

VisRMS MDS 3.0 Module

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Minimum Data Set (MDS) 3.0 Module Overview

Special Functions

CMS Manual

The MDS 3.0 Module contains On-Line access to the CMS Manual. The contents of this manual have been stored in the system. To read the manual information which pertains to each MDS 3.0 question on-line, merely hit the **F1** key which is referred to as the **HELP KEY** when your cursor is on the question and the manual help information will appear on the screen.

Look at Prior MDS 3.0 Data

A new record is created every time you create a new assessment. The data from all MDS 3.0 assessments can be viewed while the user is working in a 3.0 assessment. Merely hit the **F10** key (the History Key) while the cursor is on a specific question and the responses entered for that specific question and the dates of all the assessments appear on the screen.

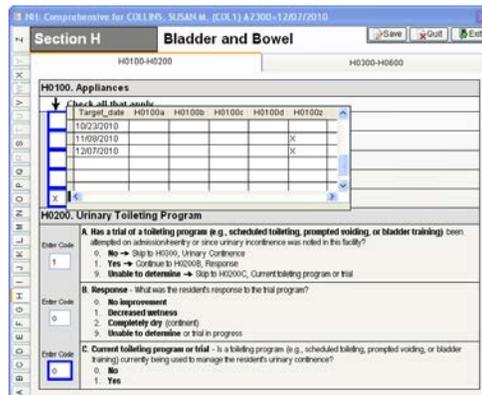


Figure 1

MDS 3.0 RUG IV Scores

Where appropriate, the Groupers will calculate the RUG IV scores for Medicare fields Z0100 and Z0150 and the Medicaid “cross-walked” RUGs III score in Z0200.

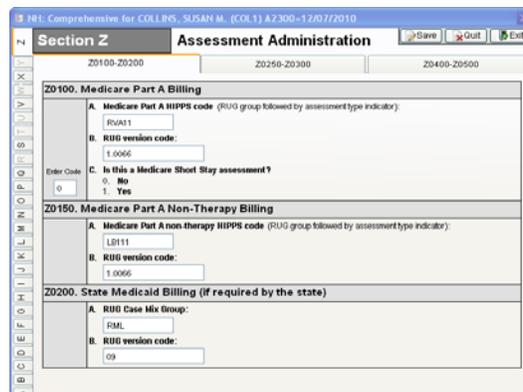


Figure 2

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Triggers

The system features the ability to automatically calculate the appropriate CATs (Care Area triggers), and produce reports with this information. MDS 3.0 CAT items will be used by and may be viewed in the MDS 3.0 Care Planning Module.

ADT Data Used in MDS 3.0

Data from ADT will be brought into the MDS. Items such as Birth date, Gender, Race, Medicaid, Medicare, and Social Security Numbers, Name, Zip Code, Date of Entry, Occupation, Marital Status and Nickname. However, it is the responsibility of staff to verify the accuracy of the data.

MDS 3.0 Validity Checks

P&NP checks to make sure that you enter only the data that you should and only within the ranges that are allowable. We use a technique known as screen audits to perform this task. When incorrect data is entered, the field turns pink or red indicating a data issue. Of course, because there are so many extant relationships between data fields in 3.0, a pink/red field can merely signify that other related questions have not yet been answered.

Special Key Strokes

In addition to the common keystrokes, the MDS 3.0 module uses a few that are unique.

F1 Key	Help Screens (Relevant pages from the CMS 3.0 manual)
F2 Key	In MDS 3.0 Set-Up Questions utility, F2 marks questions to always come forward blank.
	In Section I (I8000 A-J) brings up the Diagnoses database
F10 Key	Shows the history for the current question
Save	Save the changes to data and continue working in MDS 3.0.
Quit	Exit the MDS and do not save data entered in the current session.
Exit	Save the MDS data entered in current session and exit MDS.

MDS 3.0 Set Up

Before the MDS 3.0 module can be used, there are key set-up procedures that must be completed in order for the module to work properly. Make sure that all of the following information is entered accurately before starting.

Set Up MDS 3.0 Questions by Discipline

The MDS system allows for identification of MDS questions by discipline. The password entered as the user goes into RMS will be carried forward into the MDS Module. The Password Rites assigned will alert the system as to the user's discipline for MDS 3.0 and the user's Security Level.

In the MDS Module, click on the UTILITIES menu and select MDS QUESTION SELECTION. Read the directions on the screen carefully. See Figure 3.

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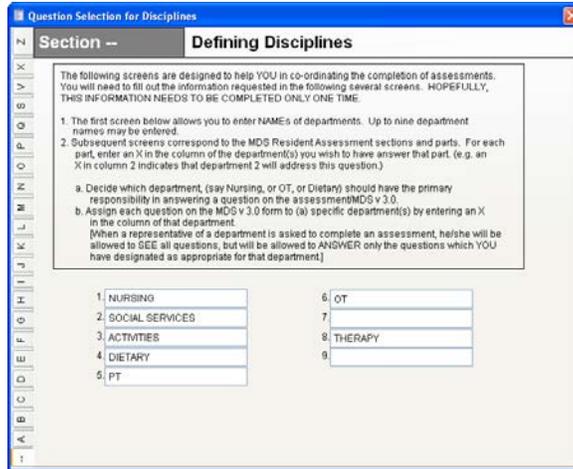


Figure 3

In the nine numbered fields at the bottom of the screen list all disciplines involved in completing the MDS. The field numbers (1-9) are then assigned to that discipline. This number will then be used in assigning MDS questions and accessing the assessment system questions by discipline.

