Department of Health and Hospitals

Louisiana Advisor

Vol. 10, Issue 1 - March 2011

Louisiana Advisor is a quarterly notification of policy changes on the MDS related to the case mix reimbursement system

The *Louisiana Advisor* is a publication produced under contract with The Department of Health and Hospitals by Myers and Stauffer LC
9265 Counselors Row, Suite 200
Indianapolis, IN 46240

The *Louisiana Advisor* is published to keep all interested parties current on Louisiana Case Mix Reimbursement. It is our goal to provide official information on major issues such as:

** Clarifications/ changes to the Supportive Documentation Guidelines*
**Case Mix Review Process*
**Policies and Procedures*
**Upcoming Training*

MDS Clinical Questions?
Health Standards
(800) 261-8579

Documentation or Review Questions and Medicaid CMI Report Questions?
Myers and Stauffer LC
(800) 763-2278

2011 Training!

"THE DAWN OF A NEW DAY" The MDS 3.0 Is Here To Stay is an educational seminar offered under contract with the Department of Health and Hospitals.

This new and revised seminar will detail the MDS 3.0 application to the RUG-III calculation, based on the coded information submitted on the MDS 3.0 RUG items. New exercises have been developed including new ADL examples. The revised (version "B") Supportive Documentation Guidelines with an emphasis on the new MDS 3.0 RUG items will be reviewed. Finally, the Case Mix Reports will be reviewed. A basic understanding of the MDS 3.0 is helpful.

This workshop includes an instructional binder containing the following:

- The RUG-III 34-Grouper Classification System including coding of RUG items
- New MDS 3.0 exercises
- New ADL exercises *(including the Key of "7")*
- Updated MDS 3.0 Supportive Documentation Guidelines
- Understanding the Case Mix Report

Dates & Locations

Baton Rouge - June 20th
Baton Rouge - June 21st
Pineville - June 23rd
Pineville - June 24th

To Register
(or for more information):
Go to **http://la.mslc.com** and click on "Seminars".

REGISTRATION OPENS MID-APRIL!

In This Issue

Supportive Documentation Guidelines "Update"

Updated Supportive Documentation Guidelines are now available in the *Resources* section of our website at http://la.mslc.com. The new version is dated 10-1-10B. The "B" designation reflects the most current version and replaces the "A" version. The "B" version identifies all new information in **bold**. None of the new clarifications have any material impact on the guidelines.

ADL Clarification for MDS 3.0
Case Mix Documentation Review

In the Louisiana case mix classification system for Medicaid reimbursement, the late loss ADLs (including bed mobility, transfer, toilet use and an eating component) are scored and applied along with other clinical factors to place residents in the appropriate classification group. Once the resident is classified into the RUG group a predetermined Case Mix Index (CMI) value is assigned. The nursing facility is reimbursed based on the case mix system.

With the implementation of the MDS 3.0 effective October 1, 2010, the ADL keys used by the nursing facilities when coding Section G must be equivalent to the intent and definitions of the MDS ADL key according to the Resident Assessment Instrument (RAI) Manual to support a designated Resource Utilization Group (RUG) category. Correct ADL definitions are an essential component to a successful Case Mix Documentation Review.

Section G of the MDS 3.0 Activities of Daily Living (ADL) Assistance values are reviewed for all assessments selected for the Case Mix Documentation Review. Therefore, supporting the ADL transmitted value is vital to validating the assessment. Below is the key from the MDS 3.0 assessment.

ADL Self-Performance Key Descriptions:

Code 0 – independent – no help or staff oversight at any time
Code 1 – supervision – oversight, encouragement or cueing
Code 2 – limited assistance – resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight bearing assistance
Code 3 – extensive assistance – resident involved in activity, staff provide weight-bearing support
Code 4 – total dependence – full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

Code 7 – activity occurred only once or twice – activity did occur but only once or twice
Code 8 – activity did not occur – activity (or any part of the ADL) was not performed by resident or staff at all over the entire 7-day period

ADL Support Provided Key Descriptions:

Code 0 – No setup or physical help from staff
Code 1 – Setup help only
Code 2 – One person physical assist
Code 3 – Two+ persons physical assist

If the nursing facility's definitions deviate from the MDS 3.0 ADL keys, there are key words necessary to maintain the intent of the definitions. The Case Mix Reviewers cannot support the ADL documentation without these key words.

