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Simple and Easy: Winning in PDPM Payment and Regulatory Strategies

Untangle Your MDS 3.0 Data Processes

Review of Regulatory Tags Defining the MDS 3.0 Process

F Tag 636 483.20 Resident Assessment

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

(XVIII) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

Utilization Guidelines provide instructions for when and how to use the RAI. The Utilization Guidelines are also known as the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual.

The facility is expected to use resident observation and communication as the primary source of information when completing the RAI. In addition to record review, direct observation and communication with the resident.

Does the facility have a system in place to assure assessments are conducted in accordance with the specified timeframes for each resident?

F Tag 641 483.20(g) Accuracy of Assessments

The assessment must accurately reflect the resident's status.

Intent 483.20g – To assure that each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline.

Facilities are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.

The assessment must represent an accurate picture of the resident's status during the observation period of the MDS. The Observation Period (also known as the Look -back period) is the time period over which the resident's condition or status is captured by the MDS assessment and ends at 11:59 p.m. on the day of the Assessment Reference Date (ARD).

When the MDS is completed, only those occurrences during the observation period will be captured on the assessment. In other words, if it did not occur during the observation period, it is not coded on the MDS.

Based on your total review of the resident, observations, interviews and record reviews, does each portion of the MDS assessment accurately reflect the resident's status as of the Assessment Reference Date?

Is there evidence that the health professionals who assessed the resident had the skills and qualifications to conduct the assessment?

Review of Regulatory Tags Defining the MDS 3.0 Process (continued)

F Tag 642 483.20 (H) (I) Coordination & Certification

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Backdating Completion Dates is not acceptable - note that recording the actual date of completion is not considered backdating. For example, if an MDS was completed electronically and a hard copy was printed two days later, writing the date the MDS was completed on the hard copy is not considered backdating.

Are the appropriate certifications in place, including the RN Coordinator's certification of completion of an MDS assessment or Correction Request, and the certification of individual assessors of the accuracy and completion of the portion(s) of the assessment or tracking record completed?

Regulatory F Tags related to MDS Assessments State Operations Manual

F636

(Rev. 173, issued: JJ-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.20 Resident Assessment

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

§483.20(b) Comprehensive Assessments

§483.20(b)(l) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:

(l) Identification and demographic information

(ii) Customary routine.

(iii) Cognitive patterns.

(iv) Communication.

(v) Vision.

(vi) Mood and behavior patterns.

(vii) Psychological well-being.

(viii) Physical functioning and structural problems.

(ix) Continence.

(x) Disease diagnosis and health conditions.

(xi) Dental and nutritional status.

(xii) Skin Conditions.

(xiii) Activity pursuit.

(xiv) Medications.

(xv) Special treatments and procedures.

(xvi) Discharge planning.

(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).

(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.

(i) **Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)**

(iii) Not less than once every 12 months.

INTENT §483.20(b)(1)-(2)(i)&(iii)

To ensure that the Resident Assessment Instrument (RAI) is used, in accordance with specified format and timeframes, in conducting comprehensive assessments as part of anongoing process through which the facility identifies each resident's preferences and goals of care, functional and health status, strengths and needs, as well as offering guidance for further assessment once problems have been identified.

DEFINITIONS §483.20(b)(l)-(2)(i)&(iii)

"Minimum Data Set": The Minimum Data Set (MDS) is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes. It is a core set of screening, clinical and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment.

"Care Area Assessment (CAA) Process" is a process outlined in Chapter 4 of the MDS manual designed to assist the assessor to systematically interpret the information recorded on the MOS. Once a care area has been triggered, nursing home providers use current, evidence-based clinical resources to conduct an assessment of the potential problem and determine whether or not to care plan for it. The CAA process helps the clinician to focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the resident. This process has three components:

- **Care Area Triggers (CATs)** are specific resident responses for one or a combination ofMDS elements. The triggers identify residents who have or are at risk for developing specific functional problems and require further assessment.
- **Care Area Assessment (CAA)** is the further investigation of triggered areas, to determine if the care area triggers require interventions and care planning.
- **CAA Summary** (Section V of the MOS) provides a location for documentation of the care area(s) that have triggered from the MOS, the decisions made during the CAA process regarding whether or not to proceed to care planning, and the location and date of the CAA documentation.

"Comprehensive Assessment" includes the completion of the MOS as well as the CAA process, followed by the development and/or review of the comprehensive care plan. Comprehensive MOS assessments include Admission, Annual, Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment.

"Resident Assessment Instrument (RAJ)" consists of three basic components: the Minimum Data Set (MOS) version 3.0, the Care Area Assessment (CAA) process and the RAI utilization guidelines. The utilization of these components of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified.

