MDS 3.0 Basic I Training

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Brief History of the MDS

- Surveys started in OH in the 1960's
- Major federal nursing home reform-OBRA '87
- 1990 Nursing Home Case Mix and Quality Demo
- 1991 MDS 1.0 implemented
- 1995 MDS 2.0 implemented
- 1998 Medicare PPS & National MDS automation for data transmission
- 1999 QI's for survey
- 2002 QM's publicly reported/RAI manual revised
- 2010 MDS 3.0 RAI implemented on October 1- updated several times since July 2010 (updated 10/2016 Version 1.14).

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What is the RAI?

- Resident Assessment Instrument
- A structured, standardized approach to applying a problem identification process
- It helps nursing home staff look at residents *holistically* as *individuals* for whom quality of life and quality of care are mutually significant and necessary

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Closer look at RAI

- RAI is comprised of 3 basic components
  1.) MDS version 3.0 (Minimum Data Set)

  2.) Care Area Assessment Process (CAA)
  -Includes Care Area Triggers (CATS)

  3.) RAI Utilization Guidelines

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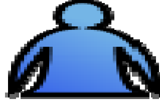
INTENT OF RAI

- Ensures collection of *minimum*, standardized assessment for each resident at regular intervals
- Drives development of an *individualized* plan of care based on residents identified needs, strengths and preferences



- Promotes highest level of functioning:
  - Improvement when possible, *or*
  - Maintenance and *prevention of avoidable decline*

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Privacy of MDS Data

- MDS data is considered part of the resident's medical record and is protected from improper disclosure
- MDS data can be released when required by:
  - Transfer to another health care institution,
  - Law (both State and Federal), and/or
  - The resident
- Privacy Act of 1974 requires that all individuals whose data are collected and maintained in a federal database must receive notice
  - MDS Chapter 1, has a Privacy Act Statement (2005) and is the updated notice informing the resident and/or family that MDS data is being collected and submitted to the national system.

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Uses for MDS Data

Resident Care Planning

Medicare and Medicaid Payment

Monitoring Quality of Care

Consumer Access to Information

Documentation

- The MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues that are relevant for a resident.
- Documentation **must** substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS. (Chapter 1 – page 7).
- A2400 – pg. A-30, Definitions box: Medicare-Covered Stay: Skilled Nursing Facility stays billable to Medicare Part A. **Does not include stays billable to Medicare Advantage HMO plans.**

"HELPS" for Accuracy

- **READ** and have current manuals available for all staff involved with the RAI
- Involve all staff in learning about the MDS
- Use an interdisciplinary approach to the assessment
- Read and respond to the federal validation reports after submission
- Review the MDS before submitting
- Develop policies for RAI completion

Who is required to have an MDS Assessment?

- **All** residents in Medicaid/Medicare certified beds in LTC facilities
- **All** residents who have been in the facility for 14 days or more
- **Is not required for licensed-only facilities or for licensed-only part of a Medicare/Private facility. It is also not required for stays less than 14 days (e.g., Respite Care)**

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WHO COMPLETES THE RAI?

- **Facilities need policies and procedures as to "who does what sections"**
  - **Federal regulations require the RAI be conducted or coordinated with the appropriate participation of health professionals.**
  - **Facility must ensure that those who participate have the knowledge and expertise to do an accurate and comprehensive assessment in all areas.**
  - RAI must be conducted or coordinated by an RN who will sign and certify the assessment is COMPLETED (Z0500B). **IDT members should sign their completed sections = ACCURACY**

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WHERE DOES INFO COME FROM?

- Multiple sources
  - Resident, resident family, sig others
  - Health Care Team members
    - Licensed and non-licensed
    - Physician, Therapists, Dietary, etc.
- Multiple methods
  - Observation
  - Interview
  - Record Review

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RESOURCES NEEDED

- RAI MDS 3.0 User's Manual, Version 1.14 revised October 2016
- Evidence/research based protocols or tools for assessment and care planning
- Internet Access
  - –CMS, CMS Contractors
  - –Websites in Appendix B: State Agency and CMS Regional Office Contacts

Maintenance of MDS Assessments

- Must maintain 15 months worth of MDS's in resident's active clinical record – a Federal reg.
  - MUST be adhered to!
  - Includes all assessments and tracking forms
  - Can be stored electronic or by hard copy (most electronic)
- The 15 month period may not restart with each re-admission
- When resident discharges return anticipated and returns within 30 day, facility must copy previous RAI and transfer that copy to the new record
- If resident doesn't return in 30 days, a new Admission must be completed.

Website Addresses

- Appendix PP of the SOM for interpretive guidelines
  - http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html
  - MDS Manual:
  - http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html
  - QIES technical support
  - http://www.qtso.com

Website Information

- Medicare Information for Part A PPS:
  - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/index.html
  - Medicare Manuals:
  - http://www.cms.gov/Manuals/iom/list.asp
- Ohio Department of Health
  - http://www.odh.ohio.gov/odhprograms/io/mds/mds1.aspx

MDS 3.0 Item Sets For SNFs

- **There are 10 Item Sets for Nursing Homes - Formerly called forms (updated 10/1/16)**

  - NC = Nursing Home Comprehensive Item Set — for all Comprehensive Assessments
  - ND = Nursing Home Discharge
  - NO = Nursing Home OMRA – Set of items active on a standalone End of Therapy OMRA
  - NOD = Nursing Home OMRA Discharge –Set of items active on a PPS - End of Therapy OMRA assessment combined with a Discharge Assessment
  - NP = Nursing Home PPS Item Set–for all PPS assessments (5, 14, 30, 60 or 90 day assessments)
  - NPE = Nursing Home Part A PPS Discharge

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SNF MDS Item Sets - cont.

- NQ = Nursing Home Quarterly – (currently the same as the PPS but they are separate Item Sets)
- NS = Nursing Home Start of Therapy –Set of items active on a standalone Start of Therapy OMRA
- NSD = NH OMRA Start of Therapy & Discharge –Set of items active on a PPS start of therapy OMRA combined with a Discharge (either return anticipated or not)
- NT = Nursing Home Tracker – Entry Record - Set of items active on an Entry Tracking Record or Death in the Facility record.
- XX = Inactivation item request – 3 pages – to inactivate a record

Item Sets for Swing Beds

- NO/SO = Swing Bed OMRA
- SS = Swing Bed OMRA-Start of therapy
- ST = Swing Bed Tracking
- SD = Swing Bed Discharge
- SOD = Swing Bed OMRA Other Discharge
- SP = Swing Bed PPS
- SSD = Swing Bed OMRA SOT Discharge
- XX S = Inactivation

Swing Bed Hospitals **only** complete the PPS assessments for Medicare Payment

Resident Interviews

- Resident interviews are an integral part of the resident assessment process
- All residents capable of any communication should be asked to give information about what is important in their care
- Include resident family, significant others, legally appointed representatives when needed
- 5 specific areas of MDS 3.0 require a direct interview of the resident as the primary source of information

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Interview Basics

- Be sure the resident can see and hear you
- Establish rapport
- Explain the purpose of the questions
- Say and show the item responses
- Ask the questions as written in 3.0 manual
- Break the questions apart if necessary and ok
- Appendix D of the manual has information on interviewing, including techniques to use

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Sections for Resident Interview

Section C – Cognition (BIMS)

Section D – Mood (PHQ-9)

Section F – Preferences for Customary Routine and Activities

Section J – Pain

Section Q – Preferences for Return to the Community

If the resident can't be interviewed, then staff interview can be completed– but not both

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Staff Interviews

- When residents are **unable** or **refuse to participate** in the 4 specific resident interview items, staff assessment interviews will need to be done
- **This is the only reason to do the staff interview**
- These interviews will focus on the same information as the resident interview
- Staff will base their responses on observations they have made of the resident during cares and activities in the look-back period

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MDS CODING CONVENTIONS

- The standard look-back period is **7 days** unless otherwise stated
- Does not include data from a hospital stay except for certain items in limited sections (e.g., K and O)
- For items that say "check all that apply" **if** specified conditions are not met, leave boxes empty (blank)
- Use numeric response for MDS items that require a coded response
  - When the count or measurement of an item exceeds the number of boxes available, use the code of "9"
- When a resident interview is required this symbol is present

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OBRA Assessment Types

- **A0310A. Federal OBRA Assessments - Comprehensive Assessment = RAI**
  - MDS+CAT+CAA
  - Admission, Annual, Significant Change of Status, Significant Correction of prior comprehensive
  - **OBRA Non Comprehensive**
    - Quarterly Assessment, Significant Correction of prior quarterly
    - MDS **minus** the CAA
- 6 OBRA assessments and (99.) None of the Above

