New York’s Common MDS Coding Errors: Strategies to Improve MDS Accuracy

SCHOOL OF PUBLIC HEALTH
UNIVERSITY AT ALBANY State University of New York

New York’s Common MDS Coding Errors:
Strategies to Improve MDS Accuracy

Today’s Presenter

Sandy Biggi
BSN, SNT, RAC-MT, C-NE

Producers

Allison Davenport
Program Coordinator
School of Public Health, SUNY Albany

Sue Brooks
Administrative Assistant II, Web Page Manager
Expert Synchronous Webinar Producer
School of Public Health, SUNY Albany
Today’s Webinar

- Please designate one person at the computer
- Adobe Features:
  - Chat Box
- All questions will be submitted to coned@albany.edu and answers will be shared as a Frequently Asked Questions (FAQ) document posted on our website www.mds-ny.org
- Today’s session is being recorded for future archived viewing on our website www.mds-ny.org

Links Document

In the FILES box on your screen you will find a document that contains all links referenced in today’s training.
You will also find a document containing a group sign-in sheet with fax instructions if you are attending this webinar as a group.
Introduction

This web-based training was developed by the New York State Department of Health, in partnership with the University at Albany School of Public Health, to highlight common MDS coding errors identified through an audit by the Office of the Medicaid Inspector General, and offers strategies for providers to improve accuracy in this area.

Agenda

- Role and responsibilities of the MDS Coordinator
- MDS coding resources
- MDS coding accuracy
- Documentation to support MDS coding and care delivery
The Role and Responsibilities of the MDS Coordinator

- Critical to MDS accuracy and effective RAI System
- Define role of MDS coordinator
  - Must be knowledgeable, dependable, well-respected, excellent communicator, effective as trainer, understands audit process and can analyze data, understands Medicare rules, coordinates with billing and IDT
- Hire qualified RN
  - Pre-hiring screen
Questions for Determining Skills of the MDS Coordinator

- How do you stay current with MDS updates?
- How do you set up the “calendar” including PPS assessments; can we use grace days without fear?
- How does information from the frontline staff become incorporated into MDS and medical record?
- How are you educating/remediating staff on MDS issues?
- What is your method to assess supporting documentation for the MDS?

Questions for Determining Skills of the MDS Coordinator

- What is an ARD, a SOT, a COT, and EOT?
- What is required CAA documentation?
- Describe the system you use to determine residents who have changed significantly
- Tell me how you determine if the MDS is accurately coded and if not, what do you do?
- What MDS audit tools are you using?
- What happens with the validation reports?
MDS Coordinator

- Once you have found a skilled MDS coordinator, that RN must have responsibility and authority built into the organizational process

Organizational Diagram
MDS Coordinator

Responsibilities
- Policies and procedures
  - Updated reflecting regulations and RAI manual changes
  - Details responsibility by discipline
  - Storage and transmission of MDS
- Assess resources
  - Personnel
  - Technology (software, computers, printers)
  - Education and competency evaluation process

MDS Coordinator

Responsibilities
- Maintains personal competence in the RAI process
- Assesses staff training needs and assures educational needs are met
- Communicates effectively and facilitates team cooperation and coordination
- Assures information from frontline staff is incorporated into data collection
- Assures timely completion of the MDS by IDT
  - IDT must work timely to meet deadlines
MDS Coordinator

- Responsibilities
  - Monitors documentation in the medical record to assure it supports the MDS data
    - Including information from frontline staff
  - Develops and implements competence measures and audits MDS coding by clinicians completing the MDS
  - Understands the audit process and corrects MDSs with erroneous data (prior to submission)

MDS Coordinator

- Responsibilities
  - Assures timely submission of the MDS and reviews/takes action on validation reports
  - Analyzes and responds to audit trends; embraces CQI
  - Reports to QAA and effectively works to solve problems
Coding Resources

RAI Manual
CMS website
Skilled Nursing Facilities (SNF)/Long Term Care (LTC) Open Door Forum
NYS RAI Coordinator
School of Public Health MDS trainings
  • In person
  • Webinar series
  • Internal audits of MDS data
New Definition of “RAI Manual”

- For payment and quality monitoring purposes, the RAI Manual consists of both:
  - The instructions in the actual manual
  - The interpretive guidance and policy clarifications posted on the MDS web site at:


MDS User’s Manual
Chapter 1: Resident Assessment Instrument (RAI)

- An Overview
  - Content of RAI in nursing homes
  - What are the components?
  - How does it fit in with the Problem Identification Process?
  - Layout of the RAI manual
  - Protecting the privacy of MDS data

Chapter 2: Assessments for the Resident Assessment Instrument (RAI)

- When do we complete the RAI?
- What are the timeline requirements for completion, submission etc.?
- How are the key concepts defined?
  - OBRA assessments
  - PPS assessments
  - Significant Change in Status Assessment
- When can assessments be combined?
- Key resource for the MDS coordinator
Chapter 3: Overview to Item-by-Item Guide to the MDS 3.0

- Intent
- Item Display
- Item Rationale
- Health Related Quality of Life
- Planning for Care
- Steps for Assessment
- Coding Instructions
- Coding Tips/ Special Populations
- Examples

B0100: Comatose

**DEFINITIONS**

**COMATOSE (coma)**
A pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; he/she does not open his/her eyes, does not speak and does not move his/her extremities on command or in response to noxious stimuli (e.g., pain).

**Item Rationale**

**Health-related Quality of Life**
- Residents who are in a coma or persistent vegetative state are at risk for the complications of immobility, including skin breakdown and joint contractures.

