UPCOMING CHANGES TO MDS

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NEW DISCHARGE ASSESSMENT

Changes to the RAI Manual are being implemented in October 2016. One change is adding a new discharge assessment, Part A PPS Discharge Assessment. The draft of the manual is https://downloads.cms.gov/files/draft_mds_30_rai_manual_v114_may_2016.pdf

PPS DISCHARGE ASSESSMENT

In order for the federal government to collect admission and discharge data for a new quality measure that addresses admission and discharge functional status as well as discharge goals, a new discharge assessment will be implemented in October 2016. This new discharge assessment, Part A PPS Discharge Assessment (NPE) Item Set, is to be used when the Medicare Part A PPS stay ends but the resident will remain in the facility. The assessment consists of demographic, administrative, and clinical items.

THREE DISCHARGE ASSESSMENTS

There will be three types of discharge assessments: OBRA required- return anticipated, OBRA required- return not anticipated, and the Part A PPS Discharge Assessment. The new manual differentiates between OBRA Discharge Assessment and Part A PPS Discharge Assessment.

PART A PPS DISCHARGE ASSESSMENT

Per current requirements, the OBRA Discharge Assessment is used when the resident is physically discharged from the facility. The Part A PPS Discharge Assessment is completed when a Medicare Part A stay ends, but the resident remains in the facility. Item A0310H, "Is this a SNF Part A PPS Discharge Assessment?, identifies whether or not the discharge is a Part A PPS Discharge assessment (Code 0, no: If this is not a Part A PPs Discharge Assessment. Code 1, yes: If this is a Part A PPS Discharge Assessment.)

The PPS Discharge Assessment is also required when the resident is physically discharged on the same day or within one day of the end of the Medicare Part A stay. In this case, the OBRA Discharge Assessment and Part A PPS Discharge Assessment are both required and may be combined. In this situation, the resident receiving services under SNF Part A PPS has a discharge date (A2000) on a planned discharge that occurs on the day of or one day after the end date of the most recent Medicare stay (A2400C). When the OBRA and Part A PPS Discharge Assessments are combined, the ARD (A2300) must be equal to the discharge date (A2000).

CODING INSTRUCTIONS

For a standalone Part A PPS Discharge Assessment, the ARD (Item A2300) is not set prospectively as with other assessments. The ARD (Item A2300) for a standalone Part A PPS Discharge Assessment is always equal to the end date of the most recent Medicare stay (A2400C) and is the same as the discharge date (A2000).

The Part A PPS Discharge Assessment may be combined with most PPS and OBRA required assessments when requirements for all assessments are met.

The ARD may be coded on the assessment any time during the assessment completion period (i.e. end date of most recent Medicare stay (A2400C) + 14 calendar days. Item Z0500B must be completed within 14 days after the end date of the most recent Medicare stay (A2400C + 14 calendar days). The assessment must be submitted within 14 days after the MDS completion date (Z0500B +14 days).

If the resident's Medicare Part A stay ends and the resident subsequently returns to a skilled level of care and Medicare Part A benefits resume, the Medicare schedule starts again with a 5-day assessment.

If the resident dies on the same day as the end date of the most recent Medicare stay, a Death in Facility Tracking record is completed with the discharge date (A2000) equal to the date the resident died. A Part A PPS Discharge Assessment is not required.

COMBINING EOT OMRA AND PART A PPS DISCHARGE ASSESSMENT

ARD (A2300) must be set for the last day of the Medicare Part A stay (A2400C) and the last day of the Medicare Part A stay must fall within 1-3 days after the last day therapy was furnished. The ARD must be set by no more than two days after the date of discharge. The date of discharge (A2000) must be equal to the ARD (A2300) and the last day of the Medicare Part A stay (A2400C).

COMBINING SOT OMRA AND PART A PPS DISCHARGE ASSESSMENT

ARD (A2300) must be set for the last day of the Medicare Part A stay (A2400C) and the last day of the Medicare Part A stay must fall within 5-7 days after the start of therapy day therapy was furnished. The ARD must be set by no more than two days after the date of discharge. The date of discharge (A2000) must be equal to the ARD (A2300) and the last day of the Medicare Part A stay (A2400C).

COMBINING SOT, EOT OMRA AND PART A PPS DISCHARGE ASSESSMENT

ARD (A2300) must be set for the last day of the Medicare Part A stay (A2400C) and the last day of the Medicare Part A stay must fall within 5-7 days after the start of therapy and 1-3 days after the last day therapy was furnished. The ARD must be set by no more than two days after the date of discharge. The date of discharge (A2000) must be equal to the ARD (A2300) and the last day of the Medicare Part A stay (A2400C).

