Building A Successful MDS Program

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Objectives

- Acquire essential knowledge about what is required in order for MDS coordinators to be successful.
- Gain information you can use about common MDS coding errors so you can avoid them.
- Understand the recent MDS changes and how your internal processes must incorporate them.

Who Can Participate in the MDS Process

- The facility determines who should participate in the assessment process
- The Requirements:
  - A registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals
  - Nursing homes are responsible for ensuring that all participants in the assessment process have the necessary knowledge to complete an accurate assessment

Uses of MDS Data

- Reimbursement
- Quality Monitoring Programs
- Consumer Access to Information Regarding NH Performance
- The Survey Process
- The Development of the Resident Care Plan

Common Causes of Inaccurate Assessments

- Staff turnover and lack of staff training
- Failure to follow RAI User Manual instructions
- Failure to keep up with the changes
- Coding events that occurred outside of the LBP
- Failure to collect data from multiple sources
- Failure to collect data from all three shifts
- Lack of supporting documentation
- Failure to clarify inconsistencies

Elements of Success

Common MDS Coding Problem

- Resident Interviews-
- Staff must attempt the Resident Interviews on **ALL** residents unless.
  - The resident is rarely or never understood
  - The resident refused to participate
  - The interview was started and determined to be incomplete
  - An interpreter is needed, but one was not available
  - Resident has an unplanned discharge e.g. sent to hospital, left AMA.
- A resident is considered rarely or never understood if, at best, the resident's understanding is limited to staff interpretation of highly individual, resident-specific sounds or body language

Common MDS Coding Problem

- Section G0110- ADLs
- Most commonly miscoded section of the MDS
- Impacts every RUG classification
- Impacts quality monitoring
- Very complex- Extensive assistance is not just weight bearing support
- Write clarification notes
- Auto-populating software issues

Common MDS Coding Problem

- Active Diagnoses-
- Only active diagnoses are coded on the MDS- An active diagnosis is one that was documented by the physician within the last 60d and has an impact on the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7d look back period.
- Keep diagnoses lists current and identify resolved/historical diagnoses
- Include only the diagnoses confirmed by the physician
- Develop a system to ensure physician documentation is obtained q60d

Common MDS Coding Problem

- Section M-
- Must use the RAI Manual definitions, not the NPUAP's definitions
- Use consistent, well trained staff to complete wound assessments
- Document wound assessments at least weekly
- Determine the primary cause of the wound, before coding it on the MDS
- If the primary cause of a wound is pressure, it is a pressure ulcer
- Use consistent language when describing the location of a pressure ulcer

Identifying Errors in Assessments

- Assessments must accurately reflect the resident's status during the LBP
- Errors must be corrected within 14 days of identifying them
- Errors are corrected with either a
  - Modification- modifies the erroneous assessment data in the CMS database
  - Inactivation- removes the erroneous assessment from the CMS database
- The assessment must be replaced with a new assessment
- The new assessment must have a new ARD

Modifying Significant Errors

- Significant Errors are errors that inaccurately reflect the resident's clinical status and/or result in an inappropriate care plan.
- To correct a Significant Error in a OBRA Comprehensive or Quarterly assessment-
  - Modify the assessment submitted with an error, then
  - Determine if the error has been corrected by the submission by a more recent assessment.
    - If so, no further action is needed
    - If not, complete a Significant Correction Assessment SCPA, SCQA, or SCSA

MDS Coding Tips

- N0410 Medications Received-
- Medications are coded according to their pharmacological classification, not why they are being used
- Medications that have more than on pharmacological classification should be coded in all classifications assigned to the medication
- Anticoagulants do not include antiplatelet medications e.g. ASA, heparin used in flushes, and Plavix
- Fentanyl patches are considered long acting medications; only the days the patch is applied are counted for the purpose of coding the MDS

Pharmacological Classifications of Drugs

- USP Pharmacological Classification of Drugs
- http://www.usp.org/health-quality-safety/usp-medicare-model-guidelines/medicare-model-guidelines-v50-v40#Guidelines6
- Directions: Scroll to the bottom of this webpage and click on the pdf download for “USP Medicare Model Guidelines (With Example Part D Drugs)”

MDS Coding Tips

- Antipsychotic Medication Review (N0450)-
- Any medication that has a pharmacological classification or therapeutic category of an **antipsychotic** medication must be recorded in this section, regardless of why the medication is being used.
- Only includes GDR attempts since admission
- Only includes physician documentation that a GDR attempt is clinically contraindicated since the resident was admitted to the facility
- If a GDR is clinically contraindicated the physician must document a rationale

MDS Coding Tips

- Alarms (P0200)-
- P0200E- A wander/elopement alarm is a device worn by the resident or attached to their belongings that:
  - Alerts staff when the resident nears or exits a specific area or the building, or
  - Signals a door to lock, whether or not the device alerts staff
- P0200F- Other Alarm includes:
  - Bedroom/Bathroom door alarm
  - Toilet Seat alarms
  - Seatbelt alarms
  - Exit doors that require a code to exit

Resources Every MDS Nurse Should Have

- A current RAI Manual
- A Minnesota Case Mix Manual
- A MDS 3.0 Quality Measures User's Manual
- A Minnesota Nursing Facility Quality Indicators and Risk-Adjusters Manual
- A Skilled Nursing Facility Quality Reporting Program Measure Calculations and Reporting User's Manual
- A Minimum Data Set (MDS) Provider User's Guide, Chapter Five

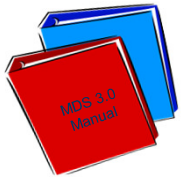
MDS Manual

- A current manual and any errata documents can be downloaded from the following web site:

  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-instruments/NursingHomeQualityInits/MDS30RAIManual.html

  (Scroll down to the download section)

- The most current manual is MDS 3.0 RAI Manual v1.15R



REMINDER

Need Help Call Us

For MDS Scheduling and Clinical Coding Questions

- Phone 651-201-4313
- Email health.mds@state.mn.us

For Submission or Validation Report Questions

- Phone 651-201-3817
- Email health.mdsoasistech@state.mn.us

Need Help Call Us

- For Medicare Billing and Eligibility Questions
  - National Government Services 1-877-702-0990
  - Website https://www.ngsmedicare.com
- For Private Pay and Medicaid Billing Questions
  - Phone 651-201-4301
  - Email health.fpc-cmr@state.mn.us