DEPARTMENT OF HEALTH

# Common MDS Coding Errors

Nadine Olness RN, RAC-CT
MN State RAI Coordinator
Licensing and Certification Program
March 1, 2023



1

## Objectives

- Understand the implications of an inaccurate assessment
- Identify the most common MDS coding errors and how to prevent them
- Understand the MDS correction process



2

## Why Does MDS Accuracy Matter?

MDS assessments impact:

- Resident Care Planning
- Reimbursement
- Quality Measures/Quality Indicators
- Consumer Access to NH Information
- Survey Process

MDS errors are more than just paper errors. MDS errors have far reaching implications for a resident and the facility.



3

## Ways to Improve MDS Accuracy

- Ensure staff have appropriate training
- Ensure that staff have enough time to complete the MDS
- Provide supervision and support for staff
- Ensure staff have and are using updated resources
- Collect data from multiple sources (observation, interview, and record review)
- Ensure there is supporting documentation in the medical record
- Always investigate and clarify documentation inconsistencies

4

4

## General Guidelines for Resident Interviews

- The decision to complete the resident interviews is not directly tied to item B0700, Makes Self Understood
- Attempt to conduct the resident interviews with **ALL** residents
- Resident interviews must be completed during the look back period
- Conduct the interviews using the resident's preferred method of communication
- Ask the questions in the order presented
- Record the resident responses as stated

5

5

## General Guidelines for Resident Interviews

- Missed Resident Interviews (e.g. staff did not get to it, they forgot or could not connect with the resident):
  - The gateway questions would be coded "yes" and
  - The resident interview questions and the gateway question for the staff assessment must be dashed (C0200-C0600).
- Exception- When completing a standalone, PPS assessment if the resident has an unplanned discharge prior to the completion of the BIMs interview the staff assessment can be completed

6

6

## 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 standalone BIMs assessment if the resident had an unplanned discharge prior to the completion of the BIMs interview.
- Staff assessments should be completed after the ARD and prior to the assessment completion deadline.

7

7

## Incomplete BIMS Interviews (C0500)

- 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 responses and nonsensical responses to **ALL** questions so far.
- If the interview is stopped:
  - C0400A-C is dashed, Code "99" in the BIMS Summary Score (C0500), and complete the Staff Assessment for Mental Status

8

8

## Incomplete PHQ-9 Interviews (D0300)

- If the response to a resident interview question(s) is nonsensical, 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.

9

9

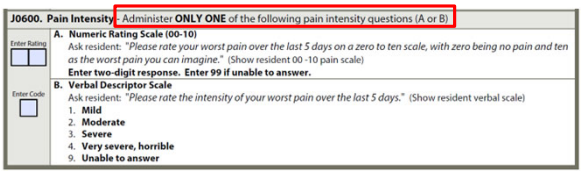
## Incomplete Pain Interviews (J0300)

- Pain Presence (J0300)- If the resident is unable to answer, does not respond, or gives a nonsensical response. Code 9, skip to the Staff Assessment for Pain
- The pain interview is successfully completed if the resident reported:
  - No pain in item J0300, or
  - They had pain and the pain frequency (J0400) question was answered

10

10

## Pain Intensity (J0600A/B)



**J0600. Pain Intensity** - Administer **ONLY ONE** of the following pain intensity questions (A or B)

Enter Rating

**A. Numeric Rating Scale (00-10)**

Ask resident: *"Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine."* (Show resident 00 -10 pain scale)

**Enter two-digit response. Enter 99 if unable to answer.**

Enter Code

**B. Verbal Descriptor Scale**

Ask resident: *"Please rate the intensity of your worst pain over the last 5 days."* (Show resident verbal scale)

1. **Mild**
2. **Moderate**
3. **Severe**
4. **Very severe, horrible**
9. **Unable to answer**

11

11

## Hallucinations vs. Delusions (E0100A/B)

- 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

12

12

## 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 considered rejection of care**

13

13

## Coding Exercise

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.

