DEPARTMENT OF HEALTH

Basic Training for New MDS Nurses

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Objectives

Participants will be able to:

- Identify the importance of MDS accuracy and the impact of an inaccurate assessment
- Identify the OBRA and PPS assessment scheduling requirements
- Understand the coding requirements for the resident interview items
- Understand how to correctly code ADLs on the MDS
- Identify the requirements to code an Active Diagnosis on the MDS
- Identify the components of a comprehensive CAA and Care Plan
- Understand the MDS Correction Process

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Common Acronyms

- RAI- Resident Assessment Instrument
- MDS- Minimum Data Set
- CATs- Care Area Triggers
- CAAs- Care Area Assessments
- ARD- Assessment Reference Date
- OBRA- Omnibus Reconciliation Act
- PPS- Prospective Payment System
- IPA- Interim Payment Assessment
- PDPM- Patient Driven Patient Model
- RUG- Resource Utilization Group or Guidelines

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- DRA- Discharge Return Anticipated
- DRNA- Discharge Return Not Anticipated
- SCSA- Significant Change in Status Assessment
- SCPA- Significant Correction of a Prior Comprehensive Assessment
- SCQA- Significant Correction of a Prior Quarterly Assessment
- MI- Mental Illness
- ID- Intellectual Disability

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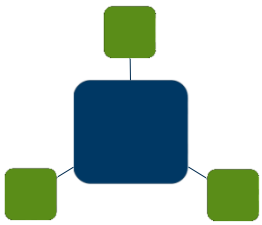

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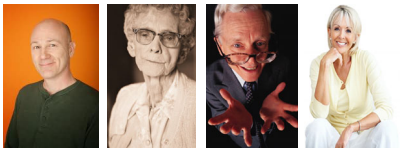
Federal Requirement

All residents admitted to a Medicare or Medicaid certified nursing facility who reside in the facility for more than 14 days regardless of their payer source.



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State Requirement

- MN Statute 144.0724 requires a facility to submit an Admission assessment for all residents who are admitted to the nursing facility regardless of their length of stay or payer source.
  - Exception- The resident is Admitted and Discharged on the same calendar day
- May opt out of this requirement by electing the short stay rate for ALL residents who stay ≤14 days.
- The facility's Administrator makes the election annually
- It applies to ALL admissions between July 1st – June 30th (state fiscal year)

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Who Can Participate in the Assessment Process?

- CMS does not dictate who can participate in the assessment process other than the requirement for an RN to coordinate the assessment.
- Facilities are responsible for ensuring that all participants in the assessment process have the necessary knowledge to complete and accurate and thorough assessment.
- MN Nurse Practice Act indicates completing a comprehensive assessment and the development of a care plan are the functions of an RN.
- Completion of the MDS requires an interdisciplinary team.
- The medical record documentation must support what is coded on the MDS.

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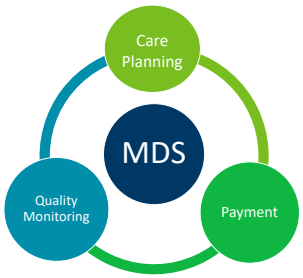
Uses of MDS Data



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Care Planning

The Primary purpose of the MDS is to aid in the development of the person centered, individualized, resident care plan

The Nursing Process

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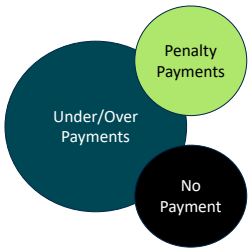
Payment

MDS Inaccuracies can result in:



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Quality Monitoring

- Facility Quality Improvement Projects
- Regulatory Oversight
- Consumer Access to NH Information
  - Federal NH Compare Website
  - MN Nursing Home Report Card
- Reimbursement

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Improving the Quality of Care



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Common Causes of Inaccurate Assessments

- Staff turnover and lack of staff training/supervision
- Coding events that occurred outside of the LBP
- Not following the RAI User's Manual instructions
- Failure to collect data from multiple sources
- A lack of supporting documentation
- Failure to keep up with the changes

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Scheduling Assessments

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MDS Assessment Types

Admission
Annual
SCSA
SCPA

Quarterly
Discharge
SCQA

Entry
Death in Facility

5 day

IPA

*Tracking Records are not considered assessments and they cannot be combined with assessments

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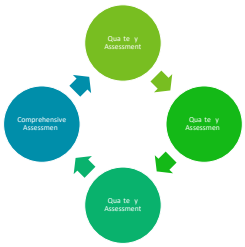
Typical OBRA Assessment Schedule



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Assessment Reference Date (ARD) (A2300)

- The last day of the assessment look back period (LBP)
- The LBP ends at 11:59 p.m. on the ARD
- The LBP varies depending on the MDS item (3d-180D)
- The ARD is not set until its documented on an item set (paper or electronic)
- Only events/observations that occur during the LBP are coded on the MDS

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Admission Assessments

- If the facility has elected to complete the Admission assessment for all admissions, when a resident is DRA prior to the completion of the Admission assessment, the facility may choose to:
  1. Complete the Admission assessment (CAAs too) with the information you have available, combine it with the DRA assessment, or
  2. Complete the Admission assessment when the resident returns to the facility if the resident returns within 30d of discharge.
- With option 2, set the Admission assessment ARD for the day of discharge. Don't complete it just leave it in your system. This assessment would need to be completed **ONLY** if the resident does **NOT** return within 30 days of discharge.
- If the resident returns within 30 days, discard this assessment. The facility has 14d, including the day of reentry, to set the ARD and complete the Admission assessment

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Significant Change In Status Assessments

- A Significant Change in Status Assessment (SCSA) is required when there is a major decline or improvement in a resident's status:
  - That will not normally resolve without intervention or by implementing standard disease-related clinical intervention.
  - Impacts two or more areas of the resident's health status (may be two areas in ADLs).
  - Requires IDT review and/or revision of care plan.

