Minimum Data Set (MDS) 3.0 Focused and Staffing Surveys 2015

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Sponsored by: SimpleLTC™ Texas Medicaid Coalition

February 2015

Objectives

Describe the intent of the 2015 MDS focused and staffing surveys.

Explain the survey and enforcement process for the 2015 surveys.

Identify the focus areas and key findings from the 2014 pilot surveys in five states.

Objectives

Discuss the accurate staging and documentation of pressure ulcers in item M0300.

Identify the criteria for coding antipsychotic drugs in item N0410A.

List the criteria for the proper evaluation and coding of restraints in item P0100.

CMS S&C Memorandum 15-06-NH

DATE: October 31, 2014

SUBJECT: Nationwide Expansion of Minimum Data Set (MDS) Focused Survey

DOWNLOAD:

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-06.pdf

CMS S&C Memorandum 15-06-NH

History:

- In mid-2014, CMS piloted a short-term MDS focused survey.
- The pilot surveys were conducted in nursing homes in five states.

CMS S&C Memorandum 15-06-NH

About the Pilot:

- Five nursing facilities in each of the five states were surveyed.
- The total number of homes surveyed was 25.
- Deficiencies were written in 24 out of 25 homes.

CMS S&C Memorandum 15-06-NH

MDS/Staffing Focused Surveys:

- In 2015, CMS will expand these surveys to be conducted nationwide.

CMS S&C Memorandum 15-06-NH

The intent of the MDS Survey:

- To assess MDS 3.0 coding practices and its relationship to resident care in nursing facilities, and
- To enhance surveyors' ability to identify errors and deficiencies related to MDS coding and resident care.

CMS S&C Memorandum 15-06-NH

Reported Staffing:

- The scope of some or all of the focused surveys will also be expanded.
- The increased scope will include an assessment of the staffing levels of nursing facilities.

CMS S&C Memorandum 15-06-NH

Reported Staffing:

- The aim is to verify the data self-reported by the nursing home, and
- Identify changes in staffing levels throughout the year.

CMS S&C Memorandum 15-06-NH

Survey and Enforcement Information:

- The number of surveys conducted will vary from state to state.
- The exact number of surveys Texas will complete is still under discussion at this time.

CMS S&C Memorandum 15-06-NH

Survey and Enforcement Information:

- States will be expected to allocate two surveyors for each survey, requiring an estimated 2 days on average.
- Surveyors will also need to complete and submit post-survey information to CMS or its contractor (e.g., questionnaire about the process and findings).

CMS S&C Memorandum 15-06-NH

Survey and Enforcement Information:

- CMS staff will also collaborate with States to identify the specific facilities to be surveyed.
- CMS is developing both the survey protocol and tool for the States' to use.

CMS S&C Memorandum 15-06-NH

Survey and Enforcement Information:

- The MDS 3.0 inaccuracies and insufficient staffing noted during the survey will result in relevant citations.
- Citations issued could also include those related to quality of care and/or life, or nursing services.

CMS S&C Memorandum 15-06-NH

Survey and Enforcement Information:

- If patterns of inaccuracies are noted, the case will be referred to the CMS Regional Office and Central Office for follow-up.

- In the event that care concerns are identified during on-site reviews, the concerns may be cited or referred to the State Agency as a complaint for further review.

CMS S&C Memorandum 15-06-NH

Survey and Enforcement Information:

- Record review, augmented by resident observations and staff and/or resident interviews, will be used by the surveyors to validate MDS 3.0 coding and staffing levels.

- Additionally, while on-site, the surveyors will ask a series of questions regarding staffing and MDS related practices of the facility staff, leadership, and others as appropriate.

CMS UPDATES

CMS updates listed are based on the MDS 3.0 RAI Manual (RAIM3), v1.12

Effective Date: October 1, 2014

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

Item M0300

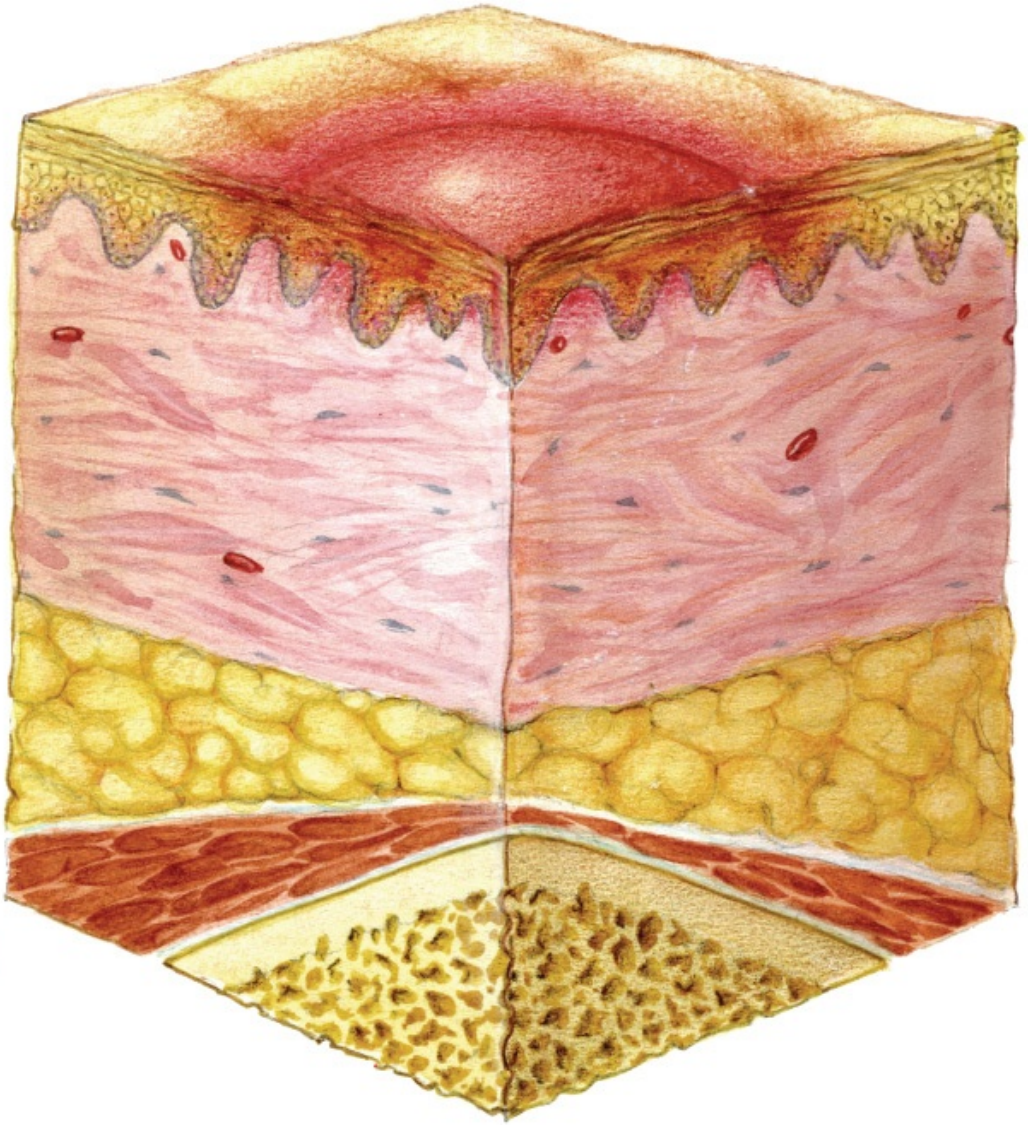
From page M-5 of the RAIM3, under Coding Tips:

