

## MDS 3.0 Advanced Training

Understanding PPS  
Care Area Assessments and Care Planning



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## MDS 3.0 Version 1.13 Changes Effective 10/1/15

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## Chapter 2

- Section 2.9  
Pages 2-52–2-61

October 2015 In cases where the last day of the Medicare Part A benefit (the date used to code A2400C on the MDS) is prior to Day 7 of the COT observation period, then no COT OMRA is required. If the date listed in A2400C is on or after Day 7 of the COT observation period, then a COT OMRA would be required if all other conditions are met.

Finally, in cases where the date used to code A2400C is equal to the date used to code A2000—that is, cases where the discharge from Medicare Part A is the same day as the discharge from the facility—and this date is on or prior to Day 7 of the COT observation period, then no COT OMRA is required. Facilities may choose to combine the COT OMRA with the Discharge assessment under the rules outlined for such combination in this chapter. **\*\*If COT checkpoint is on the day of discharge, and the RUG increases, a COT / discharge assessment is allowable. The COT OMRA is not required if the RUG decreases on the COT checkpoint /discharge date. In that case only a discharge assessment is required.**

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**Chapter 3**

- Chapter 3

Section I  
Page I-4

If an individual is receiving aftercare following a hospitalization, diagnosis is a Z code may be assigned. Z codes cover situations where a patient requires continued care for healing, recovery, or long-term consequences of a disease when initial treatment for that disease has already been performed. When Z codes are used, another diagnosis for the related primary medical condition should be checked in items I0100–I7900 or entered in I8000. ICD-10-CM coding guidance with links to appendices can be found here:  
<http://library.ahima.org/xpedio/groups/public/documents/>

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(Chapter 3 continued)

- Section M0210  
Page M-5

If a resident had a pressure ulcer that healed during the look-back period of the current assessment, and was not present but there was no documented pressure ulcer on the prior assessment, code 0.

Section A2400  
Page A-31 - 32

— Date of last day covered as recorded on the effective date from the Generic Notice (changed to Notice of Medicare Non-Coverage (NOMNC); for

- A2400

A-32

Examples

1. Mrs. G. began receiving services under Medicare Part A on October 14, 2010. Due to her stable condition and ability to manage her medications and dressing changes, the facility determined that she no longer qualified for Part A SNF coverage and issued an Advanced Beneficiary Notice (ABN) and a Generic Notice NOMNC with the last day of coverage as November 23, 2010. Mrs. G. was discharged from the facility on November 24, 2010. Code the following on her Discharge assessment

- Check the MDS 3.0 Website periodically for any updates at:  
<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQuality/mcsMDS30RAIMannual.html>

**Chapter 3**

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**Skilled Nursing Facility  
Prospective Payment  
System**

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### PPS

- Used to determine reimbursement for nursing home residents under Medicare Part A
- Projects the cost of a resident's care by classifying into a category that reflects his/her acuity
- Timeframes are shorter than OBRA because resident acuity likely to change over time
- RUG-IV category computed by assessments and billed to Medicare for specific time periods
- Section V Care Area Assessments not required for PPS purposes

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### ARD and PPS

- ARD drives payment under PPS
- Establishes time period for capturing care and services
- Varies by assessment type and facility determination
- First Medicare Part A day is Day 1
- Look-back periods are consecutive calendar days, including weekends and holidays
- If resident dies or is discharged prior to the end of a look-back period, the ARD is adjusted to equal the discharge date
- IDT works to determine the ARD that will capture different services and conditions to calculate a RUG
- Setting ARD outside the required ARD window can result in default billing or facility assuming liability (provider liable = \$0)

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### Grace Days

- Specific number of days that can be added to the ARD window without penalty
- Used in situations where an assessment might be delayed or additional days are needed to fully capture therapy or other treatments
- For PPS assessments only
- If grace days will put an OBRA assessment outside the required timeframe, OBRA rules must be followed

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### Types of PPS Assessments