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Significant Decline Criteria

Decline in two or more of the following:

- Resident's decision-making ability changed;
- The presence of a new resident mood or behavior item not previously reported and/or an increase in mood or behavior symptom frequency;
- Changes in frequency or severity of behavior symptoms
- Any decline in an ADL where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment and does not reflect normal fluctuations in the resident's function.

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Significant Decline Criteria (cont.)

- An incontinence pattern change or the placement of a new indwelling catheter;
- The emergence of unplanned weight loss (5% change in 30 days or 10% change in 180 days);
- The emergence of a new pressure ulcer at Stage 2 or higher, a new unstageable PU, a new DTI, or worsening in pressure ulcer status;
- The resident begins to use a new restraint of any type
- Emergence of a condition/disease in which the resident is judged to be unstable

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Significant Improvement Criteria

Improvement in two or more of the following:

- Any improvement in an ADL area where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment;
- A decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases;
- The resident's decision making improves;
- The resident's incontinence pattern improves;

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A SCSA is Required

- When all therapy services end if the previous comprehensive or noncomprehensive assessment resulted in a rehab RUG classification in Z0200A. The ARD must be set on day 8 after therapy ends.
- When isolation services end, if isolation was coded on the previous comprehensive or noncomprehensive assessment and the assessment resulted in a ES1, CA1, or CA2 RUG classification in Z0200A. The ARD must be set on day 15 after isolation ends.
- When a terminally ill resident enrolls in hospice, discontinues hospice, or switches hospice providers. Set the ARD and complete the assessment within 14 days of the hospice election, revocation, or change in providers.

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SCSA and PASRR

- Two levels of screening:
  - Level I- (for all admissions)
  - Level II- (required for those with known or suspected MI or ID)
- When a resident who has had a level II PASRR experiences a SCSA a referral to the Local Contact Agency (LCA) for a PASRR review is required.
- This should be done when it is determined that the criteria is met for a SCSA

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A SCSA is Not Required

Completion of the SCSA is not required when:

- A resident signs onto hospice during the LBP of a comprehensive assessment
- A resident discontinues hospice prior to the completion deadline of the SCSA that is required because they enrolled in hospice.

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A SCSA Is Not Required

- If:
  - There is a cyclical pattern of change
  - It is a Short-Term Acute Illness
  - If the resident's condition has not stabilized
  - Discharge is expected in the immediate future
  - The resident dies prior to the completion deadline of the SCSA

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OBRA Discharge Assessments

- Required when a resident:
  - Is discharged from the facility, or
  - Moves from a certified bed to a noncertified bed
- The ARD:
  - Is not set prospectively
  - Is always the day the resident **left** the facility
- A Discharge is unplanned if:
  - The resident is transferred to an acute care facility
  - The resident leaves AMA
  - Discharge planning is occurring and the resident unexpectedly decided to leave early

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OBRA Discharge Assessments

Two Types-

- **Discharge Return Not Anticipated (DRNA)-** Completed **when it is known, at the time of discharge**, that the resident will not return to the facility within 30d.
  - E.g. d/c to home goals met or d/c to another SNF closer to family
- **Discharge Return Anticipated (DRA)-** A resident should be DRA unless it is known on discharge that they will not return within 30d.
  - E.g. discharge to acute care facility
- **Bed Hold status has no effect on these requirements (page 2-39)**

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Is it A Discharge or LOA?

A Discharge occurs when a resident is:

- Discharged from the facility to a private residence
- Admitted to a hospital (in patient) or other care setting
- Has a hospital observation stay greater than 24 hours, regardless of whether the hospital admits the resident.

An LOA is:

- A temporary home visit of at least one night; or
- A therapeutic leave of at least one night; or
- A hospital observation stay less than 24 hours and the hospital does not admit the patient

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Tracking Records

Tracking Records
- Are not assessments
- They cannot be combined with assessments.

Two Types-
- Entry Tracking Records-
  - Completed **every** time a resident enters facility.
  - An Entry is either an Entry or a Re-entry
- Death in Facility Tracking Records-
  - Completed when a resident dies in the facility or while on a LOA

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Coding Tip

For both Comprehensive and Non-Comprehensive Assessments:

- If a resident dies or is discharged prior to the completion deadline of the assessment, completion of the assessment is not required.
- The portions of the RAI that were completed must be maintained in the medical record.
- Document in the medical record why the RAI was not completed.

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Coding Tip

- The LBP for most MDS items does not extend into the pre-admission or pre-reentry timeframe.
- When a resident is DRA to the hospital close to d92, consider whether you can combine the Quarterly with the DRA assessment. Doing so will maximize your look back period and minimize the number of assessments you have to complete.

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Test Your Knowledge

- The Admission assessment was competed on d9 of the resident's stay. How long do you have to complete the comprehensive care plan?

  Answer: The comprehensive care plan must be completed by d16

- Your facility elected to complete an Admission assessment on all residents regardless of their length of stay or payer source. A newly admitted resident was DRA to the hospital on day four of her stay. Do you have to complete the Admission assessment at the time of Discharge? The resident returned to the facility three days later.

  Answer: No, complete the Admission assessment within 14d of reentry

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Test Your Knowledge

- The Admission assessment ARD was set for d8 of the resident's stay. The resident enrolled in hospice on d12. To minimize the number of assessments you must complete, what can you do?

  Answer: You can choose to move the ARD of the Admission assessment to d12 and complete only the Admission assessment, checking Hospice in item O0100K.

