

MDS 3.0 Questions

Following are questions raised during OHCA's MDS 3.0 training programs. The reference information provided is based on the CMS Long-Term Care Resident Assessment Instrument (RAI Manual) User's Manual, Version 3.0, September 2010. Please note that page numbers may not correspond to earlier or later versions of the manual.

Section A

New Admissions - is entry tracking required or just admission assessment?

Yes, entry tracking is required see pages 2-45.

Would a skilled resident who improved but will discharge within a week need a significant change in status assessment?

If the resident is skilled it is expected that they will improve and a SCSA assessment is not necessary. Page 2-24. You also have 14 days to determine if there was a significant change for any resident. Page 2-15.

Will all PPS MDSs end up being a significant change because they are improving (hoping to return home) if only 2 areas of ADLs improve?

Read Chapter 2 - expected improvements in rehab patients do not have to be a significant change.

A0310A - Significant Change Assessment - Under significant change - Any decline in an ADL physical functioning area where a resident is newly coded as extensive assistance, total dependence, or activity did not occur since last assessment. Is the understanding then, that if the resident fluctuates from independent to a limited assist than this is okay, and a significant change would not need to be done if a resident went from independent in eating and turning to a limited assist in both of these areas?

Correct. Page 2-23.

Is the ADL section considered one whole area in change, or is each area (turning, eating, etc.) considered an area by itself? Example: If the resident was independent and walking and now are extensive assist then this would be a significant change?

See discussion on page 2-23. "An SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL decline or improvement)."

Significant change criteria - Resident's incontinence pattern changes - Does this include both bowel and bladder?

Yes. Page 2-23

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Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-9); Increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (behavior) - Would a few changes, example going from a 0 to a 1 in the symptom frequency, automatically make this a change in one area because couldn't this area fluctuate in a 14 day span for anyone? Also, would this whole area be considered one change or each question A, B, C, D, etc be each it's own area?

See discussion on page 2-23 regarding consistent pattern of changes within one domain as example of significant change.

Significant Change -

Decline in two or more of the following:

- Resident's decision-making changes;
- Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-9©); Increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (behavior);
- Any decline in an ADL physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment;
- Resident's incontinence pattern changes or there was placement of an indwelling catheter;
- Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days);
- Emergence of a new pressure ulcer at Stage II or higher or worsening in pressure ulcer status;
- Resident begins to use trunk restraint or a chair that prevents rising when it was not used before; and/or
- Overall deterioration of resident's condition.

A0310A/C. When a resident is admitted with therapy orders and is skilled, do we code it as Admission 5 day or Admission 5 day Start of Therapy Assessment?

You will have to think about whether coding it as a SOT OMRA would be helpful or not. Usually this is not necessary. SOT OMRA is optional. Page 2-47.

A0310C. Can we only mark -3" if therapy lasts no more than 6 days?

Page A-4. **Code 3, both the start and end of therapy assessment:** with an ARD that is both 5 to 7 days after the first day therapy services were provided and that is 1 to 3 days after the last day therapy services were provided (except when the assessment is used as a short stay assessment, see Chapter 6).

If you do a Start of Therapy OMRA and the resident goes to the hospital - D/C Return Anticipated, do you need to do another Start of Therapy OMRA on readmit? If therapy continues?

Start of Therapy OMRA is always optional - you need to ask yourself if coding a SOT OMRA is helpful. Page 2-47.

What if you complete a discharge with return anticipated and ends up turning for the worse and dies in the hospital after the discharge with return anticipated has been submitted? Do you just do another discharge with return not anticipated or modify it?

No. Page 2-37, 2-38.

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If a resident is receiving therapy and is discharged to the hospital, is the assessment always/ever coded End of Therapy- Discharge?

This would be a discharge, but usually not an EOT OMRA. Page 2-48.

Do you have to do an End of Therapy OMRA if resident is not going to continue to be skilled?

No. Page 2-48.

A0310F - For a resident who is discharged return anticipated who did not return in 30 days, it says you must modify the d/c assessment. Do you actually modify the original d/c and if so how, or do you do a new one?

"In some situations, a resident may be discharged return anticipated and the facility learns later that the resident will not be returning to the facility. Another Discharge assessment is not necessary although the state may require a modification from "return anticipated" to "return not anticipated". Page 2-35, 2-36. The only time this is done in OH is when the resident is discharged Return Anticipated and then the facility finds out later that they are not returning for whatever reason. This is a Medicaid edit for Ohio and only occurs if the resident is not going to be returning at all. The way the modification is completed is covered in Chapter 5 and Section X. The provider will complete Section X and then pull up the previous record and modify the previous discharge and then send them both electronically to the QIES ASAP. However, if the resident is still anticipated to return, but doesn't do so within 30 days following a Discharge Return Anticipated, he/she will then have an Admission assessment completed when they do return. If the resident returns within 30 days when the provider has issued a Discharge Return Anticipated, he/she will complete a Reentry. (A1700)

What is A0310F-99- Not entry/discharge?