The MDS section letters are displayed on the tabs up the left side of the screen. Click on a section tab to view the questions in that section. For example, section O is displayed below in Figure 4.

NOTE: The MDS Coordinator (RN AC) is not assigned a discipline nor is the RN AC given rights to individual questions. The MDS coordinator is automatically given rights to all sections and all questions through the password level of “5,0”.

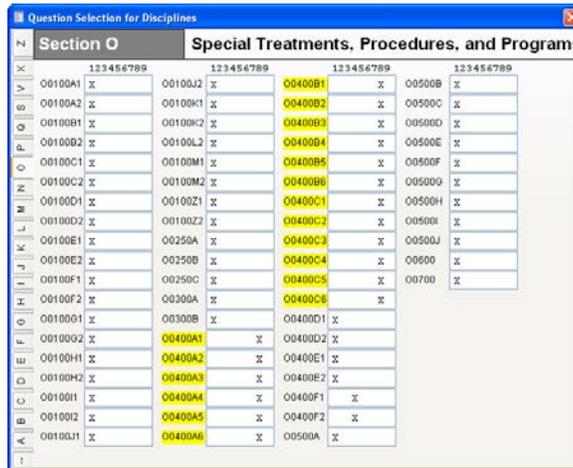


Figure 4

Assigning the Discipline

Each question in the MDS section selected is listed followed by a text field. The text ‘123456789’ appears above those fields and signifies the nine disciplines listed on the first page. To assign a discipline to the question, place an ‘X’ under the correct number for the discipline. If the discipline is a number other than one(1), spaces will have to entered prior to the “X”. For example, if Dietary

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(discipline #4) needs to answer a question, you would enter “<space><space><space>X” so that the X appears directly under the 4.

In Figure 4 Nursing (Discipline #1) is assigned questions O0100A1 through O0300B. Questions O0400A1 through O0400C6 are assigned to Therapy (Discipline #8).

NOTE: Please note that only one discipline should have rights to a particular question. Multiple disciplines can be assigned in the section but only one should have a particular question. This is especially important if your facility is using the Electronic Sign-off software.

NOTE: The MDS Coordinator (RN AC) is not assigned a discipline nor is the RN AC given rights to individual questions. The MDS coordinator is automatically given rights to all sections and all questions through the password level of “5,0”.

Blanking Out Specific Questions

When a new assessment is created for a resident, the option appears to copy from the previous assessment. If YES is answered to the question, the new assessment is created and the answers from the previous assessment will display in the questions. While this may be acceptable for certain questions (Speech Clarity, Corrective Lenses, etc.) it should not be used for questions that will vary from assessment to assessment (Section G answers, Number of therapy minutes received, etc.) For these questions, the answers should come in as blank even if the copy option is selected.

The Question Selection option is also used to mark questions to signal the system not to copy values for that field from assessment to assessment. This is accomplished by clicking in the text field next the question (where you place the X) and then hitting the **F2** key. The question name will then be highlighted in yellow. In the figure above O0400A1 through O0400C6 are marked to be ignored when the copy option is selected.

Password Set Up

All staff that will enter data into the MDS 3.0 system must have a unique password. They also must have a “security level” in the Passwords module of RMS. Below you will find suggested password configuration for the MDS 3.0 which uses the MDS 3.0 Password set-up.

RN AC(s)

RN AC(s) or whoever has oversight responsibility for the assessment process **must** have a unique password with a **security level of 5** for the module, and a **department level of 0**. (If this person will also be acting in another capacity such as a nurse filling in a portion of the assessment, she/he should have a second password, see below.) A level **5** will allow the RN AC to answer any question in the MDS. The RN AC may do an Inactivation or Modification of a record and may also delete an assessment. **A department level of 0 is necessary for the system to recognize the sign-off in Z0500 as the RN AC entered date.** Once an RN AC has placed a date in Z0500, the assessment is “secured” which means that no one except another person with RN AC rights can edit the assessment.

Clinical and Other Staff

Clinical and other staff that will enter information into the assessment should each have a unique password, a security level of 2, 3, or 4, and a discipline number (1 thru 9) which is the same as that

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used in setting up the questions. The number assigned to each discipline in the MDS module should be entered in the “Dept” field. Hitting **F2** while in the “Dept” field will bring up a grid showing the number assignment for each department. Select the correct number so that the system will know the discipline of the password owner and allow only the MDS questions assigned to that discipline to be active (for example, 1 for Nursing, 2 for Activities, 3 for Social Services, etc.)

Staff will be able to Edit an Assessment entering data for their assigned questions and Sign Off. Staff will not be able to create, delete, modify or inactivate an assessment.

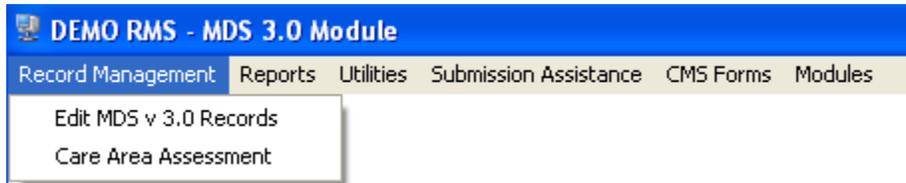
MDS 3.0 Defaults

Before you begin entering MDS 3.0 assessments or discharges, you *must* fill in the required fields in the **Default MDS 3.0 Setup** option. Move to the **Utilities** option on the MDS 3.0 main menu and select Default Setup. Enter all facility specific information requested. The system will use the information from the Default Setup for the MDS 3.0.

