

# North Carolina



Current Information on North Carolina Case Mix Reimbursement

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The North Carolina News is a publication produced under contract with The North Carolina Division of Medical Assistance by Myers and Stauffer LC 9265 Counselors Row, Ste. 200 Indianapolis, IN 46240

The North Carolina News is published to keep all interested parties current on North Carolina Case Mix Reimbursement. Its goal is to provide information on major issues, work groups, and upcoming activities. The articles presented here are only a synopsis of the topics and are not intended to present a complete analysis of the issues.



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## MDS 3.0 Update

At the December 9, 2009 CMS and State Medicaid National MDS 3.0 Teleconference, CMS announced the MDS 3.0 document release website. MDS 3.0 information for the October 1, 2010 implementation can be found by visiting [http://www.cms.hhs.gov/NursingHomeQualityInits/25\\_NHQIMDS30.asp](http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp). The following files are now available under the Downloads section of this page:

- **MDS 3.0 Item Subsets (V1.00)** - This zip file contains printable documents with the required subset of data items for each MDS 3.0 assessment and tracking document (e.g. admission, quarterly, annual, significant change, discharge, entry, etc).
- **MDS 3.0 Item Matrix (V1.00)** - This document identifies the items required for each type of assessment along with how the item is used (e.g. QMs, QIs, CATs, RUG-IV, or RUG-III).
- **MDS 3.0 RAI Manual Nov 2009** - This zip file contains chapters 1, 3, and 5. Each section in chapter 3 is contained in a separate PDF file (e.g., Section C: Cognitive Patterns). Appendices A through G, and H are also listed. **Chapters 2, 4, & 6, and Appendix C are scheduled to be posted in December.**
- **Data Technical Files V1.01 November 2009** – This document contains the following MDS 3.0 technical specification information:
  - ◆ **MDS 3.0 Data Submission Specifications (V1.00)** - Detailed data submission specifications for MDS 3.0.
  - ◆ **RUG-IV SAS Package (V.100)** - Thoroughly tested SAS code for RUG-IV classification with documentation and test data.
  - ◆ **RUG-III MDS 3.0 Mapping Specifications (V1.00)** - This document presents logic that can be used to produce RUG-III classifications using assessment items contained on MDS 3.0.
  - ◆ **MDS 3.0 CATs Specifications (V1.00)** - For each Care Area, this document provides Care Area Trigger (CAT) specifications for the MDS 3.0 items used in triggering the Care Area, the conditions for triggering, and Visual Basic code for triggering. The CATs are replacing the MDS 2.0 Resident Assessment Protocols RAPs.

(continued on page 2)

### In This Issue

<i>MDS 3.0 Update</i> .....	1-2
<i>Holiday Schedules</i> .....	2
<i>Myers and Stauffer Training</i> .....	3
<i>Policies and Procedures</i> .....	3
<i>Original Records</i> .....	3
<i>Dear Patty</i> .....	3
<i>Transmission Schedule</i> .....	4
<i>Medical Record Correction Policy</i> .	5
<i>Health Record Policy</i> .....	6-7

# MDS 3.0 Update, continued



**Important!!**

**Please Note:** Although this is the material that will be applicable with the October 1, 2010 implementation, CMS strongly encourages that all parties refrain from or delay conducting training until after the “Train-the-Trainer” sessions have been

completed (scheduled for the spring 2010.). Questions regarding the information on this page should be directed to [MDS30Comments@cms.hhs.gov](mailto:MDS30Comments@cms.hhs.gov) or your state RAI Coordinator.

(Information obtained from <http://www.cms.hhs.gov>).

## Training

### *CMS MDS 3.0 Training*

The first satellite broadcast is planned for December 17<sup>th</sup>, 2009. This program will be the first of a three-part series focused on providing information on the Minimum Data Set Version 3.0 (MDS 3.0) due to be implemented on October 1, 2010, by nursing homes across the nation. This program will focus on providing information regarding the major areas of change to, & impacts as a result of implementation of, the MDS, as well as plans and resources for the implementation of the instrument in October, 2010. All broadcasts will be available for a one year review through the S & C webstreaming at <http://surveyortraining.cms.hhs.gov/>.