99. Page A-5. If it is not an Entry record (tracking record), a Discharge assessment- Return not anticipated, a Discharge assessment- Return anticipated, or a death in the facility record (tracking record), it would be coded 99 - Not entry/discharge.

Legal name (A0500). Some residents have an initial first name and full middle name legally (i.e. M. Patricia). How do I code this?

Enter M in first name as appears on Medicare card and enter P in middle name. Page A-6. "**Legal Name** - Resident's name as it appears on the Medicare card. If the resident is not enrolled in the Medicare program, use the resident's name as it appears on a Medicaid card or other government-issued document."

If they are discharged return anticipated and they die 4 days later in the hospital, do you do "death in facility" and do you have to modify to "discharge return anticipated"?

No. Page 2-37, 2-38.

Scheduling assessments, which is correct, must be set or must be completed and by when?

ARD must be within 92/366 (quarterly/comprehensive) days of previous ARD. Completion date must be within 14 days of ARD. Except for initial, 14th calendar day of the resident's admission (admission date + 13 calendar days). See Chapter 2.

With a significant change assessment for a patient who goes hospice, we currently do not complete anymore significant changes on this patient if they continue to decline because the RAI says it is an expected decline. Will this be the same with 3.0?

As long as it continues to be an expected decline, no further significant change would be necessary.

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If a resident goes onto Hospice and then within 14 days we do a MDS on that resident but on this resident at this point does not show a change in condition except that she is now on Hospice, then does actually decline in several areas in around four weeks and now is stabilized for awhile, does another significant change have to be done or is it enough to just change the care plan since a decline was expect?
Read the discussion on Page 2-25.

Guidelines for Determining the Need for a SCSA for Residents with Terminal Conditions: Note: this is not an exhaustive list.

The key in determining if a SCSA is required for individuals with a terminal condition is whether or not the change in condition is an expected, well-defined part of the disease course and is consequently being addressed as part of the overall plan of care for the individual.

- If a terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration and the criteria are met for a SCSA, a SCSA assessment is required.
- If a resident elects the Medicare Hospice program, it is important that the two separate entities (nursing home and hospice program staff) coordinate their responsibilities and develop a care plan reflecting the interventions required by both entities. The nursing home and hospice plans of care should be reflective of the current status of the resident.

A1000 What if the resident is not able to answer what race they are, how do you code?

Ask a family member or significant other. Page A-10. Only if the resident is unable to respond and no family member or significant other is available, observer identification or medical record documentation may be used. Page A-11.

Resident discharged to hospital and returns two days later not skilled. Do you count the D/C assessment as last MDS and next assess done in 92 days?

Follow the Entry, Discharge, and Reentry Algorithms Page 2-37. Depends on how they were coded at discharge.

If a resident goes to the hospital and dies before being out of the facility > 24 hours which do you do, discharge tracking, discharge assessment, or death in facility record?

If resident dies during an observation stay less than 24 hours, they are on a LOA and should do a death record. Page 2-36.

When a resident is discharged from hospice care, is a significant change mandatory?

Yes.

A SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD must be within 14 days from one of the following: 1) the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill. Page 2-21.

Resident is discharged to hospital and comes back less than 24 hours later. Do you do discharge MDS or just D/C tracking?

If not admitted to the hospital and return within 24 hours you do not do ANYTHING.

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A1700 - If a resident was skilled prior to going to the hospital and later returns and is skilled again, what would be the first MDS 3.0 type using option 1 be called? A 5 day or a 5 day readmission?
Depends on if it was a discharge return anticipated or a discharge return not anticipated. Page 2-37.

A1800 - Psychiatric hospital - Can this be marked if a resident is sent to a psych unit in an acute care hospital or should this still be coded as an acute care hospital?
Acute Care. Page A-20.

Is the ARD for discharge assessment the day of discharge with 7 day look back?
Yes, page 2-34. Discharge date (Item A2000) must be the ARD (Item A2300) of the discharge assessment.

A2400 - If patient changes from traditional part A to a managed care that follows PPS guidelines, do we fill out the end date? What if the managed care company doesn't require following PPS guidelines?
Managed Care is not considered to be part of Part A - so you would complete the end of the stay date regardless of whether or not the managed care follows PPS guidelines. Page A-24. "Identifies when a resident's Medicare Part A stay begins and ends."

When starting part B therapy do you do a start of therapy OMRA and when they are discharged do you do an end of therapy OMRA? What if they are receiving multiple therapies and one is discharging do you do a end of therapy OMRA?
Start of Therapy OMRA and End of Therapy OMRA are only for Part A. Do not do End of Therapy OMRA when only one discipline discharges, only when the final discipline discharges. Page 2-47, 2-48.

Section B

B0700 - Rarely/Never understood - when to assess?
During the observation period, observe the resident in different settings and circumstances and consult with the primary nurse assistant over all shifts as well as (if available) resident's family and speech-language pathologist. Page B-7, B-8.

Section C

Why does the LSW do or not do the delirium section along with the cognitive sections?
It is up to the facility to determine who is the most appropriate staff member to complete each section and this may vary by resident.

