MDS 3.0 Basic 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 implemented on October 1- updated several times since July 2010 (updated 10/2015).

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
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

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

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, pg. 1-16 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.
Uses for MDS Data

- Primary: 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).

“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)

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 (20500B). IDT members should sign their completed sections = ACCURACY

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
RESOURCES NEEDED

- Evidence/research based protocols or tools for assessment and care planning
- Internet Access
  - CMS, CMS Contractors
  - Websites in Appendix C-84

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
  - 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
- MDS Manual:
- QIES technical support
  - [http://www.qtso.com](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](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/index.html)
- Medicare Manuals:
  - [http://www.cms.gov/Manuals/iom/list.asp](http://www.cms.gov/Manuals/iom/list.asp)
- Ohio Department of Health

MDS 3.0 Item Sets For SNFs

- There are 10 Item Sets for Nursing Homes - Formerly called forms (updated 10/1/13)
  - 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)

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

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
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

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

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
**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
  - 06 = Readmission/return
  - 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**

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


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

PPS Unscheduled Assessments = OMRA

- OMRA (Other Medicare Required Assessment)
  - 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 RAImanual chapter 2)
  - Significant Correction to Prior Comprehensive
    - If required by OBRA, may establish new RUG classification
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 for 3 or more consecutive days 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

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)

EOT-Resumption
- If therapy resumes within 5 calendar days, and
- 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 into RUG-IV therapy group during Medicare A stay AND no discontinuation of therapy services occurred between Day 1 of COT observation period for the COT OMRA that classified resident into current non-therapy RUG-IV and ARD of COT OMRA that reclassified resident into a RUG-IV therapy group

**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

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# 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

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# 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
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

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

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
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.

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 quarters
  - PASRR is not a RAI requirement, but an OBRA provision required to be coordinated with RAI

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
- F276 – Quarter assessment every 3 months
- F278 – Assessment accuracy/Coordination certified
- F285 – PASRR Requirements for ID/DD
- F286 – Maintain 15 months of resident assessments
- F287 – Encoding/transmitting resident assessment
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

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
  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"
A0410: Submission Requirement

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

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

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
**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

**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

**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
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

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

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
A2000: Discharge Date
- Enter date the resident leaves the facility and is gone for >24 hours and not on a LOA
- Discharge date may be later than the end of Medicare stay date if the resident is receiving services under SNF Part A PPS
- 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

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

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.
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

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

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
Federal Tags for Sections A & B

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

- **Section B** – Communication/Hearing/Vision
  - F313 – Treatment/assistive devices to maintain hearing and visual ability

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.

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
“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

Section C: 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

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
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

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

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
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)

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

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
**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

**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

**C1300: 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
C1300 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, and psychomotor retardation
• If conducting a staff assessment:
  • Ask staff members who conducted the interview about observations of signs and symptoms of delirium

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

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©)
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

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

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 problems that are known to go along with feeling down. These may seem personal, but everyone is asked to answer them. It will help us provide you with better care."
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.

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

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
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

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

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)
**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

**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

**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
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

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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

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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
**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**

**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?

**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
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.

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?

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?
**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”

**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

**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
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

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)

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
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.

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.

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.
**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

**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

**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.
**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

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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

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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.
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

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”

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.
**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

**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.

**Personal Hygiene**

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

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

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
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 Assistance

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)

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

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.
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)

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)

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
**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

**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.

**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
**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

**G0900: Functional Rehab Potential**

- **G0900A** – Resident believes he/she is capable of increased independence in at least some ADLs
  - **Code 0** = no, resident believes 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

**Federal Tags for Section G**

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

• H0100 – Appliances (check all that were used at any time during the past 7 days)
  • H0100A = indwelling catheter (includes suprapubic and nephrostomy tube)
  • H0100B = external catheter (condom or receptacle pouch)
  • H0100C = Ostomy (includes urostomy, ileostomy, and colostomy) do not include intake ostomies
  • H0100D = intermittent catheterization
  • H0100Z = none of the above

H0200: Urinary Toileting Program

• A toileting program or trial toileting program refers to a specific approach that’s organized, planned, documented, monitored and evaluated
• It is consistent with the policies and procedures of the nursing home and current standards of practice
• It does not refer to
  • Simply tracking continence status
  • Changing pads or wet clothing
  • Random assistance with toileting or hygiene

H0200: Urinary Toileting Plan

• Urinary Toileting Plan has 3 components:
  • H0200A - Trial of a toileting program
  • Look for evidence of a trial individualized toileting program that includes at least 3 days of toileting patterns with prompts to void recorded in a bladder record or voiding diary
• Coding:
  • Code 0 = No, did not have toileting trial skip to H0300
  • Code 1 = Yes continue Code 2 = completely dry, no incontinent episodes
  • Code 9 = unable to determine
H0200B- Response to Trial Program

• H0200B – Response to Trial Toileting Program
  • Code 0 = no improvement
  • Code 1 = decreased wetness
  • Code 2 = Completely dry (continent)
  • Code 9 = Unable to determine, or trial program in progress

H0200C: Current Toileting Program

• Look for documentation in the medical record showing the following 3 requirements are met:
  • Implementation of individualized, resident-specific toileting program was based on assessment of the resident’s voiding pattern
  • Evidence that the individualized program was communicated to staff and the resident verbally and through a care plan, flow records and a written report
  • Notations of the resident’s response to the program and subsequent evaluations

H0200C: Current Toileting Program

• H0200C: Current Toileting program or Trial
  • Code 0 = no
    • individualized program used less than 4 days out of the 7 day look-back period
  • Code 1 = yes
    • some kind of systematic toileting program was used 4 or more days of the 7 day look-back period
H0300: Urinary Continence

- **Continence** – The capacity to hold urine until it can be eliminated in a socially appropriate manner and location
- **Incontinence** – the involuntary loss of urine
- **Coding Range 0 to 3 and 9**
  - 0 = always continent
  - 1 = occasionally incontinent (less than 7 episodes)
  - 2 = frequently incontinent (7+ episodes but at least 1 continent void)
  - 3 = always incontinent (no continent voids)
  - 9 = not rated (has catheter, ostomy or no urine output)

H0400: Bowel Continence

- **Continence** – The capacity to hold stool until it can be eliminated in a socially appropriate manner and location
- **Coding range is 0 – 3 and 9**
  - 0 = always continent, no episodes of incontinence
  - 1 = occasionally incontinent, 1 episode
  - 2 = frequently incontinent, more than 1 episode of incontinence, but at least one continent BM
  - 3 = always incontinent, no continent episode
  - 9 = not rated (ostomy present or no BM during look back period)

H0500: Bowel Toiling Program

- Look for documentation in the clinical record that the following **3 requirements are met**:
  - Program was implemented
  - Program was communicated to the resident and staff, and
  - Resident’s response to the toileting program and subsequent reevaluations

**Toileting program being used to manage bowel continence:**
- Code 0 = no, the resident is not currently on a toileting program targeted specifically at managing bowel continence
- Code 1 = yes, resident is currently on a toileting program to manage bowel continence
H0600: Bowel Patterns

- Is Constipation present?
  - Code 0 = no
  - Code 1 = yes
- Constipation = 2 or fewer bowel movements during the 7-day look-back period or if most bowel movements produce hard and difficult to pass stool (regardless of frequency of bowel movements)

Section I: Active Diagnoses

- **Intent:** To code diseases that have a direct relationship to the resident’s current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death
- This section identifies active diseases and infections that drive the current plan of care
- Do not include conditions that have been resolved, do not affect current status, do not drive care plan during the 7 day look-back.

Section I: Active Diagnoses

- **There are 2 look back periods for this Section I**
  - 1. **Diagnosis identification Step 1 = (60-day look-back)**
    - Must have physician documented diagnosis (or by ARNP, PA, or CNS) in the last 60 days
  - 2. **Diagnosis status: Active or Inactive (Step 2) = (7-day look-back except for UTI (2300 – page I-8, which does not use the active 7 day period)**
    - Once a disease is identified, it must be determined if the disease is active
    - These have a direct relationship to functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring or risk of death
    - In past 7 days, physician must have identified the active diagnosis. Be sure you have this.
Section I: Active Diagnoses

• Coding Tips
  • Special criteria for UTI:
    • Physician dx of UTI in last 30 days, and
    • Signs and symptoms attributed to UTI, and
    • “Significant laboratory findings”, and
    • Current medication or treatment for UTI in last 30 days

Federal tags for Sections H & I

• Section H- Continence
  • F315 – Medical justification for indwelling catheter, decline in continence status; treatment and services to prevent UTI’s; toileting schedule

• Section I- Active Diagnosis
  • F441 – Infections
  • F315 – Urinary Tract Infection and services to prevent UTI’s

Frequently Asked Questions

• Can a diagnosis of skin infection or cellulitis be coded at I2500, Wound Infection (other than foot) or is this only for actual open wounds?

