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MDS Accuracy and iQIES Reports

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Objectives

• Review key aspects of the Resident Assessment Instrument (RAI) and Minimum Data Set (MDS) requirements

• Discuss accurately coding schizophrenia

• Overview of Significant Change in Status Assessment

• Accessing Reports in iQIES
Resident Assessment Instrument

• Resident Assessment Instrument (RAI)

• Three Components
  • Minimum Data Set (MDS)
  • Care Area Assessments (20 CAAs)
  • Utilization Guidelines

• Ultimate Goal and Overall Requirement
  • Assist the resident to achieve and/or maintain their highest practicable level of well-being
Importance of Accuracy

- Inaccurate MDS
- Inaccurate Care Plan
- Poor Resident Outcomes
- Possible deficiencies and Penalties
Omnibus Budget Reconciliation Act

• OBRA regulatory requirements state:
  
  • A Registered Nurse must conduct or coordinate each assessment with the appropriate participation of health professionals

  • The assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts

  • MDS assessment must accurately reflect the resident’s status
OBRA Assessments Regulatory Requirements

- Nursing homes must identify:
  - Staff members who should participate in the assessment process (Must have requisite knowledge of the information being completed)
  - How the assessment process is completed
  - How the assessment information is documented while remaining in compliance with the federal regulations and instructions contained in the RAI Manual
Documentation Requirements

• CMS does not specify or impose specific documentation procedures

• Expectation of CMS and therefore Survey:
  • Documentation should follow good clinical practice guidelines and include:
    • Resident’s problem areas/concerns/needs
    • ADL functional status
    • Treatment interventions to address problematic areas
    • How resident responded to the interventions
  • Documentation should support coding of the MDS!
Inaccurate MDS Coding: Schizophrenia
Background

• CMS issued updated guidance in QSO-23-05-NH related to inaccurate MDS coding for schizophrenia diagnosis.

• Erroneously coding a diagnosis leads to:
  • Improper Care
  • Unnecessary antipsychotic medications
  • Misleads the public
CMS Findings

• CMS identified facilities with patterns of erroneous coding of schizophrenia
• Absence of comprehensive psychiatric evaluations
• Lack of documentation reflecting behaviors related to schizophrenia
• Sporadic behaviors noted in medical record related to dementia
MDS Section I
Diagnosis
Requirements
MDS Diagnosis Requirements

• There are two look-back periods in Section I when determining if a diagnosis may be added for the resident.

  • Step 1: Diagnosis identification is to determine if there is a physician documented diagnosis in the last 60-days.

  • Step 2: Diagnosis status is determining if the diagnosis is Active or Inactive in the 7-day look-back period (except for UTI).
Step 1: Diagnosis Identification

Identify Diagnosis

• Requires a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days.

• Medical record sources for physician diagnoses include:
  • Progress notes, the most recent history and physical,
  • Transfer documents, Discharge summaries,
  • Diagnosis/Problem list (physician must confirm the diagnosis), and
  • Other resources as available
Diagnosis Identification continued

• Verbal discussions regarding diagnoses with physician must be documented in the medical record by the physician.

• Reports from family members regarding past medical history and diagnoses must be documented by the physician.
ACTIVE DIAGNOSIS: I6000 SCHIZOPHRENIA (E.G., SCHIZOAFFECTIVE AND SCHIZOPHRENIFORM DISORDERS)

- Errata Document July 15, 2022 added a supporting example to the RAI Manual on page I-16:

  The resident was admitted without a diagnosis of schizophrenia. After admission, the resident is prescribed an antipsychotic medication for schizophrenia by the primary care physician. However, the resident’s medical record includes no documentation of a detailed evaluation by an appropriate practitioner of the resident’s mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for six months prior to the start of the antipsychotic medication in accordance with professional standards.

  **Coding:** Schizophrenia item (I6000), would **not** be checked.

  **Rationale:** Although the resident has a physician diagnosis of schizophrenia and is receiving antipsychotic medications, coding the schizophrenia diagnosis would not be appropriate because of the lack of documentation of a detailed evaluation, in accordance with professional standards (§483.21(b)(3)(i)), of the resident’s mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for the time period required.
I6000: Schizophrenia Diagnosis

• Clarification on Errata guidance:
  • Is there diagnostic information (i.e., comprehensive evaluation, any behaviors/symptoms, reports of past history from family) relevant to the diagnosis being assigned?
  