- If an ulcer arises from a combination of factors which are primarily caused by pressure, then the ulcer should be included in this section as a pressure ulcer.

- If a pressure ulcer healed during the look-back period, and was not present on the prior assessment, code 0.

Assessment / Documentation

- Use a uniform/validated assessment tool
- Stage (1, 2, 3, 4 or Unstageable. There is no 5.)
- Location
- Size – includes Length, Width, Depth-to wound base (report in centimeters)
- Location/depth of undermining and tunneling/sinus tracts
- Wound bed – necrotic or granulation tissue
- Drainage/exudate (including. any odors)
- Peri-wound tissue (color, temp, bogginess and/or fluctuation)
- Support Surface



NATIONAL PRESSURE ULCER ADVISORY PANEL

STAGE 1

M0300A - Stage 1 Pressure Ulcer Definition

An observable, pressure-related alteration of **intact** skin, whose indicators as compared to an adjacent or opposite area on the body, may include changes in one or more of the following parameters:

- skin temperature (warmth or coolness);
- tissue consistency (firm or boggy);
- sensation (pain, itching); and/or
- a defined area of persistent redness in lightly pigmented skin. In darker skin tones, the ulcer may appear with red, blue, or purple hues.

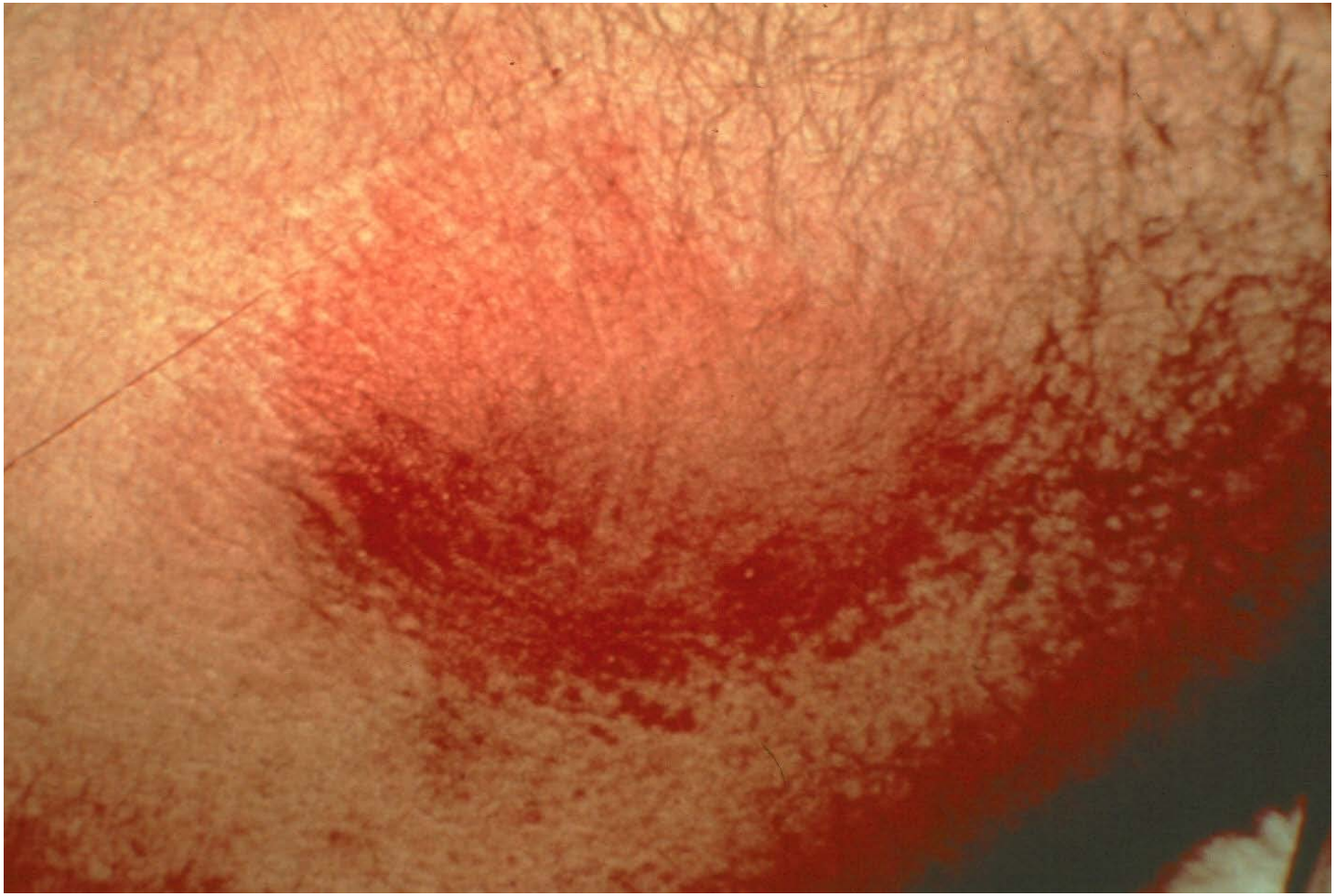
Stage 1 Pressure Ulcer Definition

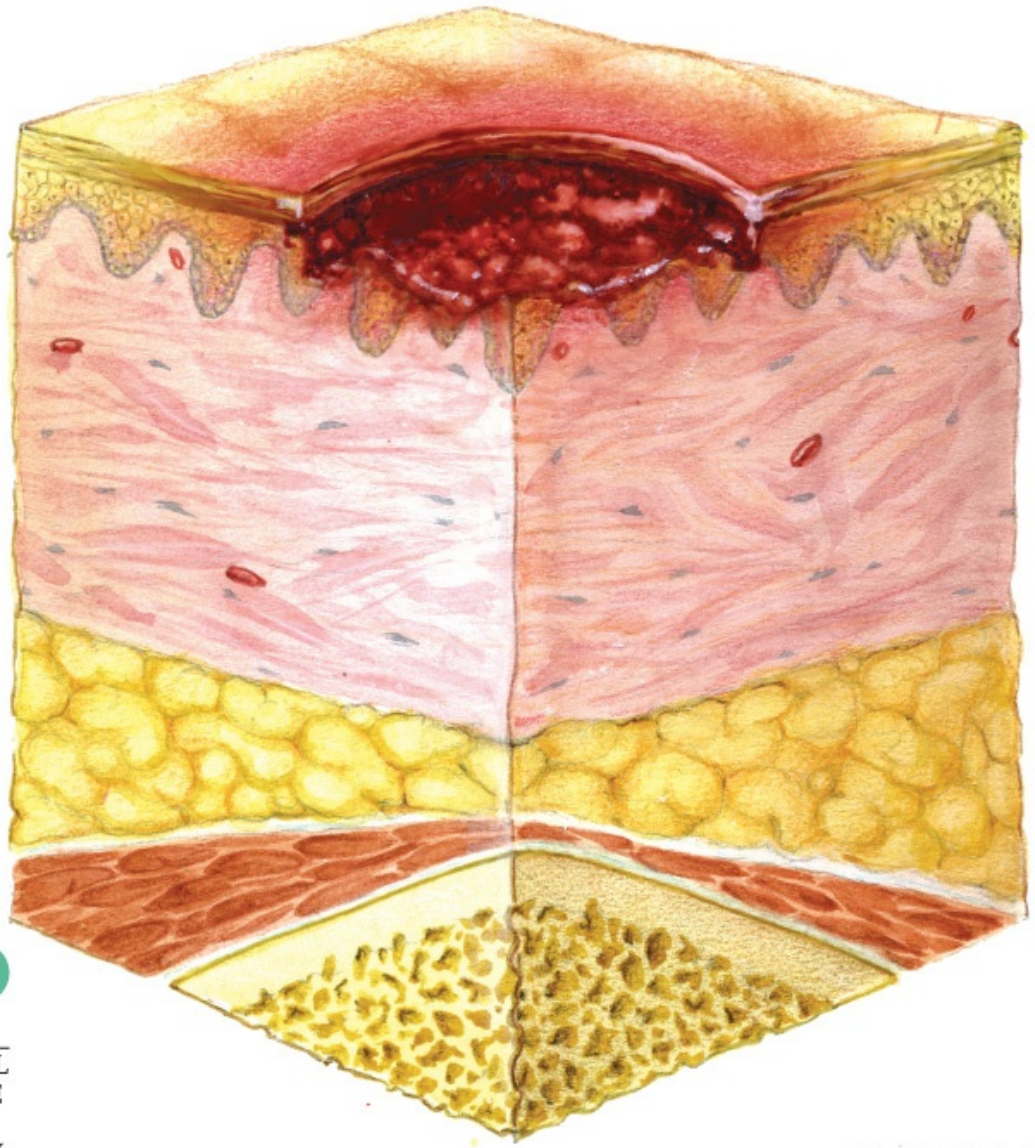
NON-BLANCHABLE

- Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device.

(Page M-8 of the RAIM3)

