Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
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MASSHEALTH
TRANSMITTAL LETTER NF-46
November 2003

TO: Nursing Facilities Participating in MassHealth

FROM: Beth Waldman, Acting Commissioner Beth Waldman

RE: *Nursing Facility Manual* (Revisions to Appendix E)

This letter transmits revisions to Appendix E in the *Nursing Facility Manual*. Appendix E contains instructions for completing Initial and Quarterly Management Minutes Questionnaires (MMQs). Among the revisions are elimination of the MLOA section, instructions for completing the monthly Nursing Summary, and scoring for topical medications requiring prescriptions. These revisions are effective December 1, 2003.

If you have any questions about this transmittal letter, please contact MassHealth Provider Services at 617-628-4141 or 1-800-325-5231.

Note: When we issued Transmittal Letter NF-47 in August 2003, we skipped over number NF-46. This Transmittal Letter now fills that gap. But please note that these numbers were used out of sequence.

NEW MATERIAL
(The pages listed here contain new or revised language.)

Nursing Facility Manual

Pages E-1 through E-6, E-13, and E-14

OBSOLETE MATERIAL
(The pages listed here are no longer in effect.)

Nursing Facility Manual

Pages E-1 through E-6, E-13, and E-14 — transmitted by Transmittal Letter NF-39

Instructions for Completing Initial and Quarterly Management Minutes Questionnaires (MMQs)

General Instructions

- An initial Management Minutes Questionnaire (MMQ) must be submitted for each new MassHealth member at the end of the admission month, or at conversion from private or Medicare coverage to MassHealth coverage. An MMQ must also be submitted on a quarterly basis for all MassHealth members who are residents of a nursing facility.

- For new members, codes must reflect the care provided on the effective date forward to the end of the month. For established residents codes must reflect the care provided during the previous month. A temporary condition may not be claimed. A temporary condition is one that requires a service for less than 50 percent of the month.

- The medical record is the source for information to complete the MMQ. Documentation must be accurate, dated, and signed by the person performing the care. The licensed nursing summary, daily licensed nursing notes, physician's orders and progress notes, ADL flow sheets, medication administration records, treatment records, and care plans should all be reviewed to complete the MMQ. Documentation for assistance with activities of daily living must be associated with resident dysfunction, and the reason given for assistance must relate to this dysfunction as described in the medical plan.

- The following terms should not be used in documentation, since they are not specific: frequently, almost always, often mostly dependent, and almost total assist.

- If a member has been in the facility for less than a month, the score is based on 50 percent of the days the resident has been in the facility.

- Initial MMQs and quarterly MMQs must be signed by a registered nurse. Clinical records must document this activity before the information is forwarded to the nursing facility staff who are responsible for preparing the electronic submission of MMQ data.

Medicare

- When a member's stay is covered by Medicare, the facility does not need to complete an MMQ.
- When Medicare coverage terminates, the member is eligible for conversion to MassHealth. The facility must submit an MMQ (Reason Code 2 for conversion) with an effective date of the first day of MassHealth eligibility.

Completing the Quarterly MMQ

- A quarterly MMQ must be submitted for every MassHealth member who is a resident of the facility on the first day of the reporting period.
- The quarterly MMQ must be completed from documentation for the previous month. It is essential to obtain quarterly MMQ information at the same time each reporting period.

With each quarterly MMQ, indicate the discharge of a resident who is no longer a MassHealth member as of the first day of the current reporting period. For example, if the effective date of the quarterly MMQ period is April 1, 2003, do not enter a discharge that occurred on April 3, 2003.

Item-by-Item Instructions for Completing the MMQ

Submission Reason

Last Name, First, MI: Last name first, first name, then middle initial (if no middle initial, leave MI field blank).

MassHealth ID: Use the 10-digit member identification number.

Code 1 — Admission: The resident is a new MassHealth admission to the facility. Submit the MMQ at the end of the month following the issuance of the member’s 10-digit member identification number.

Code 2 — Conversion: The resident is a new conversion to MassHealth. Submit the MMQ at the end of the month following the issuance of the member's 10-digit recipient identification number.

Code 3 — Category Change: The member's category has changed from the last quarterly assessment. Indicate changes on the Quarterly MMQ and submit upon quarterly review.

Code 4 — Code/Score Change: The scoring or coding for this member changed since the last quarterly assessment but the change did not result in a change in category. Indicate changes on the quarterly MMQ and submit upon quarterly review.

Code 5 — No codes or scores changed for this member since last quarterly assessment. Indicate Reason Code 5 on the quarterly MMQ and submit upon quarterly review.

Code D — Discharge: The member has been discharged from the facility.

Admission Date : The date of admission to the facility.