**Planning for Care**
- Care planning should center on eliminating or minimizing complications and providing care consistent with the resident’s health care goals.

**Steps for Assessment**
1. Review the medical record to determine if a neurological diagnosis of comatose or persistent vegetative state has been documented by a physician, nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws.

**Coding Instructions**
- **Code 0, no:** if a diagnosis of coma or persistent vegetative state is not present during the 7-day look-back period. Continue to **B0200 Hearing**.
- **Code 1, yes:** if the record indicates that a physician, nurse practitioner or clinical nurse specialist has documented a diagnosis of coma or persistent vegetative state that is applicable during the 7-day look-back period. Skip to Section G0110. *Activities of Daily Living (ADL) Assistance*.

**Example:**

<table>
<thead>
<tr>
<th>Option</th>
<th>Persistent vegetative state/ unresponsive consciousness</th>
</tr>
</thead>
<tbody>
<tr>
<td>0: No</td>
<td>Continue to B0200 Hearing</td>
</tr>
<tr>
<td>1: Yes</td>
<td>Skip to G0110. <em>Activities of Daily Living (ADL) Assistance</em></td>
</tr>
</tbody>
</table>
Chapter 4: Care Area Assessment (CAA) Process and Care Planning

- What are the CAAs?
- How are they triggered?
- What is required if a CAA is triggered?
- What is CAA documentation?
- How do CAAs relate to care planning?
- What should be covered in the care plan?
Chapter 5: Submission and Correction of the MDS Assessments

- How to submit data?
- When to submit data?
- How to interpret/ handle edits?
- What are additional submission requirements for Medicare?
- How to correct errors?
- Key chapter for MDS coordinator

Chapter 6: Medicare Skilled Nursing Facility Prospective Payment System

- What is prospective payment?
- What are the different RUGs and how are they defined?
- What is the relationship between assessments and claims?
- What are the SNF PPS eligibility criteria?
- What is a HIPPS code and why is it important?
- What is “non-compliance” with the PPS schedule and what are the consequences?
Appendices

- Glossary
- Listing of State RAI coordinators
- Interviewing techniques
- Care Area Assessments Resources

CMS MDS website

- Free training available from CMS
- You tube videos for most sections of the MDS


CMS Open Door Forum

- Skilled Nursing Facilities (SNF)/Long Term Care (LTC) Open Door Forum
  - Mailbox: SNF_LTCODF-L@cms.hhs.gov
  - Register: http://www.cms.gov/OpenDoorForums/

State RAI Coordinator

- Ask questions and get clarification from New York State RAI coordinator-
  - Email (preferred for Q &A’s)
    - mds3@health.state.ny.us
  - Telephone
    - 518-408-1658
University at Albany
School of Public Health

- Live trainings in locations across New York State
  - MDS 3.0: An Introduction
  - MDS 3.0: Beyond the Basics
- Webinars biannually
  - MDS 3.0: An Introduction Webinar Series
    - Six modules
    - Offers detailed information of each item on the MDS, as well as an introduction to Care Area Assessments (CAAs), scheduling, and care planning.
  - MDS 3.0: Beyond the Basics Webinar Series
    - Three modules
    - Offers detailed information on the Care Area Assessments (CAAs), scheduling, and care planning.

www.mds-ny.org

Internal Audit

- Prior to submission, review MDS for accuracy
  - Automated process
  - Manual process
    - Random audits
- Use the encoding process to fix MDS errors prior to submitting to federal repository
- Track coding errors to determine the root cause and strategies to remedy chronic errors
MDS Coding Accuracy

New York State Common Coding Errors

- Section A: Payor Source
  - New York State Section S
- Section C: Staff Assessment for Mental Status
- Section D: Mood Status PHQ9OV
- Section E: Behaviors and Frequency
- Section G: Activities of Daily Living (ADL) Assistance
- Section I: Diagnosis
- Section J: Fever
- Section K: Height and Weight
- Section O: IV Medications
- Section O: Therapies
- Section O: Restorative Nursing
- Section O: Physician Orders
MDS 3.0
Section A- Payor Source

- **A0700: Medicaid Number**
  - Record this number if the resident is a Medicaid recipient
    - Check the resident’s Medicaid card, admission or transfer records, or medical record
    - Confirm that the resident’s name on the MDS matches that on the Medicaid card
  - Enter a + in the leftmost box if the number is pending
  - Enter N in leftmost box if resident is not a Medicaid recipient or pending
  - Enter Medicaid number, beginning in leftmost box if Medicaid recipient

MDS 3.0
Payor Source - NYS Section S

- **S8055. Primary Payor**
  - 1 Medicare
  - 2 Medicaid
  - 3 Medicaid Pending
  - 9 None of the Above
MDS 3.0
Payor Source - NYS Section S

- To determine the primary payment source as of the MDS Assessment Reference Date (A2300)
- Check with the billing office to review current payment source(s). Do not rely exclusively on information recorded in the resident's clinical record.

MDS 3.0
Payer Source - NYS Section S

- Enter the Code of the **one** source of coverage that has primary responsibility for and pays for most of the resident's current nursing home stay on the Assessment Reference Date (A2300)
MDS 3.0
Payor Source - NYS Section S

- Code 1 - Medicare Part A (traditional)
- Code 2 - Medicaid is the primary payor (includes Medicaid HMO). Residents with Medicaid covered supplemented by Medicare Part B should be recorded as Medicaid payor
- Code 3 - Medicaid Pending - There is no other primary third party coverage being used for the resident’s present stay, and the facility has sought, or intends to seek, establishment of Medicaid eligibility for coverage as of the Assessment Reference Date (A2300).

