INDIANA MAY 2023 MDS TRAINING
QUESTIONS & ANSWERS

Time-Weighted Questions

1) When will the Time-Weighted User's Guide be updated?

- Updated guidance will be communicated when finalized and will have an October 1, 2023 effective date.

OSA Questions

1) Would the type of Optional State Assessment, coinciding with an OBRA assessment, typically be #5 at A0300B (Other payment assessment)?

- Yes. This is correct.

2) Will Myers and Stauffer only audit the Optional State Assessment (OSA) MDS?

- Yes. Myers and Stauffer will only review the OSA assessments submitted by providers.

3) What is the required OSA schedule?

- An OSA must be completed with each federally required OBRA and PPS assessment.

4) What impacts to reimbursement can we expect with the utilization of an OSA?

- There will be no change in reimbursement impact. The OSA is simply being implemented to maintain the current RUG system.

5) Will the OSA replace the IPA?

- No. The OSA is a state required assessment. The IPA is an optional PPS assessment.

6) Can MDS sections be copied from the federally required MDS to the state required OSA?

- It is suggested that providers work with their software vendors to make these determinations.

7) Will an OSA be required for all payer sources or only Medicaid?

- An OSA assessment will be required to be completed with every federally required assessment submission regardless of payer source.

8) Is an OSA required to be completed with the 5-day MDS for insurance/managed care?

- No. Only MDS assessments that are submitted through the iQIES/ASAP system should have an accompanying OSA.

9) Is an OSA required with an IPA?

- No. The IPA is always an optional assessment; therefore, an OSA is not completed with an IPA.

10) Will an OSA be needed for all residents on 10-1-23 or just when their next MDS assessment is required?

- An OSA assessment will be required with every federally required assessment with an ARD of 10-1-23 and beyond (until further notice).

11) Will quality measures be pulled from the OSA or other MDS assessments?

- Quality measures will not be obtained from MDS items on the OSA. The OSA is a state required assessment and not a federally required assessment.

12) Will the OSA have to be a stand-alone assessment or can it be combined with other assessments?

- An OSA is a stand-alone assessment and cannot be combined with any other assessments; however, it is completed concurrently with a federally required assessment.

13) Will an OSA be required for discharge assessments?

- No. An OSA will not be required with discharge assessments unless the discharge assessment is combined with another OBRA or PPS assessment.

14) Will the OSA follow the current RUG-IV Grouper?

- The OSA can support both RUG-III and RUG-IV Grouper calculations. The current RUG-IV Grouper will be maintained through the usage of the OSA.

15) Do OSA assessments need to be submitted?

- Yes. OSA assessments must be submitted with every federally required MDS assessment.

16) Can the OSA and OBRA MDS be combined?

- No. OSA assessments are stand-alone assessments completed in conjunction with federally required assessments.

17) Will the OSA count with the Part A PPS Discharge?

- No. The OSA is not required to be completed concurrent to a stand-alone Part A PPS Discharge, and would not be utilized on the time-weighted rosters.

18) Is the OSA submitted in the same manner as an OBRA assessment?

- Yes. An OSA is submitted through iQIES the same as other federally required assessments.

19) What is the purpose of the OSA?

- Beginning October 1, 2023, the Optional State Assessment (OSA) will be the only assessment type that will include all Minimum Data Set (MDS) data elements required for Resource Utilization Group (RUG) classifications.

Supportive Documentation Requirement Questions

1) For PRN oxygen use, would an order for PRN oxygen that includes the terminology "To Relieve Hypoxia" be sufficient since the signature of a licensed nurse indicates that this is the reason she applied oxygen?

- This would be reviewed on a case-by-case basis taking into consideration other clinical factors such as resident diagnosis, etc.

2) If a resident refuses multiple times to complete the PHQ-9 and facility must interview staff, how would the number of days and frequency be supported for each item?

- Does require:

  i) Documentation of the date(s) the staff mood interview was conducted and the frequency reported for each applicable item at D0500 A-J.

  ii) If family member(s) or significant other(s) were interviewed the date the interview was conducted and the frequency reported for each applicable item at D0500 A-J.

3) Why are the Supportive Documentation Requirements (SDRs) different than the Resident Assessment Instrument (RAI) (e.g. restorative evaluations required "periodical" in RAI vs. "within the observation period" in the SDRs?

- While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS. Many states have established additional MDS requirements for Medicaid payment and/or quality monitoring purposes.

4) What documentation is required for the diagnosis Septicemia?