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Record Management

The MDS 3.0 Module is selected from the Modules option on the main menu. The first screen which comes up is the MDS 3.0 main menu which includes:



Click on EDIT MDS 3.0 RECORDS under the RECORD MANAGEMENT menu. The Resident Selection Screen will then appear. This screen will be used to identify the resident for whom you wish to enter or edit an assessment. Enter one or two letters of the last name and click on **SCAN** to shop on a filtered list. Double click on the resident name to select that resident for processing. When the correct resident name and social security number appear on the screen, click **OK**. If the resident is not correct, close the window by clicking the **X** or hitting the **Esc** key and start again.

Note: The CARE AREA ASSESSMENT menu choice is an optional add-on to the system that enables an electronic version of the Care Area Assessment described in Chapter 5 of the CMS MDS 3.0 Manual. The Care Area Assessment created is interactive with both the MDS module and the Careplan Module. Please contact P&NP for more information about this feature.

Assessment Selection Screen

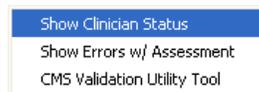
Once the resident has been selected, a screen will appear containing the following headings:

Date	Type of Assessment	#	Err	Submitted	Z0100	Z0150	Z0200	▲
03/16/11	NQ : Quarterly	00	13/ 1/ 0	NO	ES1	ES1	CC1	

The screen shows the assessment ARD, Assessment Type, # = X0100 Record Type, Number of Error/Warning/Informational messages, Submitted status and Scores.

The screen will be empty if there have been no MDS 3.0 Assessments done on this resident. If MDS 3.0 Assessments have been completed, they will appear on the screen with information listed under the headings.

To see Clinician Status (which Disciplines have finished the MDS) or to see the Error Reports, right click on the specific assessment and a menu will appear. The following choices can be made: select either the on-screen report for clinician status or one of the error reports.



Along the bottom of the screen are the options that control processing of the MDS.

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To generate a new MDS 3.0, click **Insert**. To edit an existing MDS 3.0, place the highlighted cursor on the record for editing and click **Edit**. If the assessment chosen is complete, you will be asked if you want to **Modify** or **Inactivate** the assessment. When **Insert** is selected, a screen appears asking if you want to move forward the values of the assessment on which you have currently placed your cursor. Once you have answered the question, a screen will appear with the relevant sections of the MDS.

Please note: Only users with a security level of 5 can Insert or create a new MDS 3.0 record. Only users with a security level of 5 can Delete an MDS 3.0 record, Inactivate, or Modify an assessment.

Assessment Screen

The Assessment Screen controls the creation of assessments, the entry/editing of the data, which sections/questions can be answered by the staff based on discipline, error checking and signing-off of assessments.

In the figure below, the tabs up the left side of screen designate the different sections of the MDS. The black lettered tabs are available for input (A, B, C, etc.) while the others are unavailable (R, T, U, etc.) and will change based on the type of assessment defined. The current section being edited is Section C. The tabs along the top designate the different screens containing the questions for that section. Click on each tab and answer all questions.

The screenshot shows a software interface for an assessment. At the top, it says 'Section C Cognitive Patterns'. Below that, there are several tabs for different question ranges: C0100-C0300, C0300-C0400, C0500-C0800, C0900-C1000, and C1300-C1600. The main area contains three questions:

- C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?** Attempt to conduct interview with all residents. Enter Code: 1. Options: 0. No (resident is rarely/never understood) -> Skip to and complete C0700-C1000, Staff Assessment for Mental Status; 1. Yes -> Continue to C0200, Repetition of Three Words.
- C0200. Repetition of Three Words (BIMS)** Ask Resident: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words." Enter Code: 1. Number of words repeated after first attempt. Options: 0. None; 1. One; 2. Two; 3. Three. (After the resident's first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.)
- C0300. Temporal Orientation** (orientation to year, month, and day) Ask Resident: "Please tell me what year it is right now." Enter Code: 2. A. Able to report correct year. Options: 0. Missed by >5 years or no answer; 1. Missed by 2-5 years; 2. Missed by 1 year; 3. Correct.

Figure 5

Opening and Coding the Assessment

Opening the Assessment

Before accessing sections B-Z, the RN AC must code the assessment by completing **Section A** so there is a valid MDS 3.0 Form. Form Types for an SNF are:

Nursing Home Comprehensive (NC)

Nursing Home Quarterly (NQ)

Nursing Home PPS (NP)

Nursing Home Discharge (ND)

Nursing Home OMRA-Discharge (NOD)

Nursing Home OMRA-Start of Therapy (SOT) and Discharge (NSD)

Nursing Home and Swing Bed Tracking (NT/ST)

Nursing Home and Swing Bed OMRA-Start of Therapy (SOT) (NS/SS)

Nursing Home and Swing Bed OMRA (NO/SO)

Merely select the resident, select the **Insert** button and get started. **UNTIL YOU HAVE A VALID ASSESSMENT TYPE,** you will not be able to get into Sections B through Z. Look at the top of the screen. It will tell you the form type once it has been selected. It will also give you the ARD once that has been entered. Remember that the ARD is not asked until the end of Section A!! All of Section A should be answered before going to other sections because the answers to Section A dictate some of the answers in the other sections.

Once you have coded for a valid MDS 3.0 form, you may go to any question in any section by clicking on the Section letter tab on the left side of the screen. Once in the section, the TABS above the section should be selected to go to specific questions.

Naming Conventions

Since there is a possibility of many combinations and limited space, we have attempted to show you as much information as we can about the kind of assessment record.