MDS 3.0
Payor Source - NYS Section S

- Code 9 - None of the Above - The primary third party payor is not Medicare Part A or Medicaid, and Medicaid is not pending. The payor may be commercial insurance, including Medicare Part C (Medicare Choice/HMO) or a resident who pays privately, or one who receives charity care
MDS 3.0
Section C – Staff Assessment for Mental Status

- C0700. Short-term Memory OK
  - Determine by asking resident to describe an event 5 minutes after it occurred or to follow through on a direction given 5 minutes earlier
  - Observe resident for need to be reoriented
  - Collect info over all shifts/departments from front line staff, family etc.
  - Code based on all information collected during the 7-day look-back period
    - Code the most representative level of function
MDS 3.0
Section C – Staff Assessment for Mental Status

- C0800. Long-term Memory OK
  - Engage resident in conversation, review memorabilia, observe resident response to visitors
  - Ask general questions
  - Collect info over all shifts by asking direct care givers
  - Review medical record for clues about long term memory during the 7 day look-back period

- C0900. Memory/Recall Ability
  - Ask the resident about
    - Current season
    - Room location
    - Staff names and faces
    - Living in nursing home
  - For residents with limited communication, ask direct care staff and family about recall ability
  - Collect info over all shifts and departments
  - Review medical record for info on recall ability during 7 day look-back period
MDS 3.0
Section C – Staff Assessment for Mental Status

- C1000. Cognitive Skills for Daily Decision Making
  - Choosing clothing, knowing when to go to meals, using environmental clues, seeking info from others, using awareness of one’s own strengths/limitations, acknowledging need to use assistive devices such as walker

- Coding
  - Code 0 Independent- consistent, reasonable, and organized resident decisions
  - Code 1 Modified independence- self-organized daily routine; made safe decisions in familiar situations; difficulty with new tasks
  - Code 2 Moderately impaired- poor decisions requiring reminders, cues and supervision
  - Code 3 Severely impaired- rarely or never makes decisions
MDS 3.0
Section C – Staff Assessment for Mental Status

- Documentation may include:
  - A record of discussions with direct care givers, other disciplines, family members during 7 day look-back
  - A record of direct observations during 7 day look-back
  - Notes by IDT members in medical record in 7 day look-back

---

MDS 3.0
Section D- Mood Status PHQ9-OV

<table>
<thead>
<tr>
<th>Section D</th>
<th>Mood</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ9-OV</td>
<td></td>
</tr>
</tbody>
</table>

**PHQ9-OV**

1. **Symptom Presence**
   - No (enter 0 in column 2)
   - Yes (enter 0-3 in column 2)

2. **Symptom Frequency**
   - Never or 1 day
   - 2-6 days (seven days)
   - 7-11 days (half or more of the days)
   - 12-14 days (nearly every day)

A. Little interest or pleasure in doing things
B. Feeling or appearing down, depressed, or hopeless
C. Trouble falling or staying asleep, or sleeping too much
D. Feeling tired or having little energy
E. Poor appetite or overeating
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down
G. Trouble concentrating on things, such as reading the newspaper or watching television
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual
I. States that s/he isn’t worth living, wishes for death, or attempts to harm self
J. Being short-tempered, easily annoyed
MDS 3.0
Section D- Mood Status PHQ9-OV

- Staff Assessment of Resident Mood
  - Look-back period is 14 days
  - Interview staff over all shifts who know resident best
  - Encourage staff to report symptom frequency, even if unrelated to depression
  - Select the highest frequency reported by staff or family
  - If resident has been admitted for less than 14 days, talk to family and review transfer records

MDS 3.0
Section D- Mood Status PHQ9-OV

- Documentation may include:
  - Discussions with direct care givers, other disciplines, family members during 14 day look-back period
  - Direct observations during the 14 day look-back window
MDS 3.0
Section E: Behaviors and Frequency

<table>
<thead>
<tr>
<th>Section E</th>
<th>Behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>E0100. Potential Indicators of Psychosis</td>
<td></td>
</tr>
<tr>
<td>A. Hallucinations (perceptual experiences in the absence of real external sensory stimuli)</td>
<td></td>
</tr>
<tr>
<td>B. Delusions (misconceptions or beliefs that are firmly held, contrary to reality)</td>
<td></td>
</tr>
<tr>
<td>Z. None of the above</td>
<td></td>
</tr>
</tbody>
</table>

**HALLUCINATION**
- The perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch.

**DELUSION**
- A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary.
### MDS 3.0

**Section E: Behaviors and Frequency**

- Documentation for hallucinations and/or delusions does not require frequency.
- Documentation should support the actual occurrence of these behaviors during the 7 day look-back period obtained either by direct observation or by interview with staff; or by notes in the resident's medical record reflecting such behaviors.