• Answer: Cellulitis is a bacterial infection of the skin often associated with open wounds or even microscopic breaks in the skin. Because it can involve underlying tissues, bacteria can spread into bloodstream. To be coded as a wound infection, the skin infection or cellulitis must be at the site of a pre-existing open wound. If not, then code at I8000.
Section J

• Intent is to document a number of health conditions that impact the resident’s functional status and quality of life.
• Items include:
  • Assessment of pain, uses an interview to assess the presence of pain, pain frequency, effect on function, intensity, management and control.
  • Dyspnea
  • Tobacco Use
  • Prognosis
  • Problem conditions
  • Falls

J0100: Pain Management

• 5 day look back period
• Medical record review provides data to answer the 3 questions
  • Interventions must be included as part of a care plan
  • Must be documentation that the intervention(s) were received and the effectiveness was assessed.
• J0100A – Has the resident received scheduled pain medication regimen?
• J0100B – Has the resident received PRN pain medications or was offered and declined?
• J0100C – Has the resident received non-medication intervention for pain?

J0100: Pain Management Coding

• Coding for all 3 questions:
  • Code 0 = no, the medical record does not contain required documentation of this intervention
  • Code 1 = yes, the medical record contains documentation to support intervention was received. For item B also includes “or offered, but declined”. For item C, the efficacy must also be documented.
**J0300–J0600—Pain Assessment Interview**

- Conduct this assessment close to the end of the 5-day look-back period (ARD date)
- Directly ask the resident each item in J0300 thru J0600 in the order provided
- Use resident’s terminology for pain, ie: such as hurting, aching, burning

**J0300: Pain Presence**

- Ask the resident, “Have you had pain or hurting at any time in the last 5 days?”
- Code for the presence or absence of pain regardless of pain management efforts
  - Code 0 = no, resident says there was no pain even if the reason for no pain was due to receipt of pain management interventions
  - Code 1 = yes, pain was present in last 5 days (proceed to J0400)
  - Code 9 = unable to answer, no response to question or a nonsensical answer was provided (skip to J0800 if coded a 9)

**J0400: Pain Frequency**

- Ask the resident, “How much of the time have you experienced pain or hurting over the last 5 days?”
- Coding
  - Code 1 = almost constantly
  - Code 2 = frequently
  - Code 3 = occasionally
  - Code 4 = rarely
  - Code 9 = unable to answer (resident cannot, does not or provides nonsensical response)
J0500: Pain Effect on Function

- Ask the two questions exactly as written
  - J0500A – “Over the past 5 days, has pain made it hard for you to sleep at night?”
  - J0500B – “Over the past 5 days, have you limited your day-to-day activities because of pain?”
- Coding:
  - Code 0 = no, pain did not interfere
  - Code 1 = yes, pain interfered with sleep or activities
  - Code 9 = unable to answer (unable to respond, did not answer or gave nonsensical response)

J0600: Pain Intensity

- There are two choices available to rate pain intensity
  - Numeric Rating Scale
  - Verbal Descriptor Scale
- Whichever scale is used, attempt to use the same scale on all pain assessments for that resident
- If resident is unable to answer using one scale, attempt to use the other
- Leave the coding for the unused scale blank

J0600: Pain Intensity

- J0600A – Numeric Rating Scale
  - Ask the resident to rate their worst pain over the last 5 days on a zero to 10 scale, where zero is no pain and 10 as the worst pain they can imagine.
  - Record resident response in box A
  - If unable to answer, code is 99
**J0600: Pain Intensity**

- **J0600B- Verbal Descriptor Scale**
  - Ask the resident to rate the intensity of the worst pain over the last 5 days using the following words
    - Code 1 = mild pain
    - Code 2 = moderate pain
    - Code 3 = severe pain
    - Code 4 = very severe, horrible
    - Code 9 = unable to answer (use this if resident either unable, chooses not to respond, or gives a nonsensical response)

**J0700: Should the Staff Assessment for Pain be Conducted**

- **J0700 closes the pain interview** and determines if the resident interview was complete or incomplete
  - The pain interview is successfully completed if the resident reported no pain or if they reported pain and they were able to answer the follow-up question at J0400.
  - If incomplete, proceed to staff interview, J0800.

**J0800—Indicators of Pain**

- **Complete only if Pain Assessment Resident Interview was NOT done**
  - Review the medical record, interview staff and observe the resident during cares/activities for past 5 days
  - **Check** all indicators that apply
    - A = Non-verbal sounds (crying, whining, moans)
    - B = Vocal complaints of pain (ouch, it hurts, stop)
    - C = Facial expressions (grimaces, wincing)
    - D = Protective body movements or postures
    - Z = None of these signs observed or documented (skip J0850) & move to J1100
J1100: Shortness of Breath (Dyspnea)

- Can be an extremely distressing symptom that can lead to decreased interaction and quality of life
- Check all that apply
- Resident has shortness of breath
  - A. on exertion
  - B. when sitting at rest
  - C. when lying flat
  - Z. None of the above

J1300: Current Tobacco Use

- The negative effects of smoking can shorten life expectancy and can create health problems that interfere with daily activities and adversely affect quality of life
- This item includes tobacco used in any form
  - Code 0 = no, resident did not use tobacco in last 7 days
  - Code 1 = yes, resident used tobacco in some form in the last 7 days

J1400: Prognosis

- There must be physician documentation in the medical record to support coding this item
- Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?
  - Code 0 = no, medical record does not contain physician documentation that the resident is terminally ill and the resident is not receiving hospice services
  - Code 1 = yes, medical record includes physician documentation that the resident is terminally ill; or receiving hospice services
J1550: Problem Conditions

- Check all that apply in past 7 days
  - J1550A – Fever
    - Must be 2.4 degrees F above baseline or
    - Temperature of 100.4 F on admission
  - J1550B – Vomiting – document in clinical record
  - J1550C – Dehydration
    - must have 2 of the 3 criteria to code
  - J1550D – Internal bleeding – must be documented to justify coding
  - J1550Z – None of the above

J1700: Fall History on Admission

- Importance of identifying falls
- Definition:
  - Unintentional change in position coming to rest on the ground, floor or onto the next lower surface.
  - Falls are not the result of an overwhelming external force (pushed by another person, or object)
  - An intercepted fall is still considered a fall (this can be intercepted by another person or the resident “catches” themselves)
  - A resident found on the floor or ground without knowledge of how they got there, is a fall

J1700: Fall History on Admission

- Complete if A0310A = 01 or A0310E =1
- Ask resident and family or significant other about falls in the past month and prior 6 months before admission (A1600 entry date)
  - J1700A-any fall in the last month before admit
  - J1700B-any fall in last 2-6 months before admit
  - J1700C-any fracture related to a fall in the 6 months before admit
    - Code 0 = no falls or fractures in time frame
    - Code 1 = yes, a fall/fracture occurred in the time frame
    - Code 9 = unable to determine
**J1800: Any Falls since Admission or Prior Assessment**

- If this is the first assessment, review the record for the time period from admit date to ARD
- If this is not the first assessment, review the record for the time period from the day after the ARD of last MDS to the ARD of current MDS
- Has the resident had any falls since admission or the prior assessment?
  - Code 0 = no falls since last MDS (skip to K0100)
  - Code 1 = yes, resident has had a fall since last MDS (proceed to J1900)

**J1900: Number of Falls since Admission or Prior Assessment**

- Determine the number of falls that occurred since admission or prior assessment
  - J1900A – No injury
  - J1900B – Injury (except major)
  - J1900C – Major injury
- Coding (for each of the above levels)
  - Code 0 = none since admission or prior assessment
  - Code 1 = one fall with or without injury since admission or prior assessment
  - Code 2 = 2 or more falls since admission or prior assessment

**Federal Tags for Section J Health Conditions**

- F 309- Quality of Care (Pain Management)
- F 309- Quality of Care (Shortness of Breath)
- F 309- Quality of Care (End of Life)
- F 323- Accident hazard, supervision, and assistive devices
Frequently Asked Questions

• What medications are considered in a scheduled pain medication regimen, only those pharmacologically classified as medications or any pharmacologic agent primarily used to treat pain?
  • Answer: Count all medications for which the primary use is to treat pain.

• Can routine meds such as Celebrex be counted here?
  • Answer: Yes, given routinely, they are coded as a scheduled medication.

• Is a medication like Flexeril considered a medication for pain?
  • Answer: No as it is a muscle relaxant used to treat an underlying condition and can’t be coded specifically for pain.