Copying Data from One Assessment to Another

It is possible to create a new assessment for an individual resident and pull-in data from a previous assessment. On the Assessment Selection Screen click on the assessment you want data pulled from to start the new assessment then click on **Insert**. The system will ask you if you want to copy from the selected assessment. Click on the **YES** button.

NOTE: Not all questions should be copied from one assessment to the next. Use the QUESTION SELECTION option from the UTILITIES menu to indicate questions that should not be copied.

Editing the Assessment

Once the assessment has been created (all of Section A completed correctly) the assessment is now ready for data input. Staff will select the resident using the Resident Selection Screen. Staff will place the highlighted cursor over the assessment and click on **Edit**. The assessment will then display for editing.

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Even though the screen will display with all sections, only those sections/questions designated to be answered by the discipline of the staff member will be active. See sections below for details on filling out the Assessment Screen correctly. Once all questions have been answered correctly, the staff member needs to sign off in Section Z.

Entering Data in the Fields

Click on the appropriate MDS 3.0 field to begin processing. You may click on each subsequent entry field. On a given page, the **Enter** key will move you down through the assessment as will the **Up** and **Down** Arrow keys. Type in the correct response for each item.

For a field in which you are instructed to “Check all that apply”, you may double-click on a field that should be marked to produce the “X” and again to remove the “X”. Of course, you may merely type in the “X” using the keyboard.

Right-Click Option

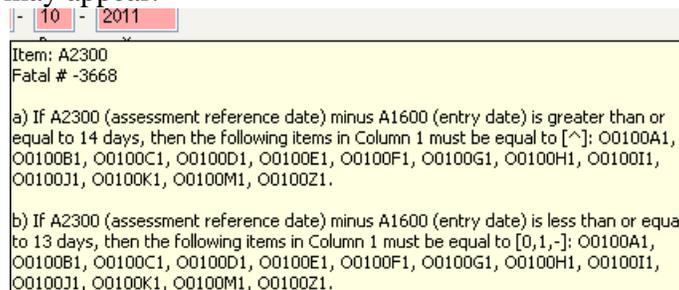
For each answer, you may also **Right Click** to select from multiple possible answers for a question. A pull-down window appears from which the answer may be selected by moving the highlighted cursor to the answer and left clicking.

X and Blank versus 1 and 0

You will notice that if you right click to select the answer, you will see that a “positive” will appear as a “1” rather than an “X”. Either answer will do. Think of it as X = 1 and Blank = 0. You may enter 0’s and 1’s or put in X’s and leave the other fields blank. When the assessment is batched, the system converts X’s to 1’s and Blanks to 0’s.

Field Data Errors

While editing the assessment all unanswered questions or questions with invalid data will appear pink. Hovering the cursor over the pink field will cause the system to display the reason why the field is in error. For example, if the ARD date entered in A2300 is incorrect (field is pink), hovering over the field the following error may appear:



Please note that each form has different “skip” patterns and different relationships amongst the questions. The MDS 3.0 has over 2100 of these relationships and the CMS error checking is extremely complicated!!!!

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Fields may be pink even though the data contained in the field may be correct but the data is dependent on another field being correct. The first time through a section, ignore the pink fields until the section is complete as they may disappear when another field is answered. In some instances, fields remain pink until a question is answered in another section. For example, the ARD date is linked with many date fields in the system and all those fields will be pink until all are entered correctly.

Error Message Viewing Recommendation

P&NP recommends that those persons responsible for filling out the MDS be running Version 9 of Foxpro and therefore, using Visrms9.exe to run the software. Some of the error messages are multi-conditional and long. Version 8 of Foxpro has a limitation on how long a pop-up window can display. A user may not be able to read the whole message before it closes. Version 9 of Foxpro allows the window to remain open until the user moves the mouse. Therefore, the user will be able to control the time to be able to read and understand what is causing the field to be in error.

Skip Patterns

The system tries to help wherever possible. There may be many fields on the MDS that must be answered under specific conditions. If those conditions do not exist, the system will prompt you by asking if you want the skip pattern. Items that appear, by CMS mandate, on a form but should NOT be answered must contain a caret (^) created by a shifted number 6. This is what the “skip pattern” prompt that appears is attempting to do. Answer **Yes** unless you are trying to undo an error.

Pulling in Linked Data (F9)

Data needed for the MDS is gathered from other modules of VisRMS, namely, Resident Observations, Therapy Quick Tracker and Immunizations. This data can be viewed easily when in the MDS and the answers can be accepted directly into the assessment form by use of the **F9** key.

Resident Observations

The Resident Observation module tracks data that can be used to supply answers to over 150 MDS 3.0 questions. Fields in the MDS that link to Resident Observations are outlined in blue.

The screenshot shows the MDS 3.0 software interface for Section H: Bladder and Bowel. The window title is "NH: comprehensive asmt for AURITT, JON S. (0323232) A2300-04/05/2011". The section is titled "Section H Bladder and Bowel" with sub-sections "H0100-H0200" and "H0300-H".

H0100. Appliances
Check all that apply

- A. Indwelling catheter (including suprapubic catheter and nephrostomy tube)
- B. External catheter
- C. Ostomy (including urostomy, ileostomy, and colostomy)
- D. Intermittent catheterization
- Z. None of the above

H0200. Urinary Toileting Program

A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or prompted voiding) since admission/reentry or since urinary incontinence was noted in this facility?

Enter Code: 0

- 0. No → Skip to H0300, Urinary Continence
- 1. Yes → Continue to H0200B, Response
- 9. Unable to determine → Skip to H0200C, Current toileting program or trial

Figure 6

If the question is part of an interview session, the following screen will appear displaying all interviews that occurred during the look-back period of the MDS. Highlight the correct interview and click **ACCEPT** to bring the data into the MDS. Click **CANCEL** if the interview is not to be used.