### MDS 3.0

**Section E: Behaviors and Frequency**

<table>
<thead>
<tr>
<th>E0200. Behavioral Symptom - Presence &amp; Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note presence of symptoms and their frequency</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coding:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Behavior not exhibited</td>
</tr>
<tr>
<td>1. Behavior of this type occurred 1 to 3 days</td>
</tr>
<tr>
<td>2. Behavior of this type occurred 4 to 6 days, but less than daily</td>
</tr>
<tr>
<td>3. Behavior of this type occurred daily</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enter Codes in Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)</td>
</tr>
<tr>
<td>□ B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others)</td>
</tr>
<tr>
<td>□ C. Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)</td>
</tr>
</tbody>
</table>
MDS 3.0
Section E: Behaviors and Frequency

- A. Physical behavioral symptoms directed toward others
- B. Verbal behavioral symptoms directed toward others
- C. Other behavioral symptoms not directed toward others

Code each of these based on how many days did the behavior(s) occur in the 7 day look-back
- Code 0- not present
- Code 1- occurred 1-3 days
- Code 2- occurred 4-6 days
- Code 3- occurred daily

Code as present even if staff have “normalized” the behavior or view it as typical and tolerable
MDS 3.0
Section E: Behaviors and Frequency

- Documentation for E0200 may include:
  - Flow sheets including frequency
  - Written notes in medical record reflecting interview with staff over all shifts
  - Record of direct observation of the resident

G0110 Activities of Daily Living (ADL) Assistance
MDS 3.0
Section G: ADLs
Column 1 Self-Performance

Definitions of late-loss ADLs

- **A. Bed mobility:** how resident moves to and from lying position, turns side or side, and positions body while in bed or alternate sleep furniture.

- **B. Transfer:** how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet).
MDS 3.0
Section G: ADLs

• **H. Eating:** how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration).

• **I. Toilet use:** how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag.

---

**MDS 3.0**
Section G: ADLs

**Coding Instructions G0110, Column 1, ADL Self-Performance**

• **Code 0, independent:** completed activity with no help /oversight every time during the 7-day look-back period and activity occurred 3+ times

• **Code 1, supervision:** if oversight, encouragement, /cueing provided 3+ during the last 7 days.
MDS 3.0
Section G: ADLs

Coding Instructions Go110, Column 1, ADL Self-Performance Continued:

• **Code 2, limited assistance**: resident highly involved in activity and received physical help in guided maneuvering or other non-weight-bearing assistance on 3+ during the last 7 days

• **Code 3, extensive assistance**: resident performed part of activity over the last 7 days and help of the following type(s) was provided 3+ times:
  — Weight-bearing support provided **three or more times**, OR
  — Full staff performance 3+ during part but not all of last 7 days

ADL Reporting

• Independent
  • No help or staff oversight (physical or verbal)
  • Resident is able to perform the activity with or without setup from staff
ADL Reporting

- **Supervision**
  - Oversight, monitoring, encouraging, verbally prompting or cueing

ADL Reporting

- **Limited Assistance**
  - Resident highly involved in activity, received physical help in guided maneuvering of limbs or other non weight-bearing assistance
ADL Reporting

- Extensive Assistance
  - Weight-bearing support

---

MDS 3.0

Section G: ADLs

Coding Instructions for G0110, Column 1, ADL Self-Performance (cont.)

- **Code 4, total dependence: full staff performance** of an activity with no participation by resident for any aspect of the ADL activity and the activity occurred three or more times. The resident must be unwilling or unable to perform any part of the activity over the entire 7-day look-back period.

- **Code 7, activity occurred only once or twice**: activity occurred fewer than three times.

- **Code 8, activity did not occur**: activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day look-back period.
MDS 3.0
Section G: ADLs

- Rule of three
  - In order to properly apply Rule of 3, the facility must first note which ADL activities occurred, how many times each ADL activity occurred, what type and what level of support was required for each ADL activity over the entire 7-day look-back period.

MDS 3.0 - Section G: ADLs

Rule of three exceptions:

- **Code 0, Independent** – Coded only if resident completed the ADL activity with no help or oversight *every time* the ADL activity occurred during the 7-day look-back period and the activity occurred at least three times.

- **Code 4, Total dependence** – Coded only if resident required full staff performance of the ADL activity *every time* the ADL activity occurred during the 7-day look-back period and the activity occurred three or more times.

- **Code 7, Activity occurred only once or twice** – Coded if ADL activity occurred fewer than three times in the 7-day look back period.

- **Code 8, Activity did not occur** – Coded only if ADL activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day look-back period.
MDS 3.0 - Section G: ADLs

Rule of Three instructions:

- When an ADL activity has occurred **three or more times**, apply the steps of the Rule of 3 below *(keeping the ADL coding level definitions and the above exceptions in mind)* to determine the code to enter in Column 1, ADL Self-Performance. These steps must be used in sequence. Use the first instruction encountered that meets the coding scenario (e.g., if #1 applies, stop and code that level).

1. When an activity occurs **three or more times at any one level**, code that level.
2. When an activity occurs **three or more times at multiple levels**, code the most dependent level that occurred three or more times.

---

3. When an activity occurs **three or more times and at multiple levels, but not three times at any one level**, apply the following:
   a. Convert episodes of full staff performance to weight-bearing, as long as full staff performance episodes did not occur every time the ADL was performed in 7-day look-back period. Weight-bearing episodes that occur three or more times or full staff performance provided three or more times during part but not all of the last 7 days are included in ADL Self-Performance coding level definition for Extensive assistance (3).
   b. When there is a combination of full staff performance and weight-bearing assistance that total three or more times—code extensive assistance (3).
   c. When there is a combination of full staff performance/weight-bearing assistance, and/or non-weight-bearing assistance that total three or more times—code limited assistance (2).

- **If none of the above are met, code supervision.**
MDS 3.0 Section G: ADLs

Column 2- Support

Coding Instructions G0110, Column 2, ADL Support

Code for the most support provided over all shifts. Code regardless of how Column 1 ADL Self-Performance is coded.