Section K: Swallowing/Nutritional Status

• Intent: to assess the many conditions that could affect the resident’s ability to maintain adequate nutrition and hydration

• Items included in this section:
  • Swallowing disorders
  • Height and weight
  • Weight loss/weight gain
  • Nutritional Approaches

K0100: Swallowing Disorder

Check all that apply:
  • K0100A – loss of liquids/solids from mouth when eating or drinking
  • K0100B – holding food in mouth/cheeks or residual food in mouth after meals
  • K0100C – coughing or choking during meals or when swallowing medications
  • K0100D – complaints of difficulty or pain with swallowing
  • K0100Z – none of the above
**K0200: Height and Weight**

- **Intent:** To record a current height and weight in order to monitor nutrition and hydration over time
- **K0200A: Height**
  - On admission, measure and record height in inches
  - Use mathematical rounding (.1 to .4 round down, .5 or greater round up)
  - Re-measure if last height was over a year ago
  - If unable to stand, use other methods per policy and procedure of the facility

- **K0200B: Weight**
  - Weigh resident on admission
  - On subsequent assessments, if last recorded weight was taken more than 30 days prior to ARD, or previous wt not available, weigh again
  - If multiple wts in preceding month, record most recent
  - Use mathematical rounding (if wt is .5# or more round wt up; if wt is .1 to .4#, round down)
  - If unable to weigh, code with a dash (-), no-information available code

**K0300: Weight Loss**

- **Intent:** to determine if there was a 5% weight loss in 30 days or a 10% loss in 180 days
- This item compares resident’s current weight to the weight from two distinct points in time only
- **#1 determine if resident lost weight in the last 30 days**
  - Compare current wt to wt from closest to 30 days ago
  - If current wt is less, calculate the % of loss by multiplying the wt 30 days ago by .95
  - If current wt is equal to or less than the resulting figure, the resident has lost 5% body weight in last 30 days
K0300: Weight Loss

• #2: determine if there has been weight loss in the last 180 days
  • Compare current wt with wt closest to 180 days ago
  • Multiply wt from 180 days ago by .90
  • If current wt is equal or less than the figure from the above calculation, the resident has lost 10% of body weight in last 180 days

K0300: Scenario for 30 day

• Resident currently weighs 150 #
• 30 days ago, weight was 154#
• 154 x 0.95 = 146.30
• Current weight of 150 # is more than 146.30 so the resident did not lose 5% of body weight in the last 30 days.

K0300: Scenario for 180 day

• Resident currently weighs 150#
• The weight 180 days ago was 164#
• 164 x .90 = 147.60
• The current weight of 150# is more than 147.60, the resident did not lose 10% or more of body weight in the last 180 days
• Coding for K0300 = 0, resident did not lose 5% in last 30 days or 10% in last 180 days
K0300: Weight Loss

- Coding
  - Code 0 = no, weight loss did not meet % or unknown
  - Code 1 = Yes, and resident is on a physician ordered weight loss regimen
  - Code 2 = Yes, resident is not on a physician ordered weight loss regimen

- A physician prescribed wt. loss regimen is defined as a plan with the care plan goal of wt. reduction. It can include calorie restriction, other wt. loss diets, exercise and planned diuresis. Bottom line is that the weight loss is intentional and must be documented as such.

K0310: Weight Gain

- Intent: to determine if there was a 5% weight gain in 30 days or a 10% gain in 180 days
- This item compares resident’s current weight to the weight from two distinct points in time only
- For an Admission and subsequent assessments
  - Ask resident, family or significant other about weight gain over past 30 and 180 days
  - Consult physician, review transfer documents for information
  - If admit weight is more than previous weights,
  - Calculate the percentage of weight gain for each time period

K0310: Weight Gain – 5 % in 30 days

- For 5% weight gain in 30 days:
  - Start with the resident’s weight closest to 30 days ago and multiply it by 1.05 or 105% - the result will be a 5% gain from the weight 30 days ago.
  - If the resident’s current weight is equal to or more then the resident has gained more than 5% body weight.
Weight Gain – 10% in 180 days

• Start with the resident’s weight closest to 180 days ago and multiply it by 1.10 or 110%.
• The resulting figure will be the 10% gain from the weight of 180 days ago.
• If the resident’s current weight is equal to or more than the resulting figure, the resident has gained more than 10% body weight.

K0510: Nutritional Approaches

• Check all approaches listed that were performed in last 7 days
  • Column 1 = While NOT a resident and
  • Column 2 = While a resident (of your facility)
    • K0510A – Parenteral/IV feeding
    • K0510B – Feeding tube
    • K0510C – Mechanically altered diet
    • K0510D – Therapeutic diet (low salt, low cholesterol, diabetic
      • Includes enteral feeding formulas
    • K0510Z – None of the above

K0510A: Parenteral/IV

• Include the following only if given for nutrition or hydration:
  • IV or Hyper alimentation, including TPN, given continuously or intermittently
  • IV fluids running at KVO (keep vein open)
  • IV fluids in IV Piggybacks
  • Hypodermoclysis and subcutaneous ports in hydration therapy
  • IV fluids provided to prevent dehydration but only if the added fluid intake is needed for hydration. Prevention of dehydration should be clinically indicated with supporting documentation in the record
K0510A: Parenteral/IV

- Do not include the following in K0510A:
  - IV medications or additives such as electrolytes and insulin added to TPN or IV’s
  - IV fluids used to reconstitute and/or dilute medications for IV administration
  - IV fluids given as a routine part of an operative or diagnostic procedure or recovery room stay
  - IV fluids given solely as flushes
  - Parenteral/IV fluids given in conjunction with chemotherapy or dialysis

K0510: Nutritional Approaches

- K0510B: Feeding tube
  - The presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the GI system

- K0510D: Therapeutic Diet
  - Not defined by the content of what is provided or when it is served, but why it is required
  - These diets provide treatment that addresses a particular disease or clinical condition manifesting an altered nutritional status
  - Food elimination diets related to food allergies (new)- Example: peanut allergy and peanut elimination

K0710: Percent Intake by Artificial route

- Skip if no parenteral or tube feeding
- Three columns: While NOT a resident, while a resident and during entire 7-day look-back

- K0710A – Proportion of total calories received
  - Review intake record for actual intake received

- K0710B – Average fluid intake per day
  - Captures only fluids by IV and/or tube received
  - Record average cc per day and record what was actually received and not what was ordered.
Federal Tags for Section K

• F321-Does not have a naso-gastric tube unless it is unavoidable
• F322-NG treatment/services – restore eating skills.
• F325-Maintain nutritional status
• F327- Sufficient fluid to maintain hydration
• F367- Therapeutic diet prescribed by physician
• F369 – Assistive devices – eating equipment/utensils

Section L—Oral/Dental Status

• Conduct oral exam of lips and oral cavity – see page L-2
• Check all applicable dental problems in past 7 days:
  • L0200A – broken or loosely fitting dentures
  • L0200B – no natural teeth or tooth fragments – not coding for dentures just this information
  • L0200C – abnormal mouth tissue
  • L0200D – likely cavity or broken teeth
  • L0200E – inflamed gums or loose teeth
  • L0200F – mouth pain with chewing
  • L0200G – unable to exam
  • L0200Z – none of the above were present
• F312 – Oral Hygiene
• F411 & F412 – Dental Services

Section M: Skin Conditions

• Intent: to document the risk, presence, appearance and change of pressure ulcers; and
• To note other skin ulcers, wounds or lesions; and,
• To document some treatment categories related to skin injury or avoiding injury.
• A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program
M0100: Determination of Pressure Ulcer Risk

- Review the medical record, any skin care flow sheets or other skin tracking forms, progress notes, etc.
- Talk with the treatment nurse and direct care staff on all shifts to confirm conclusions from the record review
- Examine the resident
- Then, check all that apply for the 3 components:
  - M0100A: Presence of a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device

M0100B: Formal Assessment/Tools

- Use one of the established pressure ulcer risk tools such as
  - Braden Scale for Predicting Pressure Sore Risk ©
  - Norton Scale
  - Other valid tools preferred by facility
- To check this item, the assessment tool would have to be completed during the look-back period

M0100C: Clinical Assessment

- Observation of the resident’s skin and/or review the medical record to identify risk factors
  - Examples of risk factors include:
    - Impaired/decreased mobility, decreased functional abilities
    - Cognitive impairment; refusal of care/treatment
    - Co-morbid conditions such as ESRD, Diabetes
    - Impaired blood flow, PVD, arterial insufficiency
    - Medications that may affect wound healing (steroids)
    - Resident refusal of care / tx’s
    - Incontinence, nutritional, hydration deficits
    - Previously healed pressure ulcers especially stage 3 & 4 which are more likely to have recurrent breakdown.
**M0150: Risk of Pressure Ulcer**

- Based on review for M0100 determine if the resident is at risk for developing a pressure ulcer.
  - Code 0 = No, resident is not a risk for developing pressure ulcers
  - Code 1 = Yes, resident is at risk for developing pressure ulcers.

**M0210: Unhealed Pressure Ulcer**

- Pressure ulcer is defined as localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction
- Conduct a full body assessment and focus on key areas for pressure ulcer development:

**M0210: Unhealed Pressure Ulcer (s)**

- For any pressure ulcers identified, measure and record the deepest anatomical stage
- Code based on presence of any pressure ulcer, regardless of stage, in past 7 days
  - Code 0 = No pressure ulcer in past 7 days (skip to item M0900-healed pressure ulcers)
  - Code 1 = Yes, resident had a Stage 1,2,3,4, or unstageable in the 7 day look-back period
M0300: Current Number of Unhealed Pressure Ulcers at Each Stage

• 3 steps to complete this section
  • Step 1: Determine Deepest Anatomical Stage
    • Do not reverse or back stage
    • Base on ulcer’s deepest visible anatomical level. Review clinical documentation for historical levels of tissue involvement
    • Classify the ulcer at the deepest stage recorded

Definitions of Ulcer Stages

• Stage 1 = observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body, may include changes in one or more of the following parameters:
  • Skin temperature, tissue consistency
  • Sensation and/or a defined area of persistent redness in lightly pigmented skin or persistent red, blue or purple hues in darkly pigmented skin
  • Non-blanchable-no white or paleness when pressed firmly

Stage 1 Pressure Ulcer

[Image of Stage 1 Pressure Ulcer]
Definitions of Ulcer Stages

- **Stage 2 = Partial thickness loss of dermis**
  - Presenting as a shallow open crater with a red-pink wound bed, without slough.
  - May also appear as an intact or open/ruptured blister.
  - Do not include skin tears, tape burns, perineal dermatitis, maceration, excoriation, or suspected deep tissue injury.