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PPS Assessment Types

A0310 B: PPS Assessment for Medicare Part A Subset of MDS items used for just for payment + Quality Measures

- Assessment Reference Date (**ARD**) is the key date
  - Must be set within a pre-determined window
  - First day of Medicare Part A coverage for the current stay is considered Day 1 for PPS scheduling purposes
- Grace Days are a Medicare only concept
  - Number of days is pre-determined
- Scheduled Medicare PPS assessments and **Unscheduled Medicare PPS assessments (OMRA)**
- **Can be completed for a Medicare HMO but NOT submitted to CMS!**

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Scheduled PPS Assessments

- **Types of Assessments: A0310 B**
  - 01 = 5 day
  - 02 = 14 day
  - 03 = 30 day
  - 04 = 60 day
  - 05 = 90 day
  - 07 = Unscheduled assessment used for PPS (OMRA - COT, EOT & SOT; Sig Change or Sig Correction)
  - 99. None of the Above
  - **Again, not submitted for Medicare HMO's, private insurance, etc.**

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Scheduled PPS Assessments—A310B

PPS Item Code A0310B	TYPE	ARD	GRACE Days	Sets Payment For:
01	5 Day	1–5	6 to Day 8	Days 1–14
02	14 Day	13–14	15 to Day 18	Days 15–30
03	30 Day	27–29	30 to Day 33	Days 31–60
04	60 Day	57–59	60 to Day 63	Days 61–90
05	90 Day	87–89	90 to Day 93	Days 91–100

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PPS Medicare Eligibility Criteria

- Beneficiaries must meet the established eligibility requirements for **Part A SNF-level stay**
- The MDS manual relates SNF-level eligibility – it is determined by Medicare and is found in Medicare manuals (see Chapter 6)
- Refer to the Medicare General Information Eligibility and Entitlement Manual, Chapter 1 (Pub. 100-1) and the Medicare Benefit Policy Manual, Chapter 8 (Pub. 100-2) for information
- https://www.cms.gov/manuals/iom/list.asp
- https://www.cms.gov/manuals/Downloads/bp102_co8.pdf

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Medicare PPS Assessments

- Timing is crucial
- Can combine with OBRA at times
- Many rules to follow:
  - early or late ARD's penalty = default days
  - Missed assessment and the patient is no longer Medicare A = often default and provider liable unless another rule comes into play

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PPS Unscheduled Assessments = OMRA

- OMRA (**O**ther **M**edicare **R**equired **A**ssessment)
  - End of therapy-Required when conditions met
  - Start of therapy- Optional
  - Both Start and End of Therapy
  - Change of Therapy Assessment – Required Q 7 Days
- Significant Change
  - If required by OBRA may establish a new RUG classification (see RAI manual chapter 2)
- Significant Correction to Prior Comprehensive
  - If required by OBRA, may establish new RUG classification
- **Medicare Part A ONLY – Not HMO's- See Chapter 2 and Chapter 6.**

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EOT: End of Therapy OMRA

- Not optional
- Must complete when therapy is discontinued **and** the resident is still requiring skilled services ; and
- Must complete when a resident who is in a therapy or Therapy plus Extensive RUG did not receive any therapy <u>for 3 or more consecutive days</u> regardless of the reason
  - It does not matter if the missed days are weekday, weekend or holiday
- ARD must be set on days 1, 2, or 3 after the last day of therapy was provided
- The EOT OMRA will produce a non-therapy RUG

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EOT OMRA

- Payment changes day after the last day of therapy
- Can be combined with scheduled PPS or OBRA but cannot replace a scheduled PPS MDS
- An ABN notice is not always required.
- If therapy resumes, facility can choose to complete either a Start of Therapy (SOT) OMRA or a new option, the End of Therapy Resumption OMRA (EOT-R)

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EOT-Resumption

- If therapy resumes **within** 5 calendar days, **<u>and</u>**
- Therapy resumes **planned** at **exactly** the same level (number of services, number of days & minutes)
- **EOT-Resumption** option can be selected O0450
- 2 MDS items in Section O relate to this:
  - O0450A - has a previous therapy regimen ended and now resumed at the same level? (yes or no)
  - O0450B - **date** on which therapy resumed, if above is coded as "yes"

SOT: Start of Therapy OMRA

- Optional Assessment
- Completed to obtain a therapy RUG only when resident is not already in a Rehab or a Rehab + Extensive group
  - If the RUG is not one of these two, the SOT assessment will be rejected.
- Starts payment on the date of the first therapy eval and continues until the next PPS assessment
- ARD must be 5-7 days after start of any therapy
- Earliest tx. evaluation is counted as day #1 when setting the ARD. Medicare payment starts on first day of therapy

Change of Therapy (COT)

- ARD is Day 7 of the COT observation period
- Informal process to determine if therapy RUG changed over the 7 day observation period
- Completed if resident currently in RUG-IV therapy group
- no change required if only ADL status change
- Modifies the payment rate starting on Day 1 of that COT observation period
- If not currently in RUG-IV therapy group, may complete only if resident has been classified

Combining Assessments

- Medicare Scheduled and Unscheduled
  - May be times when more than one Medicare MDS is due in the same time period
  - Cannot combine 2 Medicare scheduled MDSs but can combine scheduled and unscheduled
- Medicare and OBRA
  - When OBRA and PPS time frames coincide, one MDS can be used for both needs
  - Most stringent rules will apply

Combining Scheduled and Unscheduled Assessments

- See 2.10 on page Chapter 2-56 for all of the combinations:
- If an unscheduled PPS assessment (OMRA, SCSA, SCPA) is required in the assessment window (including grace days) of a scheduled PPS (PPS 5,14, 30, 60 & 90 day) assessment that has not yet been performed, then you **must** combine the scheduled and unscheduled by setting the ARD of the scheduled for the same day that the unscheduled is required.

Interviews: PPS OMRA Assessments

- When completing standalone **COT, EOT or SOT**, the interview items may be coded using responses provided by the resident from the most recently completed assessment if the responses were obtained no more than 14 days prior to the unscheduled assessment on which the responses will be used.
- Z0400 date of prior assessment to the most current Z0400 date must be no more than 14 days from the last interview that was done on a PPS OMRA assessment.
- Staff Assessments cannot be used.

ARD Compliance for OMRAs

- For an **EOT, COT or SOT** you can set the ARD for a day within the allowable window for that assessment **no more than 2 days after that window has closed.**
- **Example:** A COT OMRA needs to be done with an ARD of day 37. There is no one at the facility to set the ARD on that date which is a weekend. The ARD can be set on day 39 for day 37, but no later. Starting on day 40 the 2-day window is closed and the ARD must be set no earlier than day 40

Medicare Short Stay – for stay less than 8 days

- **All eight must be true:**
  - Must be a SOT OMRA
  - 5-day & combined with SOT
  - ARD must be on Day 8 or before of the Part A stay
  - ARD must be the last day of Part A stay
  - ARD cannot be more than 3 days after the Start of Therapy
  - Rehab must have started in last 4 days of Part A stay
  - Rehab must continue through the last day of Part A stay
  - RUG must classify into a Rehab + Extensive Service or a Rehab group RUG

Significant Change of Status Assessment (SCSA)

- Comprehensive assessment requiring CAAs
- Conducted after the resident has had an Admission assessment completed
- Specific criteria for determining if one has to be done
- Cannot be done because staff miscoded a previous MDS

Significant Change SCSA

- **Decline OR improvement** in a resident's status that:
- Does not normally resolve itself without intervention or by implementing standard disease-related clinical interventions;
  - Is not "self-limiting" (for declines only);
  - Impacts more than one area of health; and
  - Requires interdisciplinary review or revision of care plan

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Significant Change

- When unclear if a significant change has occurred, facility may take up to 14 days to make that decision.
  - Document clinical thinking
  - Make care plan adjustments
  - Monitor progress
- ARD must be within 14 days of determination of Significant Change (determination date + 14 days)
- The completion date must be no later than 14 days from the ARD and the CAA review must also be completed no later than 14 days from the ARD.
- Restarts the assessment clock for due dates

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Significant Change

- Must be done when there are either 2 or more areas of decline or 2 or more areas of improvement
- Can do one with only one area of change if you feel the resident would benefit from the total team's review
- Change may not be permanent but it has such great impact on the overall status that a significant change assessment should be done
- Do not do a Significant Change assessment prior to having completed the OBRA admission assessment

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When is a SCSA not required?