- **Code 0, no setup or physical help from staff:** if resident completed activity with no help or oversight.
- **Code 1, setup help only:** if resident is provided with materials or devices necessary to perform the ADL independently. This can include giving or holding out an item that the resident takes from the caregiver.
- **Code 2, one person physical assist:** if the resident was assisted by one staff person.
- **Code 3, two+ person physical assist:** if the resident was assisted by two or more staff persons.
- **Code 8, ADL activity itself did not occur during the entire period:** if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.
MDS 3.0 Section G: ADLs

Column 2- Support

Coding Instructions G0110, Column 2, ADL Support

Scenario

- Resident was supervised for all transfers during the 7 day look-back period with one staff member cueing him. However, during one night, resident was disoriented and needed help of two staff members who provided weight bearing assistance
- Code 1 for column 1: self-performance
- Code 3 for column 2: support

MDS 3.0 - Section G: ADLs

Scenario 1
20 episodes of independent
10 episodes of supervision
3 episodes of limited assist (non-weight bearing)

Code: limited assist (2)
MDS 3.0 - Section G: ADLs

Scenario 2

5 episodes of supervision
3 episodes of weight bearing

Code: extensive (3)

MDS 3.0 - Section G: ADLs

Scenario 3

20 episodes of independent
10 episodes of supervisor
1 episode of limited assist (non-weight bearing)
1 episode of weight bearing

Code: supervision (1)
MDS 3.0 - Section G: ADLs

Scenario 4
2 episodes of supervision
2 episodes of non-weight bearing
2 episodes of weight bearing

Code: limited assist (2)
Rationale: When there is a combination of full staff performance/weight-bearing assistance, and/or non-weight-bearing assistance that total three or more times—code limited assistance (2)

MDS 3.0 - Section G: ADLs

Scenario 5
1 episodes of supervision
2 episodes of limited assist (non-weight bearing)
2 episodes of weight bearing
2 episodes of total dependence

Code: extensive (3)
Rationale: When there is a combination of full staff performance and weight-bearing assistance that total three or more times—code extensive assistance (3).
MDS 3.0 - Section G: ADLs

Scenario 6

22 episodes of total dependence (tube fed)
1 episode of independence (fed self trial of a pleasure food one time)

Code: code 3 (extensive)
Rationale: Full staff performance of activity three or more times during part but not all of the last 7 days.

MDS 3.0 - Section G: ADLs

- Documentation for ADLs must reflect the number of times at each level for every ADL for each shift during the 7 day look-back period (information from all shifts) and the number of staff assisting the resident
  - Flow sheets
  - Nurse’s note based on interview with direct care giver recorded at the end of each shift
  - Electronic data input
- Conflict between CNA and MDS scoring for ADLs should be monitored and resolved
MDS 3.0 - Section I: Diagnosis

SECTION I: ACTIVE DIAGNOSES

**Intent**: The items in this section are intended 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. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident’s current health status.

**Active Diagnoses in the Last 7 Days**

<table>
<thead>
<tr>
<th>Active Diagnoses in the last 7 days - Check all that apply</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Cancer with or without metastasis</td>
<td></td>
</tr>
<tr>
<td>Heart/Circulation</td>
<td></td>
</tr>
<tr>
<td>10250. Anemia (e.g., splenic, iron deficiency, pernicious, and sickle cell)</td>
<td></td>
</tr>
<tr>
<td>10300. Atrial Fibrillation or Other Dysrhythmias (e.g., bradyarrhythmias and tachycardias)</td>
<td></td>
</tr>
<tr>
<td>10400. Coronary Artery Disease (CAD) (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))</td>
<td></td>
</tr>
<tr>
<td>10500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTI)</td>
<td></td>
</tr>
<tr>
<td>10600. Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)</td>
<td></td>
</tr>
<tr>
<td>10700. Hypertension</td>
<td></td>
</tr>
<tr>
<td>10800. Orthostatic Hypotension</td>
<td></td>
</tr>
<tr>
<td>10900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)</td>
<td></td>
</tr>
</tbody>
</table>

There are two look-back periods for this section:

- Diagnosis identification (Step 1) is a 60-day look-back period.
- Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period (except for Item 12300 UTI, which does not use the active 7-day look-back period).
1. **Identify diagnoses:** The disease conditions require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the **last 60 days.**

2. **Determine whether diagnoses are active:** Once a diagnosis is identified, determine if it is **active.**
   - Active diagnoses have a **direct relationship** to resident’s current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.
   - Do not include resolved conditions that do not affect resident’s current status, or do not drive resident’s plan of care during 7-day look-back period, as these would be considered inactive diagnoses.
MDS 3.0- Section I: Diagnosis

Documentation from physician
- Include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/ problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered.
- Although open communication regarding diagnostic information between physician and IDT is important, it is essential that diagnoses communicated verbally be documented in the medical record by the physician to ensure follow-up.
- Diagnostic information, including past history obtained from family, must also be documented in the medical record by the physician to ensure validity and follow-up.

MDS 3.0

Section I: Diagnosis
Documentation sources from nursing may include, but are not limited to the following:
- Nurse’s progress notes reflecting monitoring/treatment of a specific condition
- Medications that require monitoring of therapeutic efficacy of the drug
- Treatment sheets
- Vital signs/graphic sheets
- Lab reports

Key point: for medications, this does not include monitoring for adverse effects of meds as part of usual nursing practice
MDS 3.0 - Section J: Fever

**Fever:** Fever is defined as a temperature 2.4 degrees F higher than baseline. The resident’s baseline temperature should be established prior to the Assessment Reference Date.