Does BIMS replace the need for MMSE?
Yes

Can cognitive interview take the place of MMSE?
Yes

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Do you have to complete the BIMS for every PPS assessment?

Depends on the assessment type. As far as 5 day and 14 day that was the intention.

C0400 - Do you let them know they have 5 seconds, because some people hesitate and come up with the right answer after 10-20 seconds? Is it a pass/fail if not answered in 5 seconds?

No, just allow up to 5 seconds, don't tell them 5 seconds. Also it is 0 if can't recall even with category clue, 1 if can with category clue which gives an additional 5 seconds, and 2 if correct without category clue. Page C-12.

How can you do a BIMS on a discharged resident who discharges suddenly to the hospital?

You can't. Do the staff interview C-16, C0600 resident unable to complete.

C1300. My staff documents, "No unusual behaviors" for residents that have care planned behaviors, will this affect the supporting documentation for continuously present? Or do I need to change the way they document?

This would not support C1300 - will need to change the documentation. Page C-26 to C-31.

Section D

Can mood interview take the place of a depression screen?

Yes

Can the mood section count for geriatric depression scale?

Page D-3. Different assessment, same outcomes, can REPLACE Geriatric Depression Scale.

Why do we interview staff for mood even though we don't/can't do resident?

If resident is rarely/never understood, you need to interview staff to assess patient fully. Page D-1.

Should a resident interview be conducted for Section D 0200 if staff interview is indicated in Section C, or should interviews be attempted for both sections?

Attempt individually. Follow MDS skip patterns and it will show you where to go next.

If the resident can not complete the interviews in Section C, but does in Section D, can the results in Section D be considered valid?

Yes it is a resident interview based on resident responses.

D0600 - If we interview staff from all three shifts and those answers differ, which response is coded?

What if more than 3 staff members are interviewed? What if only one can answer?

The highest frequency, and if any staff rate symptom presence it is coded. Also should interview at least all shifts but if they can not answer that is okay. Can interview more than 3 though. Page D-14.

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Section E

Section E resident interview - What about proof for reimbursement? What if clinical record contradicts?
No interview in Section E. But for other interviews you document "residents" response.

E0800 - Rejection of care - Resident who fails cookie swallow who chooses to eat, or is that their goal, does waiver play a role?

Do not include behaviors that have already been addressed and/or determined to be consistent with resident values, preferences, or goals. Page E-13.

E0800, how do you code residents that are cognitively impaired and have chronic rejection of care? These behaviors are care planned and continue to be present. Resident does not understand the consequences of rejecting care.

Once care planned it is not continued to be coded here. See answer above. Page E-13.

E0800 - If a resident is A&O x 3 and their choices are not consistent with their preference/goals do you need to chart rejection of care?

Yes, the first time.

E1000 - If on an Alzheimer's unit, does wandering count as impacting others?

Not automatically. Is the residents wandering on the unit significantly intruding on the privacy or activity of others? Page E-19.

Our facility has two secured units for Alzheimer's residents. Both units have behavior problems coded on the 2.0 and care planned. Will these be coded on 3.0 since they already exist?

Some behaviors continue to be coded even though they have been care planned, just not rejection of care. Need to read all of the sections and the instructions.

Section G

If 2 people transfer a resident to bed on admission and one is the transporter and the other a staff member, are we allowed to count this as a 2 person transfer since one is not our staff member?

No. Both have to be your staff. Page G-5.

G0110I - How do you code use of EZ stand and or Hoyer with balance for toileting?

You code the support levels that are provided by the staff and the number of staff providing the assistance. Most devices require a minimum of two people to safely execute the transfer and usually they require periods of maximum assistance.

Catheter care in ADL's- How do we code if emptying does not occur by resident? Managing catheter?

G0110I -do not include emptying of bed pan, urinal, bed side commode, catheter bag, or ostomy bag. Page G-7.

Do we need chart documentation to support ADL's?

Yes

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How do we code ADL's if they are multiple levels of performance - when is it "highest level of dependence"?

Follow the ADL Self Performance Algorithm. Page G-6.

G0300 How do you code the balance test if walker is used? Or if transfers as extensive assistance with 2 staff?

The resident is able to use their walker and it is coded depending on how steady the resident is during the observation time. If steady at all times with use of walker it is coded as a 0. If the resident is able to perform the task with assistance it is coded as a 2. Pages G-19 to G-29.

G0900 - Functional Rehabilitation Potential - Only on admission(or on readmit)?

Only if A0310A=01. Page G-33.

Section H

H0100 - If a resident has an order to straight catheter PRN does that constitute intermittent catheterization and can it be marked on the MDS?

Read definition of intermittent catheter page H-2. "Intermittent Catheterization - Sterile insertion and removal of a catheter through the urethra for bladder drainage."

H0100 - Resident comes from hospital with Foley, facility policy is to remove Foley the following AM. Does the Foley get coded on admission MDS?

Yes. "Check next to each appliance that was used at any time in the past 7 days. Select none of the above if none of the appliances A-D were used in the past 7 days." Page H-2.