Stage 2 Pressure Ulcer

Definitions of Ulcer Stages

- **Stage 3 = Full thickness tissue loss.**
  - Subcutaneous fat may be visible, but bone, tendon or muscle not visible or directly palpable.
  - Slough may be present but does not obscure the depth of tissue loss.
  - Depth may vary by anatomical location.
  - May include undermining or tunneling.
    - Tunneling—passage way of tissue destruction under the skin surface with opening at skin level from wound edge.
    - Undermining—destruction of tissue or ulceration extending under the skin edges.
Definitions of Ulcer Stages

- Stage 4 = Full thickness tissue loss with exposed bone, tendon or muscle.
  - Slough or eschar may be present on some parts of the wound bed.
  - Often includes undermining and tunneling
  - Unstageable = Inability to visualize wound bed to determine accurate stage

M0300: Current Number of Unhealed Pressure Ulcers at Each Stage

- Unstageable Pressure Ulcers = (wound bed cannot be visualized)
  - Known pressure ulcers covered by non-removable dressings/devices = unstageable
  - Pressure ulcers covered by slough and/or eschar = unstageable
  - Suspected deep tissue injury = unstageable
Unstageable Pressure Ulcer covered by non-removable device

Unstageable pressure ulcer covered with eschar

Unstageable Pressure Ulcer Suspected Deep Tissue Injury
M0300: Current Number of Unhealed Pressure Ulcers at Each Stage

• Determine “Present on Admission”
  • If the ulcer was present on admit and worsened during resident’s stay to a higher stage, then the higher stage would NOT be considered present on admission
  • If ulcer was unstageable on admit, but becomes stageable later, consider it present on admission at the stage it first became stageable. If this ulcer worsens to a higher stage, the higher stage would NOT be considered present on admit

M0300: Current Number of Unhealed Pressure Ulcers at Each Stage

• Determine “Present on Admission” cont.
  • If the resident has a pressure ulcer, goes to the hospital and returns with the pressure ulcer at the same stage, do NOT code that ulcer as present on reentry
  • If a current pressure ulcer worsens to a higher stage while the resident is in the hospital, it is coded at the higher stage upon reentry and as present on admission
  • Bottom line: did the resident acquire pressure ulcers in the nursing home or somewhere else?

M0300: Current Number of Unhealed Pressure Ulcers at Each Stage

• M0300A: Enter number of Stage 1 pressure ulcers currently present
• M0300B: Stage 2 Pressure Ulcers
  • 1. enter number of current Stage 2 pressure ulcers
    • If 0, skip to M0300C
  • 2. enter the number of Stage 2’s present at the time of admission
  • 3. enter date of the oldest Stage 2
    • If date is unknown, enter a dash in each block
M0300: Current Number of Pressure Ulcers at Each Stage

- M0300C: Stage 3 Pressure Ulcers and M0300D: Stage 4 Pressure Ulcers
  - 1. enter number of current ulcers at the stated stage
  - 2. enter the number of these present on admission/reentry
- M0300E: Pressure Ulcers due to non-removable dressing/device, M0300F: Pressure Ulcers due to slough and/or eschar and M0300G: Pressure Ulcers due to Suspected Deep Tissue Injury
  - Enter number of ulcers unstageable due to above
  - Enter number noted at time of admission/reentry

Dimensions of a Pressure Ulcer- What to Measure

- Identify pressure ulcer with the largest surface area from the following:
  - Unhealed (nonepithelialized) Stage 3 or 4
  - Unstageable pressure ulcer related to slough or eschar
- Measure every Stage 3, Stage 4, and unstageable related to slough or eschar pressure ulcer to determine the largest and record in centimeters.

M0610A Length

- Stage IV PU
- Measure the longest length from head to toe using a disposable device.
M0610B Width

• Measure widest width of the pressure ulcer side to side perpendicular (90° angle) to length.

M0610C Depth

• Moisten a cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water.
• Place applicator tip in deepest aspect of the wound and measure distance to the skin level.

M0700: Most Severe Tissue Type for any Pressure Ulcer

• Examine the wound bed of each pressure ulcer to determine the type of tissue present
• Code for the most severe tissue type
  • Code 1 = epithelial tissue - all Stage 2 pressure ulcers should be a “1” for this item
  • Code 2 = granulation tissue (no slough or eschar) wound is clean
  • Code 3 = slough (any amount, but no eschar)
  • Code 4 = eschar
  • Code 9 = none of the above if a mix of different types of tissue, code for most severe
Scabs and Eschar

- **Eschar** is a collection of dead tissue within the wound that is flush with the surface of the wound.
- A **scab** is made up of dried blood cells and serum, sits on top of the skin and forms over exposed wounds such as wounds with granulating surfaces.
- A scab is evidence of wound healing.
- A pressure ulcer that was staged a 2 and now has a scab on it is a healing stage 2 and therefore the staging does not change.
- It is extremely important to have staff who are trained in wound assessment and who are able to distinguish scabs from eschar.

M0800: Worsening in Pressure Ulcer Status since Prior Assessment

- This item documents whether skin status, overall, has worsened since last MDS
- Definition of “worsening” = A pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1-4

M0800: Worsening in Pressure Ulcer Status since Prior Assessment

- Look-back for this item is back to the ARD of the prior MDS. If no prior MDS, skip to M1030.
- Enter the number of current ulcers that are new or have worsened since last MDS for each stage (2, 3 and 4)
- Code 0 = no ulcers have worsened or there are no new ulcers
**M0900: Healed Pressure Ulcers**

- Look-back period is the ARD of the prior MDS to the current ARD
- M0900A: Were pressure ulcers present on the prior assessment
  - 0 = No, skip to M1030
  - 1 = Yes, continue with rest of items
- M0900B: Enter the number of Stage 2 ulcers
- M0900C: Enter the number of Stage 3 ulcers
- M0900D: Enter the number of Stage 4 ulcers

**What is “Present on Admission?”**

- A resident was admitted with a Stage 2 pressure ulcer on April 2nd and was discharged back to the hospital on April 6th
- Discharge assessment was coded to reflect the Stated 2 was Present on Admission
- On readmission to the nursing home, the ulcer remained a Stage 2
- On her next assessment (first assessment following re-entry), should the ulcer be coded “Present on Admission” in M0300?

Source: CMS, State RAI Coordinator Training

**M0700: Most Severe Tissue Type for Any Pressure Ulcer: Scenario 1**

A resident has a Stage 4 pressure ulcer on the sacrum that presents with red bumpy tissue that has filled 75% of the ulcer, light pink tissue that has resurfaced 20% of the ulcer and 5% of the ulcer is covered with stringy, yellow tissue.

How would you code this pressure ulcer:

- 1. Epithelial tissue
- 2. Granulation tissue
- 3. Slough
- 4. Eschar
- None of the above

Source: CMS, State RAI Coordinator Training
M0700: Most Severe Tissue Type for Any Pressure Ulcer: Scenario 2

A resident arrives to the nursing home with both heels having purple areas of discolored skin. The resident's heels are boggy and warmer than the surrounding tissue.

How would you code these pressure ulcers?
- a. 1, Epithelial tissue
- b. 2, Granulation tissue
- c. 3, Slough
- d. 4, Eschar
- e. 9, None of the above

Source: CMS State RAI Coordinator Training

M1030: Number of Venous and Arterial Ulcers

- Look-back period is the last 7 days
- Do not code pressure ulcers in this item
- Enter the number of venous and arterial ulcers present
- These wounds are typically not found over bony prominences and pressure forces play virtually no role in the development of the ulcers

M1040: Other Ulcers, Wounds, and Skin Problems

- Check all that apply in last 7 days
- Foot Problems - Infection of foot, diabetic foot ulcer, open lesion on foot
- Other Problems - Open lesions other than ulcers, rashes, cuts, surgical wounds, burns, skin Tear(s), Moisture Associated Skin Damage (MASD)
- None of the Above
- FYI: Mucosal Pressure Ulcers are not coded here but at L0200C
M1200: Skin and Ulcer Treatments

• Intent: To document any specific or generic skin treatment that the resident received in the past 7 days
• Items
  • M1200A and M1200B—pressure reducing devices for chair and bed
  • M1200C: Turning/Repositioning Program
  • M1200D: Nutrition/Hydration intervention

M1200: Skin Treatments

• M1200E: Pressure Ulcer care includes any intervention for treating pressure ulcers coded in M0300.
• M1200F: Surgical Wound Care includes any intervention to treat or protect any type of surgical wound
• M1200G: Application of non-surgical dressings (with or without topical medications) other than to feet

M1200: Skin Treatments

• M1200H: Application of ointments/medications other than to feet
• M1200I: Application of Dressings to the Feet (with or without topical medications)
  • Includes interventions to treat any foot wound or ulcer other than a pressure ulcer
• M1200Z: None of the above were provided
Federal Tags for Sections M

