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MDS, Exception Review, and Quality Update 2022

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Objectives

- Discuss updates for MDS
- Discuss the most common reasons an assessment would not validate during an Exception Review
- Discuss best practices to prepare for an Exception Review, and quality assurance measures to ensure MDS documentation accuracy
- Review updates to the VBP and QRP programs

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October MDS Updates

- All changes to the MDS RAI manual, scheduled for 2020, are still delayed.
  - CMS indicates the updates will not go into effect until 2 years after the public health emergency ends.
- Updates have been made to ICD-10 codes for PDPM.

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MDS Accuracy and Audits

Medicare and Medicaid participating LTC facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status.

- CMS RAI Manual v1.17.1 page 1-16

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Intent of the Exception Review

- Identify any patterns or trends related to resident assessments submitted in accordance with rule 5160-3-43.1 of the Administrative Code that could result in inaccurate case mix scores used to calculate the direct care component of the nursing facility per diem rate

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Exception Review Rule

- Ohio Administrative Code (OAC 5160-3-43.4) Nursing Facilities: exception review process
- Ohio Revised Code (ORC 5165.193) Exception review of assessment data

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Exception Review Timing

- Exception reviews had been on hold during the COVID 19 pandemic, but have resumed
- Exception reviews may be virtual at this time
- As of April 2022, reviews are being conducted for 4th Quarter 2022
  - Always verify the quarter for review

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Sources of Information

- In order to complete the MDS accurately the interdisciplinary team MUST:
  - Review the medical record
  - **Communicate with** and **observe** the resident
  - Communicate with direct care staff from all shifts
  - Communicate with other disciplines who have recently had contact with the resident.
  - Communicate with the resident's physician
  - Communicate with the resident's family if applicable

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Documentation Requirements

- "The MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues that are relevant for a resident" – RAI Manual
  - Can be accomplished through use multiple tools such as: completion of additional assessments, Care Area Assessments, progress notes and completion of the plan of care
  - No mandated format for this documentation

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Exception Review Notification

- Provider will be notified at least 2 business days in advance of review
  - Notified by email
  - Notified by phone call

  - Alert anyone who may receive notification
  - Do they know what to do with the information?
  - Some changes with virtual reviews

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Entrance Conference

- Reviewers will provide an overview of the process
- Initial sample will be provided
  - Will include resident name and ARD
- Policies needed for review will be identified
  - Protection of EHR
  - Mattress policy
  - Master signature log

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What Type of Records are Acceptable?

- Electronic or paper records are both acceptable
- If a laptop is needed – have it available immediately following the entrance conference
- Electronic signatures are acceptable
  - If the signature is not electronic ONLY THE ORIGINAL SIGNED DOCUMENT WILL BE ACCEPTABLE (Some changes with virtual reviews)
- Only information from the medical record will be accepted

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Exception Review Process

- 90% of the initial sample will be Medicaid residents
- 10% of the initial sample could be another payer source

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Exception Review Process

Supporting Documentation:

- The first 2 records must be presented to the reviewer within 15 minutes after the entrance conference
- The remaining records must be provided within 60 minutes after the entrance conference

Failure to comply with timing guidelines could lead to expansion of the survey

- Timeframes may change during virtual review

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Exception Review Process

Documentation which has been requested for each review:

- ADL supporting documentation
- Copy of section Z (Signatures)
- The care plan related to the RUG score elements

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Exception Review Examples

Supporting Documentation Example:

RMB

- Signed physician order for therapy
- Signed therapy plan of care/evaluation
- Therapy minute logs
- ADL documentation
- Care plan to support therapy and ADLs

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Exception Review Examples

Supporting Documentation Example:

HE2 (for COPD with SOB)

- Evidence that the COPD diagnosis was present in the last 60 days and active in the last 7 days
- Proof of SOB while lying flat, or that an intervention was put in place to prevent SOB while lying flat – During the assessment reference period

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Exception Review Examples

Supporting Documentation Example:

HE2 (for COPD with SOB)

- Proof of PHQ-9 interview
  - Record would not validate unless the interview was completed on the ARD, or prior to the ARD but within the assessment reference period
  - Copy of section Z to verify signature date

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Exception Review Process

Supporting Documentation Example:

HE2 (for COPD with SOB)

- ADL Documentation
- Plan of care to support diagnosis of COPD, shortness of breath, ADLs, and s/s of depression

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Exit Conference

- Facility may decide who will be included in the exit conference
- Findings are detailed
- Following the review, a summary of findings letter will be provided by ODM

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Commonly Misunderstood Items