- You decided to keep the ARD set on d8. What do you have to do next?

  Answer: Complete the Admission assessment followed by the SCSA. The SCSA must be completed by d26 of the resident's stay

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PPS Assessments

Assessment Type	ARD	Payment Days
The 5d Assessment	Days 1-8	Entire Med A Stay unless an IPA is completed
Interim Payment Assessment (IPA)	Optional	Beginning on the ARD of the assessment and continues until the last Medicare A day or until another IPA is completed
PPS Discharge Assessment	Last Day of Medicare A (A2400C) or combined with an OBRA Discharge Assessment if the Part A stay ends on the same day or the day before the resident's discharge (A2000)	NA

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The 5d Assessment

- Completed for Medicare Part A payment purposes
- Completed when a Medicare Part A stay begins
- The ARD must be set on days 1-8 of the Medicare Part A stay
- Not required when a resident resumes a Part A-covered stay following an interrupted stay, regardless of the reason for the interruption e.g. facility discharge, resident no longer skilled, payer change, etc.
- Sets the Payment Rate for the Entire Medicare Part A stay
  - Unless an Interim Payment Assessment is completed

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What is an Interrupted Stay?

Interrupted Stay
A stay in which a resident is discharged from Medicare Part A and subsequently resumes Medicare Part A **in the same SNF** during the interruption window

Interruption Window
A three day period starting with the calendar day of Part A discharge and including the two immediately following calendar days.

Resumption
Medicare Part A services must resume in the same SNF by 11:59 p.m. on day three after Medicare Part A services were discontinued

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Test Your Knowledge

- Mr. J was admitted for skilled services in a SNF under Medicare Part A for rehabilitation. Mr. J fell and was sent to the acute care hospital for an evaluation. Since staff expect Mr. J to return to the facility, he was discharged return anticipated.
- Mr. J left the SNF on October 2nd at 4 p.m. and returned to the same SNF and resumed skilled services under Part A on October 4th at 7 p.m.
- Is this an Interrupted Stay?

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The Interim Payment Assessment (IPA)

- Optional assessment
- Completed to capture changes in the resident's status and condition
- Sets payment for the remainder of the Medicare A stay beginning on the ARD
- The ARD for an IPA may not precede that of the 5-Day assessment
- It is a standalone assessment. It cannot be combined with any other assessment (PPS or OBRA) type

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Part A PPS Discharge Assessment (A0310H)

Completed when a resident's Medicare Part A stay ends. Completed as a:

- Standalone assessment- when a resident's Part A stay ends and the resident remains in the facility,
  - The ARD = the last Medicare A covered day
  - A2300 = A2400C
- Must be combined with an OBRA Discharge assessment when the Part A stay ends **on the day of or one day prior to the day of discharge from the facility.**
  - The ARD = the day the resident is discharged from the facility
  - A2300 = A2000

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The Midnight Rule

Midnight Rule:

- If a resident is out of the facility over a midnight, but for less than 24 hours, and is not admitted to an acute care facility, the day preceding the midnight on which the resident was absent from the facility is not a covered Medicare Part A day.
- The Medicare **scheduled** PPS assessment clock is adjusted by skipping the LOA day when calculating when the next scheduled PPS assessment is due.

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Midnight Rule Example

- The resident is sent to the ER for an evaluation at 9:00 pm. on day 4.
- The resident was not admitted and returned to the facility at 2 am on day 5.
- Day 4 is no longer a billable day.
- Day 5, is now considered day 4 of the Medicare Part A stay for the purposes of determining the ARD of the 5d assessment.
- The facility may include services furnished during the LOA (when permitted under MDS coding guidelines) on the MDS but may not extend the observation period.

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Early, Late, and Missed PPS Assessments?

- Early and Late PPS assessments are assessments that do not have an ARD set within the required ARD window and the resident is still on Medicare Part A.
- Early/Late assessments are paid at the default rate for the number of days the assessment is out of compliance.
- A Missed PPS assessment is a PPS assessment that was not completed prior to the Medicare Part A stay ending.
- In most situations, when an assessment is Missed, regardless of the reason, the facility cannot bill for the services provided.
- There are a few exceptions to this rule listed on page 6-53 on the current RAI Manual

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What Assessments Will You Do?

Your facility has elected to complete an Admission assessment for all admissions

A Medicare Part A resident admitted on 2/1/2023,
Admission/5d ARD was set for 2/8/2023,
The resident is DRA to the hospital on 2/3/2023,
The resident returned to the facility on 2/5/2023, on Medicare Part A
The resident was DRNA on 2/28/2023

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What Assessments Should You Do?

- Entry Tracking Record 2/1/2023
- A DRA assessment with an ARD on 2/3/2023
- An Entry Tracking Record 2/5/2023
- 5d Assessment options:
  - Combine the 5d with the DRA on 2/3/2023, or
  - Complete the 5d with an ARD set by day 8, 2/10/2023
- Set the ARD and complete the Admission assessment by 2/18/2023
  - Could combine the 5d/Admission assessments but ARD can be no later than 2/10/2023
- DRNA/PPS Discharge assessment 2/28/2023

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The MDS 3.0 Item Set

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Unit Certification (A0410)

A0410. Unit Certification or Licensure Designation	
Enter Code ☐	1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State 2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State 3. Unit is Medicare and/or Medicaid certified

- This item is coded solely based on CMS' authority to collect MDS information
- It is not determined by payer source
- If the resident resides in a Medicare or Medicaid certified bed, CMS has the authority to collect MDS information and the item is coded a 3

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Medicaid Number (A0700)

- When adding an MA number to an assessment it is not necessary to modify all the MDS' ever completed.
- Only the most recent Tracking Record or assessment needs to be modified.
- Entry and Death in Facility Tracking Records
- OBRA, PPS, Discharge and combined assessments
- The MA number can also be added to the next assessment.