Below are key words in **bold** that are required to maintain the intent of the MDS ADL keys:

ADL Self-Performance Key Descriptions:

Code 0 – independent – **no help or staff oversight at any time**
Code 1 – supervision – **oversight, encouragement or cueing**
Code 2 – limited assistance – **resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight bearing assistance**
Code 3 – extensive assistance – **resident involved in activity, staff provide weight-bearing support**
Code 4 – total dependence – **full staff performance every time** during entire 7-day period
Code 7 – activity occurred only once or twice – activity did occur but only once or twice during the entire 7-day period
Code 8 – activity did not occur – **activity (or any part of the ADL) was not performed by resident or staff at all** over the entire 7-day period

Other ADL Case Mix Documentation Review Comments:

- Providers with no ADL key associated with the ADL values will be considered unsupported.
- Providers with more than one ADL supporting documentation (tool) per assessment (one the CNA completes and one the LPN/RN completes) will be asked to designate the one to be used for the Case Mix Documentation Review. The designated tool must be maintained in the medical record as a legal document.
- ADL key supporting documentation with words for self-performance such as limited, extensive assist, etc., without the full definition will be considered unsupported for the Case Mix Documentation Review.
- All MDS ADL codes must be represented on the ADL supporting documentation tool (with the exception of code "7"). ADL supporting documentation tools that lack any one of the codes will be considered unsupported. For example, for self performance, the ADL supporting documentation tool must contain the codes for independent, supervision, limited assistance, extensive assistance, totally dependent and activity did not occur. ADL tools that lack codes for all the possible MDS coding options (with the exception of code "7") will not be accepted as supporting documentation.
- The ADL supporting documentation tool must contain the appropriate keys for both the self-performance and the support provided.
- ADL supporting documentation will be reviewed consistent with current review protocol and guidelines for MDS 3.0.
- Electronically documented ADLs must meet the same requirements as hand-written ADL documentation.

Contacts for questions related to the MDS Coding or the Case Mix Documentation Review are:

DHH/Health Standards Section
Rose Helwig, State MDS/RAI Coordinator
225-342-2449

Department of Health and Hospitals – Rate & Audit
Sharon Burch
225-342-6116

Myers and Stauffer – Case Mix Documentation Review
Patty Padula or Cindy Smith, Case Mix Documentation Review
317-846-9521

Electronic Records & Signatures

Per RAI Version 3.0 Manual, page 2-6
"Nursing homes may use electronic signatures for clinical record documentation, including the MDS, when permitted to do so by state and local law and when authorized by the long-term care facility's policy. Use of electronic signatures for the MDS does not require that the entire clinical record be maintained electronically. Facilities must have written policies in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs."

"Nursing homes must ensure that proper security measures are implemented via facility policy to ensure the privacy and integrity of the record."

If electronic signatures or data collection is used by a facility, the RN Reviewer will ask to see the facility's electronic records policy.

MDS/RAI Modification Policy Update per CMS

An updated policy on record modifications will be implemented with submission of MDS 3.0 assessments as of April 1, 2011 as follows:

- Current policy (Chapter 5, page 5-10 of the RAI manual) allows providers to modify an assessment when key resident ID items (name, birthdate, gender, or SSN), Reason for Assessment Items (A3010), and event date (ARD, Entry Date, and Discharge Date) are determined to be inaccurate.
- CMS has reviewed the policy and will make the following policy changes:
  - **Providers <u>will not be able to</u> modify assessments when reason for assessment items and/or event dates are inaccurate. Reasons:**
    - <u>Assessment items:</u> The facility might not have gathered data for all required items. If one item or more is inaccurate, the assessment can't be modified.
    - <u>Event dates:</u> The lookback window is altered when these dates are changed. Existing assessments cannot be modified and event dates cannot be changed.
  - As stated in Chapter 5, page 5-10 of the RAI manual, providers will be able to modify assessments to correct key resident ID items.
- CMS will update Chapter 5 to reflect the new policy.
- What should be done if the event date is inaccurate? The assessment that contains the incorrect information will have to be inactivated and a new corrected assessment submitted; the inaccurate version will be moved to a history file.

Information obtained from QTSO Memo 2011-014.

Dear Cindy...

The "Dear Cindy..." column is a regular feature in each issue of the *Louisiana Advisor.* Cindy Smith, Myers and Stauffer's RN consultant, will discuss questions that are frequently answered by our staff. We welcome your questions for future issues. As always, please refer all coding/regulatory issues to the state RAI Coordinator.

Dear Patty:

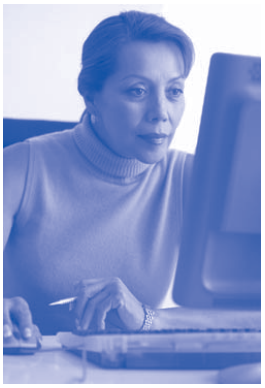
Q: What documentation for the Case Mix Documentation Review is needed to support that the BIMs and/or PHQ-9 interviews were completed?