- ADLs – Rule of 3
- COPD/Shortness of breath while lying flat
- Diagnosis
- Calories and fluid to support feeding tube/parenteral/IV feeding
- Depression – PHQ-9
- Mental Status – BIMS and Staff Assessment
- Restorative nursing programs
- Respiratory Therapy
- Isolation
- Software Inaccuracies – signature dates

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Activities of Daily Living Concerns

- Use the Rule of 3 Document
- Must be able to validate that each late loss ADL occurred at least 3 times during the assessment reference period
- Omission of all ADL key options required on the MDS
- Lack of complete definitions for ADL key options
- Lack of complete definition for the four late loss ADLs

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Activities of Daily Living Concerns

- Providing supporting documentation that is not from the medical record/permanent documentation
- Conflicting documentation
- If multiple terms are used, such as “min, mod, max assist” crosswalk to link back to MDS section G definitions

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Diagnosis Concerns

- Must be able to validate that the diagnosis was current both:
  - Within 60 days of the ARD via documentation from a physician, NP, or PA
  - Active within the 7 day assessment period from the ARD
- Deleting inactive diagnoses from one assessment to the next

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COPD/Shortness of Breath While Lying Flat

- Must be able to validate the diagnosis of COPD
- Documentation must be present in the medical record indicating that:
  - The resident experienced shortness of breath while lying flat during the assessment reference period – OR –
  - An intervention was put in place to prevent shortness of breath while lying flat during the assessment reference period

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COPD/Shortness of Breath While Lying Flat

- Documentation to support shortness of breath while lying flat can be anywhere in the medical record. For example:
  - Progress notes
  - Orders signed by the nursing team

- Would documentation in the care plan alone support coding of shortness of breath?

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Mood PHQ-9 Concerns

- Conduct the interview preferably the day before or the day of the ARD.
  - Documentation must be present to validate the date of the interview
- Must read the questions as scripted
  - Remember interview tips in Appendix D of the RAI Manual
- Provide resident with cue cards as needed and allow them to respond in the way they feel comfortable

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BIMS Concerns

- Conduct the interview preferably the day before or the day of the ARD.
  - Documentation must be present to validate the date of the interview
- Must read the questions as scripted
- Provide resident with cue cards as needed and allow them to respond in the way they feel comfortable
- Validating degree of mental/cognition loss
  - Making self understood
  - STM loss
  - Decision making

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Isolation

Isolation coding guidelines **have not** changed

- **Potential change in FY 2023**

O0100M (Isolation for active infection disease)

Code only when the resident requires transmission-based precautions and single room isolation (alone in a single room) because of active infection (i.e., symptomatic **and/or** have a positive test and are in the contagious stage) with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission

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Isolation

Do not code if:

- The resident only has a history of infectious disease
- The precautions are standard precautions only
- The precautions are for:
  - Urinary tract infection
  - Encapsulated pneumonia
  - Wound infections

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Isolation

"Single Room"

- The resident is in a room alone because of active infection and cannot have a roommate
- The resident must not be cohorted with a roommate regardless of whether the resident has a similar active infection
- The resident must remain in his/her room
  - All services must be brought to the resident
  - Includes: rehabilitation, activities, dining, etc…
- Remember that the census is not considered part of the medical record for validation

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Other Commonly Misunderstood Documentation Items

- Treatment administration verification when service provided outside of facility
  - Example: Dialysis, Chemotherapy
- Need for parenteral/IV feeding must include hydration and/or nutrition documentation
- Lack of respiratory therapy minutes/training

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Other Documentation Pitfalls

- Illogical dating for ARD, Z0400 and Z0500
  - ARD 09/09/2017
  - Z0400 09/19/2017
  - Z0500 09/15/2017
- Restorative Nursing Programs
  - No actual minutes reported
  - Combined programs
  - Inadequate evaluation
  - Lack of measurable interventions

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Other Documentation Pitfalls

- Obliterations, write-overs, illegible entry
- The medical record, including the MDS, is a legal document.
  - Ensure the interdisciplinary team is aware of correction guidelines
  - Documentation should be objective, not subjective.