- Minor or temporary variations such as short term illness (fever from a cold) occurs where team expects return to baseline within 2 weeks
  - Note changes in clinical record, implement necessary assessments, care planning, and interventions
- When discharge is expected in the immediate future and discharge planning is actively occurring with the resident

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Terminal Conditions

- Is the change an expected well-defined part of the disease course and is it care planned?
  - **If not, then a significant change is to be done**
- If a terminally ill resident enrolls in a Medicare Hospice or other structured hospice program and remains a resident at the nursing home
  - **Must do SCSA to ensure coordinated plan of care between the hospice and the nursing facility**
  - **Must also complete a SCSA when a resident who is receiving hospice services decides to discontinue the services**.

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SCSA and PASRR Level II

- If a resident known or suspected to have a mental illness, mental retardation or condition related to mental retardation has a SCSA, facility **must** make referral to state mental health or Intellectual Disability /DD authority for a possible Level II PASRR evaluation
- Determination made by comparing current status to most recent comprehensive and quarterlies
- PASRR is not a RAI requirement, but an **OBRA provision required to be coordinated with RAI**

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FEDERAL TAGS FOR INFO IN CHAPTER 2

- F271 – Admission Physician Orders for Immediate Care
- F272 – Comprehensive Assessments
- F273 – Comprehensive Assessments 14 days after Admit
- F274 – Comprehensive Assessments after Sig Change
- F275 – Comprehensive Assessment every 12 months

Format for Sections in Chapter 3

- Intent Statement
- Screen shot of MDS item
- Item Rationale
- Health related Quality of Life
- Planning for Care
- Steps for Assessment
- Coding Instructions
- Coding Tips and Special Populations
- Examples

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Section A ("Accuracy")

- The following items in Section A must be coded accurately. Certain items can be modified as long as there is no change in the item set (more later)
- Consequences can be major: **citation by surveyors or money penalty by Medicare**

1. **A0200 – Type of Provider**
2. **A0310 – Type of Assessment- including H. Is this a PPS Discharge Assessment?**
3. **A1600 – Entry date (on an Entry Record)**
4. **A2000 - Discharge date (on Discharge/Death)**
5. **A2300 - ARD date (on OBRA or PPS)**

Type of Assessment

- Swing Bed Assessment
  - Same subset as SNF/PPS
- **A0310C**: PPS OMRA
  - 0. Not an OMRA
  - 1. Start of therapy
  - 2. End of therapy
  - 3. Both Start and End of therapy
  - 4. Change of therapy
- **A0310E:** Is this the first assessment since most recent admission?
  - Very first MDS 3.0 that a resident has since an Entry/Reentry must be coded as a "yes"

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A0410: Submission Requirement

- Coding if the unit resident resides on is Medicare and/or Medicaid certified
- In Ohio, the answer will be #3

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A0600: SSN and Medicare

A. SSN

- If no number available, leave blank and go to Section S0150 and complete

B. Medicare Number

- Enter exactly as it appears on documents
- May use railroad insurance number if no Medicare number
- If no Medicare number, leave blank
- Must have BOTH SSN and Medicare or RR insurance number to submit PPS assessments

HMO/Insurance

- **DO NOT** code any number in place of Medicare or RRI number

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A0800 - Gender

- Enter the Code for Gender:
  - 1. Male
  - 2. Female
- No excuse for not knowing the resident's gender or getting it wrong on the MDS!
- Must match gender for SSN

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A1000—Race/Ethnicity

- Ask resident to select categories that most closely correspond to his or her **race/ethnicity**
- Inform resident that the goal is to ensure that all residents receive the best care possible
- If resident can't answer, ask family member or significant other
- Provide category definitions only if requested
- Check the medical record only if necessary

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A1100: Language

- A. Does the resident need or want an interpreter to communicate with a doctor or health care staff?
- B. Document Preferred language if answer to "A" is yes
- This item is used to help determine if resident interviews should be done for specific assessments in Sections B, C, D and J

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A1500: Preadmission Screening and Resident Review (PASRR)

- Complete item if this is a comprehensive OBRA MDS (A0310A = 01, 03, 04 or 05)
- If resident occupies non-Medicaid certified bed, item is not applicable - Code 9
- If Level II PASRR not required or found no serious mental illness or mental retardation related condition - Code 0 “no” and skip to A1550
- If Level II PASRR was positive – Code 1 “yes” and continue to A1510

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A1510 - Level II PASRR

- If the answer to previous question was “1” Yes and this is an OBRA assessment (A0310 A = 01, 03, 04 or 05) then complete this item
- Intent is to identify which conditions contributed to the Level II being positive
- Check all that apply
  - A. Serious Mental illness
  - B. Intellectual Disability (was “mental retardation”)
  - C. Other related conditions

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A1600: Date of Entry and A1700 Type of Entry

- The initial date of admission to the nursing home, or
- The date the resident most recently returned to your facility after being discharged return anticipated.
- A1700 reflects whether A1600 date represents an admission or a reentry date

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A1900 Admission Date

- For this episode of care in facility
- **Stay vs Episode**
  Stay=set of contiguous days in facility
  Episode=continues across a stay until resident DCRNA, DCRA
  but is out more than 30 days, or resident dies in facility
- Admission date should stay the same on all assessments for a given episode even if interrupted by temporary discharges
- If resident is discharged and reenters within an episode, the admission date will be the same but the entry date will change

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A2000: Discharge Date

- Enter date the resident leaves the facility and is gone for >24 hours
- Discharge date may be later than the end of Medicare stay date if the resident is receiving services under SNF Part A PPS and converts to another payer
- Do not include LOA or hospital observation stays of less than 24 hours unless resident admitted as an inpatient
- The discharge date (A2000) and ARD (A2300) must be the same when doing a Discharge Assessment

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A2300: Assessment Reference Date (ARD)

- Designates the end of the look-back period for the entire assessments
  - Events outside observation period are **not coded**
  - **This date also determines the due date for the next MDS**
- For an OBRA admission assessment, ARD can be any date from admission day up (Day 1) to Day 14
  - For other OBRA required assessments, it must be within 92 days or 366 days of the previous ARD
  - For SNF/PPS it must be set within prescribed Medicare collection window plus Grace Days
  - Important to know the rules before setting this date

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Adjustment of the ARD

- If a resident dies or discharges prior to the end of the observation period, you must adjust the ARD to equal the date of discharge
- Once the ARD is set, if the date is changed be sure to notify the entire IDT so that everyone is gathering information from the same look-back period. Can only be changed if in the window for the ARD.
- Once an MDS is transmitted, the ARD could be changed as long as there will be no change in the look-back period and only if incorrect.

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A2400: Medicare Stay

- Has resident had a Medicare-covered stay since the most recent entry (admission or re-entry)?
  - If "no", do not answer B and C
  - If "yes", enter start date of most recent Medicare stay in B and end date in C (or dash fill if still in Medicare stay)
  - The end date is used to determine if the resident's stay qualifies for the short stay assessment
  - **Remember: this is not for HMO managed care PPS stay - for those there is no place to code**

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Federal Tags for Section A

- **Section A** – Identification Information:
  - F274 – Significant Change of Status
  - F285 – PASRR Coordination

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Section B: Hearing, Speech and Vision

- **Intent:** Document resident's ability to hear, understand and communicate with others and whether the resident experiences visual limitations or difficulties r/t diseases common in aged persons
- B0100: Comatose
  - There must be a **Documented Diagnosis** of coma or persistent vegetative state made by a physician, nurse practitioner or clinical nurse specialist

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Section B: Hearing, Speech, and Vision

B0200 Hearing

- Confirm that the resident is wearing his/her normal hearing device.
- Interview resident and ask about hearing function in different situations: hearing staff members, communicating with visitors, using telephone, watching TV, attending activities
- Observe resident throughout the day and consult direct care staff, IDT, and family.
- How do you best communicate with this patient? Do you: speak clearer, louder, slower, use gestures; does the resident need to see your lips, do you need to speak directly into their ear, turn the TV volume down/mute, remove to a quieter area?

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Section B: Hearing, Speech, and Vision

B0200 Hearing

0, adequate: no difficulty with normal conversation, social interaction, listening to TV, social interaction; hears normal conversational speech, telephone conversations, and statements in group activities.

1, minimal difficulty: difficulty in some settings such as a person speaking softly, or in a noisy setting; hears speech at conversational levels, but has difficulty hearing when conditions are not quiet, or not in 1:1 situations. Hearing is adequate when adjustments to environment made: reducing background noise, move to quiet room, adjust volume on TV/radio.