14

14

## 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.

15

15

## Activities of Daily Living (G0110)

- Clarify inconsistencies in documentation with the person who documented the information. Write a clarification note
- Always double check auto-populated responses
- The components of an ADL activity include only the activities listed on the MDS item set. E.g.,

| | |
|---|---|
| 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 |
| J. | **Personal hygiene** - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** baths and showers) |

16

16

## Balance During Transitions and Walking (G0300)

- Must be assessed during the look back period of the assessment
- Coded based on the least steady episode, using assistive devices
- Balance Sit to Stand
  - Code "2" Not steady, only able to stabilize with staff support if a stand lift is used.
  - Code "8" Activity did not occur, if the resident did not move from a seated to standing position or a full body lift is used.
- Balance While Walking
  - Code "2" Not steady, only able to stabilize with staff support or
  - if the resident fell while walking in the 7 day look back period

17

17

## Functional Limitations in ROM (G0400)

- Definition- A limited ability to move a joint that interferes with ADLs or places the resident at risk for injury.
- Must be assessed during the look back period of the assessment
- Two Part Process
  - First, test the resident's Range of Motion for a UE/LE limitation, then
  - Determine if the limitation interferes with function or places the resident at risk for injury. If not, the limitation in ROM is not coded on the MDS.
- Functional Limitations are not limited to contractures can include:
  - Flaccid Extremities
  - Tremors
  - The absence of a limb d/t amputation

18

18

## Toileting Programs (H0200 and H0500)

- Requirements:
  - Based on the resident's unique elimination pattern
  - Care planned and communicated to staff
  - Implemented on at least 4 of the 7 days during the LBP
  - Response is monitored, evaluated and documented
- 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

19

19

## Comprehensive Bladder Assessments

A comprehensive B/B assessment includes an evaluation of:

- The History of Incontinence
- Elimination Patterns
- Fluid Intake Patterns
- Pelvic/Rectal Examinations
- Functional Factors
- Cognitive Factors
- Environmental Factors
- Medications
- Diagnoses
- The Type of Incontinence

20

20

## Toileting Program Care Plans

A Toileting Program care plan has three components

- **A clearly defined problem statement**- Identify the problem, what is causing the problem, and the baseline bladder function.
- **A measurable goal**- Identify what you expect to achieve with the toileting program
- **Individualized interventions**- Identify the interventions that will be used to assist the resident to meet their goal. Tailor the resident's toileting schedule to their specific elimination patterns

DEPARTMENT OF HEALTH

21

21

## Toileting Program Evaluations

- Toileting Programs must be evaluated at least quarterly and whenever there is a change in cognition, physical ability, or level of control
- Evaluations must address:
  - The resident's progress towards the goal
  - Any barriers that interfere with the resident's progress
  - An assessment of frequent refusals to participate
  - The rationale for the decision to continue, discontinue, or revise the toileting program
  - Evaluations must be completed by an RN

22

22

## Sample Care Plan

**Problem-** The resident is frequently incontinent of bladder. She is aware if the urge to void but, does not always make her needs known. The resident has functional bladder incontinence related to dementia and an inability to safely get to the toilet independently as evidenced by an average of four incontinent episodes per day during waking hours.

**Goal-** She will have no more than two incontinent episodes per day during waking hours by 09/09/2021.

**Interventions-** Toilet upon arising between 8-8:30 am, 11:30-12pm, 1:30-2:00 pm, 5-5:30 pm, and 7:30-8:00 pm. If the resident refuses toileting assistance provide encouragement. If she still refuses reapproach in 15 minutes.

