MDS 3.0 Issues – Important Information
AHCA – 11/8/10

Useful Websites

- https://www.qtso.com/mds30.html - Helpful Hints is new document, posted on 11/4/10, and is an overview of the steps required to submit an MDS 3.0 file, verify its submission status, and obtain a Final Validation report. The Helpful Hints can also be accessed on the MDS 3.0 Welcome Page when nursing homes sign into CASPER.
- http://www.cms.gov/NursingHomeQualityInits/30_NHQIMDS30TechnicalInformation.asp#TopOfPage - Use for general MDS 3.0 updates.
- http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage. The MDS 3.0 website containing coding training slides, instructor guides, training aides, MDS 3.0 RAI Manual updates and linkages to CMS internal and external websites. The MDS 3.0 Provider User's Manual also outlines error messages (Chapter 5). For information on how to bill Medicare, providers need to contact their Fiscal Intermediary.
- http://www.medicare.gov/publications/pubs/pdf/11477.pdf - A brochure that allows adding Medicaid Agencies, Money Follows the Person programs, Ombudsman, etc. contact information. Residents and family members can call 1-800-MEDICARE to order a free copy.
- http://productordering.cms.hhs.gov/ - For providers to order the brochure. Providers are asked to set up an account to order. Once the account is approved providers will be able to log on and place orders.
- http://www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp#TopOfPage. The website provides the most up to date point of contact list and Section Q, Questions and Answers document, best practice tools and links to CMS Section Q training, brochure and videos resources.
- http://www.youtube.com/watch?v=vfCSd9eK9F0 - Money Follows the Person videos can be found at. A 10-minute video of two recently transitioned nursing home residents provides perspectives on returning to home after being admitted to a nursing home.

Where to Get Help

- mds30comments@cms.hhs.gov – Use to submit MDS coding questions for regulation related to MDS, reimbursement, care planning, etc. In general, answers to questions are provided within 3 business days and 5 business days is the question needs to be researched.
- mdsformedicaid@cms.hhs.gov – Use to submit questions and issues related to Section Q.
- help@qtso.com – Use too submit questions and issues related to MDS transmission/validation.
- mdstechissues@cms.hhs.gov – Use this website to submit technical questions related to RUG specs and jRAVEN.

Most Common Error Codes Reported

- 1057: This code provides the RUG III value for facilities for billing purposes (see details in Chapter 5 of the MDS 3.0 Provider User's Manual). CMS recommends using the RUG listed on the validation report for billing.
- 3616a/b/c: The 3616 error means that the facility software did not calculate RUGS IV correctly and the facility needs to use the RUGS IV calculated by QIES ASAP. The QIES ASAP RUG is the correct RUG as

shown on the validation report. The facility needs to work with their software vendor to correct this issue.

Common Tech Issues – Ongoing Reasons for Not Receiving Validation Reports

- The ASAP System could not determine what provider the records belong to so it could not put them on the provider's Final Validation Report.
- If submission files with a 'Completed Status' and the Total Record Count is zero, a Final Validation Report is NOT generated. An MDS 3.0 Submitter Final Validation Report can be requested to identify the severe errors. Generally, these error messages are associated with Invalid Zip Files (i.e. Unable to unzip submitted file OR Zip file contains no files)
- Be sure to login to the CASPER Reporting application with your individual user ID/password. This is the same user ID/password (MDSxxxxxxx or SWBxxxxxxx) with which you access the MDS3.0 Submission System.

Section Q – Common Questions & CMS Response

Q: Everyone with an active discharge plan needs a referral to a local contact agency regardless of whether the resident, family, significant other, or guardian/legal representative wants one.

A: Every resident with an active discharge plan does not require a referral to a local contact agency. An example would be when the nursing home has arranged a short stay SNF or its planned NF discharge and does not need to involve the local contact agency (LCA). When Q0400A is ***coded 1 "Yes***" - **an active discharge plan is in place for the resident to return to the community** and the nursing home staff has already developed a 'complete' discharge plan, no referral to the LCA is needed. Since there is an active discharge plan in place, the assessor skips to Q0600 - Referral. At Q0600, there are two coding options described on Page Q-16 of the RAI manual coding instruction in addition to a referral to the LCA that could be used.

If the resident's discharge planning has been developed by the nursing home staff and a LCA referral is not needed, the assessor could select ***Code 0 – "NO"*** - **determination has been made by the resident and the care planning team that contact is not required**.

If the care planning team needs additional time to talk to the resident (or family or significant other, or guardian or legally authorized representative) about residential community options, needs, opportunities, feasibility, family support etc. or plans are not finalized regarding a discharge plan, the assessor could select ***Code 1 "NO"*** - **referral was not made.**

Q: Discharge planning is the responsibility of the SNF and not the local contact agency. If the SNF does not do discharge planning then why do they employ Social Workers?"

A: Discharge planning is still the responsibility for the NF social workers and a regulatory requirement at CFR 483.20(l)(3). The local contact agency can be new partner to collaborate with, particularly on difficult to place clients and offer expanded resources. In general, the LCA's role is to contact individuals referred to them by nursing facilities through the Section Q processes in a timely manner,

provide information about choices of services and supports in the community that are appropriate to that individual's needs, and collaborate with the nursing facility to organize the transition to community living if possible. The exact mode and content of that contact with the nursing facility resident is to be determined by each state in response to their goals for providing choices of services and settings to individuals, with substantial input from all stakeholders involved.

Q: Some States, like OH, plans to pull MDS 3.0 Section Q data and they plan to make the referral to the local contact agency. Is this how it should be done?

A: Since each state handles Section Q, LCA referrals differently, provider issues should also be discussed at a state level. The proposed approach by the state of Ohio does not relieve the nursing facility from their responsibility of calling the local contact agency within 10 working days of a resident saying yes to Q0600.

MDS and Survey

- CMS issued S&C memo 11-02-NH to provide guidance to surveyors related to MDS 3.0 final validation report issues that arose because of a computer glitch in the MDS 3.0 Assessment Submission and Processing (ASAP) system. The memo addresses the requirement that LTC facilities transmit MDS data within 14 days after completion (F-287).