2, moderate difficulty: speaker needs to increase volume and speak distinctly. Even though hearing deficient, resident compensates when tone adjusted and speaker speaks distinctly; or the speaker's face must be clearly visible; speaking toward "good" ear.

3, highly impaired: absence of useful hearing. Only hears some sounds and frequently fails to respond when the speaker adjusts tonal quality, speaks clearly, or is positioned face to face. No comprehension of conversational speech even with maximum adjustments.

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Section B: Hearing, Speech, Vision

- B0700 : Makes Self Understood and
- B0800 : Ability to Understand Others
  - Both require using the resident's preferred language
  - May need an interpreter
  - If difficulties with spoken word, offer alternative communication options (writing, pointing, cue cards)

  Coding
  - 0=understands or is understood
  - 1-usually understood or understands
  - 2=sometimes understood or understands
  - 3=rarely/never understood or understands

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Section B: Hearing, Speech, and Vision

Definition SPEECH: The verbal expression of articulate words.

B0600 Speech Clarity

0, clear speech: distinct intelligible words

1, unclear speech: slurred or mumbled words

2, no speech: absence of spoken word

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Section B: Hearing, Speech, and Vision

Definition MAKES SELF UNDERSTOOD: Able to communicate requests, needs, opinions and to conduct social conversation in his/her primary language, whether in speech, writing, sign language, gestures, or a combination of these. Deficits in the ability to make one's self understood can include reduced voice volume, and difficulty producing sounds, or finding the right word, making sentences, writing and/or gesturing.

B0700 Makes Self Understood

0, understood- expresses requests and ideas clearly

1, usually understood- difficulty communicating some words or thoughts but is able if prompted or given time

2, sometimes understood- limited ability but able to express concrete requests (food, drink, sleep, toilet).

3, rarely or never understood- at best, the understanding is limited to staff analysis of specific sounds or body language.

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Section B: Hearing, Speech, and Vision

Definition ABILITY TO UNDERSTAND OTHERS: Comprehension of direct person-to-person communication whether spoke, written, sign language, Braille. Includes the resident's ability to process and understand language. Deficits in the ability to understand (receptive communication deficit) can involve decline in hearing, comprehension (spoken or written) or recognition of facial expressions.

R 11/2015

Section B: Hearing, Speech, and Vision

B0800 Ability to Understand Others

0, understands- clearly ***comprehends*** messages and validates understanding by words, actions, behaviors.

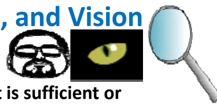
1, usually understands- misses some part/intent of message ***but*** comprehends most of it; may have difficulties integrating information but usually demonstrates understanding by response in words/actions.

2, sometimes understands- frequent difficulties integrating information; responds adequately only to simple/direct questions or instructions. Rephrasing/simplifying enhances understanding.

3, rarely/never understands- very limited ability to understand; staff difficulty determining comprehension; can hear sounds but not understand message.

R 11/2015

Section B: Hearing, Speech, and Vision



Definition ADEQUATE LIGHT: Lighting that is sufficient or comfortable for a person with normal vision to see fine detail.

B1000 Vision

Ability to see in adequate light (with glasses or usual appliances)

0, Adequate- sees ***fine detail***-regular print in newspaper/book

1, Impaired- sees ***large print,*** but **not** regular print in newspaper/books

2, Moderately Impaired- limited vision; not able to see newspaper headlines, but can identify objects

3, Highly Impaired- object identification in question but eyes appear to follow objects

4, Severely Impaired- no vision or sees only light, color or shapes; eyes do not appear to follow objects.

75 11/2015

Section B: Hearing, Speech, and Vision Potential Federal Tags

F313 Treatment/assistive devices to maintain hearing and visual ability

F272 Administration of RAI

&/or

F278 Administration and Accuracy of Assessments

76

11/2015

Frequently Asked Questions

Question: How do you code Section A for non-OBRA, non-PPS assessments, i.e.: Medicare Advantage, private insurance, HMO, etc?

Answer: These are not done for these residents. OBRA-required assessments are done and transmitted for all residents in Medicare/Medicaid certified beds, including those with Medicare Advantage, private insurance, HMO's etc. Any other assessments are not submitted, not even for the purposes of obtaining a RUG score for the payer. You will need to find out what their procedures are for billing .

11/2015

Sections for Resident Interviews

- **Section C – Cognition (BIMS)**
- **Section D – Mood (PHQ-9)**
- **Section F – Preferences for Customary Routine and Activities**
- **Section J – Pain**
- **Section Q – Preferences for Return to the Community**
- **If the resident can't be interviewed, then interview the staff – but not both**

78

"LOOK BACK PERIODS"

The following items have different time frames:

- D0200 or D0500 - Mood items = last 14 days
- I2300 – UTI = last 30 days
- J0100 - J0850 - Pain items = last 5 days
- J1700 - J1900 - Falls = since admission/entry, re-entry, or prior assessment whichever is more recent
- K0310 - Wt. Loss and Wt. Gain in past 30 and 180 days
- O0100 – Special Treatments/Procedures,O0600 - Physician Visits and O0700-Physician Orders = last 14 days

11/2015 79

Cognitive Patterns

- Determines resident's attention, orientation, and ability to register and recall information
- These items are crucial factors in many care-planning decisions
- Resident interview based assessments using two new processes:
  - BIMS-Brief Interview for Mental Status
  - CAM©-Confusion Assessment Method
    - Identifies possible delirium

11/2015 80

Resident Interviews

- All interviews must be attempted to achieve the minimum score before moving on to the staff interview
- If the resident can answer 4 questions on BIMS, you can score
- All residents capable of any communication should be asked to give information about what is important in their care
- 5 specific areas of MDS 3.0 require direct interview of the resident as the primary source of information
- See pages Appendix D for more techniques that will assist you with interviewing

11/2015 81

Staff Interviews

- Before the staff interview, if the resident attempts to answer at least four (4) questions in C0200-C0400 it will be a complete interview except:
- When residents are unable or refuse to participate in specific resident interview items, staff assessment interviews will need to be done
- These interviews will focus on the same questions/items as the resident interview but will be more subjective in nature
- Staff will base their responses on observations they have made of the resident during care and activities

11/2015 82

C0100 – C0500: BIMS

- C0100-Should BIMS be conducted?
  - Determine if the resident is rarely/never understood verbally or in writing and review A1100-Does the resident want or need interpreter
  - Conduct BIMS if resident is at least sometimes understood and, if interpreter is needed, one is available.**
  - If either criteria not met, code C0100 as "0" and complete Staff Assessment of Mental Status

  **CMS expects that you will attempt the interview for all residents who can be understood

11/2015 83

Stopping the BIMS Interview

- Stop the BIMS interview if necessary
- Stop after C0300C "***Day of the Week***" **(4th question**) if:
  - All responses have been nonsensical **OR**
  - There has been no verbal or written response to any items up to that point **OR**
  - There has been no verbal or written response to some items and nonsensical responses to the other questions

11/2015 84

C0600: Should Staff Assessment for Mental Status be Conducted?

- Staff assessment is completed if the resident was unable to complete the interview
- Review C0500 Summary Score
  - If summary score is coded 00, do not complete staff assessment as 00 is a legitimate value
  - If summary score is coded 99, complete staff assessment (**items C0700 through C1000)**

11/2015 85

C0700: Short-term Memory OK

- Determine short-term memory status by asking resident:
  - To describe an event 5 minutes after it occurred if you can validate the resident's response, or
  - To follow through on a direction given 5 minutes earlier
  - Observe how often the resident has to be re-oriented to an activity or instructions
- Coding
  - Code 0, memory ok if resident recalled information after 5 minutes
  - Code 1, memory problems if the most representative level of function shows absence of recall after 5 minutes

11/2015 86

C0800: Long Term Memory OK

- Ask questions that you can validate about past events (names of children, birthdays, etc.)
- Coding
  - Code 0 memory OK if resident accurately recalled long past information
  - Code 1, memory problem if resident did not recall long past information, or recalled in incorrectly
  - If unable to conduct the test code using a dash

11/2015 87

C0900: Memory/Recall Ability

- Ask the resident about each item listed
  - Current season, location of own room
  - Staff names and faces, knowing that he/she is in a nursing home
  - If none are recalled, code C0900Z
- For resident with limited communication skills, ask staff and family members or significant others about recall ability

11/2015 88

C1000: Cognitive Skills for Decision Making

- Intent is to record what the resident is doing (actual performance) re: actively making decisions about tasks and activities of daily life
- Do not code based on what staff believe the resident is capable of doing
- Coding range is 0 (independent) to 3 (severely impaired)
- A resident's decision to exercise the right to decline treatment is not considered impaired decision making