COMBINING COT OMRA AND PART A PPS DISCHARGE ASSESSMENT

ARD (A2300) must be set for the last day of the Medicare Part A stay (A2400C) and both A2300 and A2400C must be on day 7 of a COT 7-day observation period. The ARD must be set by no more than two days after the date of discharge. The date of discharge (A2000) must be equal to the ARD (A2300) and the last day of the Medicare Part A stay (A2400C).

SCHEDULED ASSESSMENT AND PART A PPS DISCHARGE ASSESSMENT

ARD (A2300) must be set for the last day of the Medicare Part A stay (A2400C) and the last day of the Medicare Part A stay must fall within the allowed window of the Medicare scheduled assessment. The date of discharge (A2000) must also be equal to the ARD (A2300) and the last day of the Medicare Part A stay (A2400C).

TRANSFERS OR DISCHARGE BEFORE OR ON THE 8TH DAY

If the beneficiary is discharged from the SNF or the Medicare Part A stay ends (i.e. transferred to another payer source) before or on the eighth day of the covered SNF stay, the provider should prepare a Medicare-required assessment as completely as possible and submit the assessment as required.

When the Medicare Part A stay ends on or before the eighth day of the covered SNF stay, and the beneficiary remains in the facility, a Part A PPS Discharge Assessment is required. If the Medicare Part A stay ends on or before the eighth day of the covered SNF stay and the beneficiary is physically discharged from the facility the day of or the day after the Part A stay ends the Part A PPS and OBRA Discharge Assessment assessments may be combined.

SECTION GG

Changes to the RAI Manual are being implemented in October 2016. One change is adding a new section, Section GG. The draft of the manual is https://downloads.cms.gov/files/draft_mds_30_rai_manual_v114_may_2016.pdf

SECTION GG: FUNCTIONAL ABILITIES AND GOALS

This is a new section to be added to the MDS item set in October 2016. This is an assessment developed from the Impact Act to measure assistance with self-care and mobility upon admission and at discharge. The primary focus is the actual resident's performance with these activities. Section GG must be completed in addition to Section G.

Staff members who may complete an assessment must be in compliance with facility, Federal, and State requirements. Physical therapists, occupational therapists, speech language pathologists, and nurses are typically involved in these assessments.

THIS SECTION INTRODUCES A NEW DEFINITION:

"Helper"- defined as facility staff who are direct employees and facility-contracted employees, ie., rehabilitation staff, nursing agency staff). Only consider facility staff assistance when coding according to amount of assistance provided.

GG0130 SELF-CARE (RATIONALE)

Residents may have self-care limitations on admission and may be at risk of further functional decline during their Medicare Part A SNF stay.

STEPS FOR ASSESSMENT

Start with the date in A2400B, the most recent Medicare stay and assess the resident's self-care status based on direct observation, the resident's self- report, family reports and direct care staff reports documented in the resident's medical record during the 3-day assessment period.

Allow residents to perform activities as independently as possible, with safety as a priority.

Only consider staff assistance when scoring according to amount of assistance provided.

The use of assistive device(s) to complete and activity should not affect coding of the activity.

Coding is based on “usual performance” or baseline performance, which is the residents usual activity/performance of any self-care of mobility activities, not the most dependent or independent performance over the assessment period.

Facility, Federal and State policy and procedures are referred to in determining which staff member may complete an assessment.

CODING INSTRUCTIONS FOR ADMISSION OR DISCHARGE PERFORMANCE

Complete only if A0310B = 01, PPS 5-Day assessment or A0310G =1, Planned and A0310H =1, Part A PPS Discharge.

Code 01 – Dependent: Helper does ALL of the effort. Resident does none of the effort to complete activity, or the assistance of 2 or more helper is required to complete the activity.

Code 02 - Substantial/maximal assistance: Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

Code 03 – Partial/moderate assistance: Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.

Code 04 – Supervision or touching assistance: Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. This assistance can be continual or intermittent

Code 05 – Setup or clean-up assistance: Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following activity.

Code 06 – Independent: Resident completes the activity by him/herself with no assistance from a helper.

Code 07 – Resident refused: If the resident refused to complete the activity.

Code 08 – Not Applicable: If the resident did not perform this activity prior to the current illness, exacerbation, or injury.

Code 88 – Not attempted due to medical condition or safety concerns: If the activity was not attempted due to medical condition or safety concerns. Ex. Not able to eat due to swallowing problems; uses G-tube, or did not ambulate d/t risk of falls.