- F309 - Quality of Care (non-pressure related skin ulcer/wounds)
- F314 – Treatment and services to prevent/heal pressure ulcers

Frequently Asked Questions

- If a pressure ulcer heals during the 7-day look back period, how is it coded in Section M?
  - Answer: PageM-5. If a resident had a PU that healed during the look-back period of the current ARD, but there was no documented PU on the prior assessment, code 0 for M0210
  - How is a scab coded?
    - Answer: A scab is evidence of healing. A Stage 2 pressure ulcer that has a scab indicates healing but the staging would not change.
  - How is M0700, Most Severe Type for Any Pressure Ulcer, coded for a Stage 1, a closed Stage 2 blister, a DTI or non-removable dressing/device?
    - Answer: Code 9. None of the above

Section N: Medications

- Intent: to record the number of days, during the last 7 days (or since admission/reentry if less than 7 days) that any type of injection, insulin, and/or select oral medications were received by the resident.
  - N0300: Injections
    - Count the number of days that the resident received any type of injection while a resident of the nursing home, enter that number
    - If a resident gets insulin injections, also include here
**N0350: Insulin**

- N0350A: Record the number of days during the last 7 days (or since admission/reentry if less than 7 days) that insulin injections were received
- N0350B: Record the number of days that the physician (or authorized extender) changed the resident’s insulin orders

**N0410: Medications Received**

- Record the number of days the resident received any of the medications listed during the last 7 days or since admission/entry or reentry if less than 7 days
- Code these medications according to the pharmacological classification not how they are used
- Combination medications should be coded in all categories that constitute the combination
- Long acting medications can only be coded if given during the look-back period

### N0410A: Antipsychotic
### N0410B: Antianxiety
### N0410C: Antidepressant
### N0410D: Hypnotic
### N0410E: Anticoagulant
### N0410F: Antibiotic
### N0410G: Diuretic
### N0410Z: None of the above

- Check the manual for information on Adverse Drug Reactions, Gradual Dose Reduction and other Care Planning considerations
Federal Tags for Section N

- F 222 - Chemical Restraints
- F 329 - Unnecessary Drugs
- F 428 - Drug Regimen Review
- F 328 - Special Needs
- F 309 - Quality of Care (Diabetic Management)

Section O: Special Treatments, Programs and Procedures

- Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by the facility staff.

- If service was provided solely in conjunction with a surgical procedure (including routine pre-and post-operative procedures) - Do Not Code

Section O: Special Treatments, Programs and Procedures

- Look-back period is the last 14 days
- Two columns available to record information
  - Column 1 is to be used if treatments, programs or procedures were received or performed by the resident prior to admission/re-entry
  - Column 2 is to be used for treatments, programs or procedures received or performed by the resident after admission/re-entry to the nursing home
Section 0: Special Treatments, Programs and Procedures

- O0100A: Chemotherapy
  - Code any type of chemotherapy agent given as an anti-neoplastic
  - The drugs coded here are used to treat cancer, not for other reasons
  - IV's, IV medication and blood transfusions provided during chemo are not coded; also not coded under MDS items K0510A, O0100H and O0100I

- O0100B: Radiation-Includes intermittent as well as radiation implants

Section 0: Special Treatments, Programs and Procedures

- O0100C: Oxygen therapy
  - Continuous or intermittent via mask, cannula, etc to relieve hypoxia
  - If BiPAP/CPAP hooked up to oxygen, ok to code
  - May code if resident places or replaces mask/cannula himself/herself
  - Do not code hyperbaric oxygen for wound therapy

- O0100D: Suctioning
  - Only tracheal and/or nasopharyngeal suctioning
  - May code if resident does own suctioning
  - Do not code oral suctioning here

Section 0: Special Treatments, Programs and Procedures

- O0100E: Tracheostomy care
  - Code cleansing of tracheostomy and/or cannula
  - May code if resident does own trach care

- O0100F: Ventilator or respirator
  - Any type of electrically or pneumatically powered closed-system mechanical ventilator support systems

- O0100G: BiPAP/CPAP
  - If ventilator or respirator is used as a substitute for BiPAP or CPAP may code here
  - May code if resident places/removes own mask
Section O: Special Treatments, Programs and Procedures

- **O0100H: IV Medications**
  - Code any drug or biological given by IV push, epidural pump, or drip through a central or peripheral port
  - Can also include intrathecal and baclofen pumps, but not subcutaneous pump

- **O0100I: Transfusions**
  - Any blood or blood products (platelets, synthetic blood products), given directly into the bloodstream

- **O0100J: Dialysis**
  - Code both peritoneal and renal that occurs at the nursing home or at another facility.

- **O0100K: Hospice Care**
  - Hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider

- **O0100L: Respite Care**
  - Code only short term stay for purpose of providing relief to an individual’s primary home-based caregiver

- **O0100M: Isolation or quarantine for active infectious disease**
  - Code only when resident requires transmission-based precautions and single room isolation alone in a separate room because of active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission
  - Do not code if resident only has a history of infectious disease, even when facility policy requires cohorting of similar infectious disease conditions
  - Do not code if precautions are “Standard Precautions”
  - Do not code if resident leaves the room for activities, therapy, dining, etc.
Section O: Special Treatments, Programs and Procedures

• O0250: Influenza Vaccine
  • O0250A: Did resident receive influenza vaccine in this facility for this year’s flu season?
    • If coded 0 = no, skip to item C, leaving B blank
    • Code 1 = yes, record date in item B
  • O0250B: Date vaccine received (Mmddyyyy)

CDC Seasonal Influenza website:
http://www.cdc.gov/flu/weekly/fluactivitysurv.htm or
http://www.cdc.gov/flu/weekly/usmap.htm

• O0250C: Reasons vaccine not received
  • Code 1 = resident not in facility during flu season
  • Code 2 = received outside of this facility
  • Code 3 = not eligible (medical contraindication)
  • Code 4 = offered and declined
  • Code 5 = not offered
  • Code 6 = cannot obtain vaccine due to declared shortage
  • Code 9 = none of the above
    • Also use this code if answer is unknown

Section O: Special Treatments, Programs and Procedures

• O0300: Pneumococcal Vaccine
  • O0300A: Is the resident’s PPSV vaccine up to date?
    • Refer to CDC flow chart to determine whether or not resident should receive the vaccine
    • Code 0 = no, PPSV status is not current or cannot be determined (proceed to item B)
    • Code 1 = Yes, PPSV status is current
  • O0300B: If Pneumococcal Vaccine not received, state reason
    • Code 1 = Not eligible
    • Code 2 = Offered and declined
    • Code 3 = Not offered
**00400: Therapies**

- Captures medically necessary therapies that occurred after admission/readmission in the past 7 days
- Therapy can occur inside or outside facility
- All Therapies must be:
  - Ordered by a physician (or approved extender)
  - Performed by a qualified therapist
  - Based on a therapist’s assessment and treatment plan,
  - Documented in the resident’s medical record, and
  - Care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective

**00400: Therapies—Coding Days and Minutes for Speech, OT and PT**

1. **Individual Minutes**
   - Total number of minutes of therapy provided by one therapist or assistant to one resident at a time. For Part A the total minutes used include all minutes provided on an individual basis.

2. **Concurrent Minutes**
   - Total number of minutes of therapy provided, with line-of-sight supervision by therapist or assistant, to 2 residents at the same time, both residents performing different activities. For Part A the total minutes are entered for concurrent therapy & the software divides them by 2.
   - Cannot treat Medicare Part B residents concurrently; treatment of two or more Part B residents is documented as group therapy. (Per Medicare Benefit Policy and Medicare Claims Processing Manual).

3. **Group Minutes**
   - Total number minutes of therapy provided in group setting
   - Medicare Part A = tx of 4 residents (regardless of payer source) performing same or similar activities & supervised by therapist/assistant not supervising anyone else and 1/4 of the minutes of group time are included in the total minutes for RUG IV. Total minutes are entered in MDS and software divides by 4.
   - Medicare Part B = treatment of 2 residents (or more) regardless of payer source at the same time

4. **Co-treatment minutes**
   - Total number of minutes each discipline of therapy that were administered

5. **Days**
   - Number of days therapy services were provided in the last 7 days (a day = 15 minutes or more)
O0400: Therapies—Coding Days and Minutes for Speech, OT, and PT

- **Therapy Start Date**
  - Record the date the most recent therapy regimen (since last assessment) started.
  - This is the date that the initial therapy evaluation is done regardless of whether treatment was provided on that date.
  - Code even if there are NO days or minutes coded.

- **Therapy End Date**
  - Record the date the most recent therapy regimen (since last assessment) ended. This is the last date the resident received skilled therapy treatment.
  - If therapy is ongoing, enter dashes.
  - Code even if NO Days or Minutes are coded.

O0450: Resumption of Therapy

- Completed if A0310C = 2 or 3 and A0310F = 99
- When an EOT OMRA has been done, determine whether therapy will resume.
- If it will resume, determine if it will re-start no more than 5 consecutive calendar days after the last day that therapy was provided and if it will resume at the same RUG-IV level.
- If the answer is Yes, code item O0450A as a 1, then code O0450B with the date therapy will resume.
- If the answer is No, code O0450A as a 2, skip date item.