H0300 - If resident has an indwelling catheter but it leaks at times because of bladder spasms etc, is it still coded as a "9"?

Pg H-8 doesn't specifically discuss leaks, but states if during the 7 day look back period the resident had an indwelling bladder catheter for entire 7 days it is a 9.

Regarding bowel and bladder programs - for programs other than prompted voiding/scheduled voiding - are there programs that are generally initiated by therapy department and turned over to restorative nursing?

For purposes of the MDS it doesn't matter who initiates the program, but you can speak with your therapy department to see what programs they offer. There are also continuing education opportunities if they have no experience in this area.

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Regarding a bowel program, how often should documentation be done? Is monthly enough?

No, see steps for assessment on page H-12.

1. Review the medical record for evidence of a bowel toileting program being used to manage bowel incontinence during the 7-day look-back period.
2. Look for documentation in the medical record showing that the following three requirements have been met:
 - implementation of an individualized, resident-specific bowel toileting program based on an assessment of the resident's unique bowel pattern;
 - evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, verbal and a written report; and
 - notations of the resident's response to the toileting program and subsequent evaluations, as needed.

Section I

I1700 - If MRSA is colonized is it coded on MDS?

Yes

Is a signed diagnosis list enough documentation to identify it as active or does it have to be a narrative note by physician?

No, must be active within the last 7 days. UTI has a separate look back criteria. Page I-8.

If on maintenance ATB for UTI do you code that?

Must meet all 4 criteria to code not just #4. Page I-8.

Code only if all the following are met

1. Physician, nurse practitioner, physician assistant, or clinical nurse specialist or other authorized licensed staff as permitted by state law diagnosis of a UTI in last 30 days,
2. Sign or symptom attributed to UTI, which may or may not include but not be limited to: fever, urinary symptoms (e.g., peri-urethral site burning sensation, frequent urination of small amounts), pain or tenderness in flank, confusion or change in mental status, change in character of urine (e.g. pyuria),
3. "Significant laboratory findings" (The attending physician should determine the level of significant laboratory findings and whether or not a culture should be obtained), and
4. Current medication or treatment for a UTI in the last 30 days.

Should UTI be checked if resident had a UTI in the hospital but ABO was finished prior to admission to facility and UTI is resolved?

Need to reference all 4 items on page I-8, if all true then it is coded.

I2300 - Urinary tract infection - It reads code only if all the following are met. If no UA, C&S was done, but does have number 1, 3, & 4 met, it is my understanding then that UTI cannot be marked because it does not meet the definition of the UTI. Is this correct?

Correct. Page I-8.

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Will UTI's on QI's increase because we code UTI if they are getting an ATB for it?

It will trigger potentially for CAA's. Specific criteria must be met within 30 days to code. QI changes have not been announced.

I2500 - Wound infection - Does a physician have to actually write the diagnosis of wound infection or can this one be marked if it has all of the symptoms of an infection?

All diagnoses in Section I require a physician diagnosis. Page I-5.

I5600 Malnutrition - Who does this? How is this a diagnosis? What tool is used?

This requires a physicians diagnosis.

If resident has a diagnosis of psychosis but no behaviors but is on QD behavior monitoring would you mark psychotic disorder?

Monitoring makes the diagnosis active and could be coded.

Since psychosis, schizophrenia, and bi polar are all able to be checked in section I - Will this avoid a quality indicator not being triggered for antipsychotic medication marked?

Quality Indicator changes have not been announced yet.

Are allergies recorded somewhere on the 3.0?

As with any other diagnosis not specifically listed in I, you would enter it in "other" if it has been active in the last 7 days.

Section J

Since pain assessment has changed on MDS, is it still necessary to do the quarterly pain assessment on each resident separate from the MDS?

No

If J0300 pain presence is Yes, and the resident answers J0600A Pain Intensity as 00 (no pain), don't those contradict each other? Why is 00 an option?

That would be a situation where the resident is best suited to use the Verbal Descriptor Scale (J0600B) as opposed to the Numeric Rating Scale (J0600A). Page J-13.

Can we count therapy non-medication interventions that they complete or have on their care plan for pain?

Page J-2. "Non-medication pain (non-pharmacologic) interventions for pain can be important adjuncts to pain treatment regimens. Interventions must be included as part of a care plan that aims to prevent or relieve pain and includes monitoring for effectiveness and revision of care plan if stated goals are not met. There must be documentation that the intervention was received and its effectiveness was assessed. It does not have to have been successful to be counted." **Non-Medication Pain Intervention** - Scheduled and implemented non-pharmacological interventions include, but are not limited to: bio-feedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electrical stimulation, radiotherapy, ultrasound and acupuncture. Herbal medications are not included in this category."

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Does the pain medication have to be classified as an analgesic or do anti-inflammatory or other medications used for pain (i.e. steroids) count as well?