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Entry Date (A1600)

- Entry Date
  - Initial date of Admission or
  - The date of most recent entry
- Beware of auto populated software entries
- Always double check the date in A1600 to ensure that it is the date of the most recent entry to the facility.

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Type of Entry (A1700)

There are Two Types of Entries

- An Admission Entry (when **any** of the following occur):
  - The resident has never been admitted to the facility before
  - The resident was in the facility previously and was DRNA
  - The resident was in the facility previously, was DRA, and did not return within 30 days of discharge
- A Reentry (when **all** of the following occur):
  - The resident was admitted previously and
  - They were DRA and
  - They returned within 30 days of discharge

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Admission Date (A1900)

- The Admission Date is the date the episode of care began in the facility. An Episode begins with an admission and ends with either:
  - A DRNA
  - DRA but the resident did not return within 30 days or
  - A Death in the Facility
- If A1700 = Admission A1600=A1900
- If A1700 = Re entry A1600>A1900

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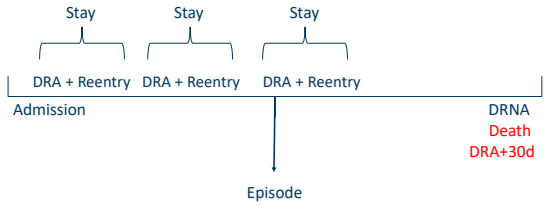
Episode or Stay



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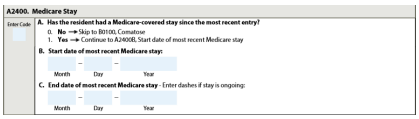
End Date of Medicare A Stay (A2400C)


A2400. Medicare Stay

Enter Code

A. Has the resident had a Medicare-covered stay since the most recent entry?
0. No → Skip to B0100, Comatose
1. Yes → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:
Month – Day – Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:
Month – Day – Year

The Medicare A end date is whichever occurs first:

- The date SNF benefit exhausts (i.e., the 100th day of the benefit); or
- The last day covered as recorded on the Generic Notice; or
- The last paid day of Medicare A when payer source changes
- The date the resident was discharged from the facility

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Makes Self Understood (B0700)

B0700. Makes Self Understood

Enter Code ☐

Ability to express ideas and wants, consider both verbal and non-verbal expression
0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

- Communication can be through speech, writing, sign language, gestures, or any combination of these.
- A resident is considered rarely or never understood if, at best, the resident's understanding is limited to staff interpretation of highly individual, resident-specific sounds or body language.

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General Resident Interview Guidelines

- The decision to complete a resident interviews is not directly tied to item B0700, Makes Self Understood
- Attempt to conduct the resident interviews with **ALL** residents unless:
  - They are rarely or never understood and they cannot communicate verbally, in writing, or other method of communication.
  - They need an interpreter and one is not available
  - The resident interview was incomplete (BIMS Summary Score of "99")
- The resident interviews must be completed during the look back period

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General Resident Interview Guidelines

- When a resident interview is missed (e.g. staff did not get to it, forgot or could not connect with the resident) regardless of the reason:
  - The gateway questions would be coded "yes," and
  - The resident interview and staff assessment items should be dashed
- There is one exception:
  - The BIMS interview on a standalone PPS assessment if the resident was unexpectedly discharged prior to the completion of the assessment

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Incomplete BIMS Interviews

- Refusals to answer a question(s) are coded as incorrect = 0
- **Stop the interview after completing C0300C, Day of the Week, if:**
  - All responses have been nonsensical, or
  - No verbal/written response to any of the questions so far, or
  - There has been a combination of no verbal/written responses and nonsensical responses to **ALL** questions so far.
- If the interview is stopped after C0300C, the interview is deemed incomplete
  - C0400A-C is dashed, C0500 = "99," and the Staff Assessment for Mental Status can be completed.

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Incomplete PHQ-9 Interviews

- If the response to a resident interview question(s) is unrelated, incomprehensible, not informative with respect to the question asked, or if the resident refuses to answer the question(s)
  - Code a "9" in column one symptom presence
  - Column two, symptom frequency, is left blank
- **If symptom frequency is blank three or more items, the interview is deemed incomplete.**
- Total Severity Score should be coded as "99" and the Staff Assessment of Mood can be completed.

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Staff Assessments

- **The Staff Assessments should only be completed when:**
  - The resident is rarely or never understood
  - The resident needs an interpreter and one is not available
  - The resident interview was deemed incomplete d/t refusals to respond and/or nonsensical responses
  - On a stand alone BIMs assessment if the resident had an unplanned discharge prior to the BIMs interview being completed.
- Staff assessments should be completed after the ARD and prior to the assessment completion deadline.

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- Common Errors-
  - The medical record lacks supporting documentation
  - Failure to understand the differences between a hallucination and delusion
- Hallucinations-perception of the presence of something that is not actually there, involves the one or more of the five senses
- Delusions -are fixed false beliefs that the resident holds true even when provided evidence to the contrary

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Test Your Knowledge

A resident carries a doll which she believes is her baby and the resident appears upset. When asked about this, she reports she is distressed from hearing her baby crying and thinks she's hungry and wants to get her a bottle.