O0400: Therapies

- **Respiratory Therapy**
  - Services provided by a qualified professional (respiratory therapist, respiratory nurse).
  - Services include coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds and mechanical ventilation, etc.
  - A respiratory nurse is one who received special training on the administration of respiratory treatments and procedures when permitted by the state Nurse Practice Act.
**O0400: Therapies**

- Psychological Therapy
  - Provided only by licensed mental health professional such as a psychiatrist, psychologist, psychiatric nurse or psychiatric social worker

- Recreational Therapy
  - Services provided or directly supervised by a qualified recreational therapist
  - It is not a skilled service per Social Security Act
  - It is beyond the general activity program of the facility.

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**O0400: Therapies—Coding Days and Minutes for Respiratory, Psychological and Recreational Therapies**

1. Total Minutes
   - Enter the actual number of minutes therapy services were provided in the last 7 days
   - Do not round up the time

2. Days
   - Enter the number of days therapy services were provided in the last 7 days
   - A day of therapy is defined as treatment for 15 minutes or more in a day

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**O0400: Therapies - Coding Tips**

- Include only therapies provided after resident admitted to the nursing home
- If a resident returns from a hospital stay, an initial evaluation must be done again after reentry and only those therapies that occurred since reentry can be coded on the MDS

- Therapist time
  - Do not count initial evaluation or documentation time
  - Can count subsequent re-evaluation time if part of the treatment process
O0400: Therapies-Coding Tips

- Resident’s treatment time starts when they begin the first treatment activity or task and ends when resident finishes the last task or last apparatus.
- Time required to adjust equipment or prepare for individualized therapy is set-up time and can be included in the count of minutes.
- COTA and PTA services for OT and PT only count as long as they function under the direction of the therapist.
- Do not round up minutes; record actual minutes not units.

O0500: Restorative Nursing

- 10 specific programs on MDS
  - Nursing interventions that promote resident’s ability to adapt and adjust to living as independently and safely as possible.
  
  - Focus—achieve or maintain optimal physical, mental and psychosocial functioning.

O0500: Restorative Nursing

- See page O-36 in Manual for criteria that must be met in order to code for this.
  - All techniques must be planned, monitored, evaluated and documented in the resident’s care plan and in the medical record.
  - Training and Skill Practice where activities include repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse.
O0500: Restorative Nursing

Activities provided by restorative nursing staff:
- O0500A: Range of Motion (Passive)
- O0500B: Range of Motion (Active)
- O0500C: Splint or Brace Assistance
- O0500D: Bed Mobility
- O0500E: Transfer
- O0500F: Walking
- O0500G: Dressing and/or Grooming
- O0500H: Eating and/or Swallowing
- O0500I: Amputation/Prosthesis Care
- O0500J: Communication

O0500: Restorative Nursing

- Record the number of days that each of the restorative nursing programs were performed for at least 15 minutes/day in the last 7 days
- Enter 0 if none or programs were less than 15 minutes daily
- The time the resident spent in the programs must be coded separately after the program was provided

O0600: Physician Examinations

- Enter the number of days that a physician has examined the resident in the last 14 days (or since admit if less than 14 days ago)
- Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized PAs, Nurse Practitioners or CNS working in collaboration with the physician
- Examination (must be full or partial) can occur
  - in the facility or in the physician’s office
  - Must be documented in the clinical record by physician
**00700: Physician Orders**

- Enter the **number of days** in the last 14 days (or since admission if less than 14 days ago) that the physician **has changed the orders**
- Includes written, telephone, fax or consultation orders for new or altered treatment
- Excludes routine admit orders, return admit orders, renewal orders, clarification orders without changes
- Orders on the day of admission as a result of an unexpected change/deterioration or injury are considered new or altered orders and do count

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**Federal Tags for Section O**

- **F 281**: Professional Standards of Quality (Quality of resident services/practices)
- **F328**: Providing special needs care. Receives proper care for special services (trach care, suctioning, respiratory care)
- **F309**: Quality of Care (Hospice care, dialysis)
- **F 441**: Infection control (Isolation)
- **F334**: Influenza and pneumococcal Immunization
- **F 317**: ROM/Prevention of Contractures. Residents who develop avoidable decrease in ROM after admission
- **F 318**: Preventing decrease in ROM levels. ROM to increase range or to prevent further decrease in ROM
- **F 323**: Accidents and supervision (R/T falls- therapy needed but not provided)

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**P0100: Physical Restraints**

- **Importance**
  - Restraints play a limited role in medical care
  - Restraints limit mobility and increase the risk of adverse outcomes
  - Cognitively impaired residents are at higher risk of entrapment, injury and death when physical restraints are used
  - Assessment must be completed to determine risk
Section P: Restraints

**Intent:** Record the frequency that the resident was restrained by any of the listed devices at any time day or night over the last 7 days.

**Definition critical:** “Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident’s body that the resident cannot remove easily which restricts freedom of movement or normal access to one’s body.”

Section P: Restraints

- Removes easily-
  - Resident intentionally removes, in the same manner as they were applied by staff
- Freedom of movement-
  - Any change in place or position for the body or any part of the body that the person is able to control or access
- Medical symptom/diagnoses-
  - Must have clear link between restraint use and how it benefits the resident by addressing the specific medical symptom

Section P: Restraints

- Must assess each resident to determine need for the device, then evaluate the effect the device has on the resident not the type, the intent or reason for use.
- Evaluate whether the resident can easily and voluntarily remove the device, material or equipment.
- If resident cannot easily and voluntarily remove the restraint, continue with assessment to determine whether it restricts freedom of movement or access to his/her body.
Section P: Restraints

- Any device, material, or equipment that meets the definition of a physical restraint must have:
  - Physician documentation of a medical symptom that supports the use of the restraint,
  - A physician's order for the type of restraint and parameters of use, and
  - A care plan and a process in place for systematic and gradual restraint reduction (and/or elimination, if possible) as appropriate.

P0100: Restraints

- Used in Bed
  - P0100A: Bed rail
  - P0100B: Trunk Restraint
  - P0100C: Limb Restraint
  - P0100D: Other
- Used in Chair or Out of Bed
  - P0100E: Trunk Restraint
  - P0100F: Limb Restraint
  - P0100G: Chair Prevents Rising
  - P0100H: Other

P0100: Physical Restraints

- Bed Rails
  - Any combination of partial or full rails
  - If bed rails are used for positioning but meet the definition of a restraint, must be coded as such
- Trunk Restraint
  - Examples include, but not limited to, vest or waist restraints, belts used in wheelchairs
- Limb Restraints
  - Includes devices, materials, or equipment that restrict movement of any part of an upper or lower extremity, including mittens
P0100: Physical Restraints

- Chair prevents rising
  - Any type of chair with a locked lap board, or one that places the resident in a recumbent position that restricts rising, or a chair that is soft and low to the floor. Also included are chairs with cushion placed in the seat that prohibit resident from getting up
- Other
  - Any device that does not fit into the listed categories but meets the definition of a restraint and has not been excluded from this section

P0100: Physical Restraints

- After determining whether or not a listed device is a restraint that was used during the 7 day look-back period, code the frequency of use:
  - Code 0 = not used or device was used but it did not meet the definition of a restraint
  - Code 1 = device met the definition and was used, but less than daily
  - Code 2 = device met the definition and was used on a daily basis

P0100: Physical Restraints

- Restraints used for fall prevention
  - Falls are not considered self-injurious behavior nor a medical symptom that will support the use of restraints
- Request for restraints
  - A resident has the right to refuse treatment, but not to demand the use of a restraint when the facility has determined the use is not appropriate
- Emergency use of restraints
  - Even if one of the listed devices was used in an emergency one time, code it on the MDS if it meets the definition of a restraint
Federal tags for Section P - Restraints

• F221 – Physical restraints without medical justification/staff convenience
• F323 – Accidents and Supervision - environment free of hazards (Ex: bed rails entrapment/ issues with unsafe bed rails)

Section Q: Participation in Assessment and Goal Setting

• Intent: to record the participation and expectations of the resident, family members or significant other (s) in the assessment and to understand the resident’s overall goals related to returning to the community
  • Q0100A: Resident participated in assessment
    • Definition: actively engages in interviews and conversations as necessary to meaningfully contribute to the completion of MDS 3.0
    • Code 0 = No
    • Code 1 = Yes

Section Q: Participation in Assessment and Goal Setting for Discharge to Community

• Q0100B: Family or Significant Other participated in assessment
  • Code 0 = No
  • Code 1 = Yes
  • Code 9 = resident has no family or significant other

• Q0100C: Guardian or legally authorized representative participated in assessment
  • Code 0 = No
  • Code 1 = Yes
  • Code 9 = No guardian or legally authorized representative - resident does not have a guardian or legal rep
**Q0300: Resident’s Overall Expectation**

- Complete this item only if the MDS is coded as the first assessment since the most recent admission (A0310E = 1)
- Ask the resident about overall expectations after the assessment is complete and there is a better understanding of the current situation and implications of alternative choices
- If the resident is unable to communicate preferences, obtain information from family or significant others.