- Scheduled: 5-day, 14-day, 30-day, 60-day and 90-day
- Unscheduled: Significant Change in Status, Significant Correction of Prior Comprehensive Assessment, Start of Therapy Other Medicare Required Assessment (SOT OMRA), End of Therapy (EOT) OMRA, Change of Therapy (COT) OMRA
- Unscheduled assessment in a scheduled assessment window can't be followed by a scheduled assessment later in that window (combine assessments with ARD appropriate to the unscheduled)

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### 5-day

- First Medicare assessment completed for SNF Part A stay
- ARD set on days 1-5 of the Part A stay, extended up to 8 with grace days
- Authorizes payment for days 1-14

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### Other Scheduled Assessments

- 14-day: ARD set on Days 13-14 with grace days up to Day 18; pays days 15-30
- 30-day: ARD set on Days 27-29 with grace days through Day 33; pays days 31-60
- 60-day: ARD set on Days 57-59 with grace days through Day 63; pays days 61-90
- 90-day: ARD set on Days 87-89 with grace days up to Day 93; pays days 91-100

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### Other Medicare Required Assessments

Start of Therapy (SOT): used only to classify resident into RUG-IV Rehab Plus Extensive Services or Rehabilitation group

- Completed only if resident hasn't already been classified into Rehab Plus or Rehab group.
- May be combined with scheduled PPS assessments
- Not necessary if rehab services start within ARD for 5-day (therapy starts paying Day 1)
- ARD may not precede ARD of first scheduled PPS assessment
- Required if more than 5 consecutive days since the EOT.

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### Other Medicare Required Assessments

End of Therapy (EOT): required when resident was classified in Rehab Plus Extensive or Rehab group and still needs Part A services after planned or unplanned discontinuation of all therapies for 3 consecutive days

- ARD set on Days 1, 2 or 3 after all therapies have stopped for any reason
- Will keep resident in non-Rehab RUG
- Last day of therapy is Day 0
- Day 1 is first day after last therapy treatment
- Not required if the last day of Medicare Part A benefit is prior to the 3<sup>rd</sup> consecutive day

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### Other Medicare Required Assessments

Change of Therapy (COT): required when intensity of therapy changes to such a degree that it would no longer reflect the RUG-IV classification assigned based on most recent PPS assessment

- ARD is Day 7
- Observation periods are successive 7-day windows starting the day after the ARD for most recent scheduled or unscheduled assessment

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### Combining Assessments

- Used when more than one Medicare-required assessment is due in the same time period
- Two scheduled assessments may never be combined
- May combine scheduled and unscheduled or two unscheduled assessments
- If assessments aren't combined as required by combined assessment policy, payment is controlled by the unscheduled assessment
- Can combine OBRA and Medicare assessments when all requirements are met
- See User's Manual for information on combination types

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- Resident expires or transfers before/on 8<sup>th</sup> day: complete as much as possible and submit; bill at default rate if no PPS assessment in QIES ASAP; also must complete Death in Facility tracking as appropriate
- Short Stay: must meet all criteria to qualify
- Leave of Absence (LOA): assessment schedule adjusted to exclude LOA days for scheduled assessments; unscheduled assessments not affected
- Resident leaves/returns during observation period: observation period not extended
- Resident D/C Medicare Part A to different payer source and remains in facility in Medicare/Medicaid certified bed: OBRA schedule continues; PPS assessments not completed

### PPS Factors

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### PPS Factors

- Early assessments (ARD not in defined window): will be paid at default rate for the # of days out of compliance
- Late assessments: will be paid at default rate for the # of days out of compliance
- Missed assessments: if resident already d/c'd, cannot complete the missed PPS or bill for those days; existing OBRA (except standalone d/c) can be used to bill for some Part A days in specific circumstances (see Chapter 6)

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## Care Area Assessments (CAA) and Care Planning

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## Overview-RAI Process

The development of an individualized care plan is built by using the RAI Process to its fullest and then some.

Remember to use Critical Thinking: 1. Collect the data. 2. Analyze and UNDERSTAND the significance of the data to the patients particular circumstances. 3. Arrive at realistic conclusions about the patient's status, needs, problems and strengths to generate an effective plan of care.