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Rejection of Care (E0800)

- The intent of this item is to determine if the resident's refusal of care is a matter of personal preference or a behavioral symptom that requires further assessment and interventions.
- To identify rejection of care ask:
  - **Did the resident refuse cares that were necessary to achieve the RESIDENT'S goals for health and well-being?**
    - If yes, this is rejection of care
    - If no, it is a matter of personal preference

A refusal of care is not automatically rejection of care

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Test Your Knowledge

A resident with heart failure recently returned to the nursing home after surgical repair of a hip fracture is offered physical therapy and declines. She says that she gets too short of breath when she tries to walk even a short distance, making physical therapy intolerable. She does not expect to walk again and does not want to try. Her physician has discussed this with her and has indicated that her prognosis for regaining ambulatory function is poor.

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Test Your Knowledge

A resident chooses not to eat supper stating that the food causes her diarrhea. She says she knows she needs to eat and does not wish to compromise her nutrition, but she is more distressed by the diarrhea than by the prospect of losing weight.

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Functional Status (Section G)




To accurately code ADLs staff must thoroughly understand the definitions of:

- ADL Activity
- ADL Self-Performance
- ADL Support Provided
- Rule of Three

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ADL Coding (G0110)

ADL Self Performance-
- Independent (0) - no staff help or oversight at **ANY** time
- Total Dependence (4) - full staff performance **EVERY** time
- Supervision (1) - oversight, cueing, or encouragement
- Limited Assistance (2) - guided maneuvering or other NWB assistance.
- Extensive Assistance (3) –
  - Weight bearing support, or
  - **Full Staff Performance of a component of an ADL activity during part, but not all of the LBP.**
- Activity occurred but only 1-2 times (7)
- Activity did not occur or non-facility staff provided care 100% of the time (8)

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Rule of Three

- The steps must be used in sequence.
- When a criterion is met, stop and code that level.

The Rule of Three:

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

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RULE of Three (cont.)

3. When an activity occurs three or more times at multiple levels, **but not three times at any one level,** apply the following:
   - When there is a combination of FSP and extensive assistance that total three or more times, code Extensive assistance.
   - When there is a combination of FSP, extensive and limited assistance that total three or more times, code Limited assistance.
4. If none of the above conditions are met, code supervision

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Rule of Three Exceptions

- Activity code 0- Independent
  - The activity occurred at least three times and
  - No help or oversight at **ANY** time during the ARP
- Activity code 4- Total Dependence
  - The activity occurred at least three times and
  - Full staff performance **EVERY** time during the ARP
- Activity code 7- The activity occurred only once or twice
- Activity code 8-
  - The activity never occurred or
  - Non-facility staff provided assistance 100% of the time

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Test Your Knowledge

5x S	1x L	3x S	1x S	3x I
1x L	2x E	3x L	7x L	1x L
2x E	1x T	3x T	2x E	2x E
			1x T	1x T

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Functional Abilities and Goals –Section GG

- SNF QRP item completed at the beginning and end of a Medicare Part A stay
- The Assessment Reference Period
  - 5d Assessment- The first three days of a Medicare Part A stay
  - The PPS Discharge Assessments- The last three days of a Medicare Part A stay
  - The IPA and OBRA Assessments- The ARD plus the two previous days
- This sections captures the resident's usual performance, not their most dependent or their most independent performance
- Must identify at least one discharge goal at the beginning of the Medicare Part A stay, the rest can be dashed

72

Functional Abilities and Goals (cont.)

- A Helper = facility staff or facility contracted staff, same as section G
- Section GG is not active on a Part A PPS Discharge Assessment when the:
  - Discharge was unplanned or
  - Resident is discharged to an acute care facility
  - Medicare Part A stay is <3 days.
  - Last Part A covered day is also the day the resident dies.
- If section GG is active in these situations check the coding of items in section A to ensure they are coded accurately

73

Toileting Programs (H0200/H0500)

- Requirements:
  - Based on the resident's unique voiding pattern
  - Care planned and communicated to staff
  - Response is monitored, documented, and evaluated
- The documentation must reveal the toileting program was implemented on at least 4 of the 7 days during the LBP
- If a toileting program leads to a decrease or resolution of incontinence, the program should be continued.
- If not, reassess and modify the interventions, not the goal

74

Primary Medical Condition Category (I0020/B)

- SNF QRP item completed at the start of a Medicare Part A stay on the 5d and IPA
- Also required on the OBRA comprehensive and non-comprehensive assessments
- This item captures the primary medical condition category that best describes the reason for the resident's Medicare Part A stay or continued long term stay
  - Select the appropriate category, and
  - Enter the ICD-10 diagnosis code for the specific condition in item I0020B
- The diagnosis is coded again in the Active Diagnoses (I0100-18000) section

75

Test Your Knowledge

- Mrs. H has a history of hypertension (HTN) and a hip replacement two years ago. She was admitted to an extended hospitalization for idiopathic pancreatitis (ICD K85.00). She is NPO and a central line was placed during the hospital stay to receive TPN. During her SNF stay she is being transitioned from TPN to oral nutrition. The hospital discharge summary diagnoses included pancreatitis, HTN, and malnutrition.
- What is Mrs. H's primary medical condition category?

76

Active Diagnoses (Section I)

- Active Diagnoses have a direct impact on the resident's functional status, cognition, mood, behavior, medical treatments, nursing monitoring or risk of death within the last seven days
- Two look back periods:
  - First, MD diagnosis identification within 60 days
  - Second, the diagnosis status-
    - Active in the last 7 days
    - Except UTI which is 30 days

77

UTI (I2300)

To code a UTI on the MDS **both** of the following criteria must be met during the 30d look back period:

- The physician documents the diagnosis in the last 30 days **AND**
- The UTI must meet the evidence based criteria identified in the facility's Infection Prevention and Control Program Surveillance System, (e.g. McGeer, NHSN, or Loeb) in the last 30 days

78

SOB when Lying Flat (J1100C)

- Determined by observation, resident interview, and/or medical record review.
- There must be evidence in the medical record **during the LBP** that indicates the resident had either:
  - Experienced SOB when lying flat, or
  - Avoided lying flat d/t shortness of breath
- A serious condition that must be assessed and care planned

79

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.
- A resident found on the floor or ground without knowledge of how they got there, is considered to have had a fall.
- An intercepted fall is still considered a fall.
- A fall can be intercepted by the staff, family, visitor, or the resident

80

Falls Since Admission… (J1800)

J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

Enter Code ☐ Has the resident **had any falls since admission/entry or reentry or the prior assessment** (OBRA or Scheduled PPS), whichever is more recent?