- Active Diagnosis Definition:

  i) A physician-documented diagnosis (Optometrist, nurse practitioner, physician assistant, or clinical nurse specialist) in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

  ii) There are two look-back periods for this section:

    (1) Diagnosis identification (Step 1) is a 60-day look back period.

    (2) Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period (except for I2300 UTI, which does not use the active 7-day look-back period).

      (a) Does include:

        (i) Functional limitations – loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis or paralysis.

        (ii) Nursing monitoring – clinical monitoring by a licensed nurse (e.g. serial blood pressure evaluations, medication management, etc.).

      (b) Does NOT include:

        (i) Conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period; these would be considered inactive diagnoses.

5) If the MD will not change a diagnosis of functional quadriplegia, but the State Surveyors require that we code quadriplegia for this diagnosis, how can we justify this so we are not penalized?

- For concerns related to survey activities or potential citations, please contact your area's long term care survey supervisor.

6) To support isolation – is a positive lab result required? Or, would a physician/NP documentation of active diagnosis/test result be sufficient? If a positive test result is required, would a paper document from an infection preventionist indicating a positive test result at bedside be sufficient?

- For the MDS review, an MD progress note indicating a positive test would be sufficient for the active infection portion of the requirements for Isolation.

7) D0500 – From all shifts: Do you have to have documentation from each shift? So, for 8 hour shifts there would be 3 entries and for 12 hours shifts there would be 2 entries?

- Yes, Page D-13 of the RAI Manual: Interview staff from all shifts who know the resident best. Conduct interview in a location that protects resident privacy.
- Additionally, does require:
  - i) Documentation of the date(s) the staff mood interview was conducted and the frequency reported for each applicable item at D0500 A-J.
  - ii) If family member(s) or significant other(s) were interviewed the date the interview was conducted and the frequency reported for each applicable item at D0500 A-J

8) Who can be interviewed for D0500? Nurse only? Or, nurses & CNAs?

- The RAI Manual, page D-13 under “Steps for Assessment” states the following without indicating which staff members are included:
  - i) Interview staff from all shifts who know the resident best. Conduct interview in a location that protects resident privacy.

9) For RT – how often do “respiratory nurses” have to be trained?

- For purposes of the MDS Review: RN Reviewers expect to see training on all respiratory nurse-provided modalities at least one time since the initial hire date.

10) For RT – what is the definition of “initial assessment” – is that the assessment preceding each treatment or an initial assessment at the onset of the RT?

- The initial assessment is based on the qualified therapist’s assessment and treatment plan – that would occur at the onset of the RT.

11) What items can an LPN not assess legally?

- Please see the Indiana Nurse Practice Act and/or contact the Indiana Professional Licensing Agency for further information.

12) Is there a specific timeline for which Section GG items must be completed?

- GG0130 & GG0170 Admission Assessments (3-day assessment period)
  - i) Assessment period is the first 3 days of the stay
- GG0130 & GG0170 Discharge Assessments (3-day assessment period)
  - i) Assessment period is the last 3 days of the stay
- GG0130 & GG0170 OBRA/Interim Assessment
  - i) Assessment period is the ARD plus 2 previous calendar days

13) Is the assessment period days 1-3 on ALL admission assessments?

- Yes.

14) When will new supporting documentation requirements be out for changes going into effect?

- The anticipated date for updated Supportive Documentation Requirements is 10-1-23 which will be in effect for all assessments with an ARD of 10-1-23 and after.

15) What type of documentation is expected for “usual performance” in Section GG (progress note, assessments, etc.)?

- Documentation utilized to support the facility’s decision in the coding of each task reviewed will be required to support “usual performance.” Facilities are advised to work with their vendors in determining the best tools for Section GG documentation.

16) What are the documentation requirements to successfully capture Restorative Nursing programs?

- Does require:

  i) Documentation of actual direct minutes on a daily/shift/occurrence basis for each restorative program.

  ii) Associated initials/signature(s) on a daily basis to support the total number of minutes of restorative nursing program(s) provided.

  iii) Each program must be individualized to the resident’s needs, planned, monitored, evaluated, and documented.

  iv) Time must be provided separately for each restorative program.

  v) Documentation must include the five criteria to meet the definition of a restorative nursing program:

     (1) Measurable objectives and interventions must be documented in the care plan and in the medical record; and

     (2) Evaluation of the program by a licensed nurse. (For the case mix review, reassess progress, goals and duration/frequency of each program within the observation period.); and

     (3) Staff trained in the proper techniques; and

     (4) Supervised by licensed nurse; and

     (5) No more than 4 residents per supervising helper or caregiver.

  vi) Documentation for splint or brace assistance must include an assessment of the skin and circulation under the device within the observation period. Does include:

  vii) An evaluation of the program written by a CNA and co-signed by a licensed nurse once the purpose and objectives of treatment have been established. (Contingent on state rules).