Stage I Pressure Ulcer





NATIONAL PRESSURE ULCER ADVISORY PANEL

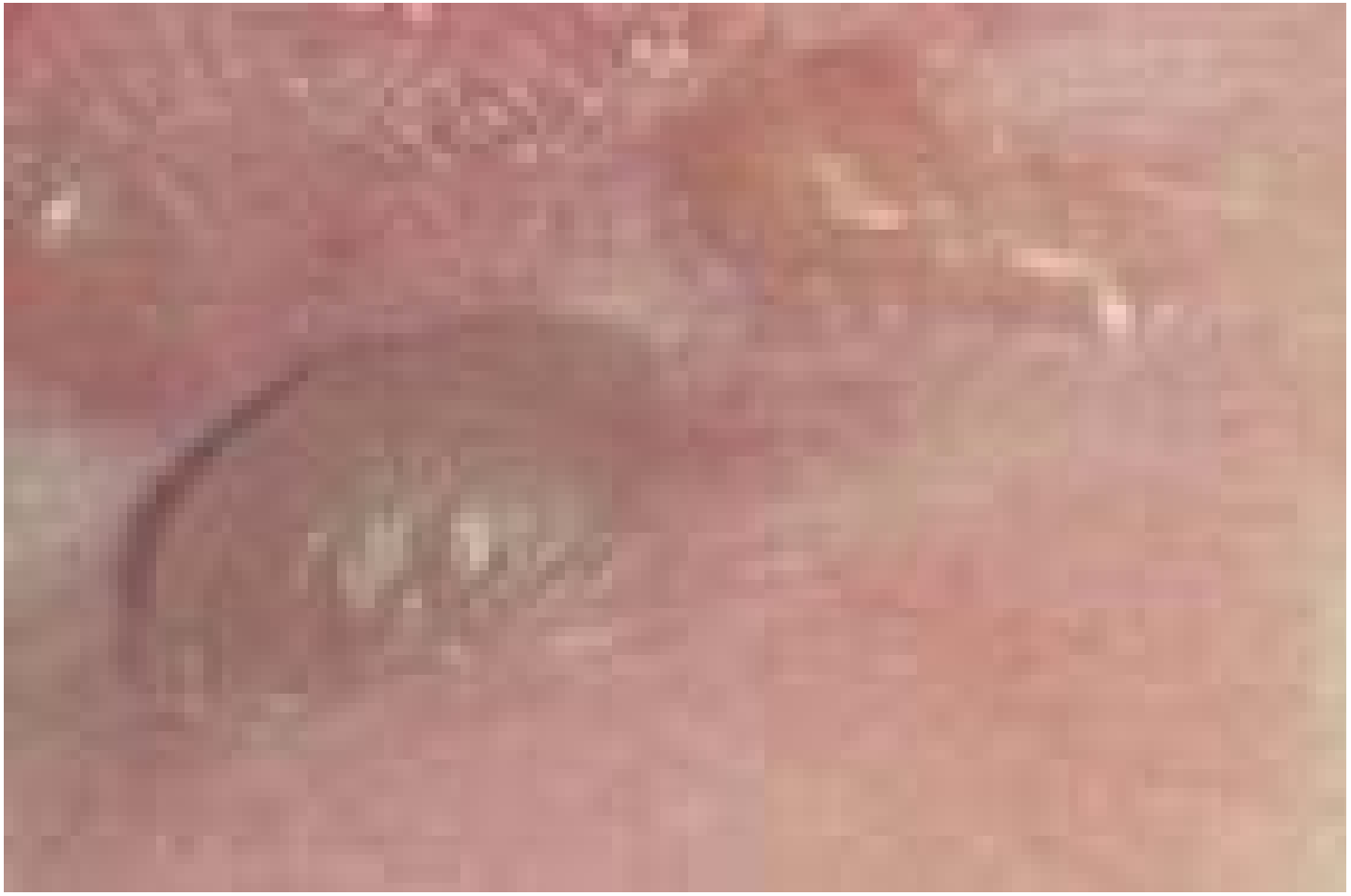
STAGE 2

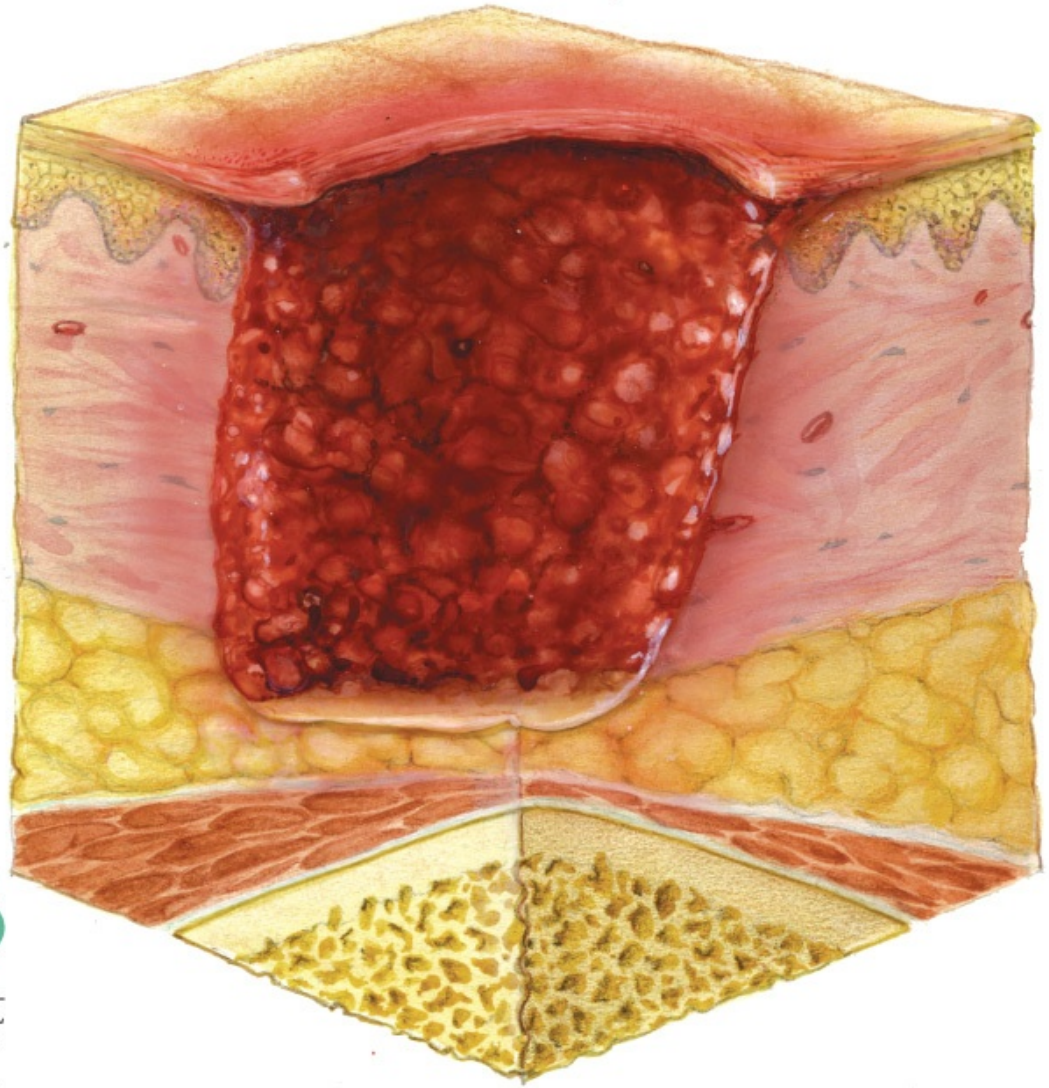
M0300B - Stage 2 Pressure Ulcer Definition

- Partial thickness loss of dermis, presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

(Page M-9 of the RAIM3)