0. **No** → Skip to J2000, Prior Surgery
1. **Yes** → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

- The look back period is since admission, reentry, or prior OBRA or scheduled PPS assessment, whichever is more recent.
  - The only scheduled PPS assessment is the 5d assessment
- Includes all falls that occurred while a resident of the facility regardless of where, or with whom, they occurred.

81

Injuries Related to Falls (J1900C)

- Injuries related to a fall defined:
  - Any injury that occurred as a result of or was recognized within a short period of time (hours to a few days) after a fall and was attributed to the fall.
- Injuries are classified into two categories,
  - Major (**e.g.** bone fracture, dislocation, closed head injury with altered LOC, and subdural hematoma, **not an all inclusive list**)
  - Not Major
- Code each fall only once. If a resident has multiple injuries in a single fall, code for the highest level of injury.

82

Prior Surgery (J2000)

- SNF QRP item completed only at the start of a Medicare Part A stay on the 5 day assessment
- Major Surgery refers to surgery that meets the following criteria:
  - The resident was an inpatient in an acute care hospital for at least one day, and
  - The surgery carried some degree of risk to the resident's life or the potential for severe disability

83

Recent Surgery Requiring Active SNF Care (J2100)

- Completed only on the 5d and IPA
- Identifies whether the resident had major surgery **during the inpatient stay** that **immediately preceded** the resident's Part A admission
- Major surgery for item J2100 refers to a procedure that meets the following criteria:
  1. The resident was an inpatient in an acute care hospital for at least one day in the 30 days prior to admission to the skilled nursing facility (SNF), and
  2. The surgery carried some degree of risk to the resident's life or the potential for severe disability.

84

Calculating Significant Weight Loss (K0300)

- Start with the resident's current weight in K0200,
- Note the date the current weight was taken, it must be within 30d of the ARD
- Determine the date 30d and 180d earlier than the date of the current weight
- Next, record the resident's weight CLOSEST to the 30d and 180d dates
- To calculate a significant weight loss at 30d/180d
  - Use the weight closest to 30d earlier x .95 = ???
  - Use the weight closest to 180d earlier x .90 = ???
- The resident has experienced a significant weight loss if the resulting figure is less than the resident's current weight in K0200

85

Physician Prescribed Weight Loss (K0300)

- The weight loss must be:
  - Prescribed by a physician
  - Care Planned
  - Intentional

- A physician prescribed weight loss regimen is a:
  - A calorie restricted diet and exercise program
  - Planned diuresis with expected weight loss

86

Parenteral/IV Feeding (K0510A)

- Includes any nutrition and hydration received in the look back period either at the nursing home, at the hospital (outpatient or inpatient) provided they were administered for nutrition or hydration purposes.
- Requires supporting documentation in the medical record that reflects the need for additional fluid supplementation
  - Includes IV fluids needed to prevent dehydration
- Does not include:
  - IV fluids administered as part of a pre/post operative or diagnostic procedure.
  - IV fluids administered in conjunction with chemotherapy or dialysis.
  - IV fluids administered solely as flushes.

87

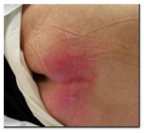
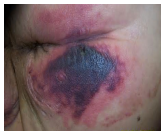
Pressure Ulcers (M0300)

- Definition: a 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.
- If the ulcer is not a PU, don't stage it
- No reverse staging
- Present Upon Admission- the pressure ulcer was not acquired or worsened to a deeper stage while a resident of your facility.
- A surgically debrided pressure ulcer is still a pressure ulcer
- A PU that is surgically closed, completely with a flap/graft is a surgical wound

88

Stage I vs. Deep Tissue Injury

- Stage One PU –has intact skin with ***non-blanchable redness*** of a localized area **usually** over a bony prominence
- DTI- is a purple or maroon area of discolored intact skin due to damage of underlying soft tissue.

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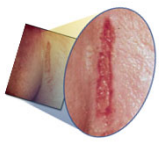
Stage II Pressure Ulcer

Characteristics:
- Partial thickness skin loss presents as:
- Shallow open ulcer
- Red or pink wound bed
- **No slough**
- **No granulation tissue**
- **No necrotic tissue**
- A clear blister
- A blood blister that lacks evidence of surrounding tissue damage
- Do not code maceration or excoriation as a stage two ulcer



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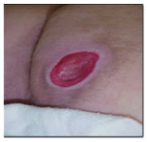
Stage III Pressure Ulcer

Characteristics:

- Full thickness skin loss
- Subcutaneous fat may be visible
- Bone, tendon, cartilage, or muscle is NOT exposed.
- Usually presents as a deep crater with or without undermining



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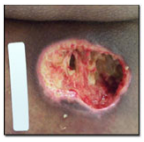
Stage IV Pressure Ulcer

Characteristics:

- Bone, tendon, muscle, or cartilage is exposed or palpable
- Slough or eschar may be present
- Often includes undermining and tunneling
- Depth varies by anatomical location (bridge of nose, ear, back of the head, elbows, and ankles. These ulcers can be shallow)



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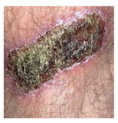
Scab vs. Eschar

- A scab is made up of dried blood and wound drainage. A scab sits on top of the skin.
- Necrotic/eschar- tissue that is hard or soft in texture and brown, black or tan in color. Flush with the skin.