Effective Date : Start date for the category. Enter the month, day, and year for the date that applies as follows:

a. New MassHealth admission: the date of admission to the facility;
b. Conversion: the first date of MassHealth eligibility; or
c. Quarterly Update: the first date of the new period.

Sex: Enter 1 for male, 2 for female.

Race: Enter one of the following codes:

1 - White (not of Hispanic origin);
2 - American Indian or Alaska Native;
3 - Asian or Pacific Islander;
4 - Black (not of Hispanic origin); or
5 - Hispanic.

Date of Birth: The member's date of birth.

MassHealth Provider Number: Enter the facility's MassHealth provider number.

Facility Name: Enter the facility's "Doing Business As" name.

Clinical Instructions for the Initial and Quarterly MMQ

To justify the member's casemix score and category, the member's condition and care requirements must be documented for at least 15 days of the month during which the MMQ assessment takes place. If the individual has been a MassHealth member in the facility for less than a month, the score is based on 50 percent of the MassHealth eligible days the member has been in the facility.

In completing the initial and quarterly MMQ, information from the physician's orders, monthly nursing summary, nursing progress and daily notes, MDS, care plan, ADL flow sheets, medication record, treatment record, and all pertinent documentation must be reviewed. A licensed nursing summary must be completed monthly (or no later than five days after the end of the month), summarizing all of the care provided to the member.

All documentation must be accurate, dated, and signed by the person performing the care. Prompting or predetermining documentation is unacceptable. For example, licensed nurses may not indicate how nurse's aides are to complete an ADL flow sheet by highlighting, circling, or otherwise marking items. Only the original writer who made the original entry may change that entry. Late entries, corrections, and addendums must be made within fifteen days of the original entry or before the MMQ is submitted, whichever is sooner. To correct an error, draw a single line through the error, leaving the original entry legible; then initial and date the entry.

The member's score and category are based upon the services provided and recorded through the nurse's and nurse's aide's documentation. When conflicting documentation exists, the lower score will be applied.

Justification for assistance with activities of daily living and special attention must be associated with the member's clinical and functional status as documented by the licensed nurse according to the member's care plan.

A service may be claimed as either an intermittent PRN service or a continuous service and only as ordered by the physician and documented in the clinical record. For example, oxygen PRN may be claimed under Item 2 ("Skilled Observation Daily"), or continuous or daily oxygen may be claimed under Item 12 ("Skilled Procedure Daily/Other"). Both items must not be claimed on the same MMQ.

To ensure accuracy and objectivity, the monthly nursing summary must be completed by a licensed nurse who provided direct member care or was directly responsible for the care provided. The licensed nurse who completes the monthly nursing summary must not complete the MMQs. The Initial and Quarterly MMQ must be completed by a licensed nurse (RN, LPN) and must be signed by a registered nurse.

1. Dispense Medications and Chart (includes all routine documentation)

Code 1, Score 30 for All Residents

Pouring, delivering, and charting all medications, including psychoactives (see exclusion under Skilled Observation), intermittent I.V. antibiotics, routine injections, PRN medications, eye drops, eye ointments, inhalation aerosols, topical medications, suppositories, miscellaneous brief services such as vital signs that must be taken in conjunction with various medications, routine vital signs, and routine sugar and acetone. All residents receive 30 points since it reflects the necessary presence of a licensed nurse on duty at the nursing unit. The Code and Score data field is prefilled on the data-entry screen.

2. Skilled Observation Daily

No Documented Observations Required — Code 1, Score 0

Daily Skilled Observations — Code 2, Score 15

A skilled observation must be specifically ordered with parameters in writing by a physician, performed by a licensed nurse, and recorded at least DAILY (for example, neurological signs, B/P, and TPR) over and above any vital signs that must be taken and recorded as a prerequisite for the administration of certain medications. This also includes any nonroutine measurement of a resident's condition, such as the need for suctioning a resident with a tracheostomy, observation of the edema and/or congestion in a resident with congestive heart failure, the need for oxygen, and blood tests for insulin administration. This may include the introduction and/or titration of a psychoactive medication for a resident with a diagnosis of a major mental disorder that is defined as one or more of the following:

- schizophrenia;
- major affective disorder;
- atypical psychosis;
- schizoaffective disorder;
- bipolar depression;
- unipolar depression; or
- organic mental syndrome with associated psychotic and/or agitated behavior;

specifically to:

- titrate the dose for maximum effectiveness;
- manage unexpected harmful behaviors that cannot be managed without a psychoactive medication.

Note: The resident's condition must indicate the clinical complexity and justify the need for skilled observation, with documentation of a current or recent episode within the past 60 days. Document the date and type of episode.

Documentation: Daily licensed nursing documentation must be specific to the observation, including the nursing action and effect. Specific observations must be noted daily on a treatment sheet. Each episode must be documented and dated.