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Exception Review Statistics

2018

- 93 Exception Reviews
- Average Unsupported Assessments - 20%
- Average Facility Percent Unsupported - 16%

2019

- 87 Exception Reviews
- Average Unsupported Assessments - 19%
- Average Facility Percent Unsupported – 14%

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Total Number of Reviewed Assessments by RUG

	6/8/2018	6/30/2019
Rehabilitation:	781 (36%)	1582 (35%)
Extensive Services:	83 (4%)	153 (3%)
Special Care High:	423 (19%)	976 (22%)
Special Care Low:	242 (11%)	485 (11%)
Clinically Complex:	249 (12%)	542 (12%)
Behavioral/Cognition:	240 (11%)	451 (10%)
Reduced Physical Function:	162 (7%)	340 (7%)

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Number and Percent of Unsupported Assessments by RUG

	6/8/2018	6/30/2019
Rehabilitation:	86 (11%)	167 (11%)
Extensive Services:	12 (14%)	22 (14%)
Special Care High:	146 (35%)	307 (31%)
Special Care Low:	49 (11%)	92 (19%)
Clinically Complex:	64 (26%)	112 (21%)
Behavioral/Cognition:	63 (26%)	121 (27%)
Reduced Physical Function:	23 (14%)	52 (15%)

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Tips for Exception Review Success

Make sure you can validate the RUG score ***BEFORE*** handing the record to the reviewer.

- If you can’t validate the RUG….Keep looking for documentation!!!!
- Be honest if the documentation is not there, and educate the team

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Tips for Exception Review Success

- Confirm which quarter will be reviewed
- Review the MITS case mix report immediately to determine the RUG score
- Determine why each resident qualified for their RUG score
- Pull all documentation needed to support the achieved RUG score
  - Have this ready to go at the entrance conference
- Prepare with each completed MDS
- Call for help if needed!

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MDS TASK MANAGEMENT
Structure Daily, Weekly, Monthly & Quarterly Tasks

An overview of expected MDS related daily, weekly monthly, and quarterly tasks:

Daily
- Census Review
  - Add new residents to MDS calendar, remove discharged residents
  - Open any needed MDS assessments
    - Send/notify calendar changes to IDT
- Update Case Mix/Billing Tracking Logs
- Participate in Morning Meeting
- Participate in 3-day huddle
- Updates to Insurance Case Managers
- Complete MDS interviews
- Complete MDS assessments
- Complete care plans
- Review MDS list and close/complete assessments

Weekly
- Participate in weekly UR/Medicare
- Review residents for case mix opportunities
- MDS submissions
- Monitoring and completing Physician Certifications
- Log-in/monitor CASPER
- Care Conferences

Monthly
- Participate in Triple Check
- Generate QM Report CASPER and distribute (1 month look back)
- Generate Missing Assessment CASPER report to monitor
- Pull 5-Star Preview Report CASPER and distribute
- Create next month MDS calendar and open assessments, distribute to IDT

Quarterly
- Generate QM Report CASPER and distribute (3 month look back)
- Generate SNF QRP QM Reports CASPER and distribute
- Pull Preliminary and Final Case Mix Reports, review and distribute

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Additional MDS Roles and Responsibilities

- On-call rotation
- Weekend manager
- Work the floor
- Back-up DON
- Update acute care plans
- Physician rounding
- Admissions paperwork
- Quarterly assessments (Braden, fall risk, etc.)
- Wound nurse
- Clerical duties (Filing records, thinning charts, uploading documentation)
- ICD-10 coding
- Discharge planning
- Care Conferences
- Monthly change over
- COVID testing
- Infection control tasks
- Restorative nurse

Your MDS Nurse is your only revenue generating Nursing position

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WHO DOES YOUR MDS NURSE REPORT TO?

Administrator

Pros:
- Oversees facility financial and clinical quality of care
- Less likely to be pulled into additional Nursing tasks
- Better continuity of IDT members involved in coding MDS

Cons:
- Lack of understanding of clinical coding requirements
- Not viewed as part of clinical team

Director of Nursing

Pros:
- Continuity of clinical services

Cons:
- Pulled into additional Nursing duties
- Does not have a role in facility financial performance
- Conflict of capturing Quality Measures vs. Reimbursement
- Viewed as Nursing support when staffing issues arise

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MDS Accountability

MEETING MANAGEMENT

Are the following meetings taking place, and what is the role of the MDS nurse?