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Figure 10

Figure 11

Immunizations

Immunization and Vaccination History can be tracked using the INFECTION module of VisRMS. This data is accessible when answering questions O0250 and O0300 by hitting the **F2** key on those fields. When the data screen comes up, click on the pull-down arrow and choose either INFLUENZA or PNEUMOCOCCAL from the list and the data for that type will display.

Type	Date Given	Reason Not Given
Primary	10/31/2010	

Figure 12

History (F10)

A new record is created every time you create a new assessment. The data from all MDS 3.0 assessments can be viewed while the user is working in a 3.0 assessment. Merely hit the **F10** key (the History Key) while the cursor is on a specific question and the responses entered for that specific question and the dates of all the assessments appear on the screen. Hit the **ESC** key to exit.

Target_date	H0100a	H0100b	H0100c	H0100d	H0100z
11/01/2010					X
11/06/2010				X	
11/06/2010				X	
11/16/2010				X	
11/16/2010				X	
12/01/2010				X	

Figure 13

Help (F1)

The MDS 3.0 Module contains On-Line access to the CMS Manual. The contents of this manual have been stored in the system. To read the manual information which pertains to each MDS 3.0 question on-line, merely hit the **F1** key which is referred to as the HELP KEY when your cursor is on the question and the manual help information will appear on the screen.

Save, Quit or Exit

The **SAVE** button can be used to save the work that you have done already and then continue to work in the MDS. The **EXIT** button should be used to save the data and then exit the system. Error checking

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will start processing when the **Exit** button is used. Hitting the **QUIT** button exits the assessment and does not save. You will be asked to verify that you do want to lose the data input.

Error Checking

Please note that each form has different “skip” patterns and different relationships amongst the questions. The MDS 3.0 has over 2100 relationships between questions and the CMS error checking is extremely complicated!!!!

Each time you close an MDS 3.0 assessment (Quit button is clicked), the system validates (error checks) the assessment and puts a report out to the screen.

Recommendation: When the validation process comes up on the screen, there is a **CANCEL** button. **CANCEL the validation until you have the MDS completed.** There are so many relationships being checked that an incomplete MDS will produce many, many pages of errors. (Let it go once and you will see items in Section A marked as erroneous because items in Section M and O and P, etc. have not been completed.)

To help you with obvious errors while you are inputting data into the assessment, a field in the MDS marked in red or pink has an error. Run your cursor over the field and you will get the cause of the error. You will notice that blank fields are red/pink.

Error Checking from the Assessment Selection Screen

The error report can be generated from the Assessment Selection Screen. Simply right-click on the assessment to check and a menu will pop up. Select the **SHOW ERRORS W/ASSESSMENT** option and the same error routine will be run as above. If you are using electronic signatures, you will be asked if you want to verify signatures. Answer **Yes** if you are ready to submit.

Error Numbers on Assessment Selection Screen

The Err column on the Assessment Selection Screen will display the number of errors, warnings and informational items in the assessment. The display of “??/??/??” signifies that an error report has not been run on that assessment. The first column is the number of errors. *This field must be zero before an assessment can be submitted.* The second number is the number of warnings. An assessment can have warnings when submitted and will still be accepted. The third number is the number of informational messages.

Date	Type of Assessment	#	Err	Submitted
03/16/11	NQ : Quarterly	00	13/ 1/ 0	NO
01/10/11	NC : Sig Chg / 5-day	00	0/ 0/ 0	NO
10/14/10	NQ : Quarterly	01	????????	NO

Figure 14

Check the Clinician Status

On the Assessment Selection Screen for a resident, right-click on a MDS listed and a menu will come up. Chose **SHOW CLINICIAN STATUS** to get a report of who has worked on the assessment, what sections and their status.

Signing Off

All sign-off's will be done in Section Z and, where appropriate, in Section V. Of course, Section V only exists for a Comprehensive Assessment.

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Only the MDS Coordinator will be able to sign off on Z0500 (think R2b). Once the date has been entered in Z0500, nobody can get into the assessments with the exception of either the MDS Coordinator or a clinician with RIGHTS to Section V question V0200 C2 (Care Plan). V0200B2 is supposed to be signature and date by the RN Coordinator.

Once the coordinator knows that all disciplines have signed off, the sign-offs in V and Z for the Coordinator can be done.

All disciplines can get to Z0400 and should be instructed to enter a date in Z0400 to signify that the part of the MDS completed by the user is done.

Generating a Submission File

These instructions only pertain if you do not have the BATCH SELECTION (BATCH AND ZIP) add-on option under the SUBMISSION ASSISTANCE menu option. Otherwise, see the documentation *Batching and Zipping MDS 3*.

With MDS 3.0 each assessment must be generated as a single file. After the assessment has been completed, all sign-offs are done and a final error check has been done that reports 0 errors, the assessment is ready for exporting. Click on the **Export** button found at the bottom of the Assessment Selection Screen. A file meeting CMS specifications will be created in the DISKS directory.

After creation, it is up to the facility to zip this file or batch of files before submitting.

Viewing and Printing the MDS

To see the contents of an MDS 3.0 or to print the form from the resident's Assessment Selection screen, select the **PRINT** button. The MDS Form will appear in PDF format. You may scroll through it to see the contents of the MDS or you may print the form. When you close the form, you will be prompted to save by ADOBE. Do not SAVE. The data has already been saved and the form exists. There is no need to save anything.

