2$

Pressure Ulcers Present on Admission (cont.)

- If a resident who has a pressure ulcer is hospitalized and returns with that pressure ulcer at the same stage, the pressure ulcer **should not be coded as "present on admission" because it was present at the facility prior to the hospitalization.**

- If a current pressure ulcer worsens to a higher stage during a hospitalization, it is coded at the higher stage upon reentry and **should be coded as "present on admission."**

Coding Questions$_3$

Medications Received (N0400)

o Medication categories should only be checked if the resident received a medication whose "**approved use**" (pharmacological classification) falls into the specified category. Do not code "off label" use of medications.

o For example, oxazepam may be used as a hypnotic, but it is classified as an antianxiety medication. It would be coded as an antianxiety medication.

Coding Questions₄

Isolation or quarantine for active infectious disease(O0100M)

- Code **only** when the resident **requires** strict isolation or quarantine alone in a separate room because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with a communicable disease, in an attempt to prevent spread of illness.

- **Do not** code this item if the resident only has a history of infectious disease (e.g., MRSA or C-Diff with no active symptoms), but facility policy requires cohorting of similar infectious disease conditions.

- **Do not** code this item if the "isolation" primarily consists of body/fluid precautions, because these types of precautions apply to everyone.

- More information related to the types of transmission-based precautions can be found in the 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Isolation2007.pdf .

Coding Questions[5]

Swing Bed Assessments

- Same as for everyone else. (yes, this is more than what was required under MDS 2.0)

- The swing bed assessments are as follows:

  - Entry tracking (NT/ST) (can't be combined)

  - Death in facility tracking when applicable (NT/ST) (can't be combined)

  - Discharge assessment – return anticipated/return not anticipated (SD) (can be combined)

  - Swing bed PPS (SP) (can be combined)

  - SOT OMRA (NS/SS) (can be combined)

  - (EOT) OMRA (NO/SO) (can be combined)

Coding Questions[6]

Transition from MDS 2.0 to MDS 3.0

- **Only for the Initial MDS 3.0 Assessment – item A0310E should be coded as "1" (yes) for all existing residents.**

- If such assessments have been coded as "0" (no) then the assessments need to be corrected.

- Future assessments should be coded based on the resident's status at the time of the assessment.

- Please thoroughly review the transition document located at www.cms.gov/NursingHomeQualityInits/downloads/MDS30TransitionFromMDS20.pdf for special coding guidance for initial MDS 3.0 assessments.

Quality Measures[1]

- MDS 2.0 QMs are basically mapped to MDS 3.0

- NQF voting on NH measures ends November 16 www.qualityforum.org/Projects/Nursing_Homes.aspx

- Nursing Home Compare

  o January 2011 – Last MDS 2.0 QM data update

  o April 2011 – QM data removed from NHC and factored out of the 5-Star

  o Spring 2012 – QM data reposted on NHC and factored back into 5-Star (MDS 3.0 data)

Quality Measures$_2$

QM Development Plan

- o Next phase of development to begin in 2011

- o New or enhanced QMs submitted to NQF late 2011/early 2012

- o Cross setting measures

- o CMS' QM Focus – Safe, Effective, Patient-Centered, Timely, Efficient, and Equitable

- o Topic areas under consideration:

  - Hospitalizations and Re-hospitalizations

  - Satisfaction

  - Reduce Injuries

  - Advanced Directives

Next Steps

- Evaluate data and comments from the initial implementation of MDS 3.0 (~3 months)

- All comments are valuable and are being evaluated

- Re-assess the item set composition and item sets for each assessment

- Modify instrument / guidance as deemed appropriate

- Manual / Item Set update (spring 2011)

- Q&A dissemination

Questions