**Q0300: Resident’s Overall Expectation**

- Q0300A: Resident’s overall goal
  - Code 1 = expects to be discharged to community
  - Code 2 = expects to remain in facility
  - Code 3 = expects to be discharged to another facility/institution
  - Code 9 = unknown or uncertain
- Q0300B: Indicate information source for item A
  - Code 1 = resident
  - Code 2 = family or significant other
  - Code 3 = guardian or legally authorized representative
  - Code 9 = unknown or uncertain

**Q0400: Discharge Plan**

- Q0400A: Is active discharge planning already occurring for the resident to return to the community?
  - Code 0 = No
  - Code 1 = Yes, (skip to Q0600, Referral)
- The manual contains helpful information related to planning for discharge and what minimum instructions should be present. See pages Q-8 to Q11
Q0490: Resident’s Preference to Avoid Being Asked Question Q0500B
• Complete only if A0310A = 02, 06, or 99 (quarterly, correction to quarterly and non-OBRA assessments)
• Does the resident’s clinical record document a request that this question be asked only on comprehensive assessments?
  • Code 0 = No (nothing in the record about this)
  • Code 1 = Yes (skip to Q0600, Referral)
  • Code 8 = Information not available

Q0500: Return to Community
• This item identifies the resident’s desire to speak with someone about returning to community living
• Goal is to obtain the informed choice and preferences expressed by the resident and to provide information about available community supports and services.
• This item is completed on admission, quarterly and annual OBRA assessments

Q0500: Return to Community
• Q0500B: Ask the resident, (or family or significant other if unable to respond)”Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?”
  • Code 0 = No, resident or family, et al, do not want to talk to someone about possibly returning to community
  • Code 1 = Yes, resident or family want to talk to someone about possibly returning to community
  • Code 9 = Unknown or uncertain, if resident cannot understand or respond and family, et al is not available
Q0550: Resident’s Preference to Avoid Being Asked Q0500B Again

• A. Does the resident (or others) want to be asked about returning to the community on all assessments?
  • Code 0 = No
  • Code 1 = Yes
  • Code 8 = Information not available

• B. Indicate information source for Q0550A
  • Code 1 = Resident
  • Code 2 = If not resident, then family or sig. other
  • Code 3 = If not above, then guardian or legal rep
  • Code 8 = No information source available

Q0600: Referral

• Has a referral been made to the local contact agency? (document reasons in the clinical record)
  • Code 0 = No, a referral is not needed
  • Code 1 = No, a referral is or may be needed but has not been initiated at this time.
    • This will trigger Care Area Assessment #20 if this is a comprehensive assessment.
  • Code 2 = Yes, a referral was made to the Local Contact Agency.

Q600-Facility Responsibilities

• Collaboration is important
• Social worker needs to respond to communications from the CLS and work with him/her
• Sharing of information helps CLS better understand the resident and research any potential options
• Helpful information for CLS:
  • Guardianship
  • Diagnoses
  • Information supports
  • Past efforts in the community
  • Social worker’s opinion about feasibility of resident living in community
Section V: CAA Summary

- The MDS, by itself, is not a comprehensive assessment. It is a preliminary assessment to identify potential resident problems, strengths and preferences.
- Care Areas represent conditions common in nursing homes and there are 20 Care Areas with MDS 3.0
- CAAs are identified, or “triggered” based on certain responses to select MDS items
- This summary form lists the “triggered” items from the MDS that will require further assessment and identifies where further information is found
- CAAs are required with OBRA comprehensive assessments

V0100: Items from most recent Prior OBRA or PPS Assessment

- 2 care areas (Delirium and Mood State) require information from the most recent prior MDS 3.0 to allow evaluation of resident decline.
- The 6 items in this section of V are recorded based on the coding of the most recent prior OBRA or PPS MDS, if available
- Complete these items only if a prior MDS has been completed since the most recent admission to the facility
- Do not include or consider prior discharge or entry records

V0100: Items from most recent Prior OBRA or PPS Assessment

- V0100A – OBRA reason for assessment most recent prior MDS
- V0100B – PPS reason for assessment (most recent prior MDS)
- V0100C – ARD (A2300) from most recent prior OBRA or PPS assessment
- V0100D – C0500 BIMS summary score from most recent prior OBRA or PPS MDS
- V0100E – D0300 PHQ-9 total severity score from most recent prior OBRA or PPS MDS
- V0100F – D0600 PHQ-9-OV total severity score (staff assessment) from most recent prior OBRA or PPS MDS
V0200: CAA and Care Planning

- Summarizes the “triggered” items from the MDS that will require further assessment
- V0200A: CAA Results
  - Column A: record which CAAs are “triggered”
  - Column B: record the care planning decision
  - Last column: record the location and date of CAA documentation
- Most software will generate the report with the triggered items checked, based on the MDS responses

V0200: CAA and Care Planning

- Not all triggers identify deficits/problems and/or the MDS may not trigger every relevant issue
- Some triggers indicate areas of resident strengths and can suggest possible approaches to improve functioning or minimize decline
- CAAs should help staff consider resident as a whole, identify areas that may warrant intervention, develop interventions to improve, stabilize or prevent physical, functional and psychosocial decline
- CAAs paint a picture of resident status and provides a way for staff to better know the resident and provide and monitor care

V0200: CAA and Care Planning

- V0200B 1 & 2: Signature of RN Coordinator for CAA process and date that process is complete
  - CAA review done no later than the 14th day of admission for admission MDS, and
  - Within 14 days of ARD for annual, significant change or significant correction assessments
  - This is the “Completion Date” of the RAI
- V0200C: Signature of person facilitating the care planning decision-making process and the date this column was completed
  - Care plan must be done within 7 days of the V0200B date
  - Signature does not need to be that of an RN
Section X: Correction Request

• Intent: to identify an MDS record to be modified or inactivated.
• Complete this section only if item A0050: Type of Record is coded as a 2 or 3 (modification or inactivation)
• Item X0150: Type of Provider identifies if you are a nursing home or a swing bed

Section X: Correction Request

• Items X0200 through X0700 identify the existing record that is in error. These items function as locators
• Reproduce the information exactly as it appeared in the record that needs to be corrected even if that information is wrong
• If the information is not 100% the same, the correction process will not work because the system will not be able to find the prior document.

Section X: Correction Request

• X0900: Reasons for Modification
  • Complete this item when A0050 = 2
  • Examples include transcription, data entry, software product, item coding error, EOT-R date and other
• X0150: Reasons for Inactivation
  • Complete this item when A0050 = 3
  • Examples include event did not occur and other
• X1100: RN Assessment Coordinator Attestation of Completion
  • Entire process should be completed within 14 days of discovering the error
Section X: Correction Request

- Find assessment or tracking form that is to be corrected and make the corrections on that document
- Submit both Section X and the corrected MDS/Tracking form
- Make a copy of the correction request form and attach it to the MDS or tracking form that you corrected and place in the clinical record

Section Z: Assessment Administration

- Intent: Provide billing information and signatures of persons completing the MDS
- Z0100 – Z0300:
  - These items reflect the RUG category and HIPPS modifiers for the particular type of assessment done
  - Typically the software product calculates this value
  - Also allows capturing of case mix codes required by other payers (VA, private insurance, etc)

Section Z: Assessment Administration

- For Z0400: What should be done when a staff member completed sections of the MDS but didn’t sign and in no longer employed by the facility?
- Answer: Portions may be verified by the medical record, resident, staff and/or family. The person signing the attestation must review the information to ensure accuracy and then sign for those sections and date when this review was done.
- For sections requiring resident interviews, person signing the attestation will need to interview the resident to ensure accuracy and then sign and date that the verification occurred.
Section Z: Assessment Administration

• Z0400: Signatures of persons completing Assessment or Entry/Death Reporting
  • Signatures certify accuracy of sections completed
• Z0500: Signature of RN Assessment Coordinator
  • Signature certifies completion of assessment
  • Whenever copies of the MDS are printed and dates are automatically encoded, be sure to note that it is a “copy” and not the original

Chapter 4 and Appendix C of the RAI Manual

Care Area Assessment and Care Planning

CAA

• Care Areas are triggered by MDS item responses that indicate the need for more in-depth evaluation. These items are called CATs
• A CAT (Care Area Trigger) provides a focal point for the beginning of the further assessment
  • Because these items may be associated with possible presence of a condition, concern, risk, or problem. Further assessment is needed to determine significance
**Care Areas**

- The CAAs are described in Chapter 4
- Each Care Area has two parts:
  - An introduction that provides general information about the condition, and
  - A list of items and responses from the MDS that serve as the trigger(s) for review called CATS (Care Area Triggers)

**Care Area Assessment Goals**

- Promote the highest practicable level of functioning for a resident through assessment of triggered care areas from the MDS
- Determine if there is a problem and understand the causes/contributing factors

**CAA Process**

- Provides a framework for guiding the review of triggered areas, clarification of a resident’s functional status and related causes of impairments
- It also provides a basis for additional assessment of potential issues, including related risk factors
- There is not a mandated tool for completing this further assessment but critical thinking must be done using tools based in current clinical standards of practice. These may be referred to as research or evidence based.
CAA Process Steps

- Identify what Care Area is triggered and why
- Determine if the Care Area is a problem for this resident, if so, describe nature of it and impact on functioning.
- Not all triggers identify deficits or problems. Some triggers indicate areas of resident strengths and can suggest possible approaches to improve resident functioning or minimize decline.
- An item may not trigger but still could be pertinent to the resident and care plan for this issue.