11/2015 89

C1310: Signs/Symptoms of Delirium

- Items were adapted from the Confusion Assessment Method (CAM©)
- Delirium is a serious condition that can be misdiagnosed as dementia or be a symptom of an acute, treatable illness
- Prompt detection is necessary in order to identify and treat the cause

11/2015 90

C1310 Conduct the Assessment—Signs and Symptoms of Delirium—CAM©

- After Completing the BIMS:
  - Observe resident behavior for signs and symptoms of delirium
  - Inattention, disorganized thinking, altered level of consciousness. (Psychomotor retardation has been removed with October 2016 MDS 3.0 RAI updates)
- If conducting a staff assessment:
  - Ask staff members who conducted the interview about observations of signs and symptoms of delirium

91

C1600: Acute Onset of Mental Status Change

- Acute onset of mental status change may indicate delirium or other serious medical complications
- Code 0 = no evidence of change from resident's baseline
- Code 1 = alteration in mental status observed in the past 7 days or in the BIMS that represents a change from baseline

92

Section D: Mood

- Intent is to identify the presence or absence of clinical mood indicators, not to diagnosis depression or a mood disorder
- Determination is made by either a resident interview (PHQ-9©) or by staff assessment (PHQ-9-OV©)

93

Section D: Mood

- D0100: Should Resident Mood Interview be Conducted?
  - Determine if the resident is rarely/never understood verbally or in writing and review A1100-Does resident want or need interpreter
  - Code 0 if resident is rarely/never understood or resident needs interpreter and one is not available
    - Skip to D0500 and conduct staff assessment
  - Code 1 if resident interview should be conducted

11/2015 94

D0200: Resident Mood Interview PHQ-9©

- PHQ-9© is a 9-item validated interview that screens for symptoms of depression
- It provides a standardized severity score and rating for evidence of depressive disorder
- Conduct interview if D0100 = 1 (yes)
- This has a 14 day look-back period
- There are two parts for each item
  - Symptom presence
  - Symptom frequency

11/2015 95

D0200: Resident Mood Interview

- Conduct interview as close to ARD as possible, preferably the day before or the actual ARD
- Use interpreter if indicated
- May use paper form to assist in interview
- **Interview steps: Be sure to follow the manual!**
  - Explain the reason for the interview, "I am going to ask you some questions about your mood and feelings over the past 2 weeks. I will also ask you about some common

11/2015 96

D0200: PHQ-9© Interview

- Explain and/or show the interview response choices to the resident
  - "I am going to ask you how often you have been bothered by a particular problem over the last 2 weeks. I will give you the choices you see on this card."
  - Then show the cue card and verbally describe the choices.

11/2015 97

D0200: PHQ-9© Interview

- Coding tips and Special Populations
  - For item D0200I-Thoughts that you would be better off dead or of hurting yourself in some way:
    - The assessor must notify a responsible clinician if coded Yes (1) under Symptom Presence
  - Select only one frequency response per item.
    - If resident has difficulty choosing between two frequencies, or an item has more than one phrase and the resident assigns different frequencies, code for higher frequency

11/2015 98

D0300: Total Severity Score – PHQ-9

- Your software will add the numeric scores for all frequency items in Column 2 together and record as Total Severity Score
- **Score range is 00 – 27**
- Total Severity Score interpretation:
  - 1-4: minimal depression
  - 5-9: mild depression
  - 10-14: moderate depression
  - 15-19: moderately severe depression
  - 20-27: severe depression

11/2015 99

D0350: Safety Notification

- Complete only If D0200I, (Thoughts you would be better off dead or of hurting yourself in some way), is coded as a 1
- Item coding
  - Code 0 if responsible staff or provider was not informed of potential for resident self harm
  - Code 1 if notification of responsible staff or provider occurred

11/2015 100

D0500: Staff Assessment of Resident Mood (PHQ-9-OV©)

- Alternate means of assessing mood for residents who cannot communicate, or refuse or are unable to do PHQ-9© Interview
- Look-back is 14 days
- Use same techniques/codes as in PHQ-9© Interviews

11/2015 101

D0500: Staff Assessment of Resident Mood-Coding

- 1. Symptom Presence
  - 0 = No
  - 1 = Yes
- 2. Symptom Frequency
  - 0 = Never or 1 day
  - 1 = 2-6 days (several days)
  - 2 = 7-11 days (half or more of the days)
  - 3 = 12-14 days (nearly every day)

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D0600: Total Severity Score – PHQ-OV

- The interview is successfully completed if staff members were able to answer the **frequency responses of at least 8 items**
- Add the numeric scores across all frequency items from Column 2
- Total score must be between 00 and 30

11/2015 103

D0650: Safety Notification – PHQ-OV

- Complete only If D0500I , (States that Life isn't Worth Living, Wishes for Death, or Attempts to Harm Self), is coded as a 1
- Item coding
  - Code 0 = responsible staff or provider was not informed of potential for resident self harm
  - Code 1 = notification of responsible staff or provider occurred

11/2015 104

Section E: Behavior

- Intent is to identify behavioral symptoms in the last 7 days that cause distress to the resident, or are distressing or disruptive to facility residents, staff members or the care environment
- Focus is on resident actions, not intent of behavior
- Do not take intent into account when coding

11/2015 105

E0100: Potential Indicators of Psychosis

- **E0100A – Hallucinations**
  - Perception of something being present that is not actually there
  - May be auditory or visual; may involve smells, tastes or touch
- **E0100B – Delusions**
  - Fixed false belief, not shared by others that the resident holds even in the face of evidence to the contrary
- **E0100Z – None of the above**
- Check all that apply

106

E0100: Potential Indicators of Psychosis

- Code based on **behaviors observed and/or thoughts expressed in the last 7 days** not on the presence of a medical diagnosis only.
- **Tips**:
  - If a belief cannot be objectively shown to be false, or it is not possible to determine whether it is false, do not code as a delusion
  - If a false belief is expressed but resident easily accepts a reasonable alternative explanation, do not code as a delusion
  - Do not challenge the resident

107

E0200: Behavioral Symptoms

- To identify the presence and frequency of 3 groups of behaviors:
  - **Physical** behavioral symptoms directed towards others
  - **Verbal** behavioral symptoms directed toward others
  - **Other** behavioral symptoms not directed toward others
- **Goal** - to develop interventions to improve symptoms or reduce their impact

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E0200: Behavioral Symptoms

- Coding
  - Code 0 = behaviors not present in last 7 days
  - Code 1 = behaviors occurred 1 to 3 days
  - Code 2 = behaviors occurred 4 to 6 days, but not daily
  - Code 3 = behaviors occurred daily
  - **Item E0200C does not include wandering, there is a separate item to evaluate this condition

109

E0500: Impact on Resident

- Intent is to identify behaviors that may require treatment planning and intervention
- Consider all behaviors in E0200 for coding
- Evaluate impact in 3 areas:
  - Did any of the symptoms **put the resident at significant risk** for physical illness/injury?
  - Did any of the symptoms **interfere with the resident's care?**
  - Did any of the symptoms **interfere with** the resident's **participation in activities** or social interactions?

110

E0500: Impact on Resident

- "**Significant**" refers to effects, results or consequences that affect or are likely to affect the resident's well-being either positively or negatively
- **Item A**: code based on whether risk for physical injury/illness is known to commonly occur under similar circumstances

111

E0500: Impact on Resident

- **Item B**: code if care delivery is impeded to such extent that necessary or essential care cannot be received safely, completely or timely
- **Item C**: code if behaviors keep resident from participating in solitary or group activities, or having positive social encounters with visitors, other residents or staff.

11/2015 112

E0600: Impact on Others

- **Intent**: to identify behaviors that may require treatment planning and intervention
- Evaluates impact of behaviors in 3 areas:
  - Did any of the symptoms put others at significant risk for physical injury?
  - Did any of the symptoms significantly intrude on the privacy or activity of others?
  - Did any of the symptoms significantly disrupt care of the living environment?