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## What are CAA's? (Care Area Assessments)

- Triggered responses to coded MDS items which are specific to possible problems, needs or strengths of the resident.
- The Care Area Assessments (CAA's) reflect conditions, symptoms and areas of concern
- These are common in SNF residents
- Commonly identified by MDS findings
- Interpreting and addressing CAA's is basis for the development of individualized care plan.

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### CAA's

- Each CAA has two parts:
  - An introduction that provides general information about the condition, **and**
  - A list of items and responses from the MDS that serve as the trigger(s) for review called CATS (Care Area Triggers)

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### 20 CARE AREA ASSESSMENTS

1. Delirium	2. Cognitive Loss/Dementia
3. Visual Function	4. Communication
5. ADL Functional/Rehab Potential	6. Urinary Incontinence/Indwelling catheter
7. Psychosocial Well-Being	8. Mood State
9. Behavioral Symptoms	10. Activities
11. Falls	12. Nutritional Status
13. Feeding Tubes	14. Dehydration/Fluid Maintenance
15. Dental Care	16. Pressure Ulcer
17. Psychotropic Medication Use	18. Physical Restraints
19. Pain	20. Return to Community

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### The IDT

- **Interdisciplinary Team considers:**
  - Resident / Patient as a whole
  - Identify areas of concern
  - Develop interventions to improve, stabilize or prevent decline
  - Address the need and desire for important considerations
  - Determine connections between triggered items and underlying causes of triggered items and other areas pertinent to resident / patient

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- Identify and use tools that are **current**
- Must use current clinical standards of practice
- Must use evidence-based or expert-endorsed research
- Must use clinical practice guidelines and resources
- Use sound clinical problem solving skills
- Use **critical thinking** skills

**The Process**

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### Why is Critical Thinking Important?

- Critical thinking is the ability to think clearly and rationally. It includes the ability to engage in reflective and independent thinking.
- Someone with critical thinking skills is able to do the following:
  - understand the logical connections between ideas
  - identify, construct and evaluate arguments
  - detect inconsistencies and common mistakes in reasoning
  - solve problems systematically
  - identify the relevance and importance of ideas
  - reflect on the justification of one's beliefs and values

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### Critical Thinking for CAA's

**These questions are intended to develop critical thinking skills.**

1. Questions for **clarification**: Why do you say that? How does this relate?
2. Questions that probe **assumptions**: What could we assume?
3. Questions that probe **reasons and evidence**: What is an example?
4. Questions about **viewpoints and perspectives**: What is an alternative? What is another way to look at it?
5. Questions that probe **implications and consequences**: What are you implying? What generalizations can you make?
6. Questions about the question: **What was the point** of this question? What does ----- mean? How does ----- apply in this situation?

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- Critical thinking is a disciplined manner of thought that a person uses to assess the validity of something: a care plan, statement, news story, argument, research, etc.
- Critical thinking is disciplined thinking that is clear, rational, open-minded, and informed by evidence
- Reading everyday from Medline or other websites for current clinical information <http://www.nlm.nih.gov/medlineplus/>
- Look up conditions at "the Hartford Institute for Geriatric Nursing" or other places on page C-84 of the MDS 3.0 manual to stay current with standards of practice

**What will help?**

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### Purpose of Section V

- Documents **key information** to support the CAA process:
  - **Type** of the most recent prior assessment
  - **ARD** for the most recent prior assessment
  - **Summary Score** for the BIMS from the most recent prior assessment
  - **Total Severity Score** for the Resident Mood Interview or Staff Assessment of Resident Mood from the most recent prior assessment
  - **CAA summary** for the current assessment

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### V0100: Items - most recent Prior OBRA or PPS Assessment

- 2 care areas require information from the most recent prior MDS 3.0 to allow evaluation of resident decline.
- The 6 items in this section of V are recorded based on the coding of the most recent prior OBRA or PPS MDS, if available
- Complete these items only if a prior MDS has been completed since the most recent admission to the facility
- **Do not include or consider prior discharge or entry records**

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### V0200A: CAA and Care Planning

**Summarizes** the “triggered” items from the MDS that will require further assessment

- V0200A: CAA Results
  - Column A: record which CAAs are “triggered”
  - Column B: record if they are addressed in the care plan
  - Last column: **record the location and date of CAA Assessment documentation**
- Most software will generate the report with the triggered items checked, based on the MDS responses