"Utilization Guidelines" provide instructions for when and how to use the RAI. The Utilization Guidelines are also known as the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual.

GUIDANCE §483.20(b)(l)-(2(i)&(iii)

Each facility must use the RAI specified by CMS (which includes the MDS, utilization guidelines and the CAAs) to assess each resident. The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or CAAs. The scope of the RA I does not limit the facility's responsibility to assess and address all care needed by the resident.

The infonnation required in §483.20(b)(l)(i-xviii) is incorporated into the MDS, which forms the core of the RAJ process. Additional assessment information is also gathered using triggered Care Area Assessments (CAAs) after the completion of the comprehensive MDS.

The facility is expected to use resident observation and communication as the primary source of information when completing the RA!. In addition to record review, direct observation and communication with the resident, the facility must use a variety of other sources, including communication with licensed and non-licensed staff members on all shifts and may include discussions with the resident's physician, the resident's representative, family members, or outside consultants.

At a minimum, facilities are required to complete a comprehensive assessment of each resident within 14 calendar days after admission to the facility, when there is a significant change in the resident's status and not less than once every 12 months while a resident. For the purpose of this guidance, not less than once every 12 months means within 366 days.

For additional requirements regarding a Significant Change in Status Assessment, see §483 .20(b)(2)(ii).

If a comprehensive assessment was completed, any time prior to a temporary absence for hospitalization or a leave of absence, and upon return to the facility, the resident does not meet the criteria for a Significant Change in Status Assessment (SCSA), as defined in §483.20(b)(2)(ii), a comprehensive assessment is not required. For example, a resident had a comprehensive assessment completed within 14 days of admission, four months later was hospitalized, then returned to the facility. Upon return to the facility, the resident's status does not meet the criteria for a SCSA, therefore a comprehensive assessment is not required.

For additional information on assessment scheduling and completion requirements, see Chapter 2 of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual. Link to the LTCF RAJ User's Manual: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-lnstruments/NursinghomeQualityinits/MDS30RAIManual.html.

The facility must use the RAI process to develop a comprehensive care plan, to provide the appropriate care and services for each resident, and to modify the care plan and care/services based on the resident's status.

PROBES §483.20(b)(l)-(2)(i)&(iii)

- Did the facility complete a comprehensive assessment, using the CMS-specified RAJ process, within the regulatory timeframes (i.e. within 14 days afteradmission and at least annually) for each resident in the sample?

- ls there evidence in the clinical record that the facility gathered and analyzed supplemental information based on the triggered CAAs prior to developing the comprehensive care plan? For reference a list ofCAAs is found in Section V of the MDS (Care Area Assessment Summary).
- Is there evidence of resident and/or resident representative participation in the assessment process? Examples include participating in the resident interviews, providing information about preferences or discharge goals.
- Ask licensed and non-licensed direct-care staff if they participate in the resident assessment process.
- Does the facility have a system in place to assure assessments are conducted in accordance with the specified timeframes for each resident?

F641

(Rev. 173, issued: 11-22-17, Effective: 11-28-17, implementation: 11-28-17)

§483.20(g) Accuracy of Assessments.

The assessment must accurately reflect the resident's status.

INTENT §483.20(g)

To assure that each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline.

GUIDANCE §483.20(g)

"Accuracy of Assessment" means that the appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial stahls using the appropriate Resident Assessment Instrument (RAI) (i.e. comprehensive, quarterly, significant change in status).

Facilities are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.

The determination of appropriate participation of health professionals must be based on the physical, mental and psychosocial condition of each resident. This includes an appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, medical social workers, dietitians, and other professionals, such as developmental disabilities specialists, in assessing the resident, and in correcting resident assessments. Involvement of other disciplines is dependent upon resident stahls and needs.

The assessment must represent an accurate picture of the resident's status during the observation period of the MOS. The Observation Period (also known as the Look-back period) is the time period over which the resident's condition or status is captured by the MDS assessment and ends at 11:59 p.m. on the day of the Assessment Reference Date (ARD). Be aware that different items on the MDS have different Observation Periods.

When the MOS is completed, only those occurrences during the observation period will be captured on the assessment. In other words, if it did not occur during the observation period, it is not coded on the MDS.

The initial comprehensive assessment provides starting point data for ongoing assessment of resident progress.