11/2015 113

E0800: Rejection of Care

- **Intent:** to identify **potential** behavioral problems, not situations where care is rejected based on a choice that is consistent with the resident's preferences or goals for health and well-being or a choice made by the resident's family or proxy decision maker
- Rejection of care may appear as:
  - Verbally declining or making statements of refusal
  - Physical behaviors that avoid or interfere with care
  - **Is it INFORMED CHOICE or REJECTION OF CARE?**

11/2015 114

E0800: Rejection of Care

- If resident declines or refuses care, explore this further to determine reasons
- Do not include behaviors that have already been addressed and/or determined to be consistent with the resident's values, preferences or goals.
- Residents who have made an informed choice about not wanting a particular treatment, procedure, etc., should not be identified as "rejecting care"

11/2015 115

E0800: Rejection of Care

- Coding
  - Code 0 = no rejection of care occurred
  - Code 1 = care rejection occurred 1-3 days
  - Code 2 = care rejection occurred 4-6 days but not daily
  - Code 3 = care rejection occurred daily
  - Note: you are coding based on the number of days that care was rejected, not on the number of episodes that occurred each day

11/2015 116

E0900: Wandering

- **Intent:** to identify if wandering occurred and, if so, the frequency during the last 7 days
- **Wandering** is the act of moving (walking or locomotion in a wheelchair) from place to place **without a specified course or known direction.**
- **Coding**
  - Code 0 = no wandering occurred in last 7 days
  - Code 1 = wandering occurred 1-3 days
  - Code 2 = wandering occurred 4-6 days, not daily
  - Code 3 = wandering occurred daily

11/2015 117

E1000: Wandering Impact

- **Intent** is to provide information for care planning and to determine the need for environmental modifications to enhance resident safety
- **E1000A** - Does wandering place the resident at significant risk of getting to a potentially dangerous place?
- **E1000B** - Does wandering significantly intrude on the privacy of others?
- **Code:**
  - **0 = no**
  - **1 = yes**

118

E1100: Change in Behavioral or Other Symptoms

Change in behavior may be an important indicator :

- Changes in health status or in environmental stimuli,
- Positive responses to treatment,
- Adverse effects of treatment

- **Coding:**
  - Code 0 = same
  - Code 1 = improved
  - Code 2 = worse
  - Code 3 = N/A (no prior MDS has been done)

119

Federal Tags for Cognitive Patterns, Mood & Behavior

- F250 - Medically related Social Services provided
- F251 – Qualified Social Worker
- F319 - Treatment & services for mental & psychological difficulties
- F320 – Decreased in resident's mental/psychosocial status
- F323 - Accident hazard, supervision and assistive devices
- F329 - Psychotropic medications

120

Section F: Preferences for Customary Routine and Activities

- Quality of life can be enhanced when care respects choices regarding things important to the resident
- Resident responses can provide clues to understanding pain, perceived functional limitations and perceived environmental barriers
- Information gathered through either resident interview or staff assessment

11/2015

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Section F: Preferences for Customary Routine and Activities

- **F0300:** Should Interview for Daily and Activity Preferences be Conducted?
  - Determine if resident is rarely/never understood and if family/significant other is available.
  - Review A1100-Does resident want or need interpreter
  - Code 0 If resident is rarely/never understood or needs interpreter and one is not available and there is no family/significant other available for interview
    - Skip to F0800 and conduct staff assessment
  - Code 1 if resident interview should be conducted

11/2015

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F0400: Interview for Daily Preferences

- Explain reason for interview
  - To find out what is important to the resident while they are in this facility to help plan care around those preferences.
- Explain response choices and show written responses in list form or on a cue card
  - Focus on the importance of activities and routines while in the nursing home
  - Use interview techniques such as echoing to help resident select option that best applies

11/2015

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F0400: Daily Preferences

- Each of the items begins, “While you are in this facility, how important is it for you to…”
  - Choose what clothes to wear
  - Take care of your personal belongings, things
  - Choose between tub bath, shower, bed or sponge bath
  - Have snacks available between meals
  - Choose your own bedtime
  - Have family or close friend involved in discussions on your care
  - Be able to use the phone in private
  - Have a place to lock your things to keep them safe

11/2015 124

F0400: Daily Preference Interview

- Coding choice
  - Code 1 = very important
  - Code 2 = somewhat important
  - Code 3 = not very important
  - Code 4 = not important at all
  - Code 5 = important, but can’t do or no choice
  - Code 9 = no response or non-responsive
- Stop interview and skip to Item F0700 if
  - Resident gives 3 nonsensical responses to 3 questions or, Resident has not responded to 3 questions

11/2015 125

F0500: Interview for Activity Preferences

- As with the daily routines, responses may provide insights into perceived functional, emotional and sensory support needs
- Activities are a way for individuals to establish meaning in their lives and the need for enjoyable activities does not change on admission to a nursing home.
- 8 items will be evaluated using the same coding scale as in daily preference item.

11/2015 126

F0500: Activity Preferences

- Each of the items begins, "while you are in this facility, how important is it for you to…"
  - Have books, newspapers, and magazines to read
  - Listen to music you like
  - Be around animals such as pets
  - Keep up with the news
  - Do things with groups of people
  - Do your favorite activities
  - Go outside to get fresh air when the weather is good
  - Participate in religious services or practices

11/2015

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F0600 and F0700

- **F0600**: Respondent for Daily and Activity Preferences
  - Code 1 = Resident
  - Code 2 = Family or significant other
  - Code 9 = interview could not be completed
- **F0700**: Should Staff Assessment of Daily and Activity Preferences be done?
  - Code 0, no if F0400 and F0500 was completed by resident or family/significant other
  - Code 1, yes if 3 or more items were coded as a 9 in F0400 or F0500

11/2015

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F0800: Staff Assessment of Daily and Activity Preferences

- Conduct only if resident/family interview not completed
- Assessment is done by observing the resident when care, routines and activities specified in these items are made available to the resident
- Observations are made by staff across all shifts and departments during the look-back period
- Check any item for which the resident appears content or happy during the activity
  - Resident is involved, pays attention or smiles etc.

11/2015

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Federal Tags for Section F

- **F242** - Self determination and right to make choices
- **F245** - Participation in other activities (social, religious, and community activities)
- **F248** - Activities meet the interests and needs of each resident
- **F248** – Qualifications of activity personnel

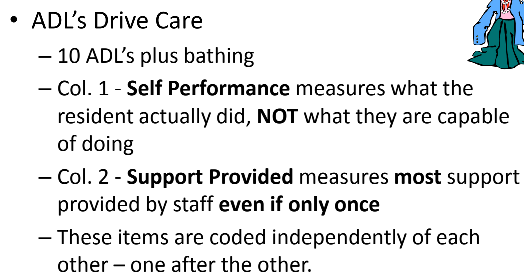
11/2015 130

Section G: Functional Status

- Items in this section assess need for assistance with ADLs, altered gait and balance and decreased range of motion.
- VERY IMPORTANT SECTION
- One of the major targets of OBRA is to "maintain or attain the highest practicable well being"

11/2015 131

Section G0110: ADL Assistance



- ADL's Drive Care
  - 10 ADL's plus bathing
  - Col. 1 - **Self Performance** measures what the resident actually did, **NOT** what they are capable of doing
  - Col. 2 - **Support Provided** measures **most** support provided by staff **even if only once**
  - These items are coded independently of each other – one after the other.

11/2015 132

ADL Coding-Eating

- Special rules for coding eating
  - General supervision of dining room is not to be coded as “supervision”
  - If resident is being individually supervised either alone or in a “feeding/eating group” you can code “1” Supervision in Eating Self-Performance

11/2015 133

Toilet Use

- How resident uses the toilet room, commode, bedpan, or urinal
  - **Does not include staff emptying of devices (bedpan, urinal, bedside commode, catheter bag or ostomy bag)**
- **Only** includes how resident **transfers** on/off toilet, **cleanses** self, **changes** pad, **manages** ostomy or catheter, and **adjusts** clothing.