1. **Daily PPS or 3 Day Huddle**
   - Is the primary diagnosis being chosen by IDT to reflect optimized codes?
   - Does the team discuss GG usual performance?
   - Is the ARD carefully chosen based on documentation from the hospital? (Not always using day 8)
   - Are measures being put in place for "documentation compliance" leading up to the ARD?
   - Are all team members coming prepared? (GG information, swallowing info, BIMS, PHQ9 from first few days)
2. **Weekly UR/Medicare**
   - Are all team members coming prepared?
   - Are IDT conversations ongoing pertaining to DC planning?
3. **Monthly Triple Check**
   - Is there a large number of discrepancies between billing and MDS information?
   - Does MDS Nurse take an active role in validating information on the UB04?
4. **Weekly Case Mix Review**
   - Does the IDT meet weekly to discuss current LTC population and potential case mix opportunities?
   - Does the MDS Nurse keep a list of current lower scoring CMI residents to discuss?
5. **Monthly Quality Measure Review**
   - Does the MDS Nurse understand what MDS items drive Quality Measure Scores?
   - Does the team actively move ARDs as needed to improve Quality Measures?
   - Does the team understand the impact of Quality Measures on Quality Incentive Payment programs?
6. **Quarterly SNF Quality Reporting Program Review**
   - Does the MDS Nurse review the Review and Correct Report to validate coding is accurate?

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Retaining Top-Tier MDS Talent

- Include MDS Self-Assessment in annual performance reviews
  - Develop goals based on results
- Labor Analysis to ensure adequate time to complete MDS Tasks
- Eliminate additional duties not pertaining to MDS
- Provide support and encouragement for additional training/resources
- Consider alternative MDS staffing models

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Impact of Quality on Reimbursement

Ohio Quality Incentive Programs

- "Old" Quality Incentive
  - Long stay and short stay pressure ulcers
  - Long stay and short stay anti-psychotics
  - Unplanned weight loss
  - Staff retention
  - Customer satisfaction survey
- "New" Quality Incentive
  - Percentage of residents whose ability to move independently worsened
  - UTIs
  - Catheters
  - High-risk residents with pressure ulcers

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Impact of Quality on Reimbursement

Value Based Purchasing Program

- FY 2023 – Proposal to continue flat 0.8% VBP reduction
- FY 2024 – Return to previous methodology including hospital readmission rate
- FY 2025 – Continue previous methodology
- FY 2026 – Add Total nurse staffing and health care-associated infections requiring hospitalization
- FY 2027 – Add discharge to the community

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MDS Accuracy and Audits

CMS/Ohio Department of Health Annual and Complaint Surveys

- F636 – Comprehensive Assessments & Timing
- F637 – Comprehensive Assessment After Significant Change
- F638 – Quarterly Assessment Every 3 Months
- F641 – Accuracy of Assessments
- F656 – Develop/Implement Comprehensive Care Plan
- F657 – Care Plan Timing and Revision
- Use of CAAs to validate citations in other areas

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MDS Accuracy and Audits

RAC Audits (Recovery Audit Program)

Intent

The Recovery Audit Program's mission is to reduce Medicare improper payments through the efficient detection and collection of overpayments, the identification of underpayments and the implementation of actions that will prevent future improper payments.

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Common Unsupported RAC Audit Items

- Primary Diagnosis
- Section GG
- Diagnoses to support the Nursing and NTA categories
- Interview timing
- Medical Necessity of Skilled Care

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Managed Care Audits

- Audits continue, even if the score was approved by the insurance case manager
- Common unsupported items are similar to RAC Audit unsupported items, but there is increased emphasis placed on connecting coding elements to the reason for hospitalization
  - Example: Denial of COPD diagnosis, although it fits CMS RAI guidelines, due to the reason for hospitalization was a hip fracture
  - Is your MDS team prepared to state their case?

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Managed Care Audits

- Claims are frequently unsupported due to lack of information sent to the reviewer, or incorrect information sent
  - Make sure to send all information needed to support medical necessity and the HIPPS score
  - There is sometimes a difference between what the insurance reviewer asks for, and what they really need
  - Organization of the file is a key factor to ensure the reviewer is able to locate all needed information

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For the Most Up-to-date MDS 3.0 Information

- Check the CMS MDS 3.0 site regularly:
www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp

- CMS Website:
www.cms.gov

- CMS Open Door Forums

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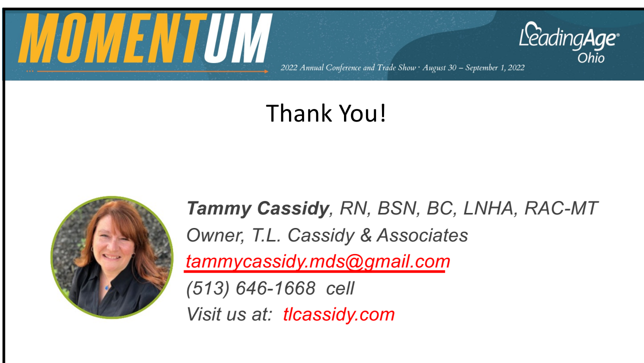
Thank You!



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