MDS Corrections

Presented for the DOH by
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January 14, 2016

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Updates

- Draft MDS Item Sets (v. 1.14.0) and data specifications (v. 2.0) for October 2016: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html
- New version of QM User's Manual (v. 9.0): https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html

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Legal Record

"It is important to remember that the electronic record submitted to and accepted into the QIES ASAP system is the legal assessment. Corrections made to the electronic record [in the NF] after QIES ASAP acceptance or to the paper copy maintained in the medical record are not recognized as proper corrections. It is the responsibility of the provider to ensure that any corrections made to a record are submitted to the QIES ASAP system in accordance with the MDS Correction Policy." (p. 5-7)

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Code of Federal Regulations

- §483.20(g) The assessment must accurately reflect the resident's status
- §483.20(h) A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals
- §483.20(i)(1) A registered nurse must sign and certify that the assessment is complete.
  (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment

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Z0400 Signatures of Persons Completing the Assessment

- I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements….I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information.

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Code of Federal Regulations

- §483.20(j) Penalty for Falsification
  - (1) 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 that $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 of not more than $5,000 for each assessment
  - (2) Clinical disagreement does not constitute a material and false statement

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Validation Edits

- NF software should perform all edits
- QIES ASAP validates
  - Fatal File Errors: If the file structure is unacceptable, e.g., ZIP file cannot be extracted or file read, file will be rejected
  - Fatal Record Errors: Each MDS record in the file is validated individually for Fatal Errors
    - Out of range responses
    - Inconsistent relationships between items
    - Inconsistent date pattern

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Validation Edits

  - Non-Fatal Errors (Warnings)
    - Missing or questionable data of a non-critical nature or
    - Item consistency errors of a non-critical nature
      - Timing Errors: Submission date more than 14 days after Z0500B; Completion date more than 14 days after ARD
      - Record sequencing errors: Entry record submitted after a Quarterly with no intervening Discharge assessment
- Provider User's Guide https://www.qtso.com/mdstrain.html

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Clinical Error

- Directly related to the resident's status
- Errors must be corrected to assure that:
  - Resident is accurately assessed
  - Care plan is accurate
  - Resident is receiving the necessary care
- May require reassessment of the resident (SCSA, SCPA) as well as corrections to the information in the QIES ASAP system

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Significant Error

- An error in an assessment where the resident's clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment and/or results in an inappropriate plan of care, and the error has not been corrected via submission of a more recent assessment.

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Correct a Significant Error

- Complete a corrected record with all items included in the OBRA comprehensive or Quarterly assessment; A0050 = 2 Modify existing record
- Complete Section X items and include with corrected record
- Submit the modification request record
- Perform a new assessment: a SCSA or SCPA and update the care plan as necessary

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Correcting Assessments in QIES ASAP

- Must correct errors to insure that information in QIES ASAP accurately reflects the resident's identification, location, overall clinical status, or payment status
- Timing
  - Correct within 3 years if facility open
  - Correct within 2 years of NF termination date
  - Correct within 14 days of error discovery

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Modification

- Moves the inaccurate record into history in the QIES ASAP system and replaces it with the corrected record as the active record
- Accepted record contains clinical or demographic errors
- Can modify MDS items not specifically listed under inactivation
- A0050 = 2 Modify existing record

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Modifiable Items

- Target Date
  - Entry Date (A1600) on Entry Tracking record (A0310F = 1)
  - Discharge Date (A2000) on Discharge/Death in Facility record (A0310F = 10, 11, 12)
  - ARD (A2300) on an OBRA or PPS assessment if due to data entry/typographical error and does not change the look back period or alter actual assessment timeframe

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Modifiable Items

- Type of Assessment (A0310) if the ISC of the assessment does not change
- Clinical Items (B0100 – V0200C)
- Identification Information (not A0200 Type of Provider or A0410 Unit Certification or Licensure Designation)

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Invalid Record

- As defined by the MDS Correction Policy, a record that was accepted into QIES ASAP that should not have been submitted. Invalid records are defined as: a test record submitted as production, a record for an event that did not occur, a record with the wrong resident identified or the wrong reason for assessment, or submission of an inappropriate non-required record.

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Inactivation

- Moves the inaccurate record into history in the QIES ASAP system but does not replace it with a new record
  - Submit an Inactivation Request record (ISC = XX)
  - Contains only A0050 = 3 Inactivate existing record and Section X items
- If a replacement record is being created, there must be a new ARD which is the date the error is determined or later.
  - New MDS record must include new signatures and dates based on the new lookback period

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Inactivation Required

- Type of provider (A0200)
- Type of assessment (A0310) when ISC would change had the MDS been modified
- Discharge date (A2000; A0310F = 10, 11) when the look-back period and/or clinical assessment would change had the MDS been modified
- ARD (A2300) on OBRA or PPS assessment when the look-back period and/or clinical assessment would change had the MDS been modified