  • Review the medical record for the physician-documentation that supports a diagnosis, (any diagnosis, not just schizophrenia), rather than questioning the physician’s decision to assign a particular diagnosis.
  
  • Do not code a diagnosis on the MDS if supporting documentation is not available in the medical record.
Step 2: Active Diagnosis

- Active diagnoses have a direct relationship, or impact, on the resident, and the resident’s care plan, in the 7-day look-back period.

- After receiving documentation from the physician, do not include the following if not applicable in the 7-day look-back window:
  - Diagnosis or condition that has been resolved, Or
  - Does not affect the resident’s current status, Or
  - Does not drive the resident’s care plan

- Consider if a Significant Change in Status Assessment (SCSA) is needed.
Step 2: Active Diagnosis continued

- Listing a diagnosis on the resident’s medical record is not sufficient.
- Only physicians, and physician extenders, may diagnose.
- Monitoring a medication’s effect on the resident’s condition (therapeutic efficacy) would indicate an active diagnosis (e.g., insulin or coumadin).
Quality Measure: Antipsychotic Medication Use
Quality Measure

Long-Stay quality measure

• Percent of Residents Who Received an Antipsychotic Medication
• N0410A Antipsychotic: Coded for the number of days the resident received this medication.

• Excludes residents with a diagnosis of:
  • Schizophrenia
  • Huntington’s Disease
  • Tourette Syndrome
Antipsychotic Quality Measure

- The resident did not qualify for the **numerator** and
  - For assessments with target dates on or after 04/01/2012: (N0410A = [-]).

**Will be included if:**

- Long-stay residents with a **selected target assessment** is:
  - **Selected target assessment** = Most recent 3 months
  - Reason for assessment (RFA):
    - A0310A coded any number except 99, OR
    - A0310B coded as 5 Day, OR
    - A0310F = 10 (Discharge Return Not Anticipated) or 11 (Discharge Return Anticipated)
Adjusting Five-Star Ratings

• Antipsychotic quality measure reported on Nursing Home Care Compare and in the Five-Star rating calculation.

• CMS will conduct off-site audits of schizophrenia coding and will adjust Five-Star ratings if audit reveals inaccurate coding.

• Aligns with efforts to bring down the inappropriate use of antipsychotic medications.
Adjusting Five-Star Ratings

Coding inaccuracies of schizophrenia will result in:

• Five-Star Overall quality measure (QM) and long-stay QM ratings downgraded to one star for 6 months. This will result in the facility’s overall star rating being dropped by one star.
• Short-stay QM rating will be suppressed for 6 months.
• Long-stay antipsychotic QM will be suppressed for 12 months.
Audit Process

If selected for an audit:

- Facility will receive a letter explaining the purpose of the audit
- What the audit process will be
- Instructions for providing supporting documentation
- Facilities will have the ability to ask questions
- At the conclusion of the audit, the facility may discuss results with CMS
Audit Process

• Facilities will have the opportunity to forego the audit by admitting errors in coding schizophrenia and committing to correcting the issue.

• If admitted prior to the start of the audit, CMS will consider a lesser action related to the star ratings, such as suppression of the QM rather than downgrading.

• CMS will continue to monitor each audited facility and a follow-up audit may be conducted.
Correction Process

• Coordinate with your psychiatric provider and medical directors

• Refer to the SOM Appendix PP (F-tags 658, 740, and 758) and

• MDS RAI Manual guidance in Section I

• For assistance in reducing antipsychotic medications, contact one of the Telligen QIN/QIO facilitators:
  • Morgan Satterlee, LPN (msatterlee@telligen.com);
  • Tamara Carter, RN (tcarter@telligen.com)
  • Micki Reyman, MS, RN (mreyman@telligen.com) or 405-509-0720
Significant Change in Status Assessment (SCSA)

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RAI Definition of Significant Change Status Assessment:

- SCSA is a comprehensive assessment that is required when the IDT (Inter-disciplinary Team) has determined that a resident meets the significant change guidelines for either improvement or decline.