"Pain medication regimen - Pharmacological Agent(s) prescribed to relieve or prevent the recurrence of pain. Include all medications used for pain management by any route and any frequency during the look-back period. Include oral, transcutaneous, subcutaneous, intramuscular, rectal, intravenous injections or intraspinal delivery. This item does not include medications that primarily target treatment of the underlying condition, such as chemotherapy or **steroids**, although such treatments may lead to pain reduction." Page J-1.

We use PRN pain medication prior to therapy but not for complaints of pain. Will this trigger anything because PRN pain medication will be marked J0100B but under J0300 the answer will be no?

There are many circumstances where J0100 and J0300 will appear to conflict. This is okay.

Why is pain look back 5 days instead of 7?

Research shows that recollection of pain is only accurate within about 5 days.

If they have both routine pain and PRN pain medications do you code both?

Yes

With these new assessments such as pain - will this eliminate the need for quarterly assessments done separately at this time?

There is no requirement to do two different forms to assess the same thing.

If pain section is done by interview does documentation of pain during ARD count?

No - you must record what the resident reports during the interview.

If a resident goes OOF to hospital and they are diagnosed with dehydration, they hydrate them and send them back do we code dehydration on the MDS?

Page J-26.

Dehydrated: Check this item if the resident presents with two or more of the following potential indicators for dehydration:

1. Resident takes in less than the recommended 1,500 ml of fluids daily (water or liquids in beverages and water in foods with high fluid content, such as gelatin and soups). Note: The recommended intake level has been changed from 2,500 ml to 1,500 ml to reflect current practice standards.
2. Resident has one or more potential clinical signs (indicators) of dehydration, **including but not limited to** dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, or abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium, albumin, blood urea nitrogen, or urine specific gravity).
3. Resident's fluid loss exceeds the amount of fluids he or she takes in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement).

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Does menstrual bleeding count as internal bleeding?

No, Page J-26. **"Internal Bleeding:** Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools). Clinical indicators include black, tarry stools, vomiting –coffee grounds," hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed) that requires packing. However, nose bleeds that are easily controlled, menses, or a urinalysis that shows a small amount of red blood cells should not be coded as internal bleeding."

J1550 - Internal bleeding - it reads a urinalysis that shows a small amount of red blood cells should not be coded as internal bleeding. Is there an amount that can be coded? At one time, I thought it was >3 red blood cells. Is this correct?

Must be hematuria documented not just a urinalysis that shows a small amount of red blood cells. No specific guidelines on red blood cell count may be good to check with your lab. Page J-26.

As therapists, we get patients walking and during that process we keep patients from falling all the time, is this considered a fall on the MDS?

Yes. "An intercepted fall occurs when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person –this is still considered a fall." Page J-27.

"Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident). During balance activities, if the therapist is administering an overwhelming external force and the resident can not self right, this may not be deemed a fall."

Why if a resident self corrects before a fall is it counted as a fall?

Because this puts them at greater risk for a fall in the future.

If you state that an intercepted fall is any time that they catch themselves or someone stops them, then wouldn't anyone who uses a walker to ambulate be coded as a fall, as they would fall without the walker?

No

Is every person that ambulates with 1-2 person extensive assistance a "fall" every time they are walked?

No. If they become unsteady and are "righted" it would be a fall.

Re: Fall - if definition is "unintentional" what about residents that 1. role themselves out of bed onto a mat, 2. release seatbelts on W/C?

Remember that falls are assessed due to risk for future falls. Be very careful about "intentional".

If a resident has a fracture not related to a fall is it coded in J1900?

No. "major injurious fall" Page J-32.

If fall with skin tear and fracture do you mark both?

No - you code the highest level of injury that occurred.

How would you code a fall in J1900 that was a laceration with sutures?

Injury (except major) B

J1700A - Did the resident have a fall any time in the last month prior to admission? If during the transition period is it during the ARD period or prior to their admission to the facility (may be several years old)? Is dehydration still a sentinel event?

The changes to the QI/QM have not been announced yet.

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Section K:

K0200 - How should you report the height of a resident with contractions?

Page K-3

You should measure height consistently over time in accordance with the facility policy and procedure, which should reflect current standards of practice (shoes off, etc.). There are formulas available for estimating height of bed ridden patients online. One example is:

http://www.rxkinetics.com/height_estimate.html.

What if a resident continues to refuse weight, do you code a dash?

If you are unable to weigh someone, you code it as a dash. Page K-4. —~~la~~ resident cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code (-) and document rationale on the resident's medical record."

If a resident is on Hospice for failure to thrive and it is anticipated significant weight loss secondary to poor intake, could this be coded as a physician prescribed diet if they document this as anticipated?

They must have a care plan goal of losing weight. Page K-5.

K0300 Would Physician weight loss program include diuretic therapy due to edema? I was told you cannot count diuretics as planned wt loss is this a correct change?

No. Page K-5. —~~PHYSICIAN-PRESCRIBED WEIGHT-LOSS REGIMEN~~ - A weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. May employ a calorie-restricted diet or other weight loss diets and exercise. Also includes planned diuresis. It is important that weight loss is intentional."

K0300 Can a reduced concentrated sweets diet order be a physician's prescribed weight loss regimen?