Stage II Pressure Ulcers





NATIONAL PRESSURE ULCER ADVISORY PANEL

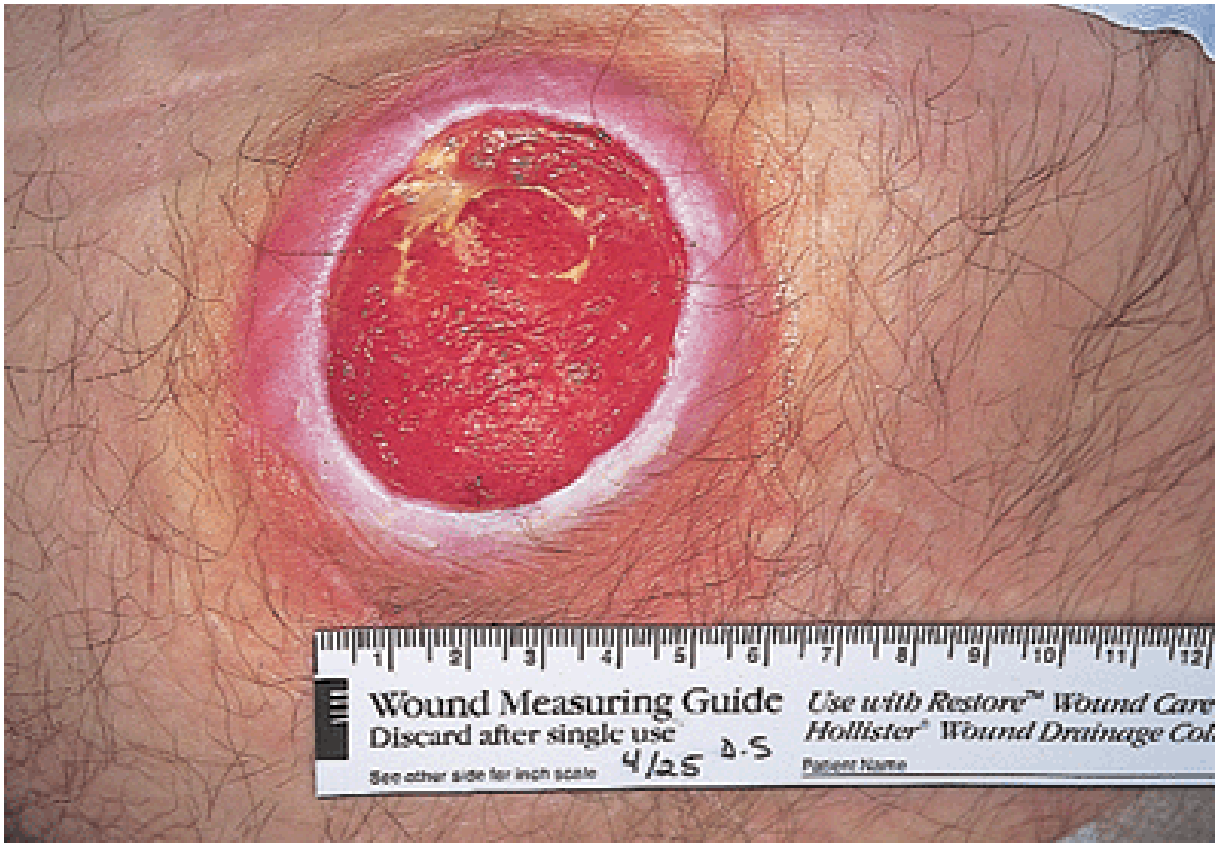
STAGE 3

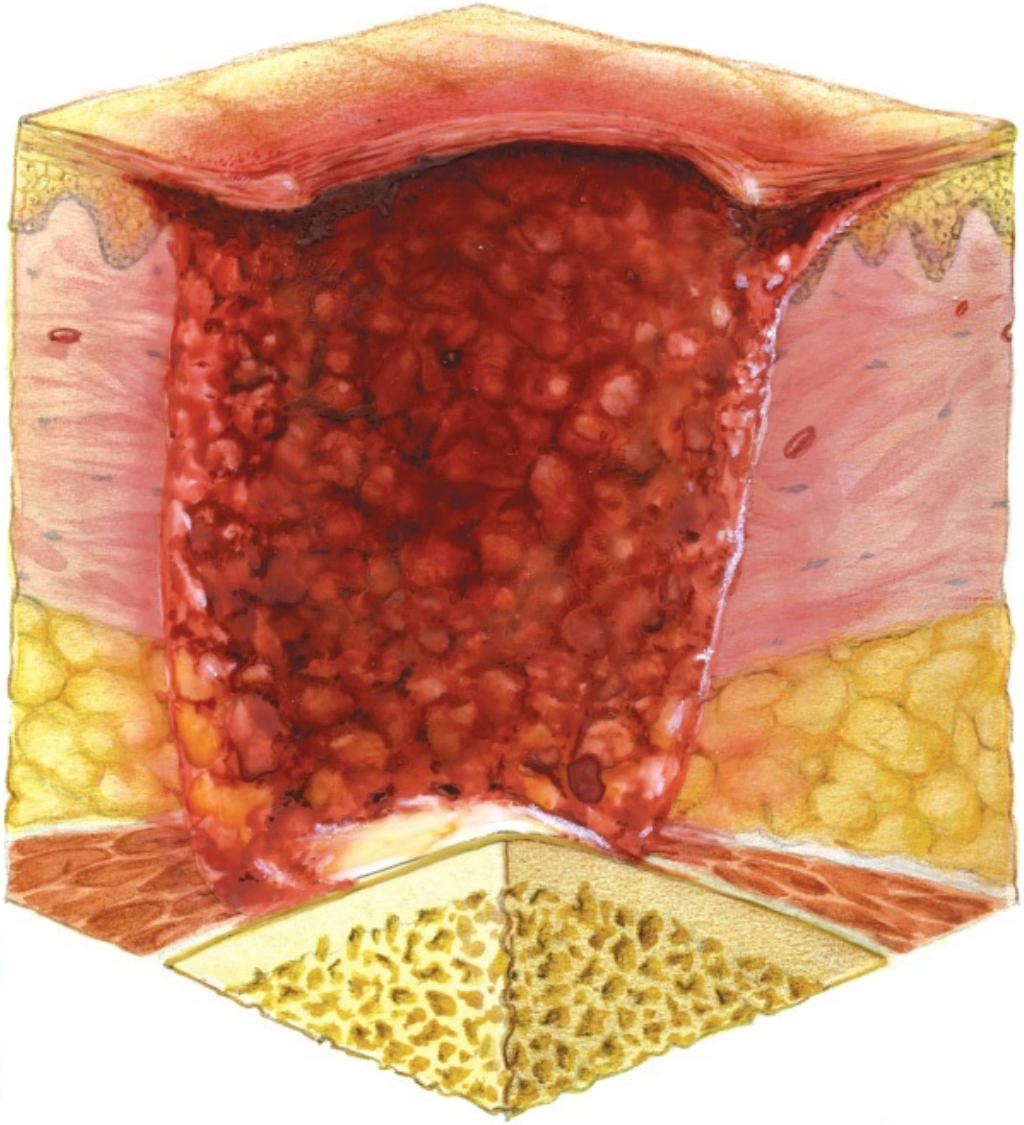
M0300C - Stage 3 Pressure Ulcer Definition

- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

(Page M-11 of the RAIM3)

Stage III Pressure Ulcer





NATIONAL PRESSURE ULCER ADVISORY PANEL

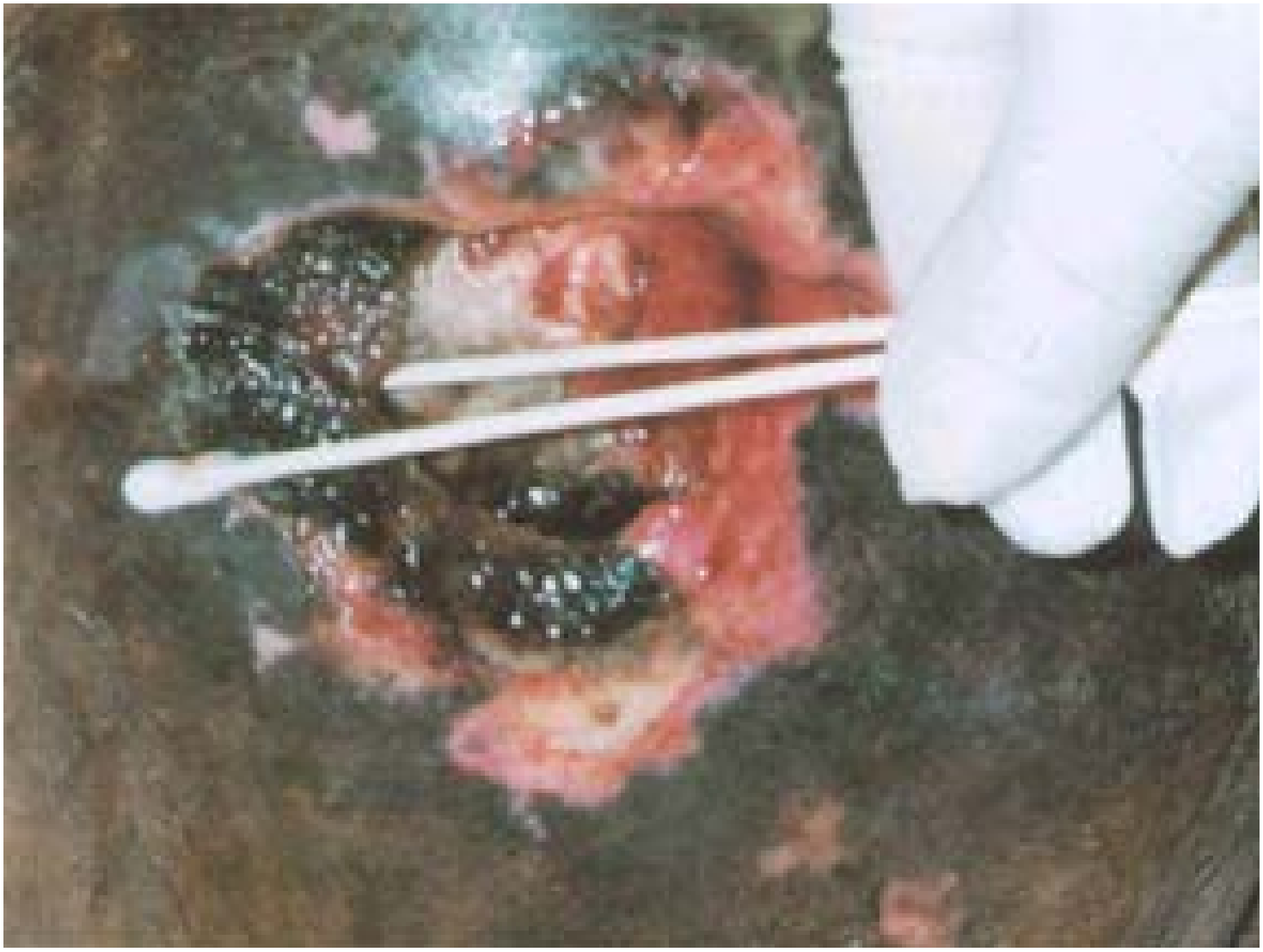
STAGE 4

M0300D - Stage 4 Pressure Ulcer Definition

- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

(Page M-13 of the RAIM3)