**Fever assessment prior to establishing baseline temperature:** A temperature of 100.4 degrees F (38 degrees C) on admission (i.e., prior to the establishment of the baseline temperature) would be considered a fever.
MDS 3.0 - Section J: Fever

- Documentation for fever (as 2.4 degrees above baseline) should appear in the medical record
- Baseline temperature only needs to be determined once
- Assure that the baseline temperature remains in the medical record

MDS 3.0
Section K: Height and weight for BMI calculation

K0200: Height and Weight

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Height (in inches). Record most recent height measure since the most recent admission/entry or reentry</td>
</tr>
<tr>
<td>B.</td>
<td>Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal with shoes off, etc.)</td>
</tr>
</tbody>
</table>
MDS 3.0
Section K: Height and weight for BMI calculation

Height
1. Base height on most recent height since most recent admission/entry or reentry. Measure and record height in inches
2. Measure height consistently over time in accordance with facility protocol, which should reflect current standards of practice (shoes off, etc.)
3. For subsequent assessments, check medical record. If last height recorded was more than one year ago, measure and record resident’s height again
4. Record to nearest whole inch using mathematical rounding principles

MDS 3.0
Section K: Height and weight for BMI calculation

Weight
1. Base weight on most recent measure in last 30 days
2. Measure weight consistently over time in accordance with facility policy, which should reflect current standards of practice (shoes off, etc.)
3. For subsequent assessments, check medical record and enter weight taken within 30 days of the ARD of this assessment
4. If last recorded weight was taken more than 30 days prior to ARD of this assessment or previous weight is not available, weigh resident again
5. If resident’s weight was taken more than once during the preceding month, record most recent weight
MDS 3.0
Section K: Height and weight for BMI calculation

Documentation

- Height and weight should appear in the medical record with weight no more than 30 days prior to the ARD and height obtained within one year of the ARD
- There is no place on the MDS to calculate the BMI. It is calculated by software using height and weight from MDS

MDS 3.0 - Section O: IV medications
(especially from hospital)

<table>
<thead>
<tr>
<th>Section O</th>
<th>Special Treatments, Procedures, and Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD1000. Special Treatments, Procedures, and Programs</td>
<td>Check all of the following treatments, procedures, and programs that were performed during the last 14 days</td>
</tr>
<tr>
<td>1. While NOT a Resident</td>
<td>Performed while NOT a resident of this facility and within the last 14 days. Only check columns 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank</td>
</tr>
<tr>
<td>2. While a Resident</td>
<td>Performed while a resident of this facility and within the last 14 days</td>
</tr>
<tr>
<td>Cancer Treatments</td>
<td></td>
</tr>
<tr>
<td>A. Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>B. Radiation</td>
<td></td>
</tr>
<tr>
<td>Respiratory Treatments</td>
<td></td>
</tr>
<tr>
<td>C. Oxygen therapy</td>
<td></td>
</tr>
<tr>
<td>D. Suctioning</td>
<td></td>
</tr>
<tr>
<td>E. Tracheostomy care</td>
<td></td>
</tr>
<tr>
<td>F. Ventilator or respirator</td>
<td></td>
</tr>
<tr>
<td>G. BiPAP/CPAP</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>H. IV medications</td>
<td></td>
</tr>
<tr>
<td>I. Transfusions</td>
<td></td>
</tr>
<tr>
<td>J. Dialysis</td>
<td></td>
</tr>
<tr>
<td>K. Hospice care</td>
<td></td>
</tr>
<tr>
<td>L. Respir care</td>
<td></td>
</tr>
<tr>
<td>M. Isolation or quarantine for active infectious disease (does not include standard bodyfluid precautions)</td>
<td></td>
</tr>
<tr>
<td>None of the Above</td>
<td></td>
</tr>
<tr>
<td>E. None of the above</td>
<td></td>
</tr>
</tbody>
</table>
MDS 3.0 - Section O: IV medications

- Include treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff.
- Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators.
  - Surgical procedures include routine pre- and post-operative procedures.

MDS 3.0 - Section O: IV medications

- Code any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item and also include baclofen pumps.
- Do **not** code flushes to keep an IV access port patent, or IV fluids without medication here.
- Subcutaneous pumps are **not** coded in this item.
- Do **not** include IV medications of any kind that were administered during dialysis or chemotherapy.
**MDS 3.0 - Section O: IV medications**

**Coding Instructions for Column 1**
- Check all treatments, procedures, and programs received or performed by the resident **prior** to admission/entry or reentry to the facility and within the 14-day look-back period. Leave Column 1 blank if the resident was admitted/entered or reentered the facility more than 14 days ago. If no items apply in the last 14 days, check Z, **none of the above**.

**MDS 3.0 - Section O: IV medications**

- Documentation to capture IV medications pre-admission are reflected in information from the hospital stay or other settings in which resident was prior to admission
- Base coding of column 1 on information supported by pre-admission history
- After 14 days of admission/re-entry, column 1 is left blank.
MDS 3.0 – Section O: Therapy - SLP, OT and PT

**O0400: Therapies**

- Code only medically necessary therapies that occurred after admission/readmission to nursing home that were
  - Ordered by physician (physician’s assistant, nurse practitioner, and/or clinical nurse specialist) based on qualified therapist’s assessment (i.e., one who meets Medicare requirements or, in some instances, under such a person’s direct supervision) and treatment plan,
  - Documented in resident’s medical record, and
  - Care planned and periodically evaluated to ensure resident receives needed therapies and that current treatment plans are effective
MDS 3.0
Section O: Therapy - SLP, OT and PT

- Services must be reasonable and necessary for the treatment of the patient's condition:
  - If the expected results are insignificant in relation to the extent and duration of the therapy services required to achieve the results, the services would not be reasonable and necessary

MDS 3.0
Section O: Therapy - SLP, OT and PT

- Must be:
  - Directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with a qualified therapist
MDS 3.0
Section O: Therapy - SLP, OT and PT

Non-Skilled Services

- Resident or family requested therapy that are not medically necessary shall **not** be counted in item O0400, even when performed by a therapist or an assistant.
- Therapy services can include the actual performance of a maintenance program in those instances where the skills of a qualified therapist are needed to accomplish this safely and effectively.