Exclusions:
- routine PRN use or tapering of psychoactive medications;
- aspiration precautions (except in clinically complex situations); and
- monitoring of temperature and signs and symptoms of infection while on antibiotic therapy.

3. Personal Hygiene

Independent — Code 1, Score 0
The resident is independent, assisted only for weekly bath/shower or on a "Restorative Bathing/Grooming" program. Score 0 if both bathing and grooming are Code 1.

Assist — Code 2, Score 18 (See Note below.)
Nursing procedures by staff to maintain personal cleanliness and good grooming including attending and/or assisting with bathing, shaving, and brushing teeth. Attending means continual supervision while the resident performs the personal hygiene task to ensure completion of the task. Includes routine skin care and the use of all bathing products.

Note: Any degree of resident involvement is considered an assist.

12. Skilled Procedure Daily/Other

Skilled procedures are procedures or treatments, other than pressure ulcer treatment, specifically ordered by a physician in writing that must be performed by a licensed nurse. See list of procedures below.

Code the daily frequency of skilled procedures in the single box (maximum of 9). Code 0 if no skilled procedures are needed. If more than one procedure is done daily, add the daily frequency for each procedure and enter the Code.

Example: If one procedure is done twice a day and another is done three times a day, the Code is 5.

Multiply the sum of the daily frequency of each procedure or treatment by 10 and enter the total on the score line.

Respiratory therapy, continuous or daily oxygen, oxygen therapy, suctioning, and continuous bladder irrigation may be claimed for a maximum of one time per shift. The same treatment to different locations is considered one procedure if the same treatment is provided. A maximum of 10 points may be taken for the checking and/or changing of an occlusive dressing. Topical medications requiring a prescription may be scored for a maximum of 20 points for a dermatological condition involving epidermal and dermal layers of skin.

Documentation: Daily licensed nursing documentation must specify treatment, frequency, description, and outcome. Specific observations must be recorded daily on a treatment sheet.

Enter appropriate procedure code(s) in the double boxes provided:

00 — None
01 — Dressing Change
02 — Catheter Irrigation
03 — Intermittent Catheterization
04 — Eye Irrigation
05 — Ear Irrigation
06 — Care of Heparin Locks
07 — Oxygen Therapy (continuous or daily therapy)
08 — Tracheostomy Care
09 — Sterile Dressing
10 — Suctioning
11 — Not in use at this time
12 — Respiratory Therapy (includes the use of inhalation aerosols for the management of episodes of bronchospasm)
13 — New Colostomy Irrigation
14 — Other

13. Special Attention

Coding: A code must be entered for each box A through D. (See Note below for Box C.) Code 0 if not applicable. Code 1 if special attention was required for 15 days of the month reviewed (or 50 percent of the total days if less than a full month).

A. Immobility: Code 1 if the resident is so heavy, helpless, or combative that two or more people are needed to change position, transfer, or ambulate. This includes use of mechanical lifting devices, for example, a Hoyer lift. The Nursing Summary must specify the resident's dysfunction and the ADL flow sheet must record the daily functional status.

B. Severe Spasticity or Rigidity: Code 1 if the problem is of such magnitude that it severely limits personal care or ambulation, requiring two or more people. The Nursing Summary must specify the resident's dysfunction and the ADL flow sheet must Code the daily functional status.

C. Behavioral Problems: Code 1, 2, or 3 may be used for behavioral problems. The disruptive behavior interferes with staff and/or other residents, causing the staff to stop or change what they are doing to control or alleviate the following disruptive behaviors:

a. Wandering — moves with no rational purpose, appears oblivious to needs or safety.
b. Verbally Abusive — threatens, screams, or curses.
c. Physically Abusive — hits, shoves, scratches, or sexually abuses others.
d. Socially Inappropriate or Disruptive Behavior — performs self-abusive acts, exhibits sexual behavior or disrobes in public, smears or throws food or feces, or rummages through others' belongings.

Note: Code 1 if behavior and intervention have been documented for 15-22 days.
Code 2 if behavior and intervention have been documented for 23-29 days.
Code 3 if behavior and intervention have been documented for 30 or 31 days.

Documentation:
For Code 1, 2, or 3, a current active treatment plan for behavioral problems must be in the medical record.
For Code 1, the Licensed Nursing Summary must verify and summarize the daily documented behavior(s), frequency, intervention(s), and the outcome of intervention(s).
For Code 2 or 3, the daily Licensed Nursing Documentation must specify behavior(s), frequency, intervention(s), and outcome of intervention(s).
For Code 2 or 3, a psychiatric assessment must document the disruptive behavior.

D. Isolation: Code 1 if gowns and gloves are required due to communicable infection or severely impaired immune status.