Stage IV Pressure Ulcer

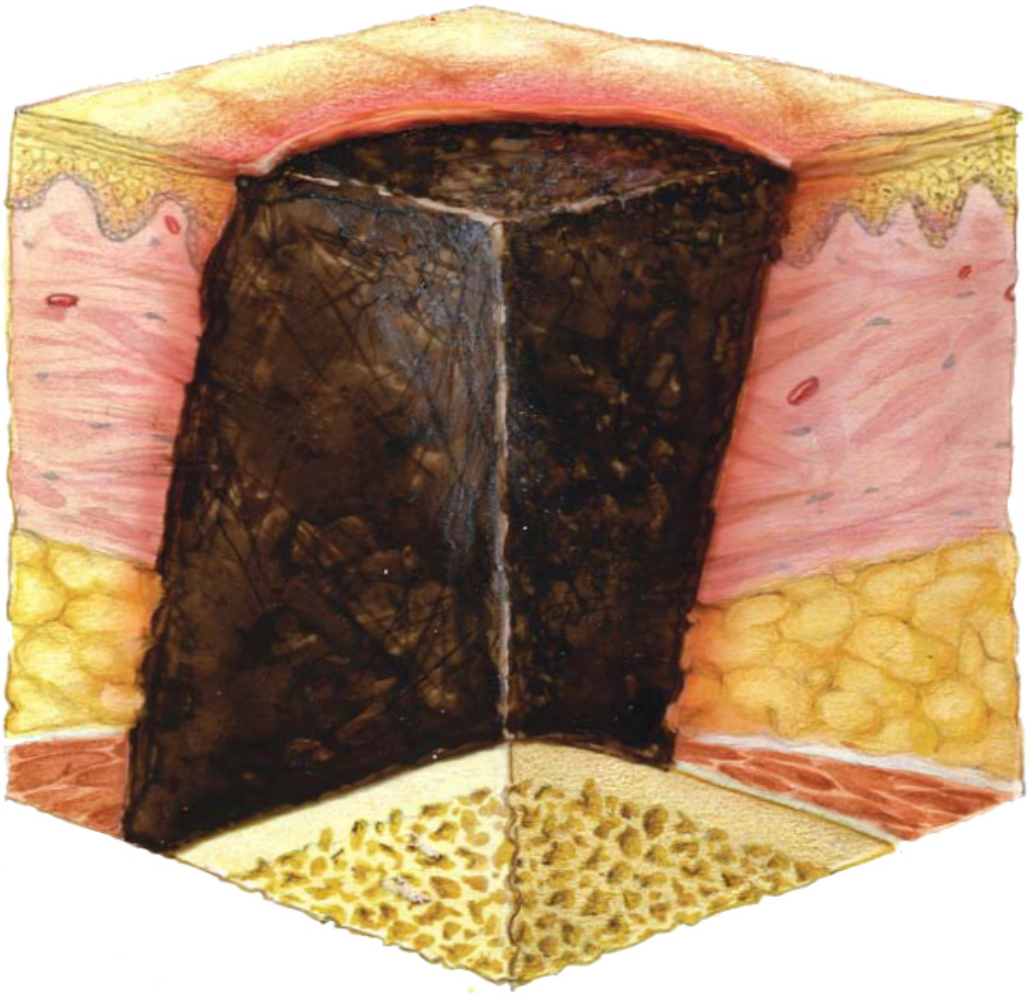


Unstageable Pressure Ulcer Definition

M0300E - Due to non-removable dressing or device:

Review the medical record for documentation of a pressure ulcer covered by a non-removable dressing. Includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast.

(Page M-15 of the RAIM3)



NATIONAL PRESSURE ULCER ADVISORY PANEL

UNSTAGEABLE

Unstageable Pressure Ulcer Definition

M0300F - Due to coverage of wound bed by slough and/or eschar:

- SLOUGH TISSUE
- Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

Unstageable Pressure Ulcer Definition

M0300F - Due to coverage of wound bed by slough and/or eschar:

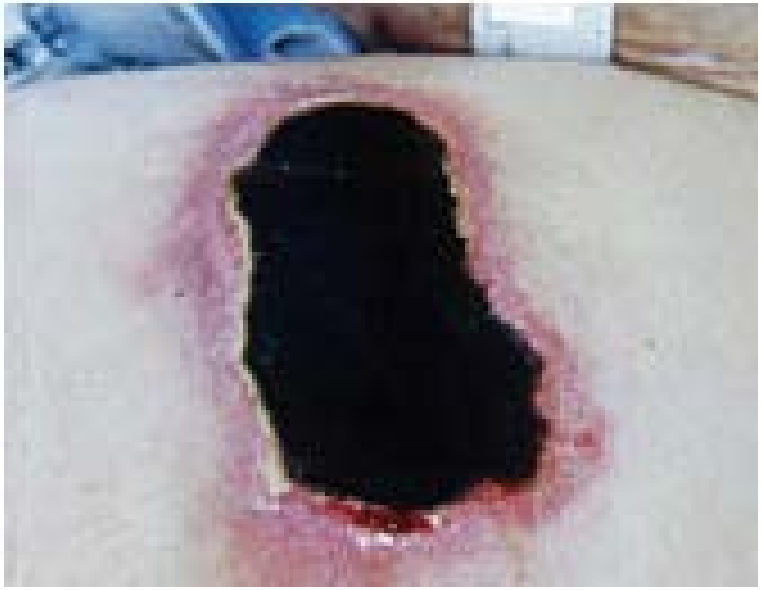
ESCHAR TISSUE

- Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.

(Page M-16 of the RAIM3)

Unstageable Pressure Ulcer Definition

M0300F - Due to coverage of wound bed by slough and/or eschar:



Item M0300

From page M-17 of the RAIM3, under Coding Tips:

- Once the pressure ulcer is debrided of slough and/or eschar such that the anatomic depth of soft tissue damage involved can be determined, then code the ulcer for the reclassified stage.
- The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue in order for reclassification of stage to occur.

Item M0300

From page M-5 of the RAIM3, under Coding Tips:

- If a pressure ulcer is surgically closed with a flap or graft, it should be coded as a surgical wound and not as a pressure ulcer.
- If the flap or graft fails, continue to code it as a surgical wound until healed.

Unstageable Pressure Ulcer Definition

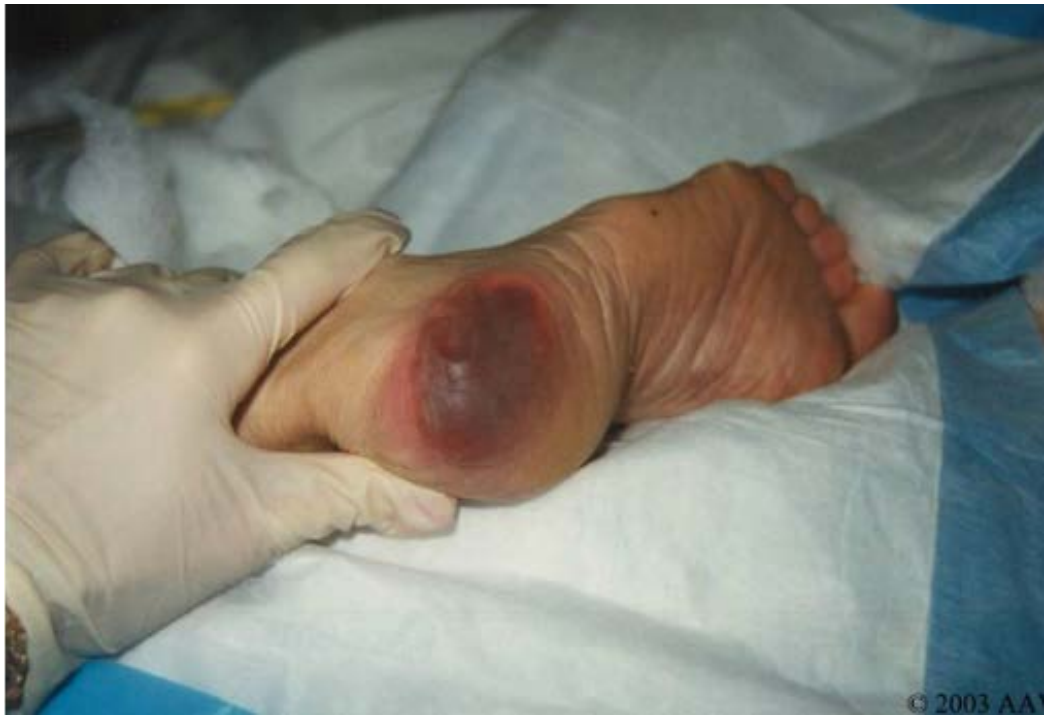
M0300G - Suspected Deep Tissue Injury:

- Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

(Page M-19 of the RAIM3)

Unstageable Pressure Ulcer Definition

M0300G - Suspected Deep Tissue Injury:



Item M0300 – Present on Admission

From page M-7 of the RAIM3, determining if Pressure Ulcers were “present on admission”:

- Review for location and stage at the time of admission/entry or reentry. If the pressure ulcer was present on admission/entry or reentry and subsequently increased in numerical 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.”**

Item M0300 – Present on Admission

- If the pressure ulcer was unstageable on admission/entry or reentry, but becomes numerically stageable later, it should be considered as “present on admission” at the stage at which it first becomes numerically stageable. If it subsequently increases in numerical stage, that higher stage should **not** be considered **“present on admission.”**

Item M0300 – Present on Admission

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

Item M0300 – Present on Admission

- 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."**

Item N0410A

Coding Instructions:

- N0410A, **Antipsychotic**: Record the number of days an antipsychotic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).

(Page N-5 of the RAIM3)

Item N0410A

Coding Tips:

- Code medications in Item N0410 according to the medication's therapeutic category and/or pharmacological classification, not how it is used.
- Include any of these medications given to the resident by any route (e.g., PO, IM, or IV) in any setting (e.g., at the nursing home, in a hospital emergency room) while a resident of the nursing home.
- Code a medication even if it was given only once during the look-back period.

Item P0100

PHYSICAL RESTRAINTS

- Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot **remove easily**, which restricts freedom of movement or normal access to one's body.

(State Operations Manual, Appendix PP)

(Page P-1 of the MDS 3.0 RAI Manual)

Item P0100

From page P-3 of the RAIM3:

"**Remove easily**" means that the manual method or physical or mechanical device, material, or equipment can be removed:

- intentionally by the resident
- in the same manner as it was applied by the staff (e.g., side rails are put down or not climbed over, ties or knots are intentionally untied),
- considering the resident's physical condition and ability to accomplish his or her objective (e.g., transfer to a chair, get to the bathroom in time).

Item P0100

Also from page P-3 of the RAIM3:

“Freedom of movement” means any change in place or position for the body or any part of the body that the person is physically able to control or access.

Item P0100

P0100: Physical Restraints Coding Instructions:

- Identify all physical restraints that were used at any time (day or night) during the 7-day look-back period.

- After determining whether or not an item listed in (P0100) is a physical restraint and was used during the 7-day look-back period, code the frequency of use.

(Page P-5 of the RAIM3)

Item P0100

P0100: Physical Restraints (cont.)

- Code **0**, not used: if the item was not used during the 7-day look-back or it was used but did not meet the definition.
- Code **1**, used less than daily: if the item met the definition and was used less than daily.
- Code **2**, used daily: if the item met the definition and was used on a daily basis during the look-back period.

Item P0100

"ENABLER" vs. PHYSICAL RESTRAINT

In classifying any manual method or physical or mechanical device, material or equipment as a physical restraint, the assessor must consider the effect it has on the resident, not the purpose or intent of its use.

It is possible that a manual method or physical or mechanical device, material or equipment may improve a resident's mobility but also have the effect of physically restraining him or her.

Item P0100

- Any manual method or physical or mechanical device, material or equipment,
- that does not fit into the listed categories but that meets the definition of a physical restraint,
- and has not been excluded from this section,

Should be coded in items P0100D or P0100H, Other.

Item P0100

Exclude from this section items that are typically used in the provision of medical care, such as:

- Catheters, drainage tubes, casts, traction, leg, arm, neck or back braces, abdominal binders and bandages that are serving in their usual capacity to meet medical need(s).

(Page P-5 of the RAIM3)

Item P0100

- For residents who have the ability to transfer from other chairs, but cannot transfer from a geriatric chair, the geriatric chair would be considered a restraint to that individual, and should be coded as P0100G–Chair Prevents Rising.

- For residents who have no ability to transfer independently, the geriatric chair does not meet the definition of a restraint, and should not be coded at P0100G–Chair Prevents Rising.

Item P0100

- Geriatric chairs used for residents who are immobile. For residents who have no voluntary or involuntary movement, the geriatric chair does **not** meet the definition of a restraint.

(Page P-6 of the RAIM3)

Item P0100

- Enclosed-frame wheeled walkers, with or without a posterior seat, and other like devices should not automatically be classified as a physical restraint.

- These types of walkers are only classified as a physical restraint if the resident cannot exit the walker via opening a gate, bar, strap, latch, removing a tray, etc.

- When deemed a physical restraint, these walkers are coded at P0100G–Chair Prevents Rising.

Other MDS Items

While pressure ulcer, antipsychotic medication and physical restraint documentation and coding were highlighted as frequent errors resulting in citations during the MDS survey pilot, that does **not** mean:

- They were the only areas where citations were written, or
- They were the only MDS areas of review.

MDS Survey

CMS staff have recommended that nursing facilities reviewing MDS:

- Are these MDS being scheduled and completed in accordance with RAIM3 instructions?
- Are all items on these MDS accurate?
- (A few areas of frequent concerns: timing of interviews; Section G ADL Coding; Coding Diagnoses in Section I, including UTI; and coding isolation in Section O.)

TEXAS MDS Resources

Call Cheryl Shiffer for Clinical Questions:

- 210-619-8010

Call Brian Johnson for Technical Questions:

- 512-438-2396

- Visit the state MDS web site: http://www.dads.state.tx.us/providers/MDS/ (Check out **The MDS Mentor!** & Sign up for e-mails)

Final thoughts

“When all else fails, read the instructions”
– Ralph Waldo Emerson, Poet, 1803-1882

“If you don't have time to do it right, when will you have time to do it over?”
– John Wooden, American Coach, 1910-2010