Not without a physicians order and a care plan goal to lose weight. Page K-5.

K0500C Can you count finger foods as mechanically altered?

This depends on the food, many finger foods are not altered so usually no. Page K-9. —~~Mechanically Altered Diet~~ – A diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet."

K0500D Can we use therapeutic diet when fortified foods are added to meals for weight gain?

Calorie specific diets and supplements during meals can be coded as a therapeutic diet. See definition on page K-9.

K0500 Someone stated you cannot mark feeding tube and mechanically altered diet; it is possible to have both so why can't you mark both?

They were correct. Page K-10.

Enteral feeding formulas:

Should not be coded as a mechanically altered diet.

Should only be coded as **K0500D, Therapeutic Diet** when the enteral formula is altered to manage problematic health conditions, e.g. enteral formulas specific to diabetics.

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If a resident is on tube feed and no PO diet, do we code therapeutic diet or just tube feed or both?

Only certain types of tube feeding are considered to be therapeutic. Definition Page K-9, "Therapeutic Diet - A diet ordered to manage problematic health conditions. Therapeutic refers to the nutritional content of the food. Examples include calorie-specific, low-salt, low-fat, lactose free, no added sugar, and supplements during meals." Page K-10. "Should only be coded as K0500D, Therapeutic Diet when the enteral formula is altered to manage problematic health conditions, e.g. enteral formulas specific to diabetics."

K0500- If a resident receives nutritional supplements (such as Boost) between meals are they considered to be on a therapeutic diet?

The definition only defines supplements with meals as being a therapeutic diet. Page K-9.

Can you please explain the updates to IV fluids and dehydration in section K?

Read pages K-8 to K-13. →IV fluids can be coded in K0500 if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration. Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record."

When is it ok to capture IV's? When is it ok to capture IV's in the hospital?

Refer to instructions Page K-9.

Parenteral/IV feeding - The following fluids may be included when there is supporting documentation that reflects the need for additional fluid intake specifically addressing a nutrition or hydration need. This supporting documentation should be noted in the resident's medical record according to State and/or internal facility policy:

- IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently
- IV fluids running at KVO (Keep Vein Open)
- IV fluids contained in IV Piggybacks
- Hypodermoclysis and subcutaneous ports in hydration therapy
- IV fluids can be coded in K0500 if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration. Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record.

The following items are NOT to be coded in K0500A:

- IV Medications—Code these when appropriate in O0100H, IV Medications.
- IV fluids used to reconstitute and/or dilute medications for IV administration.
- IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay.
- IV fluids administered solely as flushes.
- Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis.

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Section L:

In section L, oral/dental, if the resident is edentulous but wears a full upper and lower denture that are not broken/loose do I code B (no natural teeth or tooth fragments) or Z--none of the above?

Code B Page L-1.

Must the oral assessment be completed by a RN?

No. Page L-2.

Section M:

Frequently our wound nurse documents skin issues as "shearing", should this be under skin tears/cuts or pressure? There are times when the shearing is on a pressure site.

Page M-4. Pressure Ulcer = a pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction. Your facility policies should follow instructions and definitions used in the RAI Manual.

For wounds, what does an admission mean - timeframe - 24 hrs?

Location and stage, AT THE TIME of admission. Page M-9.

If we have a resident with a non removable dressing but goes to a wound clinic and we have documentation from them with a stage on it should we record unstageable or go by wound clinic measurements?

Page M-6. Unstageable. You need to stage it in the facility.

Is the RN for section M a CMS want or rule?

Board of Nursing Response: An LPN, who has the documented education, skills and competency in caring for clients with wounds (as required by Chapter 4723-4 OAC) is not prohibited from observing a wound, comparing the observation it to a severity chart and documenting and reporting her observations about the wound. If this is what you are referring to as "wound staging" then it is within the scope of LPN practice if the LPN is directed to do so in accordance with Section 4723.01(F) ORC.

If low risk with Braden Scale is that coded "yes" for risk of pressure ulcers?

Low risk is still risk. Page M-3.

M0150 - Risk of pressure ulcer, do you mark 1 (yes) risk of developing pressure ulcers if they are a low or high skin risk on the Braden?

The concept of risk is very broad. See page M-3.

Are all questions answered based on greatest stage of ulcer even if it has improved? (Example: Stage 3 wound that is now a stage 2, should we answer questions based on stage 3?)

Page M-5. Yes. You code based on the deepest stage it ever was until healed. For each pressure ulcer, determine the deepest anatomical stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement.

If stage II present on admission and we do not know exact date are dashes the correct answer?

Yes. Page M-9.

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On stage II oldest date - what if it starts at stage I? What date do you use?

Enter the date of the oldest Stage 2 pressure ulcer. The facility should make every effort to determine the actual date that the Stage 2 pressure ulcer was first identified whether or not it was acquired in the facility. If the facility is unable to determine the actual date that the Stage 2 pressure ulcer was first identified (i.e., the date is unknown), enter a dash in every block. Do not leave any boxes blank. Page M-9.