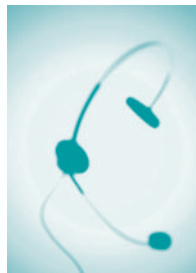
## Holiday

## Schedules



### Myers and Stauffer Help Desk

The Myers and Stauffer Help Desk will be closed on December 24<sup>th</sup> and 25<sup>th</sup>. The Help Desk will resume on Monday, December 28<sup>th</sup> at 8:00 am.



### Division of Medical Assistance MDS Validation Reviews

In observance of the upcoming holidays, there will be no MDS validation reviews conducted during the week of December 21<sup>st</sup> – 25<sup>th</sup>. Reviews will resume on December 28<sup>th</sup>.



# Myers and Stauffer Training!



The Division of Medical Assistance and Myers and Stauffer will be working in collaboration with the Division of Health Service Regulation to prepare providers for the transition to the MDS 3.0. Myers and Stauffer RUGs and Case Mix training dates and locations will be



announced in the spring. If you would like to be among the first to receive seminar notifications, newsletters, resources available, etc., please send an email to [NCHELPDESK@mslc.com](mailto:NCHELPDESK@mslc.com) to subscribe to our notification list. When sending your message, please type "subscribe" in the subject line. In the body of the message, please include your full name, title, phone number and facility/company name.

This email address may also be used for submitting general questions (not containing PHI) to the Myers and Stauffer Help Desk. Please be sure to provide all of your contact information to ensure a speedy response.

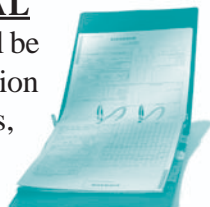
## Policies and Procedures

The Medical Record Correction Policy and the Health Record Policy are now available on-line. For your convenience and reference, we have included these documents on Pages 7-9 of this newsletter. They can also be found at <http://nc.mslc.com> in the "Resources" folder. Other information located under "Resources" includes the latest newsletters, NEW! 2010 CMI Listing Report and Transmission Schedule (also included on Page 6 of this newsletter), supportive documentation guidelines and much more.



## Original Records

Only **ORIGINAL LEGAL MEDICAL RECORDS** will be accepted for the MDS Validation Review. Copies of records, such as ADL flow sheets, will **NOT** be accepted.



## Dear Patty...

The "Dear Patty..." column is a regular feature in each issue of the *North Carolina News*. Patty Padula, Myers and Stauffer's RN consultant, will discuss questions that are frequently answered by our staff. We welcome your questions for future issues.



### Dear Patty:

*Q: How do I get ready for the MDS 3.0? How will the MDS validation review change?*

A: The Division of Medical Assistance and Myers and Stauffer are underway preparing for the 10/1/2010 implementation of the MDS 3.0. Once the complete RAI manual is issued by CMS we will be updating the ADL and supporting documentation guidelines. Tracking tools currently offered on the Myers and Stauffer website will be refined to reflect the MDS 3.0 and thorough training will be provided in ample time for providers to prepare their staff in advance of the MDS 3.0 implementation.



Any and all changes to the MDS validation review will be presented at this training. The MDS validation review protocol is not expected to change, however the supportive guidelines will be adapted to the MDS 3.0. It is also anticipated that the RUG III 34-classification model will continue to be applied to the case mix reimbursement system.

## 2010 North Carolina Division of Medical Assistance – CMI Listing Report and Transmission Schedule

January 2010						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

February 2010						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

March 2010						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

April 2010						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

May 2010						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

June 2010						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

July 2010						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

August 2010						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

September 2010						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

October 2010						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

November 2010						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

December 2010						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

Tan Day of the Month

Transmission date for Preliminary CMI Listing Reports is no earlier than 15th.

Blue Day of the Month

Preliminary CMI Listing reports are mailed to providers.

Yellow Day of the Month

Final Transmission date for Final CMI Listing reports.

Orange Day of the Month

The cut off date for payer source corrections to be received in Myers and Stauffer's office.

Green Day of the Month

Final CMI Listing reports are transferred to NC DMA for mailing with the CMI rate letters.