DEPARTMENT OF HEALTH

23

23

## Sample Toileting Program Evaluation

- Review of the resident's elimination patterns for the past 30d revealed she had met her goal on 18 days. The resident was incontinent of urine 3x/day on the remaining 12 days. The data revealed the resident was frequently incontinent in the evenings prior to dinner and again after dinner. Staff implemented the plan as written and the resident was cooperative with her scheduled toileting program. We will adjust her evening toileting times to toilet between 4-4:30 pm and 6:30-7:00 pm and reevaluate in 30 days.

DEPARTMENT OF HEALTH

24

24

## Active Diagnoses (I0100-I8000)

- 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

25

25

## Active Diagnoses (Cont.)

| Active Diagnoses in the last 7 days - Check all that apply<br>Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists | |
|---|---|
| | **Cancer** |
| ☐ | **I0100. Cancer** (with or without metastasis) |
| | **Heart/Circulation** |
| ☐ | **I0200. Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell) |
| ☐ | **I0300. Atrial Fibrillation or Other Dysrhythmias** (e.g., bradycardias and tachycardias) |
| ☐ | **I0400. Coronary Artery Disease (CAD)** (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD)) |
| ☐ | **I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)** |
| ☐ | **I0600. Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema) |
| ☐ | **I0700. Hypertension** |
| ☐ | **I0800. Orthostatic Hypotension** |
| ☐ | **I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)** |
| | **Gastrointestinal** |
| ☐ | **I1100. Cirrhosis** |
| ☐ | **I1200. Gastroesophageal Reflux Disease (GERD) or Ulcer** (e.g., esophageal, gastric, and peptic ulcers) |
| ☐ | **I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease** |

26

26

## Urinary Tract Infections (I2300)

A UTI is coded on the MDS only if **both** of the following criteria are met during the 30d look back period:

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

27

27

## Septicemia (I2100)

- I2100 is specific to septicemia only
- Sepsis, Urosepsis, and Bacteremia are not the same condition as Septicemia.
- Code diagnoses of Sepsis, Urosepsis, Bacteremia in I8000 if all the criteria is met and appropriate.
- When there are uncertainties regarding a diagnosis consult the resident's physician for clarification.

28

28

## Quadriplegia (I5100)

- Quadriplegia is paralysis of all four limbs
- A serve or complete loss of motor function in all four limbs
- Includes Quadriplegia/Tetraplegia related to spinal cord injuries only
- The Quadriplegia must be the primary diagnoses and not the result of another diagnosis e.g., advanced dementia, CVA, cerebral palsy
- If the resident has meaningful/coordinated use of a limb such that he is able perform activities like eating and operating a joystick, Quadriplegia cannot be coded.

29

29

## Parkinson's Disease (I5300)

- Specific only to Parkinson's Disease
- Does not include secondary parkinsonism diagnoses
- Where inconsistencies in physician, NP, and PA documentation exist clarify the diagnosis with the MD
- See the Parkinson's Foundation website for information regarding Parkinson's Disease vs. parkinsonism

https://www.parkinson.org/understanding-parkinsons/what-is-parkinsons/stages

30

30

## Malnutrition (I5600)

- Includes those with diagnoses of protein or calorie malnutrition and those at risk for protein or calorie malnutrition
- RD assesses but, the MD diagnose
- Must meet the criteria of an Active diagnoses:
  - Documented by the physician in the last 60d and has an impact on the resident in the 7d look back period of the assessment
- There should be a care plan with interventions in place

31

31

## 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
- Serious condition that must be assessed and care planned

32

32

## Falls

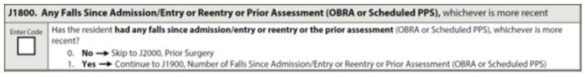
Definition:

- 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

33

33

## 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.

34

34

## 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.

35

35

## 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
  - Using the weight closest to 30d earlier multiply by .95
  - Using the weight closest to 180d earlier multiply by .90
- The resident has experienced a significant weight loss if either of the resulting figures are less than the resident's current weight in K0200

36

36

## 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

37

37

## 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.

38

38

## Pressure Ulcers/Injuries (M0300)

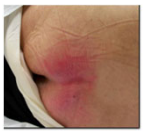
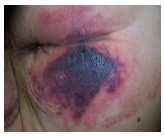
- **Definition:** A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear.
- Only pressure ulcers/injuries get staged
- No reverse staging
- Surgically debrided pressure ulcer is still a pressure ulcer.
- Surgically closed with a flap or graft it is now a surgical wound
- Present Upon Admission- the pressure ulcer was not acquired or worsened to a deeper stage while a resident of your facility.