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Manual Correction Request

- Must be manually deleted:
  - Test record submitted as production
  - Wrong unit certification or licensure designation (A0410)
  - Wrong state code or facility ID in the control items STATE_CD or FAC_ID
- Must contact state RAI Coordinator for assistance in these database corrections

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Significant Change in Status Assessment (SCSA)

- A decline or improvement in a resident's status that:
  - Will not normally resolve itself without intervention or by implementing standard disease-related clinical intervention
  - Impacts more than one area of resident's health status
  - Requires IDT review and/or revision of care plan
- RAI Manual discusses specifics of identifying a significant change beginning on p. 2-22
- Individually based

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Significant Change in Status Assessment (SCSA)

- Must not be completed before an Admission assessment
- Terminally ill resident
  - Enrolls in hospice program
    - ARD within 14 days from effective date of hospice election statement
  - Revokes hospice care
    - ARD within 14 days of
      - Effective date of hospice election revocation OR
      - Expiration date of certification of terminal illness OR
      - Date physician order states resident is no longer terminally ill
  - If admitted on the hospice benefit, check Hospice Care (O0100K) on the Admission assessment and a SCSA is not required

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Significant Change in Status Assessment (SCSA)

- Referral for PASRR Level II
  - Required by law when SCSA is completed for an individual known or suspected to have a mental illness, intellectual disability, or other related condition
  - PA PASRR documents can be downloaded at http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/form/s_002613.pdf
  - Do not wait until the SCSA is complete to refer to Field Operations representative using form MA 408

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Significant Correction to Prior Assessment

- Required when uncorrected significant error is identified in a prior assessment
- Error in an assessment where:
  - Resident's overall clinical status is not accurately represented AND
  - Error has not been corrected via submission of a more recent comprehensive assessment
- Must also modify incorrect assessment in QIES ASAP database

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Significant Correction to Prior Assessment

- A0310A = 05, 06
- ARD = No later than 14th day after determination
- MDS & CAAs completion = No later than 14th day after determination
- Care plan completion = CAAs completion plus 7 days
- Transmission = Care plan completion plus 14 days

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Minor Error

- Error considered “minor” if it does not meet the Significant Error definition
  - New assessment not required
  - Note in clinical record
- Tracking forms, PPS-only assessments and minor errors:
  - Create a corrected record with all items included; A0050 = 2 Modify existing record
  - Complete Section X items and include with corrected record
  - Submit to QIES ASAP

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PPS Assessment Errors

- Only modification required if not combined with OBRA assessment
- If combining SCSA or SCPA with PPS, place in grace days to assure RUG from Day 1 of coverage period.
- Use corrected RUG for billing
- If ARD set outside window:
  - Bill default (lowest) rate for number of days out of compliance
  - No financial penalty for late completion or submission
- If resident no longer in Part A stay and assessment was missed, must accept provider liability for those days

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Section X Correction Request

- Purpose
  - Find record which is to be modified or inactivated
  - Record the type of correction
  - Record the person requesting the change
- Completion
  - A0050 must equal 2 Modify existing record or 3 Inactivate existing record
  - Supply information “on existing record to be modified/inactivated”

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X0900 Reasons for Modification

- A. Transcription error: any error made recording MDS assessment or tracking form information from other sources
- B. Data entry error: any error made while encoding MDS assessment or tracking form information into the facility’s computer system
- C. Software product error: any error created by the encoding software

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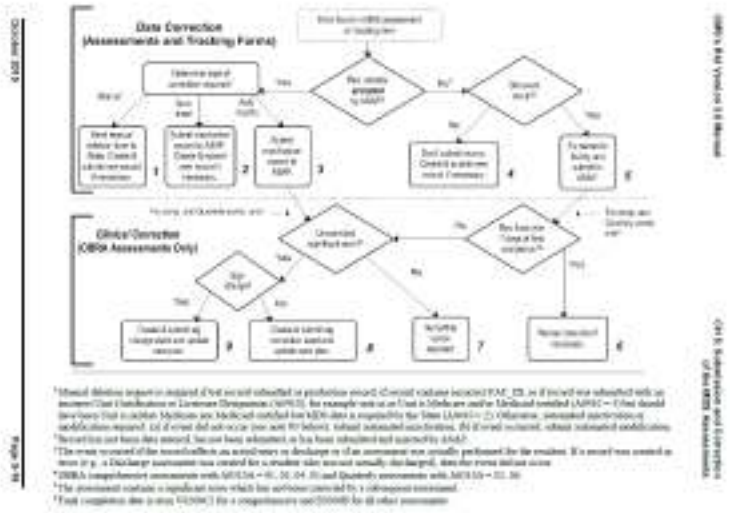
X0900 Reasons for Modification

- D. Item coding error: any error made coding an MDS item
- E. End of Therapy – Resumption date
- Z. Other error requiring modification

X1050 Reasons for Inactivation

- A. Event did not occur
- Z. Other reason requiring inactivation



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Questions

- qa-mds@pa.gov
- Next teleconference: April 7, 2016

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