North Carolina Department of Health and Human Services  
**Division of Medical Assistance**

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Beverly Eaves Perdue, Governor  
Lanier M. Cansler, Secretary

Craigian L. Gray, MD, MBA, JD, Director

**Effective:** 1/01/2008

**Medical Record Correction Policy for MDS Validation Reviews**

**Policy:** Minor changes or corrections in the resident's status should be noted in the resident's record, in accordance with standards of clinical practice and documentation. Once documentation is recorded in the medical record, facilities may not "change" previously recorded documentation. This policy allows for a correction methodology in accordance with standards of clinical practice and documentation.

**Procedure:** Such monitoring and documentation is a part of the facility's responsibility to provide necessary care and services. However, it is important to remember that the medical record is the legal assessment. Changes made to the electronic record or paper record maintained in the medical record after data transmission are not recognized as proper corrections.

Therefore, the Division of Medical Assistance has made provisions to allow proper corrections for the electronic record or paper record maintained in the medical record.

- a) If an error is discovered on or after but within 7 days of the Assessment Reference Date (A3a) of an MDS and before submission to the State MDS database, the response may be corrected using standard editing procedures on the hard copy (cross out, enter correct response, initial, and date) and correction of the MDS record in the facility database. The resident's care plan should also be reviewed for any needed changes.
- b) Any corrections including but not limited to, the Activities of Daily Living (ADL) grid must have an associated note of explanation per correction.
- c) If a major error is discovered in a record in the State MDS database, modification or inactivation procedures must be implemented by the facility to assure that the database information is corrected.
- d) Clinical documentation corrections must also be made as necessary to assure that the resident is accurately assessed, the care plan is accurate, and the resident is receiving the care needed.
- e) A quarterly or summary note will not substitute for an occurrence correction.
- f) A standard medical correction consists of drawing a line through the incorrect information, entering the correct information, dating and initialing the change. Improper or illegible corrections will not be accepted for the review.





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Lanier M. Cansler, Secretary

Craig L. Gray, MD, MBA, JD, Director

***Effective: 11/1/2009***

**Health Record Policy\***

**Policy:** It is the policy of the NC Division of Medical Assistance to examine/review original medical record documentation to support resident assessment data (Minimum Data Set--MDS) for the MDS Validation review.

**Procedure:** More and more health care providers are using Health Information Technology (IT); in particular, Electronic Health Records (EHR). Health care providers (nursing home facilities) who utilize EHR processes are required to comply with the following procedures:

- The provider must grant access to any medical record, including access to EHRs, when requested by the reviewer.
- If access to an EHR is requested by the reviewer, the facility will:
  - Provide the reviewer with a tutorial on how to use its particular electronic system and
  - Designate an individual who will, when requested by the reviewer, access the system and
  - Respond to any questions or assist the reviewer as needed in accessing electronic information in a timely fashion.
- Each reviewer will determine the EHR access method that best meets the need for that review.
- During the entrance conference in a facility using EHRs the reviewer must request that the facility provide a terminal(s) where the reviewer may access records.
- In the case of a hospital or other provider or supplier with terminals at multiple care locations, the reviewer must be provided access to a terminal at each care location.
- If the facility is unable to provide direct print capability to the reviewer, the provider must make available a printout of any record or part of a record upon request in a timeframe that does not impede the review process.
- ***Undue delays in the production of original and or EHR medical records are unacceptable and could result in unsupported documentation.***
- Whenever possible, the facility must provide the reviewer electronic access to records in a read-only format or other secure format to avoid any inadvertent changes to the record.
- The provider is solely responsible for ensuring that all necessary back up of data and security measures are in place.



## **Health Record Policy\*** **Continued**

The RN reviewer will cooperate and work with facilities that use EHR. During the entrance conference the reviewer will establish with the facility the process they will follow in order to have unrestricted access to the medical record. Electronic access to records will not eliminate the need for a reviewer to print a paper copy or to request a paper copy of certain parts of certain records. However, the reviewer shall make reasonable efforts to avoid, where possible, the printing of entire records. The reviewer should print or request a paper copy of only those parts of records that are necessary.

### **Conclusion**

Existing requirements allow the RN reviewer and others authorized by law to have access to facility records whether those records are paper or electronic record systems. Refusing access to any patient/resident records is a basis for termination of the facility's Medicaid agreement. If the reviewer requests access to EHR, the facility should ensure that data are backed-up and secure, and access does not impede the review process or the provision of care and services to beneficiaries.

\*Health Records shall be defined as computer records, scanned records and or any records otherwise maintained as legal medical documentation.