39

39

## 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.

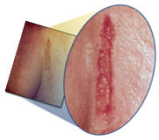
40

40

## 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
- Do not code maceration or excoriation as a stage two ulcer



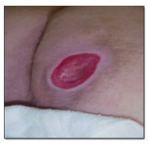
41

41

## Stage III Pressure Ulcer

Characteristics:

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



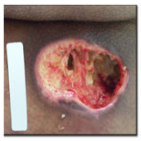
42

42

## 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, occiput, and malleolus ulcers can be shallow)

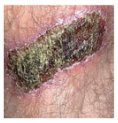


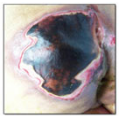
43

43

## Scab vs. Eschar

- A scab is made up of dried blood and wound exudate. 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.





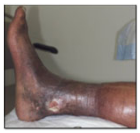
44

44

## 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

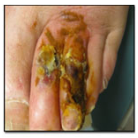


45

45

## 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

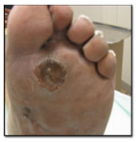


46

46

## 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



47

47

## Skin Treatments (M1200)

- Pressure Relieving Devices
  - Based on assessment and individualized needs
- 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
  - Must be evidence it was applied during the LBP

48

48

## Skin Treatments (Cont.)

- Pressure Relieving Devices
  - Based on assessment and individualized needs
- 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

49

49

## General Guidelines for Special Treatments

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

50

50

## Chemotherapy (O0100A)

- Chemotherapy- code any antineoplastic medication, given by any route, as long as the medications is for cancer treatment, not prevention.
  - Code only antineoplastic medications that kill cancer cells
  - Do not code antineoplastic medications that slow/prevent the growth of cancer cells
- No hormonal therapies i.e. Tamoxifen. Hormonal oncological medications cannot be coded in this item.
- The resident must have an active diagnosis (MD documentation within the last 60 days) of cancer

51

51

## 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

52

52

## 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.

53

53

## The SCSA When Therapy or Isolation Ends

- A SCSA is required when ALL therapy or isolation services end if:
  - The most recent comprehensive or noncomprehensive assessment resulted in a rehab RUG classification in Z0200A.
    - The SCSA ARD must be set on day 8 after therapy ends.
  - Isolation was coded on the most recent comprehensive or noncomprehensive assessment and the assessment resulted in a ES1, CA1, or CA2 RUG classification in Z0200A.
    - The SCSA ARD must be set on day 15 after isolation ends.

54

54

## 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.

55

55

## 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

56

56

## Identifying Errors in Assessments

- Assessments must accurately reflect the resident's status
- 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

57

57

## 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)

58

58

## 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**

59

59

## Significant Errors

- Significant Errors:
  - Inaccurately reflect the resident's clinical status and/or result in an inappropriate care plan, and
  - The error was 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

60

60

## Correcting Significant Errors

- To correct a Significant Error in a OBRA Comprehensive or Quarterly assessment-
  - Modify the assessment submitted with an error, then
  - Determine if the error has been corrected by the submission by a more recent assessment.
    - If yes, no further action is needed
    - If no, complete a Significant Correction Assessment SCPA, SCQA, or SCSA
- **The significant correction assessment is a new assessment with a new ARD**

61

61

## 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

62

62

## 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**

63

63

## Case Mix Review Program Website


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

64

64

## 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

65

65

## 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


66

66