A: If the BIMS and/or PHQ-9 <u>interview</u> items are completed, documentation for the Case Mix Documentation Review includes either validation of completion of these items at Z0400 ***OR*** *evidence of resident interview(s) in the medical record.*

Documentation requirements for the <u>staff assessment</u> items are unchanged from the MDS 2.0 and include an example describing the coding response(s) on the MDS 3.0 as well as documentation of the frequency of the mood symptom(s).

Preliminary CMI Report Review

Accurate MDS assessment data is an essential component of the case mix reimbursement system; therefore the Department of Health and Hospitals (DHH) requests your review of the Preliminary CMI Report to accomplish the following:



- Verify that all residents in the facility on the Point in Time Date are displayed on the CMI Report.
- Verify that the CMI Report does not include residents discharged on or prior to the Point in Time Date and remained out of the facility.
- Verify that the CMI Report reflects the most current MDS assessment as of the Point in Time Date for each resident.
- Verify that each resident's name is spelled correctly.
- Evaluate the reasons associated with any BC1 code.
- Any missing assessments must be electronically transmitted by the cut-off date stated in the preliminary CMI report cover letter in order to be included on the Final Case Mix Index Report.

If you determine that the CMI Report includes or excludes residents in error, or does not reflect the most current MDS assessment, please verify that the assessment or discharge has been accepted per the final validation report from the CMS system. If you feel you have experienced a transmission error, please contact the Health Standards MDS Help Desk at (800) 261-8579.

Questions may be addressed
to Myers and Stauffer's Help Desk
at 800-763-2278.

Stay Informed

If you would like to be among the first to receive seminar notifications, newsletters, resources available, etc., please send an email to LAHELPDESK@mslc.com to subscribe to our notification list. When sending your message, please type "**subscribe**" in the subject line. In the body of the message, please include your full name, title, phone number and facility/company name.

This email address can also be used for submitting general questions to the Myers and Stauffer Help Desk. Please be sure to provide all of your contact information to ensure a speedy response. Remember, **resident information is considered Protected Health Information (PHI). Email is not a secure format for transmitting this type of sensitive information.** Please consult your HIPAA Security Officer for more information.

Merging Residents When, Why & How

The CMS system assigns and maintains a numbering system called a resident ID unique to each resident as the MDS assessment data is processed and added to the CMS database. As long as the personal identifiers contained in the MDS assessments do not change, this resident maintains the same resident ID for any MDS assessments submitted. The resident should retain this unique resident ID even when transferred between health facilities within the state. The resident ID should also be independent of the type of assessments being performed, for example under MDS 2.0 or MDS 3.0.

There are 5 personal identifiers that are used to distinguish a resident from all other residents within a facility. These identifiers are first name, last name, date of birth, gender, and social security number. A change in one or more of these identifiers can indicate to the CMS system that this is a different resident. Some examples of a change would be an alternative spelling of a resident's first name, the birth date or gender was entered incorrectly. When this occurs, the same resident is displayed as two different residents with two unique resident IDs. As a result, the original assessment (ID) may appear as delinquent on the Time-Weighted CMI Resident Roster Report because the CMS system thought the latest submission was a new resident due to a change in one of the identifiers.

The first indication that a resident may have been assigned a different resident ID is a message on the CMS validation report stating that this assessment does not logically follow the type of assessment in the record received prior to this one (error message -1018 or error message -1027).

In some cases the Medicaid Case Mix Index roster report will display 2 residents listed with the same or similar name. When this happens, it is easy and quick to identify the issue as the two residents will display a different resident ID next to their name on the Time-Weighted CMI Resident Roster report. To correct this error, the resident's personal identifiers need to be verified to determine the correct ones, then a call will need to be made to the State RAI Coordinator to request that the 2 resident IDs be merged into the correct resident ID with the 5 correct identifiers.

Once the merge is completed in the CMS system, the state RAI coordinator must contact Myers and Stauffer's help desk and tell us which resident IDs were merged. Myers and Stauffer will merge the resident IDs in the Medicaid Case Mix system and then all assessments for the resident can be programmatically evaluated and the delinquency will likely be corrected if all assessments are present and pass CMS sequencing and the State Medicaid delinquency requirements.

Ask The Helpdesk

This is a new help desk feature article that will be in future newsletters. Please feel free to submit any comments, questions and or suggestions.

Downloading CMI Reports

Question: How do I access and download my preliminary and final CMI report(s)?

*Answer: Effective 10/1/2010 CMI reports, newsletters and other Medicaid publications must be downloaded from the **MDS 2.0 directory** NOT the Casper Reports application. Call the Myers and Stauffer help desk if you have any questions.*