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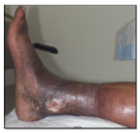
Venous Ulcers (M1030)

Characteristics:
- Typically occur on the lower leg or near the malleolus
- Min to mod amounts of yellow fibrous material
- Surrounding tissue may be red and warm
- Moderate to large amount of drainage
- Shallow irregular wound edges
- Hemosiderin staining
- Leg edema
- Red granular wound beds
- May or may not be painful



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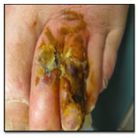
Arterial Ulcers (M1030)

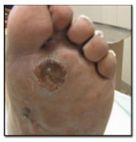
Characteristics:
- Distal foot, top of the foot, tips and tops of the toes.
- Pale pink wound beds necrotic tissue
- Minimal bleeding and drainage
- Often painful
- Absent or diminished pulses
- Trophic skin changes-
  - Dry skin
  - Brittle nails
  - No hair
  - Muscle atrophy



95

Diabetic Foot Ulcers (M1040B)

Characteristics:
- Typically occur of the planter surface of the foot
- Regular in shape, with even calloused wound edges
- Deep with necrotic tissue
- Moderate drainage
- Typically not painful



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Skin Treatments (M1200)

- Pressure Relieving Devices
  - Based on assessment and individualized needs
  - Should be care planned
- Nutrition/Hydration Interventions
  - Only if necessary to prevent or treat a skin condition
  - Vitamin and mineral supplementation can be coded only if a confirmed or suspected nutritional deficiencies has been identified in a thorough nutritional assessment
- Application of Ointments/Medications other than to feet
  - Must be applied to manage a skin condition
  - Doesn't have to be prescription. Barrier creams can be coded

97

Medications (N0410)

- N0410E Anticoagulants- Includes anticoagulants which may or may not require laboratory monitoring
  - Includes Target Specific Oral Anticoagulants (TSOAC)
    - E.g. Pradaxa, Xarelto, Eliquis
  - Does not include antiplatelet medications
    - E.g. Plavix, Aggrenox, Ticlid
- N0410H Opioids- Record the number of days the resident received an opioid medication in the 7d LBP.
  - Fentanyl Patches –count only the days the patch was put on

98

Antipsychotic Medication Review (N0450)

- Code any medication that has a pharmacological/therapeutic classification of an antipsychotic.
- Does not include GDRs attempted prior to admission to the facility
- The physician documentation indicating a GDR is clinically contraindicated must include the rationale for this decision.
- GDRs do not include medication tapers performed for the purpose of switching from one antipsychotic medication to another

99

Drug Regimen Review (N2001)

- SNF QRP item completed at the start of a Medicare Part A stay on the 5d and again at the end of a Medicare Part A stay
- Intent- to identify and if possible prevent clinically significant medication adverse consequences.
- A review of all medications administered by any route, including:
  - Prescribed and OTC medications
  - Nutritional supplements e.g. Ensure and vitamins
  - TPN and Oxygen
  - Homeopathic and Herbal products e.g. Essential Oils

100

Drug Regimen Review (Cont.)

- **A clinically significant medication issue-** A potential or actual issue that **in the clinician's professional judgement warrants** communication with the physician and completion of the prescribed actions by midnight of the next calendar day, at the latest.
- Examples:
  - Medication prescribed, despite medication allergy or prior adverse reaction
  - Adverse reactions to medications
  - Ineffective drug therapy
  - Drug Interactions
  - Duplicate Therapy
  - Medication Errors

101

Special Treatments (O0100)

- Does not include treatments provided solely in conjunction with surgical or diagnostic procedure (including pre and post operative procedures),
- Look-back period is the last 14 days
- Includes treatments the resident performed independently
- Includes treatments that were provided while a resident, even if those treatments were completed outside of the facility.
- Includes treatments or procedures that occurred while on an LOA from the facility.

102

Special Treatments (O0100)

- Chemotherapy- code any antineoplastic medication, given by any route, if the medications is for cancer treatment, kills cancer cells. Chemotherapy cannot be coded for medications used to slow the growth of cancer or prevent the return of cancer.
- Does not include IV Medications administered for surgical or diagnostic procedures e.g. ECT treatments, IV flushes, IV contrast,
- Does not include IV Medications administered during dialysis and chemotherapy treatments.
- Invasive Mechanical Ventilator- includes ventilation administered through endo tracheal tube or tracheostomy. Breathing is controlled by the ventilator.

103

Oxygen (O0100C)

- Oxygen is coded only if administered **to relieve hypoxia**
- PRN O2 orders (2-4LPM/NC to keeps sats >90%) require additional documentation
- Medical record supporting documentation includes:
  - Requires a physician's order, oxygen is a medication
  - Include a diagnosis in the O2 order
  - Time on/off
  - O2 sats/Respiratory Rate pre/post delivery
  - Liter Flow
- Document weaning attempts

104

Isolation (O0100M)

- Code only when **ALL** of the following criteria are met:
  - The resident **has an active infection** with a highly transmissible pathogen
  - Transmission based precautions must be in effect (droplet, contact or airborne)
  - The resident is alone in a room, because of active infection, and cannot have a roommate
  - The resident must remain in their room. All services must be brought to the resident
- Does not include isolation for:
  - Urinary tract infections,
  - Encapsulated pneumonia, and
  - Wound infections.

