

MDS 3.0 UPDATE FOR April 1, 2011

There are some **important changes** in the update for RMS Version 2011.0 that upgrades from RMS 9.9.4 that impacts the MDS 3.0 as of April 1, 2011. Please take the time to read this document.

1. As of April 1 the MDS 3.0 form will change:

Of special interest is question S8055:

Resident _____	Identifier _____	Date _____
Section S New York (Effective beginning April 01, 2011 for NH ISCs, except NT.)		
S0160. Specialty Unit / Facility Reimbursement, or Resident Eligible for Enhanced Reimbursement (Add-On) for AIDS or TBI Conditions		
<input style="width: 30px; height: 20px;" type="checkbox"/> Enter Code	01 Discrete AIDS Unit	
	02 Ventilator Dependent Unit	
	03 Traumatic Brain (TBI) Unit	
	04 Behavioral Intervention Unit	
	05 Behavioral Intervention Step-Down Unit	
	06 Pediatric Specialty Unit / Facility	
	07 AIDS Scatter Beds	
	08 Traumatic Brain (TBI) Extended Care	
	99 None of the Above	
S8055. Primary Payor		
<input style="width: 30px; height: 20px;" type="checkbox"/> Enter Code	1 Medicare	
	2 Medicaid	
	3 Medicaid Pending	
	9 None of the Above	

Definitions and Coding Instructions:

Enter the Code of the **one** source of coverage that has primary responsibility for and pays for most of the resident's current nursing home stay on the Assessment Reference Date (A2300).

- **Code 1. Medicare** – Medicare Part A (traditional) or Medicare Part C (Medicare Choice/HMO) is the primary payor. Medicaid may pay for the Medicare co-insurance and/or deductibles.
- **Code 2. Medicaid** – Medicaid is the primary payor (includes Medicaid HMO). Residents with Medicaid coverage supplemented by Medicare Part B should be recorded as Medicaid payor.
- **Code 3. Medicaid Pending** - There is no other primary third-party coverage being used for the resident's present stay, **and** the facility has sought, or intends to seek, establishment of Medicaid eligibility for coverage as of the Assessment Reference Date (A2300).
- **Code 9. None of the Above** - The primary third-party payor is not Medicare or Medicaid, and Medicaid is not pending. The payor may be commercial insurance, or a resident who pays privately, or one who receives charity care.

In the MDS for field S8055, the system will continue to suggest #1 (Medicare) for all **Medicare A** residents based on the primary payor listed in the Census and for All **Medicare C** residents

whose Primary Payor in the RMS Census has a 16 in the in the PAY CODE field in for the insurance in the Insurance Database. *(We are hoping the State will change the requirements to line up with the CMS definition of Medicare but as of the time of writing this Quick Sheet, we have received no official word from the State of NY)*

To check the Payor Coder ID field for the insurances in your Insurance Database, go to ADT→ Maintain Databases → Insurance. Select the insurance and click on the EDIT Button:

List	Details
Company	BLUE CHOICE
Address	
City/State/Zip	
Phone	
Provider Number	
Payer Identification Num	
Payer Code	16
Follows PPS Schedule?	N
All Inclusive Rate for Ancillaries?	Y
Separate Sales Journal	N
Receivable account #	1111-1111-1111
Revenue account #	2222-2222-2222
Contractual Allowance #	3333-3333-3333
Ancillary Contractual #	8888-8888-8888
Contracted Daily Rate	0.00

If the PAYER CODE field is not a 16, RMS will not be able to make to suggest MEDICARE as the State's instructions dictate. Also indicate follow the PPS Scheduling unless you do NOT want to put the covered residents on the PPS Schedule.

2. Medicare C (Medicare Advantage/Medicare HMO) assessments:

In the Open Door Forum of Thursday, March 17, 2011, CMS made very clear that long term care facilities are **NOT** to submit assessments for Medicare C residents. Furthermore, CMS indicated that combination assessments such as 5 Day and Admission, 30 day and quarterly, 60 day and Sig Chance, etc are not to be submitted if the resident is Medicare C. Indeed, on OBRA assessments, unless the resident is Medicare A, (Traditional Medicare), field A0310 b should be a 99 and A0310 c would be a 0. Field A2400 should only reflect the dates for MEDICARE A stays.

What does this mean for you??

Firstly, no combination OBRA/PPS assessments for Medicare C should be completed. You will have to do a separate PPS assessment. Make use of the system's ability to Copy from one assessment to another. Also, do not forget that the F10 HISTORY KEY will show you the response for any question for every MDS 3.0 that has been done for the resident. .

Secondly you will have to mark field A0410 in the PPS ASSESSMENTS completed for your Medicare C residents so RMS can recognize them as Medicare C assessments.

To “mark” a PPS assessment for a Medicare C resident, please put a number 1 in field A0410:

A0410. Submission Requirement	
Enter Code	1. Neither federal nor state required submission
<input type="text" value="1"/>	2. State but not federal required submission (FOR NURSING HOMES ONLY)
	3. Federal required submission

RMS will not put any assessment that has a “1” in field A0410 into the option to Batch and Zip. It will remain unsubmitted.

If your facility does not use the Batch and Zip option and you mistakenly export and a PPS assessment that was done for a Medicare C resident, the system will NOT put the assessment in a file and the submission flag will continue to say NO.

In Figure 1 below, the 03/20/2011 EOT OMRA shown in Figure 1 below has a **1 in field A0410**. The error report showed that the assessment had no errors but it did have 2 Information notices when the error report was run. See error report below for sample test.

**List of Errors for Assessment:
AAA, TRIPLE
03/20/11**

Item	Err #	Type of Error	Severity	Description of Error
A0200	-3707	Information	None	a) If A0200=[2] (if the provider is a swing bed provider), then A0410 (submission requirement) must equal [3] (it cannot equal [1,2]). b) If A0200=[1] (the provider is a nursing home), then A0410 must equal [2,3]. c) For both nursing homes and swing bed providers, A0410 must not be equal to [1].
A0410	-3707	Information	None	a) If A0200=[2] (if the provider is a swing bed provider), then A0410 (submission requirement) must equal [3] (it cannot equal [1,2]). b) If A0200=[1] (the provider is a nursing home), then A0410 must equal [2,3]. c) For both nursing homes and swing bed providers, A0410 must not be equal to [1].

Clinician Information:

BGUHDE MDS ABCDE GH O Z 03/28/11 12:41:46 PM
 Z0400 entered 03/25/11
 Z0500b entered 03/25/11

NEW ERROR LEVEL INDICATORS:

The April 1 changes from CMS include extensive changes to the error checking.

03/20/11	NO : OMRA / EOT	00	0/ 0/ 2	NO	RMA	CA2
03/10/11	NP : 14-day	00	0/ 0/ 0	NO	RMA	CA2

Figure 1

As you can see from Figure 1, there are now three areas that appear when the error report is run. The first area from left to right reports the number of errors, the second the number of warnings, and the third, the number of “information” notifications.

Color coding: Red/Pink = Errors
 Yellow = Warnings
 Green = Information Notifications

In terms of the assessments for Medicare C which are not submitted, you will see the field green indicating “information” notifications. Of course, since these assessments WILL NOT be submitted, there is no further action to be taken by the user once the MDS Coordinator has signed off on Z0500.