- Does NOT include:
  i) Requirement for physician order.
  ii) Procedures or techniques carried out by or under the direction of qualified therapists.
  iii) For both active and passive range of motion movement by a resident that is incidental to care does not count as part of a formal restorative nursing program.
  iv) Treatment for less than 15 direct minutes per day.

17) Can N0415 be clarified – what is meant by "indication noted?"

- Per page N-6, Code all high-risk drug class medications according to their pharmacological classification, not how they are being used.
  i) Column 1: Check if the resident is taking any medications by pharmacological classification during the 7-day observation period (or since admission/entry or reentry if less than 7 days).
  ii) Column 2: If Column 1 is checked, check if there is an indication noted for all medications in the drug class.

18) Is a diagnosis of pulmonary fibrosis sufficient to code J1100C (head of bed elevated to prevent shortness of breath while lying flat?)

- No specific diagnosis is required per the RAI Manual in order to code J1100C - RAI Manual page J-25:
  i) If shortness of breath or trouble breathing is present when the resident attempts to lie flat check J1100C. Also code this as present if the resident avoids lying flat because of shortness of breath.

OBRA

1) For the OBRA assessments, are we counting 3 days prior to the ARD or 3 days after the admission day including day of admission?

- For an OBRA Admission assessment, code the resident's usual performance during first 3 days of their stay starting with the date in A1600, Entry Date.

2) What is an OBRA Interim assessment?

- OBRA/Interim: The Interim Payment Assessment (IPA) (A0310B = 08) is an optional assessment that may be completed by providers in order to report a change in the resident's PDPM classification.

Coding Questions

1) **Why are washing the back and hair excluded from coding in bathing?**

   - CMS makes all decisions regarding MDS item elements to be included with each task. Please refer to the State RAI Coordinator.

2) **GG0170B – applies to "Recliner." What about power recliners/lift chairs, how would those be coded?**

   - Please refer all coding questions to the State RAI Coordinator.

3) **Do all chronic lung type diagnosis (e.g. pulmonary fibrosis, atelectasis, cystic fibrosis, lung cancer, etc.) qualify to code in section I6200?**

   - Please refer all coding questions to the State RAI Coordinator.

4) **What if there are no steps in the facility when coding in Section GG?**

   - Suggestions: Ask therapy for assistance with steps. As always, please refer all coding questions to the State RAI Coordinator.

5) **If a resident in a wheelchair (r/t Section GG picking up an object from the floor) is unable to stand, per the definition, does that mean they are dependent?**

   - Per the RAI Manual (Draft) page GG-66: "Picking up the object must be assessed while the resident is in a standing position. If the resident is not able to stand, the activity did not occur and the appropriate "not attempted" code would be used." As always, if the RAI Manual is not clear, please refer all coding questions to the State RAI Coordinator.

6) **For the Resident's Discharge Goal (Resident's Overall Goal Q0310), how would this be coded if the resident's discharge goal and the family's discharge goal are completely different?**

   - Per the RAI Manual page Q-3: "While family, significant others, or, if necessary, the guardian or legally authorized representative can be involved, the response selected must reflect the resident's perspective if they are able to express it, even if the opinion of family member/significant other or guardian/legally authorized representative differs." As always, if the RAI Manual is not clear, please refer all coding questions to the State RAI Coordinator.

7) **If ST completes BIMS on day 2 of admission and the resident scores "9" and Social Services completes the BIMS on day 7 and the resident scores "13" – which score should be utilized on the MDS?**

   - Please refer all coding questions to the State RAI Coordinator. For purposes of the MDS Review: The RN Reviewer would expect to see documentation supporting what was transmitted on the MDS assessment in review.

8) **Does the note about usual performance have to be completed during the 7-days or can it be by the completion date since the 3-days is at the end of the period?**

   - Documentation utilized to support the facility's decision in the coding of each task reviewed will be required to support "usual performance." Facilities are advised to work with their vendors in determining the best tools for Section GG documentation.