11/2015 134

Personal Hygiene

- **Includes**:
  - combing hair, brushing teeth
  - Shaving, applying makeup
  - Washing/drying face, hands
- **Excludes**:
  - baths & showers which are covered in bathing ADL

11/2015 135

G0110: ADL Coding Tips

- Do not code ADLs based on what resident should receive, or their potential but on what they DID
- Do not include assistance provided by family or other visitors or non-facility staff
- For residents with tube feeding, TPN or IV fluids coding includes resident's participation in oral intake
- Code self-performance before support provided

11/2015 136

G0110:ADL Assistance Coding

- **ADL Self Performance: Column 1**
  - 0 = Independent – no help/oversight every time
  - 1 = Supervision – oversight, encouragement or cueing provided 3 or more times
  - 2 = Limited – resident highly involved, physical help in guided maneuvering of limbs or other non-wt bearing assistance 3 or more times
  - 3 = Extensive – resident did part over last 7 days and received help 3 or more times of either wt. bearing support or full staff performance during part but not all of the last 7 days

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G0110: ADL Assistance Coding

- **Self performance continued**
  - 4 = Total Dependence – full staff performance with no participation by the resident for any part of ADL every time
  - 7 = activity occurred only once or twice
  - 8 = activity did not occur or family and/or non-facility staff provided care 100% of the time over the entire 7-day period
    - Toileting-use 8 only if no elimination occurred
    - Locomotion-use 8 only if resident on bed rest
    - Eating-use 8 only if no nourishment was provided by any route

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Section G0110: ADL Assistance - continued

- Code over last 7 days, all 3 shifts
- Review documentation in the medical record, make own observations if warranted
- Consider each episode of activity that occurred – 3 shifts x past 7 days.
- While the person was a resident during the 7 day look-back period, talk with all staff and resident
- Expect differences from one shift to another; from one discipline to another
- Only use information since resident admitted to nursing home, not from hospital or other location

G0110-1: ADL Self Performance

Rule of Three:

- Activity occurs 3 or more times at any one level, code that level
- Activity occurs 3 or more times at multiple levels code the **most dependent**
- Activity occurs 3 or more times and at multiple levels but not 3 times at any 1 level: follow algorithm
- If none of the above are met, code Supervision
- Algorithm pg. G-8 in manual is very helpful to use

Section G0110 -2: ADL Support

- **Coding**
  - Code for the **most dependent even if that level was only provided one time during past 7 days**
  - **Code regardless of self performance codes**
  - 0 = no setup or physical help from staff
  - 1 = setup help only
  - 2 = one person physical assist
  - 3 = 2+ person physical assist
  - 8 = ADL did not occur during entire period

Section G0120: Bathing

- Bathing: how the resident takes a full body bath, shower or sponge bath, including transfers in and out of the tub or shower
- Excludes washing of the back and hair
- Rule of “3” does not apply
- Code for maximum amount of assistance received during bathing. (This is the only ADL Activity for which the ADL Self Performance codes do not apply)

11/2015 142

G0120: Bathing

- **Self-performance coding**
  - 0 = Independence: no help from staff
  - 1 = Supervision: oversight only
  - 2 = Physical help limited to transfer only
  - 3 = Physical help in part of bathing activity
  - 4 = Total dependence: resident not able to do any part of activity
  - 8 = Bathing did not occur during the entire look-back
- **Support provided coding**
  - Same as G0110 Column 2, ADL support

11/2015 143

G0300: Balance During Transitions and Walking

- **Conducting the assessment**
  - Done through observations of the resident during the entire 7-day look-back period by IDT
  - During transitions from sitting to standing, walking, turning, transfers on and off toilet, and transfer from wheelchair to bed and bed to wheelchair
  - Must have documentation that reflects the resident’s stability in these activities at least once during the look-back period, otherwise the following assessment must be done.

11/2015 144

G0300: Balance Assessment

- Have assistive devices the resident normally uses available
- Start with resident sitting on the edge of the bed, in a chair or in a wheelchair
- Ask the resident to stand up and stay still for 3-5 seconds (**rate G0300A now**)
- Ask resident to walk approximately 15 feet using his/her usual assistive device (**rate G0300B now)**
- Ask resident to turn around (**rate G0300C now)**

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G0300: Balance Assessment

- Ask resident to:
  - walk or wheel from a starting point in his/her room into the bathroom
  - prepare for toileting as normal do (including taking down pants or other clothing, but leaving undergarments on)
  - sit down on the toilet (**code G0300D now**)
- Ask resident who uses a wheelchair for mobility to transfer from a seated position in the wheelchair to a seated position on the bed (**code G0300E now**)

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G0300: Balance Coding

- **Code 0** = steady at all times (no risk of falls)
  - If assistive device is used, did the resident appropriately plan and integrate the use into the transition activity
- **Code 1** = not steady, able to stabilize without staff assistance (increased risk of falls)
- **Code 2** = not steady, only able to stabilize with staff assistance (high risk of falls)
- **Code 8** = activity did not occur

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G0400: Functional Limitation in Range of Motion

- Intent to identify limitations that interfere with daily functioning or place the resident at risk of injury
- Review the medical record for references to functional ROM during the 7-day look-back period
- Talk with staff members who work with the resident as well as family/significant others

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G0400: Functional Limitation in ROM

- **Coding is a 3 step process:**
  - Test the resident's upper and lower extremity ROM
  - If the resident is noted to have limitation, review G0110 (ADL evaluation) and/or directly observe the resident to determine if the limitation interferes with function or places the resident at risk for injury
  - Code G0400 A/B as appropriate based on the above assessment
  - Do not look at limited ROM in isolation; it must impact the resident's function or place the resident at risk for injury or it does not get coded.

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G0400—Functional Limitation in ROM

- Intent to identify limitations that interfere with daily functioning or place the resident at risk of injury
- Assess ROM at the shoulder, elbow, wrist, hand for upper extremity and the hip, knee, ankle, foot and other joints for lower extremities unless contraindicated (**both sides of body**)
- Ask resident to move each joint using verbal directions and demonstration. May actively assist the resident with ROM exercises.(page G-30)
- Amputations: code in terms of function and risk of injury and not the lack of limb or digit

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G0400: ROM Coding

- Code 0 = no impairment
  - Resident has full functional ROM on both sides, upper and lower extremities
- Code 1 = impairment on one side
  - Upper and/or lower extremity impairment on one side of the body that interferes with daily functioning or places the resident at risk of injury
- Code 2 = impairment on both sides
  - Upper and/or lower extremity impairment on both sides of the body that interferes with daily functioning or places the resident at risk of injury

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G0900: Functional Rehab Potential

- G0900A – Resident believes he/she is capable of increased independence in at least some ADLs
  - Code 0 = no, resident believe will stay the same
  - Code 1 = yes, resident thinks improvement is possible
  - Code 9 = unable to determine, resident cannot indicate
- G0900B – Direct care staff believe resident is capable of increased independence in at least some ADLs
  - Code 0 = no
  - Code 1 = yes

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Federal Tags for Section G

- F 309 - Provide care/services for highest well being
- F 310 - ADLs do not decline unless unavoidable
- F 311 – Treatment/services to improve/maintain ADLs
- F 312 – ADL care provided for dependent residents
- F 317 – No reduction in ROM unless unavoidable
- F 318 – Increase/prevent decrease in ROM

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Section GG: Functional Abilities and Goals - Intent

- The ***I****mproving* ***M****edicare* ***P****ost-****A****cute* ***C****are* ***T****ransformation* ***Act (IMPACT Act)*** of 2014 requires that CMS implement cross-setting quality measures, and that the items in Section GG are used to calculate this measure.
- Section GG items assess the need for assistance with self-care and mobility activities.

Section GG: Functional Abilities and Goals – Intent (cont.)

- Section GG items focus on resident's self-care and mobility:
  1. Admission performance
  2. Discharge goals
  3. Discharge performance

Section GG. Functional Ability and Goals

- The items in Section GG are used to calculate the SNF QRP Function Quality Measure.
- During a Medicare Part A SNF stay, residents may have self-care limitations on admission. In addition, residents may be at risk for further functional decline during their stay in the SNF.
- Section GG assesses the need for assistance with, and establishes goals for self-care and mobility activities.

**This section will be utilized beginning 10/1/16- ONLY for Traditional Medicare A Admission 5 Day assessments and Planned Discharges from Medicare A.

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Section GG: Which Staff Members Should Complete This Section?

- Refer to facility, Federal, and State policies and procedures to determine which staff member may complete an assessment, as resident assessments are to be done in compliance with facility, Federal, and State requirements.
- Physical Therapist, Occupational Therapists, Speech Language Pathologists, and Nurses are the typical staff involved in the ***assessment*** of self care and mobility items.

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Section GG – Key Definition: Helper

- For the purpose of completing Section GG, a ***"helper"*** is defined as ***facility staff who are direct employees and facility contracted employees*** (e.g., rehabilitation staff, nursing agency staff).
- ***Does not include*** individuals hired, compensated or not, by individuals outside of the facility's management and administration such as Hospice staff, Nursing students / STNA (CNA) students, etc.
- Therefore, when helper assistance is required because a resident's performance is unsafe or of poor quality, only consider facility staff assistance when scoring according to amount of assistance provided.

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GG130 – Admission or Discharge Performance Coding Instructions

Complete **only** if:

- A0310B = 01, PPS 5-Day assessment **or**
- A0310G = 1 or 2, Planned & Unplanned **and** A0310H = 1, Part A PPS Discharge

- **Code 06, Independent:** if the resident completes the activity by him/herself with no assistance from a helper.
- **Code 05, Setup or clean-up assistance**: if the helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity, but not during the activity.