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### V0200B,C: CAA and Care Planning

- **V0200B1 & 2:** Signature of **RN Coordinator** for CAA process and date that process is complete
  - CAA review done no later than the 14<sup>th</sup> day of admission for admission MDS, and
  - Within 14 days of ARD for annual, significant change or significant correction assessments. \*determination date+14days
  - **This is the “Completion Date” of the RAI**
- **V0200C:** Signature of person facilitating the care planning decision-making process and the date this column was completed
  - **Care plan must be done within 7 days of the V0200B date**

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### Appendix C Resources

- Staff should follow their facility's chosen protocol or policy for performing the CAA. The resources provided in Appendix C are **not** mandated nor are they part of the MDS Item Set. They are not to be included with the MDS 3.0. This is a choice of the facility to check to see if something might be missed.
- CMS does not endorse the use of these or any other particular resource(s).
- Ensure that the resource(s) used are **current, evidence-based or expert-endorsed** research and clinical practice guidelines/ resources – see page C-84 for a non-inclusive list
- MDS 3.0 suggests that you get the physician involved with IDT

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### Chapter 4 and Care Area Assessments

- MDS alone does not provide a comprehensive assessment
  - **It is a preliminary screening to identify potential resident issues/conditions, strengths and preferences**
- Care Areas are triggered by MDS item responses that indicate the need for more in-depth evaluation. **See Chapter 4 for the MDS items that trigger a CAA.(starts on pg. 4-16)**
- These triggered care areas form the critical link between the MDS and care planning decisions

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### CAA Process

- Starts with the MDS Assessment:
  - Determine triggered care areas and assess further
  - Review MDS and gathered data
  - Decision-making and care planning via IDT & physician
  - Documentation (medical record & Section V)
  - Use CAA resources and current standards of practice, evidence-based or expert-endorsed resources

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### CAA Process

- Identify what Care Area is triggered and why
- Determine if the Care Area is a problem for this resident - describe nature of problem and the impact on functioning.
- Identify causative and unique risk factors and include
  - Potential for improvement or decline
  - Strengths to build on

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## CAA process - continued

- Identify a need for referral
- Document which research, resources (s) or assessment tool (s) were used in completing the CAA as specified in Chapter 4 of the MDS manual
- What plan of care can be developed/revised to **improve** status, **maintain** function and **prevent** decline?
- If IDT decides not to proceed with care planning, you must document why.

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## Key to writing good CAA's

- Paint a picture of the resident's status
- Talk about the resident's individual condition – the care plan must be individualized.
- The better all staff "**really know**" the resident, the better able they will be able to provide and monitor adequate care and services to help that individual reach their **highest practicable level of well-being**

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- The MDS information and the CAA process provide the foundation upon which the individualized care plan is formulated.
- Only done for OBRA comprehensive assessments (initial, annual, significant change, significant correction of full) **NOT** for non-comprehensive, PPS only or entry/discharge assessments

## CAA Summary

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- Includes measurable objectives and timetables
- Meets medical, nursing, mental and psychosocial needs
- MDS is the starting point
- Identifies areas of concern
- Identifies causes and risk factors related to triggered care area items
- Conclusions provide the basis for an individualized care plan

### Comprehensive Care Plan

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### Care Planning

- No required format or structure
  - Must have measurable goals and time tables
    - Goals should have a subject, verb, modifier and time frame
    - Mr. "B" will walk 50 ft 2x daily within the next 3 months
  - Approaches should identify what staff are to do and when they are to do it and when it will be evaluated by the RN for possible changes
    - Ambulate Mr. "B" to and from lunch and dinner with FWW and stand by assist daily
- Check Nurse Practice Act in your state; LPNs gather information and RNs assess and evaluate

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### Federal Tags for Care Planning

- F272 – Comprehensive assessment
- F278 – Accuracy of Assessment
- F279 – Comprehensive Care Plan
- F280 – Care Plan done within 7 days/reviewed & revised

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QUESTIONS?  
&  
Practice CAA Writing

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