# MDS Alert

## MDS 3.0 Quality Improvement: From Interview QA to Achieving Fair Payment, Experts Have Suggestions for You

**Hold onto this practice from the MDS 2.0 days.**

While MDS 3.0 mastery remains a work in progress, experts are finding a number of areas where facilities might shore up their practices to improve care and the bottom line.

For example, is your facility doing QA for mood and other MDS 3.0 interviews? Facilities should implement "some type of quality control over how the interviews are being done, especially the PHQ-9," says **Judy Wilhide Brandt, RN, RAC-MT, C-NE,** principal of Judy Wilhide MDS Consulting Inc. in Virginia Beach, Va.

Key: "People need to realize how important the mood interview is clinically and financially," Brandt says. The depression end split can come to $75 more a day for a number of RUGs under the RUG-IV system, she points out.

Solution: Facilities can have someone observe interviews to see how staff members are doing the PHQ-9, Brandt advises. She reports getting "some pushback" when she suggests that "because people feel like the residents are talking about personal things" during the interview. "But I don't think it is any more or less intimate than having someone observe Foley care or peri-care, etc. You wouldn't let a nurse go out and do wound care on a serious wound by herself the first time without being observed."

Look for: Brandt thinks that in some facilities, people are making "independent decisions about whether they can interview someone with dementia. And there are people who haven't bought into the system. So the results we're getting from the mood interview aren't genuine results. For example, if the person doing the interview hears a 'No' anywhere in the sentence, they put 'No' and move on.

"The person doing the interview does have to read or say the question exactly as it is on the form," Brandt says. "But you can read two different transcripts where the interviewer asks the same question, and in one it's obvious that the interviewer wanted the resident to talk to her and in the other -- it isn't."

Example: "If the person says 'No' to a question but has tears in her eyes, the interviewer can reflect that back: 'You said 'No,' but I see you have tears in your eyes about that.' Then you go from there."

In all cases, Brandt adds, "staff should be doing real-time assessment of mood issues" and suicide risk.

Revisit Your Preadmission Process

Preadmission assessment was important for the MDS 2.0 where you could capture more RUG qualifiers from the hospital lookback. But don't let the screening drop off your priority list under the MDS 3.0, experts advise.

Marilyn Mines, RN, RAC-CT, BC, reports still seeing nursing home staff doing preadmission observations in the hospital to make sure the facility doesn't admit someone they can't handle. It's "also good public relations for the facility to have a direct contact with a referring hospital," says Mines, director of clinical services for FR&R Healthcare Consulting in Deerfield, Ill.

Also: "It's really important that nurses conducting pre-admission screening for the nursing home have an understanding of what documentation to ask the hospital for," says **Jennifer Pettis, RN, WCC, RAC-MT,** director of program development for Harmony Healthcare International in Topsfield, Mass. An example includes support documentation for IV fluids used for hydration, which does count as a RUG qualifier when provided in the hospital within the lookback before

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SNF admission (for details, see the "What Do You Think?" feature in MDS Alert, Vol. 8, No. 4).

Tube feeding provided in the hospital lookback is also a RUG-IV qualifier, if the feeding meets the intake requirements specified by the RAI User's Manual. "The intake should be counted during the seven-day lookback period," says Mines. "You'll need documentation to support the amount received," which could include I&O records from the hospital. "The key thing is that the resident needs to receive the service for hydration or nutrition, which I assume is why there is a tube feeding in the first place," Mines adds.

In addition to items in K0500 (Nutritional Approaches), you also capture items in O0100 -- Column 1 (Special Treatments, Procedures, and Programs) from the hospital if they were provided during the lookback period, says Pettis.

Also: "Section I (Active Diagnoses), the date of the oldest stage 2 pressure ulcer in Section M, fall history, weight loss, and the pain and mood interviews capture information prior to admission," Pettis notes.

Get Everyone on the Same Page With the ARD

Atlanta consultant **Darlene Greenhill** is advising people doing the MDS 3.0 to review the lookback periods. "On the MDS 3.0, these are seven days unless otherwise specified but it can get confusing. You have to watch it really carefully," she says.

Greenhill has also run into situations where the MDS coordinators establish the ARD and then change it after communicating the ARD to the interdisciplinary team. That always increases the chances that other IDT members won't use the correct ARD, even though the MDS coordinator e-mails people about the change or discusses it during the Medicare meeting, she says.

Solution: Conduct some audits before submitting the MDS to make sure people are coding information within the designated lookback, advises Greenhill. When doing such audits, she usually finds that one of the disciplines involved in doing the MDS doesn't even understand the ARD. "You can't assume that because you told people about something that they understand it. I find that's particularly true with activities and dietary staff where it's really important to go back and make sure they understand the ARD."

Review Validation Reports

Facilities sometimes have a clerical or clinical person transmitting the MDS who isn't touching base frequently enough with the MDS coordinators who don't do the transmission, Greenhill observes. "And no-one is really checking the validation reports like they should for the RUG-IV score generated by the ASAP system to make sure billing is using the right RUG-IV score, which would be the one generated by the ASAP system -- not the facility's software," she says.

While the problem is improving, sometimes facilities' software will still calculate a RUG for Section Z that doesn't match the ASAP's calculated RUG, Greenhill reports. "That's a problem if the software connects to billing and the billing department uses that RUG-IV when it doesn't match the one provided by the ASAP system."

Smart move: Greenhill advises people to download the MDS 3.0 Provider User's Guide on the qtso.com site and look up the errors and warnings on their validation reports, even if they are minor ones (www.qtso.com/download/guides/MDS/mds_30/Prvdr_Users_Sec5.pdf).

Boost Efficiency by Combining Assessments

Review chapter 2 of the RAI User's Manual for instructions on coding assessments for multiple purposes, advises **Pam Campbell, RN,** with LTC Solutions Inc. in Camdenton, Mass. Keep in mind when combining assessments, however, that not only the ARD but also the completion dates "have to meet the requirements for each type of assessment for which the assessment is coded."

Example: Suppose a patient doesn't go into a rehab RUG on the 5-day PPS because he was too ill and didn't receive enough therapy days, says **Sherri Robbins, BSN, RN,** supervising consultant with BKD LLP in Springfield, Mo. "Look at how you schedule the 14-day MDS and combine [it with the Start of Therapy OMRA] so that the facility is reimbursed a

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higher rate" that extends backto when therapy started. When you combine the 14-day with the SOT OMRA, the facility will receive increased reimbursement for rehab from the day therapy starts (the therapy evaluation date) through day 30, Robbins adds.

"You can do a stand-alone SOT OMRA," Robbins agrees. "But with MDS staff struggling with the discharge assessments and everything else, if you can choose the ARD for the SOT OMRA so that it falls on day 11 or later, you should combine the assessments ... It's a time-saver."

Coding example: If you are going to combine a PPS scheduled assessment and a Start of Therapy OMRA, "the ARD Item (A2300) must be set within the ARD window for the Medicare-required scheduled assessment

and 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date)," states the RAI User's Manual. You'd choose the PPS MPAF item set to complete and code item A0310 in the following manner:

"A0310A [federal OBRA reason for assessment] = 99

A0310B [PPS assessment] = 01, 02, 03, 04, 05, or 06 as appropriate

A0310C [PPS OMRA] = 1.

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