CAA Process Steps

- Identify causative and unique risk factors
  - Risk factors increase the chances of having a negative outcome or complication
  - For example, impaired bed mobility may increase the risk of developing a pressure ulcer
  - Impaired mobility is the risk factor, unrelieved pressure is the effect of that condition and the potential pressure ulcer is the complication.

CAA process Steps

- Identify need for referral
- Document which research, resources (s) or assessment tool (s) were used in completing the CAA
  - There is not a mandated specific tool for completing this further assessment of the triggered areas but critical thinking must be done using tools based in current clinical standards of practice.
Evidence-Based Care

- If a resident has triggered multiple Care Areas
  - Then it is important to consider common cause of multiple triggered areas
    - AND multiple causes of a single consequence (e.g., symptom, impairment)
  - BECAUSE
    - Treating individual findings may not suffice
    - Irrelevant interventions may be problematic

This is what makes interdisciplinary teamwork so meaningful

Appendix C Resources

Staff should follow their facility’s chosen protocol or policy for performing the CAA.
- Resources provided in Appendix C are not mandated, however, if used they can assist in considering what should be considered in the process
- CMS does not endorse the use of any particular resource(s) including those in Appendix C.
- Ensure that the resource(s) used are current, evidence-based or expert-endorsed research and clinical practice guidelines/resources.
- Be sure you use current standards of practice
- See page C-84 web links that can be used

CAA Documentation

- Explains how the IDT determined that the underlying causes, contributing factors and risk factors were related to the care area condition
- It should include the basis for the decisions, why the findings require an intervention, and the rationale behind the selection of the specific interventions.
- It should follow the CAA process
Key to writing good CAAs

• Paint a picture of the resident’s status
• Talk about the resident’s individual condition
• The better all staff “know” the resident, the better able they will be to provide and monitor adequate care and services to help that individual reach their highest practicable level of well-being

Care Planning

• A good assessment forms the basis for a solid care plan
• Analysis of all data gathered is the key
• CAAs serve as the link between the MDS and the plan of care
• Plan of care is driven by resident problems, unique characteristics, strengths and needs
• Answer the “so what now” question

Care Planning cont.

• No required format or structure
• Must have measurable goals and time tables
  • Goals should have a subject, verb, modifier, time frame, a goal statement and when it will be evaluated
  • Mr. “B” will walk 50’ 2x daily with the help of one person in the next 2 months in order to maintain ambulation skills and eat with friends and evaluate in 2 months
• Approaches should identify what staff are to do and when they are to do it.
  • Ambulate Mr. “B” to and from the dining room for lunch and dinner with FWW and stand by assist daily
  • Who is to evaluate and change the care plan if it doesn’t work???
F Tags for CAA's, Significant Change & Care Planning

- F274: Significant Change within 14 days of determining that it has occurred
- F279: Must develop a comprehensive care plan that includes measurable objectives and time tables
- F280: The comprehensive care plan must be developed within 7 days after comprehensive assessment by an interdisciplinary team and must be periodically reviewed and revised

Chapter 5 Contents

- Transmitting MDS Data
- Timeliness Criteria
- Validation Edits
- Additional Medicare Requirements that Impact Billing for SNF PPS
- MDS Correction Policy
- Correcting Errors in MDS Records that have not been accepted to QIES ASAP
- Correcting Errors that have been accepted into QIES ASAP
- Special Manual Record Correction Request

Error Corrections

- May correct assessment, data entry or software errors
- May not change a previously completed MDS when the resident status changes during the course of their stay
- If assessment has not been transmitted successfully do not use electronic correction process
- Correct problem in software and on paper copy then submit or re-submit
Correcting MDS

• Electronic record submitted to & accepted into QIES ASAP system is legal assessment
• Changes made to electronic record after data transmission, or to paper copy maintained in medical record are not recognized as proper corrections

Error Corrections

• Data already accepted in database can only be corrected using electronic process
• There are two types of correction possible
  • Modification
  • Inactivation
• Only facility can correct data in most cases

Section X: Correction Request

• Intent: to identify an MDS record to be modified or inactivated.
• Complete this section only if item A0050: Type of Record is coded as a 2 or 3 (modification or inactivation)
• Item X0150: Type of Provider identifies if you are a nursing home or a swing bed
Section X: Correction Request

• Items X0200 through X0700 identify the existing record that is in error. These items function as locators.
• Reproduce the information exactly as it appeared in the record that needs to be corrected even if that information is wrong.
• If the information is not 100% the same, the correction process will not work because the system will not be able to find the prior document.

Section X: Correction Request

• X0900: Reasons for Modification
  • Complete this item when A0050 = 2
  • Examples include transcription, data entry, software product, item coding error, EOT-R date and other
• X0150: Reasons for Inactivation
  • Complete this item when A0050 = 3
  • Examples include event did not occur and other
• X1100: RN Assessment Coordinator Attestation of Completion
  • Entire process should be completed within 14 days of discovering the error

Section X: Correction Request

• Find assessment or tracking form that is to be corrected and make the corrections on that document.
• Submit both Section X and the corrected MDS/Tracking form.
• Make a copy of the correction request form and attach it to the MDS or tracking form that you corrected and place in the clinical record.
Inactivation vs Modification

Inactivation:
- Move a record previously accepted into QIES ASAP into ASAP database history
- Record not replaced and could require new record submitted and accepted
- Only requires completing A0050 and Section X
- Use to inactivate record of event that didn’t occur

Modification:
- Correct record previously accepted into QIES ASAP system
- Replaces corrected record as the active record (previous record maintained as inactive)
- Must include all MDS items and responses in Section X
- Normally used to correct typographical errors

Policy Prior to May, 2013

Inactivation was required for the following:
- A0200-Type of Provider
- A0310-Type of Assessment
- A1600-Entry date (on Entry Tracking record; A0310F=1)
- A2000-Discharge Date (on Discharge/Death in Facility record; A0310F=10-12)
- A2300-Assessment Reference Date (ARD)

Modification was required for errors in clinical items (B100C-V0200C) including data entry errors

Policy Effective 5/19/13

Modification may now be used for typographical errors as follows:
- A0310 Type of Assessment where there is no item set change (ISC)
- A1600 Entry Date
- A2000 Discharge Date
- A2300 Assessment Reference Date (ARD)
- Clinical items B100C-V0200D

Inactivation still required for errors in the following:
- A0200 Type of Provider
- A0310 Type of Assessment where there is an Item Set Change
A2300 Modifications

Effective 5/19/13, modifications may be used to address typographical errors in the ARD, A2300

If the change would result in a different look-back period than was used to code the previously accepted assessment, then this is not a typographical error.

Ask: Would altering the ARD result in a change to the assessment timeframe used to code this assessment?

If yes, inactivate
If no, modify

Error Messages

-1061: A change in the target date and/or RFA in combination with a change in the clinical item listed may indicate improper coding

-1062: A change in the target date and/or RFA in combination with a change in the clinical item listed and Medicare RUG may indicate improper coding.

Additionally, providers will see fatal errors in cases where the modified record contains an ISC change

-3839: Non-matching ISC—the ISC of the modified record does not match the ISC of the record to be modified

Special Manual Record Correction Request

- A few error types cannot be corrected with an automated modification or inactivation request
- Test record submitted as production
- Wrong submission requirement in A0410
- Wrong facility id in control item FAC_ID
- Facility must contact the state MDS Automation Coordinator to obtain the required form in order to correct the information
Transmission of MDS

- All assessments and entry/tracking forms submitted into the Quality Improvement & Evaluation System (QIES) Assessment Submission & Processing system (ASAP) within 14 days
- Data is subjected to validation/edit checks
- Facility receives a report with results (initial feedback or final validation report).

Websites


- Check your validation reports because there may be a warning message re: data that has been accepted but needs corrected
- Fatal message: rejected & not available at State/Federal level. Data only stored in your computer & not QIES ASAP.

Electronic Signatures

- Facilities may use electronic signatures for clinical record documentation, including the MDS, when permitted by State and Local law and when authorized by facility policy even if the entire record is not maintained electronically
- Facilities must have written policies in place to ensure proper security measures to protect the use of an electronic signature by any other than the person to whom the electronic signature belongs.
**MDS Electronic Maintenance**

- If the MDS is maintained electronically, but electronic signatures are not used, must have:
  - Hard copies of signed and dated CAA completion and signature pages (V0200B and C);
  - Hard copies of Correction Completion (X1100A-E);
  - Hard copies of Assessment Completion (Z0400-Z0500) data
  - These must be resident-identifiable
  - The MDS and Care plan can be in separate binders

**CMS Training Videos**

- YouTube videos are available through the CMS website with information and clarifications for sections I, G, M and O.

- For more information and access to the videos:
  

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MDS 3.0 Basic Training

Questions?????
Comments........

“Take the attitude of a student, never be too big to ask questions, never know too much to learn something new.”
Og Mandino