- In situations where ongoing performance of safe and effective maintenance program does not require skilled services, once the qualified therapist has designed the maintenance program and discharged resident from rehabilitation therapy program, the services performed by therapist and assistant are **not** reported here.
- These services may be reported on the MDS assessment in item O0500 **Restorative Nursing Care**, provided requirements for restorative nursing program are met.
MDS 3.0
Section O: Therapy - SLP, OT and PT

Documentation should include rationale for course of therapy treatment (resident illness resulting in physical decline), prior level of function, expectation regarding improvement etc.

- If ADLs = independent, why is therapy needed?
- If documentation does not show decline in resident function, why is therapy needed?
- Involve IDT in decision-making process regarding need for therapy treatment

MDS 3.0 - Section O: Restorative Nursing

**O0500: Restorative Nursing Programs**

<table>
<thead>
<tr>
<th>Number of Days</th>
<th>Technique</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Range of motion (passive)</td>
</tr>
<tr>
<td></td>
<td>B. Range of motion (active)</td>
</tr>
<tr>
<td></td>
<td>C. Splint or brace assistance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Training and Skill Practice In:</th>
</tr>
</thead>
<tbody>
<tr>
<td>D. Bed mobility</td>
</tr>
<tr>
<td>E. Transfer</td>
</tr>
<tr>
<td>F. Walking</td>
</tr>
<tr>
<td>G. Dressing and/or grooming</td>
</tr>
<tr>
<td>H. Eating and/or swallowing</td>
</tr>
<tr>
<td>I. Amputation/prostheses care</td>
</tr>
<tr>
<td>J. Communication</td>
</tr>
</tbody>
</table>

Also includes urinary and/or bowel toileting program
MDS 3.0 – Section O
Restorative Nursing Program

• Nursing interventions focused on achieving and maintaining the resident’s optimal functioning
• The key is:
  – If staff do not cue, guide, set-up, or supervise the resident, what happens?

MDS 3.0 – Section O
Restorative Nursing Program

• Rehabilitative or restorative care refers to nursing interventions that promote the resident’s ability to adapt and adjust to living as independently and safely as is possible.
• This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.
MDS 3.0 – Section O
Restorative Nursing Program

- People who deliver services must be trained in techniques that will be carried out
  - Need to retain records of training including return demos, post-test etc. that demonstrate understanding and competence
- Certified Nursing Assistants
- Other staff (including recreation therapy, PT, OT and others) may be assigned to work with certain residents, but always under the supervision of nursing

MDS 3.0 – Section O
Restorative Nursing Program

- Evaluation by the Registered Nurse (who then plans the program) with documentation of this present (often with input from therapists)
- Measurable objectives and interventions must be documented in the care plan and clinical record
- Periodic re-evaluation by the nurse to monitor the resident’s progress, determines appropriateness of continuing it and documents status
MDS 3.0 – Section O
Restorative Nursing Program

- Group Programs for Restorative Nursing
  - Goal of the group must be defined
  - No more than four residents to one supervising person
  - Group leader must be competent
  - Supervised by nursing
  - Planned and evaluated by the RN
  - Examples: dining, grooming, walking

MDS 3.0 – Section O
Restorative Nursing Program

- What are skills or services that are appropriate for a Restorative or Rehabilitative Nursing Program?
  - The MDS manual has been used as a reference for the next several slides which describe restorative and rehabilitative nursing services
### MDS 3.0 – Section O

#### Restorative Nursing Program

- **Range of Motion (Passive) *:**
  - Exercises must be planned, scheduled and documented in the medical record
  - Assisting a resident to dress does not in itself constitute range of motion

- **Range of Motion (Active) *:**
  - Exercises that are planned, scheduled and documented that are performed by the resident (with cueing, supervision or assist from the staff)

---

- **Splint or Brace Assistance**
  - The staff applies, manipulates and cares for the device or
  - The staff provides verbal cues, guidance and direction to teach the resident to apply it.
MDS 3.0 – Section O
Restorative Nursing Program

- Training and skills practice in self care tasks or activities including repetition, physical or verbal cueing and task segmentation. Many possible tasks are on the upcoming slides.