GG0130 – Admission or Discharge Performance Coding Instructions

Complete **only** if:

- A0310B = 01, PPS 5-Day assessment **or**
- A0310G = 1 or 2, Planned & Unplanned **and** A0310H = 1, Part A PPS Discharge

- **Code 06, Independent:** if the resident completes the activity by him/herself with no assistance from a helper.
- **Code 05, Setup or clean-up assistance**: if the helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity, but not during the activity.

GG0130 – Admission or Discharge Performance Coding Instructions (cont.)

- **Code 04, Supervision or touching assistance:** if the helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
- **Code 03, Partial/moderate assistance:** if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- **Code 02, Substantial/maximal assistance**: if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

GG130 – Admission or Discharge Performance Coding Instructions (cont.)

- **Code 01, Dependent**: If **the helper does ALL of the effort**. **Resident does none of the effort** to complete the activity, ***OR*** the **assistance of two or more helpers** is required to complete the activity.
- **Code 07, Resident refused**: if the resident refused to complete the activity.
- **Code 09, Not applicable**: if the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- **Code 88, Not attempted due to medical condition or safety concerns**: if the activity was not attempted due to medical condition or safety concerns.

GG0130 – Key Coding Questions

- Does the resident need assistance (physical, verbal/non-verbal cueing, setup/clean-up) to complete the self-care activity?

- If no, **Code 06, Independent**
- If yes…

- Does the resident need only setup or clean-up assistance?

- If yes, **Code 05, Setup or clean-up**
- If no…

GG0130 – Key Coding Questions (cont.)

- Does the resident need only verbal/non-verbal cueing, or steadying/touching assistance?
- If yes, **Code 04, Supervision or touching assistance**
- If no…
- Does the resident need lifting assistance or trunk support with the helper providing **less** than half of the effort?
- If yes, **Code 03, Partial/moderate assistance**
- If no…

GG0130 – Key Coding Questions (cont.)

- Does the resident need lifting assistance or trunk support with the helper providing **more** than half the effort?
- If yes, **Code 02, Substantial/maximal assistance**
- If no…
- Does the helper provide **all** of the effort to complete the activity **OR** is the assistance of two or more helpers needed?
- If yes, **Code 01, Dependent**

GG0130 – Key Coding Questions (cont.)

- Was the activity not attempted? Indicate why.
- **Code 07, Resident refused,** if the resident refused to complete the activity.
- **Code 09, Not applicable,** if the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- **Code 88, Not attempted due to medical condition or safety concerns,** if the activity was not attempted due to medical condition or safety concerns.

GG0130 – Admission or Discharge Performance Coding Tips

- The 5-Day PPS assessment (A0310B = 01) is the first Medicare required assessment to be completed when the resident is admitted under SNF Medicare Part A.
- On the Part A PPS Discharge assessment (A0310H = 1), the Self-Care items in GG130 are completed only if the Type of Discharge is Planned (A0310G = 1).
- When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity (e.g., eating, oral hygiene). For example, when assessing Eating (GG0130A), determine the type and amount of assistance required to bring food to the mouth and swallow food once the meal is presented on a table/tray.
- When coding the resident's usual performance, use the 6-point scale or code the reason why an activity was not attempted.

GG0130 – Admission or Discharge Performance Coding Tips (cont.)

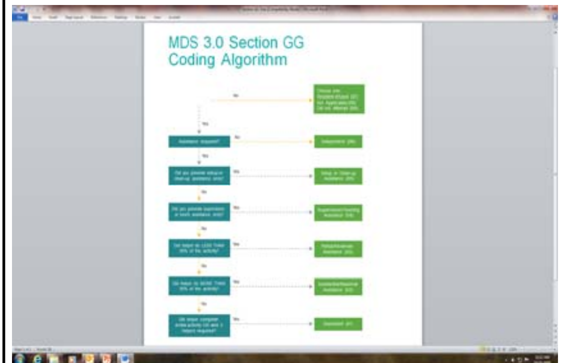
- At admission when coding for the resident's discharge goal(s), **use the 6-point scale.**
- Record the resident's **usual ability** to perform each activity (e.g., eating). **Do not record the resident's best performance**, and **do not record the resident's worst performance**, but rather **record the resident's usual performance** during the assessment period.
- Do not record the staff's assessment of the resident's potential capability to perform the activity.
- If the resident does not attempt the activity and a helper does not complete the activity for the resident, code the reason the activity was not attempted. For example, code 07 if the resident refused to attempt the activity, code 09 if the activity is not app- licable for the resident, or code 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.

GG0130 – Admission or Discharge Performance Coding Tips (cont.)

- If two or more helpers are required to assist the resident to complete the activity, **code as 01, Dependent.**
- To clarify your own understanding of the resident's performance of an activity, ask probing questions to staff about the resident, beginning with the general and proceeding to the more specific.

Coding a **dash ("-")** in these items indicates **"no information".** ***CMS expects dash use for SNF QRP items to be a rare occurrence.*** **Use of dashes** for these items **may result in a 2% reduction in the annual payment update.** If the reason the item was not assessed was that the resident refused (code 07), the item is not applicable (code 09), or the activity was not attempted due to medical condition or safety concerns (code 88), use these codes instead of a dash ("-").

GG Coding Algorithm



GG0130 Self Care – Discharge Goal

GG0130. Self-Care (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Do not use codes 07, 09, or 88 to code end of SNF PPS stay (discharge) goals.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused.**
09. **Not applicable.**
88. Not attempted due to **medical condition or safety concerns.**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
☐☐	☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
☐☐	☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.

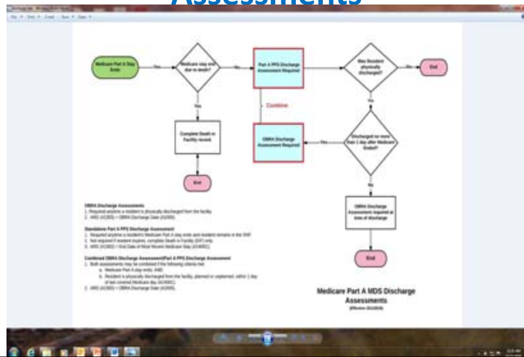
Discharge Goal: Coding Tips

- Use the 6-point scale to code the resident's discharge goal(s). Do not use codes 07, 09, or 88 to code discharge goal(s).
- Licensed clinicians can establish a resident's discharge goal(s) at the time of admission based on discussions with the resident and family, professional judgement, and the professional's standard of practice. Goals should be established as a part of the resident's care plan.

Discharge Goal: Coding Tips (cont.)

- A minimum of one self-care or mobility goal must be coded per resident stay on the 5-Day PPS assessment.
- Clinicians may code one goal for each self-care and mobility item included in Section GG at the time of the 5-Day PPS assessment.

Medicare Part A Discharge MDS Assessments



Functional QM - Numerator

Complete Stays

1. Valid score showing the resident's functional status, or a valid code indicating the activity was not attempted or could not be assessed for ***each*** of the functional items on the ***admission 5-day assessment***. **(no dashes)**
2. At least ***one*** self-care and/or mobility goal has been established. **(The rest can be dashes without a penalty.)**
3. Valid score showing the resident's functional status, or a valid code indicating the activity was not attempted or could not be assessed, for ***each*** of the functional items on the ***discharge assessment***.

Functional QM – Numerator (cont.)

Incomplete Stays

1. Valid score showing the resident's functional status, or a valid code indicating the activity was not attempted or could not be assessed for ***each*** of the functional items on the ***admission 5-day assessment***.
2. At least ***one*** self-care and/or mobility goal has been established.
3. *(There is no third requirement)* as CMS does not expect completion of section GG for ***unplanned*** discharges.

Functional QM – Calculation - Example

350

(Total # of residents who meet the QM criteria: Complete and Incomplete Stays)

375

(Total # Medicare Part A Stays)

X

100 = 93.3%

Section GG Summary

- The items in Section GG are used to calculate the SNF QRP Function Quality Measure.
- During a Medicare Part A SNF stay, residents may have self-care limitations on admission. In addition, residents may be at risk for further functional decline during their stay in the SNF.
- Section GG assesses the need for assistance with, and establishes goals for self-care and mobility activities.

Questions: MDS 3.0 Basic I Training

Questions are a sign of ***intelligence***. Ask questions because we learn from one another….

"If everyone is thinking alike, then somebody isn't thinking."
George S. Patton

11/2015