ADMISSION OR DISCHARGE PERFORMANCE CODING TIPS

The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted under SNF Part A.

On the Part A PPS Discharge assessment (A0310H = 1), the Self-Care items on GG0130 are completed only if the Type of Discharge is Planned (A0310G =1).

When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity (e.g., eating, oral hygiene). For example, when assessing Eating (item GG0130A), determine the type and amount of assistance required to bring food to the mouth and swallow food once the meal is presented on a table/tray.

When coding the resident's usual performance, use the 6-point scale or code the reason why an activity was not attempted.

At admission, when coding for the resident's discharge goal(s), use the 6-point scale.

Record the resident's usual ability to perform each activity (e.g., eating). Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance during the assessment period.

Do not record the staff's assessment of the resident's potential capability to perform the activity.

If the resident does not attempt the activity and a helper does not complete the activity for the resident, code the reason the activity was not attempted. For example, code 07 if the resident refused to attempt the activity, code 09 if the activity is not applicable for the resident, or code 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.

If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent.

To clarify your own understanding of the resident's performance of an activity, ask probing questions to staff about the resident, beginning with the general and proceeding to the more specific.

Coding a dash (“-“) in these items indicates “No Information.” CMS expects dash use for SNF QRP items to be a rare occurrence. Use of dashes for these items may result in a 2% reduction in the annual payment update. If the reason the item was not assessed was that the resident refused (code 07), the item is not applicable (code 09) or the activity was not attempted due to medical condition or safety concerns (code 88), use these codes instead of a dash(“-“).

Coding a dash (“-“) in these items indicates “No Information.” CMS expects dash use for SNF QRP items to be a rare occurrence. Use of dashes for these items may result in a 2% reduction in the annual payment update. If the reason the item was not assessed was that the resident refused (code 07), the item is not applicable (code 09) or the activity was not attempted due to medical condition or safety concerns (code 88), use these codes instead of a dash(“-“).

GG0130A EATING

The resident is able by the use of utensils, to bring food to the mouth and swallow food after meal has been placed on a table/tray. This includes modified diets.

GG0130B ORAL HYGIENE

The resident is able to use suitable items to clean teeth. If dentures apply, resident is able to remove and replace in the mouth and use equipment for soaking and rinsing them.

GG0130C TOILETING HYGIENE

The resident is able to complete perineal hygiene, adjust clothing prior to and after using the toilet, commode, bedpan or urinal. If managing an ostomy, include wiping the opening but not managing the equipment.

DISCHARGE GOAL: CODING TIPS

Use the 6-point scale to code the resident's discharge goal(s). Do not use codes 07, 09 or 88 to code discharge goal(s).

Licensed clinicians can establish a resident's discharge goal(s) at the time of admission based on the 5-Day PPS assessment, discussions with the resident and family, professional judgement and the professional's standard of practice. Goals should be established as part of the resident's care plan.

For the cross-setting quality measure, the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631), a minimum of one self-care or mobility goal must be coded per resident stay on the 5-Day PPS assessment.

Clinicians may code one goal for each self-care and mobility item included in Section GG at the time of the 5-Day PPS assessment.

GG0170 MOBILITY

(3-day assessment period) Admission (Start of SNF PPS Stay) (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B) Complete only if A0310B =0.

STEPS FOR ASSESSMENT

Assess the resident's mobility abilities based on direct observation, the resident's self-report and reports from clinician, care staff, or family as documented in the medical record during the 3-day assessment period, which is days 1 through 3, starting with the date in A2400B. Start of the most recent Medicare stay.

Residents should be allowed to perform activities as independently as possible, as long as they are safe.

If helper assistance is required because the resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.

If the resident's mobility performance varies during the assessment period, report the resident's usual status, not the resident's most dependent episode.

Refer to facility, Federal and State policies and procedures to determine which SNF staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal and State requirements.

CODING INSTRUCTIONS FOR ADMISSION OR DISCHARGE PERFORMANCE

Complete only if A0310B = 01, PPS 5-Day assessment or A0310G =1, Planned and A0310H =1, Part A PPS Discharge.

Code 01 – Dependent: Helper does ALL of the effort. Resident does none of the effort to complete activity, or the assistance of 2 or more helper is required to complete the activity.

Code 02 - Substantial/maximal assistance: Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

Code 03 – Partial/moderate assistance: Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.

Code 04 – Supervision or touching assistance: Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. This assistance can be continual or intermittent.

Code 05 – Setup or clean-up assistance: Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following activity.

Code 06 – Independent: Resident completes the activity by him/herself with no assistance from a helper.