9) **Please clarify "qualified clinician."**

   - The RAI Manual defines the "qualified clinician" as a healthcare professional practicing within their scope of practice and consistent with Federal, State, and local law and regulations. Contact the Indiana Professional Licensing Agency with questions regarding scope of practice for licensed health care providers.

10) **Does GG in the medical record need to be completed by an RN? Or, can it be co-signed by an RN if the LPN completes it?**

    - Per the RAI Manual (Draft) page GG-15, "Assess the resident's self-care performance based on direct observation, incorporating resident self-reports and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period. CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the assessment period."

11) **Can a licensed therapist complete Section GG data collection?**

    - Yes.

12) **If 2 staff assist to bring the resident from a lying position to sitting on the side of the bed and cannot let go of the resident due to fall potential, how should GG0170C be coded?**

    - Dependent – Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

13) **For isolation – how long does the resident have to be in the room alone in order to code?**

    - Isolation may be coded if all criteria are met regardless of how long the resident is in the room alone during the observation period.

14) **Definition of Lying to Sitting on Sit to Lying: How is a Hoyer lift coded? Residents usually do not sit on the side of the bed.**

    - If the qualified clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, then code the activities GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, as 88, Not attempted due to medical condition or safety concern.

15) For RT, would physician documentation on a progress note as to why the nebulizer treatment was ordered be the initial evaluation?

- No. Per the RAI Manual, code only medically necessary therapies that occurred after admission/readmission to the nursing home that were (1) ordered by a physician (physician's assistant, nurse practitioner, and/or clinical nurse specialist) based on a qualified therapist's assessment (i.e., one who meets Medicare requirements or, in some instances, under such a person's direct supervision) and treatment plan, (2) documented in the resident's medical record, and (3) care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective. Therapy treatment may occur either inside or outside of the facility.

16) For RT, would a nurse's progress note by an RN or LPN of symptoms of an upper respiratory infection be sufficient for the initial evaluation? Or, does there need to be a separate evaluation?

- Please see above.

17) Will unplanned discharges require discharge GG item sets?

- Section GG - Functional Abilities and Goals - Discharge
  - i) GG0130. Self-Care (Assessment period is the last 3 days of the Stay)
  - ii) Complete when A0310G is not = 2 and A0310H = 1 and A2400C minus A2400B is greater than 2 and A2105 is not = 04.

18) Can a physical therapist sign Section GG items? If so, does it matter the level of education (e.g. doctorate?)

- Yes, any licensed physical therapist may sign Section GG items. Level of education does not negate an issued physical therapist license.

19) Which department should complete Section GG if the resident does not receive therapy services?

- The RAI instructs that a qualified clinician determine the resident's usual function and does not dictate which "department" must complete Section GG. CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the assessment period.

20) If a resident has emphysema and COPD, official guidelines state to code only emphysema; however, COPD can still be checked in Section I. Is this an issue for Surveyors? The orders would show treatment for COPD; however, COPD would not be documented on the diagnosis list?

- A diagnosis should be included in section I if:
  - i) It has been documented in the resident's medical record by a physician, nurse practitioner, physician assistant, etc. in the last 60 days

    AND
  - ii) Has a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.
- For concerns related to survey activities or potential citations, please contact your area's long term care survey supervisor.

21) Do providers have to utilize a negative air flow room to count isolation?

- No. All criteria outlined in the RAI Manual must be met and a negative air flow room is not required per the RAI Manual.

22) Do all 4 criteria have to be met in order to code isolation?

- Yes.

23) J0520 – does the question include an ARNP?

- Rehabilitation Therapy is defined as special healthcare services or programs that help a person regain physical, mental, and/or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury, or treatment. Can include, for example, physical therapy, occupational therapy, speech therapy, and cardiac and pulmonary therapies.

24) A2121 – respond yes if discharged to another SNF or licensed assisted living facility?

- As long as a current reconciled list of medication is provided to the admitting SNF, this item should be coded 1, yes. However, a licensed assisted living facility is not covered under "subsequent provider."

SPADEs Questions

1) What exactly is SPADEs?

- The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) requires that standardized patient assessment data elements (SPADEs) be collected across post-acute care (PAC). Standardized data will enable cross-setting data collection, outcome comparison, exchangeability of data, and comparison of quality within and across PAC settings. In addition, standardized data has the potential to improve patient outcomes by improving coordination of care and discharge planning.

- SPADEs are to be nested within the four existing PAC assessment instruments. Existing PAC assessment instruments by PAC provider type are Outcome and Assessment Information Set (OASIS) for HHAs, Inpatient Rehabilitation Facility–Patient Assessment Instrument (IRF-PAI) for IRFs, LTCH Continuity Assessment Record and Evaluation (CARE) Data Set (LCDS) for LTCHs, and Minimum Data Set (MDS) for SNFs.