When unstageable or deep tissue injury that was present on admission evolves to a 3 or 4, are they still considered present on admission?

If the pressure ulcer was unstageable on admission, but becomes stageable later, it should be considered as ~~present on admission~~ at the stage at which it first becomes stageable. If it subsequently worsens to a higher stage, that higher stage **should not be considered "present on admission."** Page M-6 Step 3 # 3.

If a pressure ulcer worsens from a stage I to a stage III, we would code the stage III not present on admission? Do we also code the stage I present on admission?

You would only code the 3 and it would be Not Present on Admission.

M0300- I have a resident who had a stage 3 to bilateral heels a year ago. He becomes acutely ill and is hospitalized for one week. He returns to my facility with red heels. What stage are his heels on my current MDS?

Once the stage 3 heals it is gone for MDS purposes. The red heels would be stage 1.

Regarding wounds - How far do we need to go back for dates with residents that have been at the facility for a long time (not readmit)? When we start MDS 3.0 and do first 3.0 assessments and a resident currently has multiple wounds which have been there for years, how do we code? Does this include reopening of resolved ulcers? Do you go by original first noted date?

No. Original date it opened this time - once healed it is resolved for MDS purposes.

How can a wound vac be coded as a non removable device when it is removable and we do assess/measure the wound with each dressing change? The definition in the glossary of the manual (Appendix A-21) does not include wound vac. If there is actually a non removable dressing/device how would we know that there is even a wound there that needs to be coded until it is removed?

Wound vac should not be considered here, unless there is a physician's order that states it should not be removed until a specific date. If there is a non removable dressing, cast, etc. you would have to have documentation that there is a wound under it. For example, the physician has applied a dressing to a wound and instructed you not to remove or change it. You know there is a wound under there. Page M-14.

If a resident is admitted with a stage II pressure ulcer and a week later is sent to the hospital and returns 3 days after that hospital admission with the same stage II pressure ulcer, should that be coded as not present on admission even though you can show they had it on the first admission and were with you briefly?

If it was first present on admission and is the same stage upon hospital return, it is still present on admission.

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If the resident has a pressure ulcer upon admission (stage II) and 8 days after admission is sent out for cardiac s/s and is readmitted after 48 hour hospitalization and returns with a stage III pressure ulcer is it "present on admission"?

Yes, if the wound gets worse and the stage changes, it would be marked present on admission.

What if your floor staff, code a pressure ulcer improperly and when an appropriate person assesses the wound and determines it is a stage III instead of a stage II? The wound didn't change, it just wasn't documented correctly. Would that have to be coded as a stage II since that's what the admitting person put?

It should be coded as a stage III, and the stage III is not present on admission. It shows in your facility documentation that the wound progressed to a stage III in your facility. That is why initial assessment and staging is so important.

M0700 - Clarify what is to be done with Stage I, it indicates pressure ulcers of all types but the type of tissue is not for a stage I.

Leave it blank as there is no ulcer bed. Page M-21.

M0700, are these current look or when at worst?

Look back period.

M0700 - what do you code a fluid filled blister?

Serum filled = Stage II, blood filled = suspected deep tissue injury. Stage 2 pressure ulcers should not be coded as having granulation, slough, or necrotic tissue as by definition they do not have this extent of tissue damage. All Stage 2 pressure ulcers should be coded as 1 for this item. Page M-22.

M1040A - Infection of the foot - This area can be marked without a diagnosis correct?

Yes. Page M-30.

Do we code skin tears under M1040 D?

No.

We do not code them anywhere, unless they occur during a fall and then put them in section J1900B?

Correct

What would you code cellulitis of leg/thigh? On antibiotic but area unopened or is weeping would you code as wound infection?

(M1040D - Other lesion other than ulcers, rashes, cuts)

M1200B- Pressure reducing device for chair. Can we count Lazy Boy chairs that do not have a separate pressure relieving cushion, but it does state in the literature that the chairs redistribute weight on their own when sat on?

No

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M1200C - Is this only marked if a resident has an ulcer and is being turned or can it also be marked if a resident is on a turn schedule that has no ulcers and is just preventive?

Preventative skin treatments can be coded in M1200 if otherwise meets the definition. Page M-33. TURNING/ REPOSITIONING PROGRAM = Includes a consistent program for changing the resident's position and realigning the body. -Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs.

What if you have a hydration program for prevention of skin problems, can you check M1200D?
As long as it meets the definition in the manual.

M1200D - Can vitamin C fortified juice count for nutrition or hydration intervention to manage skin problems? What about a Multivitamin pill?

No. Page M-33. -NUTRITION OR HYDRATION INTERVENTION TO MANAGE SKIN PROBLEMS - Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions, e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplements to prevent skin breakdown, high-protein supplements for wound healing."

M1200G - Nonsurgical dressing - Can steri strips and Band-Aids be counted in this area?

Page M-34. Dressings do not have to be applied daily in order to be coded on the MDS assessment. If any dressing meeting the MDS definitions was applied even once during the 7-day look-back period, the assessor should check that MDS item. This category may include but is not limited to: dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages, etc.