Note: If Adobe opens up a blank document, look at the top of the form and a yellow informational message should be displayed. Click on the **Options** button and click on "Trust this document always".



Unsubmitting Assessments or Doing Modifications and Inactivations

When you select an assessment for editing that has already been submitted, you will need to let the system know if you are trying to Unsubmit the assessment for editing, or if you have rights, trying to create a Modification or Inactivation assessment.

Unsubmit

This option is available only for the MDS Nurse Coordinator (Discipline of 0). If the assessment was NOT ACCEPTED by CMS, this option will open the assessment form in order to make the necessary

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changes. Once the changes are made, the assessment will need to be submitted again so that it can be accepted.

Modification

This option is available only for users with security level of “5”. If the assessment was ACCEPTED by CMS and you just want to make some modifications to the data which was accepted use this option to open a Modification Form. After the changes have been made the form will need to be submitted.

Inactivate

This option is available only for users with security level of “5”. If the assessment was ACCEPTED by CMS but was submitted in error, use this option to inactivate the assessment (remove it from the CMS site.) This option will create an inactivation form which needs to be submitted.

MDS Completion Procedural Example

Step 1: Open the Assessment

The RN AC or person with rights will bring up the resident using the Resident Selection screen, insert the assessment and fill in Section A to establish the type of assessment.

Step 2: Staff Data Entry

Alert all staff that the assessment is available for “editing.” Staff will need to select the resident using the Resident Selection Screen, then click on the newly created assessment in the Assessment Selection Screen and then click the **Edit** button. Remember, only those questions designated for the user’s discipline will be available to data entry. When the staff member has completed her/his questions, the staff member should go to SECTION Z and sign off in Z0400.

When all required disciplines have signed off on Z0400, the MDS Coordinator should check the assessment for accuracy.

If the assessment is correct, the MDS Coordinator should sign-off in Z0500. Once the coordinator has entered a date in Z0500, no other staff other than someone with MDS Coordinator rights can get into the assessment.

If there is uncertainty about an answer, the staff member must ask the coordinator to remove her sign-off. Then the staff member may remove her sign-off and change the assessment. When the changes or corrections have been made, both the staff member and the coordinator must sign off again.

Step 3: Final Check

The RN AC should run the “MDS’s in Progress Report” checking to see which assessments are complete and which staff members have not yet completed their portion of the MDS. The RN AC may wish to check the RUGs category and the triggers before signing off.

Please note: Once the RN AC has signed off on Section Z, the assessment will not be available to other staff except for RN AC’s for editing. **If an error exists, the RN AC must “cancel” her sign-off thereby making the assessment available again to all staff.** Do the “cancel” by selecting the edit option and telling the system to remove sign-off.

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Step 4: Section V

P&NP suggests that the RN AC and/or the Care Plan Coordinator complete Section V. This should be set up under Question selection for the Care Plan Coordinator.

Step 5: Submission

Submission. (See section on submission below) site instructions can be followed for electronic submission directions.

Reporting

Statutory Scheduling

This report will assist you in scheduling your non-Medicare Project assessments, those which must respond to NY State DOH requirements.

The report will provide data on the last assessment done for DOH. You will see the “End Observation Date” for the last assessment. Assuming a full assessment, the next full or annual assessment must be “*completed by the end of the 365th calendar day after the most recent full RAI assessment (i.e. the date the RN Coordinator has certified the completion of the assessment on the Care Area Assessment (CAA) Summary Form under Section V0200.)*”

The system using HCFA’s specifications looks at the date in Section V0200 and uses it to establish the date by which the next assessment, the quarterly, must be completed. The quarterly must be completed within three months from the date in Z0500b. The next quarterly must be done within three months of the prior quarterly, etc. The schedule, therefore, will look at the date in Z0500b and use it to calculate the date by which the next quarterly must be completed. Thus, if a quarterly is done early, the next quarterly must be done within 90 days. However, if a quarterly is done late, the next quarterly must be completed by 180 days from the date in Z0500b or 270 days from the date in Z0500b. In other words, an early quarterly will change the schedule established by the Annual Assessment but a late quarterly will not.

PPS Scheduling Aid

Warning: This report will not indicate when the assessment should be started because each resident’s situation should dictate this decision. The ARD or Assessment Reference Date (A2300) selected may have an impact on your Medicare Reimbursement.

This report will help you to check that you are up to date on your PPS MDS assessments. However, this report is predicated on an Accurate Census being kept in Admission, Discharge, and Transfer. If a resident is listed as having Medicare as a Primary Payor Source (this includes Medicare with a Medicaid or Private Co-Pay), the report will track assessments for you.

You may request the report between any two dates. The report will show the time period in which the assessment should be started, the type of assessment which should be done, (of course, Significant Changes cannot be predicted by the system), the covered period of the assessment, the “Assessment Reference Date” of the assessment if it has been done or started in the system, and the RUGs IV category of the assessment if it has been done or started in the system. If the assessment has not yet been placed in a submission file, you will see an asterisk by the RUG IV Category.

The Report Configuration Screen allows you to request the report in Name, Room, or Assessment Date order, to separate by unit, or to print for a specific unit, use portrait or landscape and request shading.