PROBES §483.20(g)

- Based on your total review of the resident, observations, interviews and record reviews, does each portion of the MOS assessment accurately reflect the resident's status as of the Assessment Reference Date?
- Is there evidence that the health professionals who assessed the resident had the skills and qualifications to conduct the assessment? For example, has the resident's nutritional status been assessed by someone who is knowledgeable in nutrition and capable of correctly assessing a resident?

F642

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.20(h) Coordination.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

§483.20(i) Certification.

§483.20(i)(l) A registered nurse must sign and certify that the assessment is completed.

§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

§483.200) Penalty for Falsification.

§483.20U)(l)Under Medicare and Medicaid, an individual who willfully and knowingly-

(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

§483.200)(2) Clinical disagreement does not constitute a material and false statement.

INTENT §483.20(h)-(i)

Each resident's assessment will be coordinated by and certified as complete by a registered nurse, and all individuals who complete a portion of the assessment will sign and ce1tify to the accuracy of the portion of the assessment he or she completed.

GUIDANCE §483.20(h)-U)

Whether Minimum Data Set (MOS) assessments are manually completed, or computer-generated following data entry, each individual assessor is responsible for ce1tifying the accuracy of responses relative to the resident's condition and discharge or entry status. Manually completed forms are signed and dated by each individual assessor the day they complete their portion(s) of the assessment.

Electronic Signatures

When MDS forms are completed directly on the facility's computer (i.e., no paper form has been manually completed), then each individual assessor signs and dates a computer-generated hard copy, or provides an electronic signature, after they review it for accuracy of the po1tion(s) they completed.

Facilities may use electronic signatures on the MOS when permitted to do so by state and local law and when this is authorized by the facility's policy. Additionally, the facility must have written policies in place to ensure proper security measures are in place to protect use of an electronic signature by anyone other than the person to which the electronic signature belongs. The policy must also ensure access to a hard copy of clinical records is made available to surveyors and others

who are authorized access to clinical records by law, including the resident and/or resident representative.

Facilities that are not capable of maintaining the MOS signatures electronically must adhere to the current federal requirements at §483.20(d) addressing the need for either a hand-written copy or a computer-generated form. All state licensure and state practice regulations continue to apply to certified facilities.

NOTE: Where state law or regulations are more restrictive than federal requirements, the provider needs to apply the state law standard.

Backdating Completion Dates -Backdating completion dates is not acceptable - note that recording the actual date of completion is not considered backdating. For example, if an MOS was completed electronically and a hard copy was printed two days later, writing the date the MOS was completed on the hard copy is not considered backdating.

Patterns of MDS Assessment and Submissions

MOS information serves as the clinical basis for care planning and care delivery and provides information for Medicare and Medicaid payment systems, quality monitoring and public reporting. MOS information as it is reported impacts a nursing home's payment rate and standing in terms of the quality monitoring process. A willfully and knowingly-provided false assessment may be indicative of payment fraud or attempts to avoid repo1iing negative quality measures.

All information recorded within the MOS Assessment must reflect the resident's status at the time of the Assessment Reference Date (ARD).

A pattern within a nursing home of clinical documentation or of MOS assessment or repo1iing practices that result in higher Resource Utilization Group (RUG) scores, untriggering Care Area Assessments (CAAs) or unflagging Quality Measures (QMs), where the information does not accurately reflect the resident's status, may be indicative of payment fraud or attempts to avoid reporting negative quality measures. Such practices may include, but are not limited to, a pattern or high prevalence of the following:

- Submitting MOS Assessments (including any reason(s) for assessment, routine or non routine) or tracking records, where the information does not accurately reflect the resident's status as of ARD, or the Discharge or Entry date, as applicable;
- Submitting correction(s) to information in the Quality Improvement Evaluation System Assessment Submission and Processing (QIES ASAP) where the corrected infom1ation does not accurately reflect the resident's status as of the original ARD, or the original Discharge or Entry date, as applicable, or where the record it claims to correct does not appear to have been in error;
- Submitting Significant Co1Tection Assessments where the assessment it claims to correct does not appear to have been in error;
- Submitting Significant Change in Status Assessments where the criteria for significant change in the resident's status do not appear to be met;
- Delaying or withholding MOS Assessments (including any reason(s) for assessment, routine or non-routine), Discharge or Entry Tracking information, or correction(s) to infonnation in the QIES ASAP system.

PROCEDURES AND PROBES §483.20(h)-U)

- When such patterns or practices are noticed, they should be reported by the State Agency to the Regional Office and Medicaid Fraud Control Unit.

- Are the appropriate certifications in place, including the RN Coordinator's certification of completion of an MDS assessment or Correction Request, and the certification of individual assessors of the accuracy and completion of the portion(s) of the assessment or tracking record completed?