MDS 3.0 – Section O
Restorative Nursing Program

- Bed Mobility *
  - Bed positioning, moving to and from a lying position and turning and positioning in bed

- Walking *
  - Walking with or without assistive devices
### MDS 3.0 – Section O

**Restorative Nursing Program**

- **Transfer**
  - Moving between surfaces or planes with or without assistive devices

- **Dressing or Grooming**
  - Dressing or undressing, bathing and washing, and performing other personal hygiene tasks

---

### MDS 3.0 – Section O

**Restorative Nursing Program**

- **Eating or Swallowing**
  - Feeding one's self food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and/or hydration by mouth

- **Amputation/Prosthesis Care**
  - Putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body
MDS 3.0 – Section O
Restorative Nursing Program

- Communication
  - Using newly-acquired functional communication skills or assisting the resident in using residual communication skills or adaptive devices

MDS 3.0 – Section O
Restorative Nursing Program

Improvement/maintenance incontinence of bladder and/or of bowels
Section H- Scheduled Toileting Plan

- Carried out according to a specific, routine time known by resident and caregiver
- Includes toilet room, commode, bedpan, or urinal
- Excludes changing wet/soiled garments
- Requires a program that is organized, planned, documented, monitored, and evaluated

Section H  Bladder retraining program

- Resident is taught to consciously delay urinating (voiding) or resist the urgency to void.
- Residents are encouraged to void on a schedule rather than according to their urge to void.
- This form of training is used to manage urinary incontinence due to bladder instability.
- Must have been in place for at least 4 of the past 7 days (from ARD)
Section H Bowel Toileting Program

- Is the resident on a toileting program being used to manage bowel continence?
- Program must be:
  - Organized, planned, documented, monitored, and evaluated

MDS 3.0 – Section O

Restorative Nursing Program Documentation

- Staff providing the care must document the amount of minutes of care that were provided each time the care was rendered (generally on a flow sheet initiated on a monthly basis).
- Additional documentation may include information about how the resident performed in relationship to his/her goals.
MDS 3.0 – Section O

Restorative Nursing Program Documentation

- Measurable objective and interventions documented in the care plan
- Tracking sheet or other method to capture days and minutes for each RNP modality
- Progress notes and periodic re-evaluation
- Evidence of training for those carrying out the program

MDS 3.0 – Section O

Restorative Nursing Program Documentation

- During the 7 day look-back period, code MDS for each modality based on the number of days that the resident received a minimum of 15 minutes of treatment, training, practice
- Need 2 or more RNP modalities at least 6 days a week for 15 minutes each day to impact RUG
- Except for toileting programs
Enter **number of days** during 14-day look-back period (or since admission, if less than 14 days ago) in which physician changed resident’s orders

Includes orders written by medical doctors, doctors of osteopathy, podiatrists, dentists, and physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with physician as allowable by state law.
MDS 3.0
Section O: Physician Orders

- Includes written, telephone, fax, or consultation orders for new or altered treatment
- Does not include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes
- Orders written on the day of admission as result of unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes

MDS 3.0
Section O: Physician Orders

- The prohibition against counting standard admission or readmission orders applies regardless of whether or not the orders are given at one time or are received at different times on the date of admission or readmission
- Do not count orders prior to the date of admission or re-entry
- A sliding scale dosage schedule that is written to cover different dosages depending on lab values, does not count as an order change simply because a different dose is administered based on the sliding scale guidelines
**MDS 3.0**

**Section O: Physician Orders**

- When a PRN order was already on file, the potential need for the service had already been identified. Notification of the physician that the PRN order was activated does not constitute a new or changed order and may not be counted when coding this item.
- A Medicare Certification/Recertification is a renewal of an existing order and should not be included when coding this item.

---

**MDS 3.0**

**Section O: Physician Orders**

- Orders requesting a consult by another physician may be counted. However, the order must be reasonable (e.g., for a new or altered treatment).
- An order written on the last day of MDS observation period for consultation planned 3-6 months in future should be carefully reviewed.
MDS 3.0
Section O: Physician Orders

- Orders written to increase resident’s RUG classification and facility payment are not acceptable
  - E.g., d/c of prn orders that could be done during routine monthly visit
- Orders for transfer of care to another physician may not be counted.
- Do not count orders written by a pharmacist

MDS 3.0
Section O: Physician Orders

Documentation to support number of days for physician orders may be found in, but not limited to:
- Physician notes
- Physician orders
  - Written, telephone, faxed
- Consult order/notes
- Nurses’ notes
During look back period (prior to and through the ARD), flow sheets, IDT notes etc. need to reflect frequencies, specific occurrences, evaluations for MDS items such as:

- Behaviors
- Mood issues
- ADLs
- IV medications (from hospital records)
- Physician orders
- Restorative nursing
Documentation

- What happens when the medical record is in conflict with itself?
  - Two disciplines assess resident differently
  - Data conflict
- Write a progress note that clarifies the discrepancy and resolve the issue

Documentation

- Care plans
  - Care plans should paint a picture of the resident during stay in the nursing home
    - Resident specific problems, complications, risks and strengths
    - Goals and goal achievement
    - What approaches were and are being used
    - Outcome of care/evaluation
  - If the care plan is evaluated after the ARD, it does not provide documentation for supporting MDS coding
Documentation

- Audit documentation (ARD backwards throughout look-back period)
  - Can MDS be coded based on what is written in medical record/flow sheets/MARs/TARs?
  - If not, use works teams; conduct RCA analysis; “why”
    - What is missing---shift, discipline
  - Develop plan to improve documentation
  - Educate staff regarding enhanced processes
  - Roll out plan and monitor for effectiveness
  - Audit documentation to assure compliance

WORK TEAMS

Plan
What are we doing now?
Is it a big problem?
What can we try?

Act
How can we keep it going?
Should we try a new plan?

Do
Let’s try our plan.

Study
Did it work? What is our data?

PDSA
Teamwork

"In most things we do in life, people have to work with rather than against each other to get something done. Win-win situations and partnerships are the most important results of teamwork. The best teams in the world are the ones that help people become better and achieve more than they ever thought they could on their own."

Wendy's founder Dave Thomas