Please note: *It is up to the facility to look at the two reports and the facility’s off-line Medicare assessment schedule to attempt to combine the State mandated schedule and the Demonstration mandated schedule wherever possible.*

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Please Note: *If a Medicare resident has been discharged to hospital but not admitted and was not in the facility at midnight or was on home leave, the report will not be accurate. It will show that the resident's Medicare Assessment Schedule should be restarted with a new 5 day assessment. In fact, the schedule does not need to be restarted According to the Federal register : -"Given the flexibility of the assessment windows for the Medicare assessments, altering the count of days as described here (meaning extending the billing covered period to accommodate the non-covered day (s)) should have no more than a negligible effect on assessment scheduling for facilities." It is conceivable that the schedule would have to be altered if the resident leaves the facility often without being admitted to the hospital. This will have to be taken care of by the MDS Coordinator.*

IF YOU WISH TO HAVE THE REPORT IGNORE THE DISCHARGE AND CREATE THE PPS SCHEDULE AS IF NO DISCHARGE HAD OCCURRED:

1. Go to the Census Module -> Utilities sub menu -> Edit History
2. Pull up the Resident and Edit the applicable Discharge Transaction
3. Enter a **Y** for YES in the last field that asks "Ignore Discharge for PPS?"
4. Click Finished

The PPS schedule will ignore the discharge and the schedule will probably be correct BUT the billing produced from the resident data will be incorrect. If the resident was not in the facility at midnight, Medicare may not be billed for the day. The Billing staff will have to be alerted to the situation.

Individual PPS Excel Worksheet

After selecting a resident, this option will produce an Excel Spreadsheet containing the PPS scheduling information for that individual.

Generic Report

This report generator will allow anyone to create a report with residents' names, social security numbers, date of assessments, and whichever fields selected by you from the MDS Assessment. The number of fields selected are constrained by the width of the paper. As you select fields, you will be informed of the number of columns used in the report. You may utilize a total of 132 columns or characters using portrait mode and 171 using landscape mode. Most of the fields in the MDS will use approximately 4 spaces and thus you may select up to about 20 fields on a standard printer and 30 fields on a laser printer printing landscape or sideways.

To create a report, select the Generic Report option under the reports menu. You will then see a Report Configuration Screen. There are three different questions asked on this screen.

Between Two Dates Will capture data from assessments with ARD's between two dates

(P)ortrait or (L)andscape? If you have selected a Laser Printer, this option is available. Portrait Mode is using the paper as 8 ½ X 11; landscape as 11 X 8 ½.

Shading? Once again, on a laser printer printing the capability of shading every other line is available. This makes it easier to read the values.

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Once these questions have been answered, you will be taken to the screen where you select which fields you want to report on. The fields are displayed in the order they appear on the assessment. On the screen you will see the number (i.e. B3e is Section B, question 3, item e.) And what screen in the RMS system that question appears on. Select as many fields as you can fit on your report by hitting the <Enter> key on each field you want to include on the report.

Just chose the option to Finish Selection when you are done and the report will be generated using the following criteria: If it is a date field, it must be non-blank; if it is a numeric field, it must be anything other than 0; if it is a character field, then it must be anything but blank.

MDS's In Progress

This report will give you a list of all current MDS Assessments which have not been submitted. The list will appear in alpha order by resident. You will see which disciplines have signed off on sections as well as the RN AC sign-offs.

When you select this option, you will see, first, a Report Configuration Screen which contains:

Detailed Status of Assessment? This is a (Y)es or (N)o response. If **N** is entered, assessments will be listed resident name, SS#, Assessment Date, Reason for Assessment, whether or not the RN AC signed off in section R or if the Assessment has been; one line of data per resident per assessment. If **Y** is entered, the above data will appear as well a line for each discipline who has been into the assessment, the sections they entered and whether or not they signed off in Section Z. This info is imperative for ascertaining whether or not all disciplines have completed their sections.

Assessments worked on in the last how many days? Leave at 0 for all non-submitted assessments.

RN AC's must run this report to ascertain whether or not the assessment has been completed if it is being filled in by staff other than the coordinator.

MDS Comparison

Use this report to compare assessment values between two assessments. To select Assessment #1, click on the correct assessment and then click **OK**. The screen will flash, displaying the list of assessments again. Click on the second assessment and then click **OK**. Now the report will come to the screen.

ADL History

Reports on ADL scores for one year. This report is very useful for identifying Significant Changes, preparing for survey, QA, etc.

Why Not

The Why Not report is available to help you understand the MDS 3.0 Rugs IV grouper logic.

Submission Assistance

Options under this menu help to coordinate submission of completed MDS forms.

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Report on Assessments Ready

This option produces a report containing all completed MDS forms that are ready for submission. In order for an MDS to appear on the report, it must be completed AND the error check report must have been run with 0 errors being reported. If your facility is using electronic signatures, an option will display to verify valid sign-offs. Each assessment ready for submission will be listed along with clinician details and sign-offs.

Batch Selection

The Batch Selection option is an add-on feature to MDS 3.0 available for purchase from P&NP Computer Services. If you have the feature, please see the separate documentation *Batching and Zipping MDS 3*.

Outstanding Submissions

This will show all assessments that you have exported to a file. Remove the assessments which have been accepted. In this way you may keep track of assessments which have been rejected and need to be “unsubmitted”, fixed, and then re-submitted.

Process Submissions

This option allows the user to read in the validation report. Before processing, a folder should be created called *MDS30 Validations* on your network, preferably on a drive that is backed up. Download validations into this file folder so they can easily be found.

To process a validation file, choose the PROCESS SUBMISSION menu option. You will then have to select the file for processing. Using the Browse window, locate the drive and *MDS30 Validations* folder, highlight the correct file and click OPEN.