2) Are SPADEs a Federal or State requirement?

- Please see above.

3) What do SPADEs impact?

- SPADEs have a potential impact on Quality Measures, 5-Star Ratings, and Quality Incentive Programs based upon the MDS items utilized.

4) If a current reconciled medication list does not include all elements as defined in the State Operations Manual, will it still be counted as being given since it is non-compliant in content?

- For concerns related to survey activities or potential citations, please contact your area's long term care survey supervisor.

5) Define "Subsequent Provider"

- Short-term general hospital
- Skilled Nursing Facility
- Intermediate care
- Home – under the care of an organized home health service agency or hospice
- Hospice in an institutional facility
- Intermediate Rehabilitation Facility (IRF)
- Long Term Care Hospital (LTCH)
- Medicaid nursing facility
- Inpatient psychiatric facility, OR
- Critical access hospital

6) **What is the best department to complete the new sections for ethnicity, race, language, cultural preference, transportation, and health literacy?**

   - The RAI manual does not dictate which "department" should complete the sections referenced; however, the manual does state all interviews should be completed by a qualified clinician.

7) **Do facilities need to "create" the tasks for the resident to code? For example, if the resident would not be using stairs routinely, does the facility need to trial that task within the lookback period in order to code?**

   - When coding Section G0100. Prior Functioning: Everyday Activities if the activities were not applicable to the resident prior to the current illness, exacerbation, or injury the correct code would be 9: Not Applicable.

GENERAL QUESTIONS

1) **How do you suggest we train our direct care CNAs to document on both ADLs for Section G for the OSA and Section GG for other assessments?**

   - Training of facility staff is incumbent upon facility policies and procedures.

2) **Will there be additional training on changes?**

   - No additional trainings have been scheduled at this time; however, please continue to monitor the Case Mix in Indiana Newsletter for future announcements.

3) **Could the State Rule be published indicating that an LPN cannot do the initial GG assessments?**

   - Rule 2. 848 IAC 2-2-1 Responsibility to apply the nursing process identifies the registered nurse to assess the patient/client in a systematic, organized manner. Rule 3. 848 IAC 2-3-1 does not identify assessment of the patient/client; however, it does state that the LPN may assess the health status of the patient/client in conjunction with other members of the health care team, for analysis and identification of health goals.

4) **Is restorative therapy included as rehabilitation therapy in J0520? Is it part of a "prescribed therapy program" or is it different d/t the definition at O0500?**

   - Rehabilitation therapy is not the same as restorative nursing and would not be included in J0520. A resident may be started on a restorative nursing program when they are admitted to the facility with restorative needs, but are not a candidate for formalized rehabilitation therapy. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy.

5) **When can Indiana expect to move to a new classification system? Or, will the State use the OSA until the deadline of 10-1-25?**

   - No decision has been made by the Office of Medicaid Policy and Planning at this time.

6) **When care planning Activities of Daily Living, should this be done according to the "usual performance" in Section GG or is it appropriate to utilize Section G (specifically regarding the most support given)?**

- Please refer to the OSA Manual page OSA-16 for care planning guidance for Section G. If further instruction is required, please contact the State RAI Coordinator.

7) **Should the 3-day Usual Function IDT note need to be completed by Day 3 of stay or is it acceptable to make that note on day 4 or 5 (referring to the documentation on days 1-3).**

- Documentation utilized to support the facility's decision in the coding of each task reviewed will be required to support "usual performance." Facilities are advised to work with their vendors in determining the best tools for Section GG documentation.

8) **If a G-Broda chair doesn't count as a wheelchair in GG0120 will Broda chair continue to not count as a wheelchair?**

- RAI Manual pg. GG-9: Check GG0120C, Wheelchair (manual or electric): if the resident normally sits in a wheelchair when moving about. Include wheelchairs that are hand propelled, motorized, or pushed by another person. Do not include geri-chairs, reclining chairs with wheels, positioning chairs, scooters, and other types of specialty chairs.

9) **Coding "usual" performance for Section GG – the RN Reviewers may not agree with the facility determination of how "usual" was reached, how will those issues be resolved?**

- Documentation from the medical record will be utilized by the RN Reviewer to make appropriate determinations; however, in the case of disagreements the facility continues to have the option to request an Informal Reconsideration.