- The final decision regarding what constitutes a significant change in status must be based upon the judgment of the IDT.
What is a “significant change”? 

A decline or improvement in **two areas** of a resident’s health status that:

- Will not normally resolve itself without intervention by staff
- Does not return to baseline within 14 days
- Requires interdisciplinary team review and/or revision of the care plan.
Exception

• If there is only one change, staff may still decide that the resident would benefit from an SCSA

• If the IDT decides a SCSA is in order then staff should document the rationale in the resident’s medical record
A SCSA may be performed any time after the completion of an Admission assessment and may not be completed before.
When is a SCSA Necessary?

• When a resident’s status changes and it is not clear whether the resident meets the SCSA guidelines, the nursing home may take up to 14 days to determine whether the criteria are met.

• Compare current status to most recent comprehensive assessment and any subsequent quarterly assessments

• Complete SCSA instead of a Quarterly if criteria is met
Examples of SCSA Improvement

Improvement in two or more of the following:

- Resident’s decision making improves.

- Resident’s incontinence pattern improves.

- Improvement in an ADL physical functioning area whereas newly coded as Independent, Supervision, or Limited assistance since last assessment and does not reflect normal fluctuations in that individual’s functioning.
Examples of SCSA Decline

Decline in two or more of the following:

• Changes in frequency or severity of behavioral symptoms of dementia that indicate progression.

• Resident’s incontinence pattern changes or placement of a catheter.

• Unplanned weight loss (5% in 30 days or 10% in 180 days).

• Decline in an ADL physical functioning newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment and does not reflect normal fluctuations in that individual’s functioning.
Hospice and SCSA

• A SCSA is required within 14 days when a resident:
  • Enrolls in a hospice program
  • Changes hospice providers
  • Revokes hospice
Determining the Need for a SCSA for Terminal Conditions

• Is condition expected, well-defined part of the disease course?

• Is condition being addressed as part of the overall plan of care for the individual?
Guidelines for When a Change in Resident Status is Not Significant

• Well-established, predictable cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions (e.g., Bipolar disease)

• Instances in which the resident continues to make steady progress under the current course of care. Reassessment is required only when the condition has stabilized
Example of SCSA

• Mr. T no longer responds to verbal requests to alter his **screaming behavior**. It now occurs daily and has neither lessened on its own nor responded to treatment. He is also starting to **resist his daily care**, pushing staff away from him as they attempt to assist with his ADLs. This is a significant change, and a SCSA is required.
Example of SCSA

• Mrs. G has been in the nursing home for 5 weeks following an 8-week acute hospitalization. On admission she was very frail, had trouble thinking, was confused, and had many behavioral complications. The course of treatment led to steady improvement and she is now stable. She is no longer confused or exhibiting inappropriate behaviors. The resident, her family, and staff agree that she has made remarkable progress. A SCSA is required at this time.
iQIES Reports

Wanda Roberts,
State Automation Coordinator
Finding Reports

First go to https://qtso.cms.gov/
Then click on Nursing Home (MDS)/Swing Bed Providers under “I’m a Provider”.

Then click on Reference and Manuals.
Finding Reports – continued 2

Here you will find the following helpful resources.

Under iQIES MDS FAQs
- iQIES MDS FAQs for Providers v1.0

iQIES MDS User Guides and Manual
- CMS iQIES MDS Upload an Assessment v1.0
- iQIES Reports User Manual v2.3
Finding Reports – continued 3

To locate a video demonstrating how to access your reports (note: in the following video she is accessing for LTCHs but in your case put in MDS and the pathways are the same)

https://qtso.cms.gov/training

Then click on:

• iQIES: View Training Materials ›

• How to Run reports: Running Reports
Summary

• Reviewed importance of MDS accuracy

• Discussed inaccurate coding of schizophrenia diagnosis

• Reviewed requirements for a Significant Change in Status Assessment

• Discussed iQIES reports
Consistent Recorded “Picture”
Questions/Contact

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