105

Respiratory Therapy (O0400D)

Coded only when **ALL** of the following criteria are met:

- The physician orders the therapy;
- The physician's order includes a statement of frequency, duration, and scope of treatment;
- The services must be directly and specifically related to an **active written treatment plan** that is based on an initial evaluation performed by qualified personnel.
- The services are required and provided by qualified personnel
- The services must be reasonable and necessary for treatment of the resident's condition.

106

Restorative Nursing Programs (O0500)

ALL of the following criteria must be met to code a RNP on the MDS.

- Measurable objectives and interventions must be care planned and documented in the medical record
- Periodic evaluation by a RN
- Nursing Assistants must be trained
- Program supervision is provided by a nurse RN/LPN
- Groups are limited to 4 resident per one staff
- Time for each activity is coded separately with at least 15 minute during the 24 hour period

107

Identifying Errors in Assessments

- Assessments must accurately reflect the resident's status during the LBP
- Errors must be corrected within 14 days of identifying them
- Errors are corrected with either a
  - Modification- modifies the assessment data in the CMS database
  - Inactivation- removes the assessment from the CMS database
- Most errors are corrected with modifications
- Corrections can be submitted:
  - Certified Facilities- within 2 years of the assessment target date
  - Terminated Facilities- within 2 years of the termination date

108

Modifications

A Modification is used to correct:

- Entry Date (Item A1600) on an Entry Tracking Record
- Discharge Date (Item A2000) on a Discharge/Death in Facility Tracking Record, but only if the assessment data and lookback period does not change
- ARD, but only if the assessment data and lookback period does not change
- Type of Assessment, but only if the item set code (ISC) does not change
- All Clinical Items (B0100-V0200C)

109

Inactivations

- An Inactivation is completed when there is an error in the:
  - Type of Provider (Item A0200)
  - If the event did not occur (e.g.. discharge)
  - Type of Assessment (A0310) if the Item Set Code (ISC) would change
  - Discharge Date (Item A2000) if the look-back period and/or clinical assessment data would change
  - Assessment Reference Date (Item A2300) if the look-back period and/or clinical assessment data would change
- When an inactivation is completed, the assessment is removed from the CMS database and it must be replaced with a new assessment
  - **The ARD of the new assessment cannot be earlier than the day the error was noted**

110

Significant Errors

- Significant Errors:
  - Inaccurately reflect the resident's clinical status and/or result in an inappropriate care plan, and
  - Have not corrected by the submission of a more recent correct assessment.
- All other errors are considered **minor errors**.
- Minor errors in the clinical items are corrected with a modification
- A Significant Error in a OBRA Comprehensive or Quarterly assessment is corrected by:
  - First, modifying the assessment submitted with the error, then
  - Determine if the error has been corrected by the submission by a more recent assessment.
  - If not, complete a Significant Correction Assessment SCPA, SCQA, or SCSA

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DEPARTMENT OF HEALTH

CAAs and Care Plans

112

Care Area Assessment Summary (section V)

- Intent of section V is to identify care areas that may be a concern for the resident
- Data entered on the MDS triggers care areas
- Triggered care areas require additional assessment
- The CAA Summary documents which of the triggered care areas will be addressed in the care plan and the location and date of the CAA documentation.

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Care Area Assessments

For each care area triggered the CAA should identify:
- The problem and the reason why it is a concern for the resident.
- The history of the problem
- Any underlying causes/contributing factors
- Any complications affected or caused by the care area
- Any risk factors related to the care area
- Interventions attempted and the resident's response
- Any referrals made

A Care Area Assessment must include:
- Resident and/or significant other input
- An analysis of the findings

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Care Plans

The care plan should be person centered and oriented towards:

- Assisting the resident to achieve their goals
- Individualized interventions that honor the resident's preferences
- Addressing ways to preserve and build on the resident's strengths
- Preventing avoidable declines
- Managing risk factors
- The resident's preference for future discharge and discharge plan

ALL care plan goals should be measurable

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MDS Manual

- A current manual and any errata documents can be downloaded from the following web site:

  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-instruments/NursingHomeQualityInits/MDS30RAIManual.html

  (Scroll down to the download section)

- The most current manual is MDS 3.0 RAI Manual v1.17.1

REMINDER

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Contact Information

MDS
- Phone 651-201-4313
- Email health.mds@state.mn.us

CMR
- Phone 651-201-4200
- Email health.fpc-cmr@state.mn.us

Submission or Validation Report Questions
- Phone 651-201-3817
- Email health.mdsoasistech@state.mn.us

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Resources Every MDS Nurse Should Have

- A current RAI Manual
- A Minnesota Case Mix Manual
- A MDS 3.0 Quality Measures User's Manual
- A Minnesota Nursing Facility Quality Indicators and Risk-Adjusters Manual
- A Skilled Nursing Facility Quality Reporting Program Measure Calculations and Reporting User's Manual
- A Minimum Data Set (MDS) Provider User's Guide, Chapter Five

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RAI Manual

- Download the current RAI Manual v1.17.1 from the following website:

  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

  (Scroll down to the download section)

REMINDER

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Case Mix Review Program Website

https://www.health.state.mn.us/facilities/regulation/casemix/index.html

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Need Help

For MDS Scheduling and Clinical Coding Questions

Email health.mds@state.mn.us

For Submission or Validation Report Questions

Email health.mdsoasistech@state.mn.us

Subscribe to Receive Minnesota Case Review Program Emails

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Need Help

- For Medicare Billing and Eligibility Questions
  - National Government Services 1-877-702-0990
  - Website https://www.ngsmedicare.com
- For Private Pay and Medicaid Billing Questions
  - Phone 651-201-4200
  - Email health.fpc-cmr@state.mn.us

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