Code 07 – Resident refused: If the resident refused to complete the activity.

Code 08 – Not Applicable: If the resident did not perform this activity prior to the current illness, exacerbation, or injury.

Code 88 – Not attempted due to medical condition or safety concerns: If the activity was not attempted due to medical condition or safety concerns. Ex. Not able to eat due to swallowing problems; uses G-tube, or did not ambulate d/t risk of falls.

ADMISSION OR DISCHARGE PERFORMANCE CODING TIPS

The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted under SNF Part A.

On the Part A PPS Discharge assessment (A0310H = 1), the Mobility items on GG0170 are completed only if the Type of Discharge is Planned (A0310G =1).

When reviewing the health record, interviewing staff, and observing the resident, be familiar with the definition for each activity. For example, when assessing Walk 50 feet with 2 turns (item GG0170J), determine the level of assistance required to walk 50 feet while making 2 turns.

On the 5-Day PPS assessment, code the resident's "usual performance," or baseline performance, using the 6-point scale or code the reason an activity was not attempted, as well as the resident's discharge goal(s) using the 6-point scale. Instructions above related to coding Discharge Goals for the mobility items (GG0170) are the same as those for coding Discharge Goals for the self-care items (GG0130).

On the Part A PPS Discharge assessment, code the resident's usual performance using the 6-point scale or code the reason an activity was not attempted.

Record the resident's usual ability to perform each activity (e.g., eating). Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance during the assessment period.

On the Part A PPS Discharge assessment, code the resident's usual performance using the 6-point scale or code the reason an activity was not attempted.

Record the resident's usual ability to perform each activity (e.g., eating). Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance during the assessment period.

On the 5-Day PPS assessment, code the resident's "usual performance," or baseline performance, using the 6-point scale or code the reason an activity was not attempted, as well as the resident's discharge goal(s) using the 6-point scale. Instructions above related to coding Discharge Goals for the mobility items (GG0170) are the same as those for coding Discharge Goals for the self-care items (GG0130).

ADMISSION OR DISCHARGE PERFORMANCE CODING TIPS

Do not record the staff's assessment of the resident's potential capability to perform the activity.

If the resident does not attempt the activity and a helper does not complete the activity for the resident, code the reason the activity was not attempted. For example, code 07 if the resident refused to attempt the activity, code 09 if the activity is not applicable for the resident, or code 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.

If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent.

To clarify your own understanding of the resident's performance of an activity, ask probing questions to staff about the resident, beginning with the general and proceeding to the more specific.

Coding a dash ("-") in these items indicates "No Information." CMS expects dash use for SNF QRP items to be a rare occurrence. Use of dashes for these items may result in a 2% reduction in the annual payment update. If the reason the item was not assessed was that the resident refused (code 07), the item is not applicable (code 09) or the activity was not attempted due to medical condition or safety concerns (code 88), use these codes instead of a dash("-").

Coding a dash (“-“) in these items indicates “No Information.” CMS expects dash use for SNF QRP items to be a rare occurrence. Use of dashes for these items may result in a 2% reduction in the annual payment update. If the reason the item was not assessed was that the resident refused (code 07), the item is not applicable (code 09) or the activity was not attempted due to medical condition or safety concerns (code 88), use these codes instead of a dash(“-“).

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Other Changes:M0330 and J1900

M0300: CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE

Steps for Completing M0300A-G

Step 1: Determine Deepest Anatomical Stage

For each pressure ulcer, determine the deepest anatomical stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement.

For each pressure ulcer, determine if the pressure ulcer was present at the time of admission/entry or reentry; and not acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement.

If a resident who has a pressure ulcer that was “present on admission” (not acquired in the facility) is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer is still coded as “present on admission” because it was originally acquired outside the facility and has not changed in stage.

For each pressure ulcer, determine if the pressure ulcer was present at the time of admission/entry or reentry; and not acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement.

If a resident who has a pressure ulcer that was “present on admission” (not acquired in the facility) is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer is still coded as “present on admission” because it was originally acquired outside the facility and has not changed in stage.

J1900 NUMBER OF FALLS

J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent.

Health-related Quality of Life

Falls are a leading cause of morbidity and mortality among nursing home residents. Falls result in serious injury, especially hip fractures. Previous falls, especially recurrent falls and falls with injury, are the most important predictor of future falls and injurious falls.

Coding Instructions for J1900

Determine the number of falls that occurred since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS) and code the level of fall-related injury for each. Code each fall only once. If the resident has multiple injuries in a single fall, code the fall for the highest level of injury.