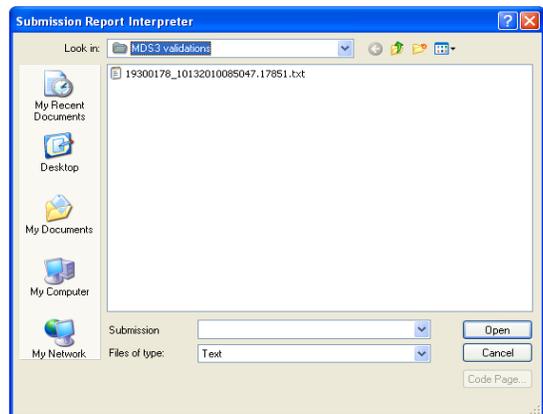


Figure 16

The file will be processed and a report will be generated depicting the results. You may only access this report once and then the system marks it as having been opened and read so you may wish to print the report for your records.

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After reading the validation report, run the OUTSTANDING SUBMISSIONS menu option to remove accepted assessments.

UPDATE CHANGES FEBRUARY 2013

Assessments for residents on Medicare Replacement (Medicare C) plans.

The tracking of MDSs for Medicare replacement residents has been changed. The new tracking can be found before the very first official MDS question in Section A which is A0050, Type of Record. The field will default to a “1” meaning that the assessment will be submitted. For “PPS” type assessments for Medicare replacement residents, the field should contain a “2”. This can be inputted by the MDS Coordinator when coding Section A. **Question A0410 should be filled in with a “3”.**

The screenshot shows the 'Section A Identification Information' form. At the top, there are navigation buttons for 'Save', 'Quit', and 'Exit'. Below these are tabs for different assessment types: '0050-0200', '0310 A-C', '0310-0410', '0500-0900', '1000-1100', '1200-1500', '1510-1550', '1600-2000', '2100-2300', and '2400'. The '0310 A-C' tab is selected. The form is divided into several sections:

- Submission Status of Assessment:** This section has an 'Enter Code' field with the value '1' circled in red. The instructions are:
 1. Submission of this assessment is required by state and/or federal guidelines
 2. Assessment is being completed for reasons NOT COVERED by state/federal guidelines (e.g. Medicare Advantage or other private insurance)
- A0050. Type of Record:** This section has an 'Enter Code' field with the value '1'. The instructions are:
 1. Add new record → Continue to A0100, Facility Provider Numbers
 2. Modify existing record → Continue to A0100, Facility Provider Numbers
 3. Inactivate existing record → Continue to X0150, Type of Provider
- A0100. Facility Provider Numbers:** This section contains three sub-fields:
 - A. National Provider Identifier (NPI):** 1234567890
 - B. CMS Certification Number (CCN):** 335311
 - C. State Provider Number:** 00309068
- A0200. Type of Provider:** This section has an 'Enter Code' field with the value '1' and a 'Type of provider' field with the following instructions:
 1. Nursing home (SNF/NF)
 2. Swing Bed

These assessments will behave exactly like the assessments wherein you had previously marked a “1” in A0410.

MDS Link for Height (K0200A), Weight(K0200B) and Weight Loss (K0300) to Vital Signs Tracking (either in Resident Observations or Charting and Clinician Notes Modules).

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M	K0200. Height and Weight
L	While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up
K	<input style="border: 2px solid red;" type="text" value="100"/> inches
J	A. Height (in inches). Record most recent height measure since admission
I	<input style="border: 2px solid red;" type="text" value="-"/> pounds
H	B. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)
G	K0300. Weight Loss
F	Loss of 5% or more in the last month or loss of 10% or more in last 6 months
E	Enter Code
D	<input style="border: 2px solid red;" type="text" value="0"/>
C	0. No or unknown
B	1. Yes, on physician-prescribed weight-loss regimen
A	2. Yes, not on physician-prescribed weight-loss regimen

K0200A, K0200B -- If height and weight are regularly recorded in the Resident Observations or Charting and Clinician Notes Modules, the data can be viewed and brought into the MDS. The fields in the MDS will be outlined in red as illustrated above.

Hit the **F9** (function key) on the field. A screen appears with the information from the latest height and weight entry in the system. If the information is correct and you wish to use it, hit the **ACCEPT** button. PLEASE carefully note the date of the information.

The data contained in the charting module (vital numbers) suggests that the following responses be entered in the MDS:

K0200a	67	Observation made on: 02/14/2013
K0200b	173	Observation made on: 02/14/2013

IMPORTANT: The clinician responsible to complete these questions for the facility must verify that these responses are correct.

Cancel
 Accept

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K0300 (See screen below) – Hit **F9** and the system will look back for weights from approximately 30 days (20-40 days) from the ARD for the 30-day comparison or approximately 180 days (165 to 195) for the 180-day comparison. It analyzes data from Vital Numbers *only*. If you see a current weight and not a past weight for calculation, the system was unable to find data it could use or unable to find data supporting a weight loss. If you select the **ACCEPT** button in that circumstance, the answer will be zero filled.

If there has been a weight loss you must manually indicate a “1” or a “2”. If you hit **ACCEPT**, the answer will be zero filled as the system cannot logically make the decision for you between “1” and “2.”

The data contained in the charting module (vital numbers) suggests the following calculation:

30-day comparison (answer 1 or 2 ONLY IF \geq 5% change, otherwise 0)

192.0	Observation made on: 01/16/2013
173.0	Observation made on: 02/14/2013
10.983% change in weight	

180-day comparison (answer 1 or 2 ONLY IF \geq 10% change, otherwise 0)

228.0	Observation made on: 08/14/2012
173.0	Observation made on: 02/14/2013
31.792% change in weight	

IMPORTANT: The clinician responsible to complete these questions for the facility must verify that these responses are correct.