Section M 12001 - Should a corn pad be coded as a foot dressing?

Page M-35. -Includes interventions to treat any foot wound or ulcer **other than a pressure ulcer.**" Is this being considered a wound? If so then it meets the definition.

Would an ulcer be coded as pressure or arterial if it was caused by new shoes that did not fit and were located on the tips of the toes?

Pressure, it is caused by the pressure of the shoe against the foot.

We have a resident who was admitted to the facility with a stage 4 pressure ulcer. Because of the downstaging that was done on the 2.0 it was listed as a stage 2 on the MDS. Now, would we code this as a stage 2 on the 3.0, or would it still be a stage 4, because the only place this was ever downstaged was on the MDS? Would this be coded as a stage 4 and a worsening of a pressure ulcer, even though it didn't worsen on the 3.0?

It would be coded as a Stage 4 but not coded as worsening.

How are skin replacement/substitutes coded when used to cover a pressure ulcer? Then how coded when substitute fails - does it become surgical wound or pressure ulcer?

M1040E This coding is appropriate for pressure ulcers that are surgically repaired with grafts and flap procedures.

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Section N:

N0300-This used to say count all injections except B12, does it still not include B12? **B12 is included.**
Page N-1. Follow the 3.0 instructions. Record the number of days during the 7-day look-back period (or since admission/reentry if less than 7 days) that the resident received any type of medication, antigen, vaccine, etc., by subcutaneous, intramuscular, or intradermal injection.

N0400-Do herbal preparations (i.e. garlic, cranberry caps, etc.) still not count in the total number of medications received?

Page N-10. Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). They are not regulated by the FDA (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted as medications (e.g. chamomile, valerian root). Keep in mind that, for clinical purposes, it is important to document a resident's intake of such substances elsewhere in the medical record and to monitor their potential effects as they can interact with other medications. For more information consult the FDA website.

Long acting antipsychotic not given in last 7 day, do we still code due to effects on body and potential side effects, long acting IM's?

No

N0400 (Medications received): Can Anticoagulants be coded for Aspirin?

Page N-5.

Do not code antiplatelet medications such as aspirin/extended release.

Section O:

Where can we code Baclofen pumps?

IV medications - Page O-3.

Can you code IV medication if Lasix is given between 2 units of PRBC's (Packed Red Blood Cells)? (Able to take credit for IV medication and transfusions?)

Yes.

Can a therapist or assistant supervise an aide?

Page O-19. The therapy aide must be under direct supervision of the therapist or assistant (i.e., the therapist/assistant must in the facility and immediately available).

Can an assistant provide line of sight supervision to a student, or just the therapist?

Page O-19.

Therapy students must be in line-of-sight supervision of the professional therapist (**Federal Register**, July 30, 1999). Physical therapy assistants and occupational therapy assistants are not precluded from serving as clinical instructors for therapy assistant students while providing services within their scope of work and performed under the direction and supervision of a qualified physical or occupational therapist.

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Is an initial therapy evaluation (97001, 97003) required if the patient has a short hospital stay and is readmitted to the SNF? Or could a therapy re-eval be done? What if they are not a bed hold?

Page O-16. If a resident returns from a hospital stay, an initial evaluation must be performed after entry to the facility, and only those therapies that occurred since admission/reentry to the facility and after the initial evaluation shall be counted. Bed hold does not change this.

Do recreational therapy minutes count along with PT/OT/SLP minutes (if delivered by a licensed RT, not activities staff)?

Recreational Therapy doesn't count as OT/ST or PT. It is coded separately. Page O-15, O-16.

O0400D Respiratory Therapy - Can we count Hand Held Nebulizers administered by a Nurse under Respiratory Therapy?

No. Appendix A-19. Respiratory Therapy - Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function. Respiratory therapy services include coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse. Does not include hand-held medication dispensers.

Regarding therapy/restorative being received at the same time, if therapy/restorative are working on the same issues, does restorative still (like in 2.0) get marked as O?

Yes, if they are doing the treatment as a co-treatment. You cannot code/bill 2 disciplines at one time. Could split the time, but this would not be advised usually due to the difference in cost. Page O-19. Co-Treatment - When two clinicians, each from a different discipline, treat one resident at the same time, the clinicians must split the time between the two disciplines as they deem appropriate. Each discipline may **not** count the treatment session in full, and the time that was split between the two disciplines, when added together, may not exceed the actual total amount of the treatment session. You should code them each separately if they are doing treatments at different times. If restorative is able to do the same treatment then it does not qualify as skilled for therapy. With respect to billing you can not duplicate services though.

O0100- If a resident goes to the hospital and is admitted, are they still a resident or not? Since they have intent to return?

When admitted to the hospital, they are discharged from the facility and therefore are not a resident.

O0100B- Does this include radiation implant?

Yes. Page O-2. Code intermittent radiation therapy, as well as, radiation administered via radiation implant in this item.

O0100M - If guest in reverse isolation can we code isolation?

No. Page O-4. Code only when the resident requires strict isolation or quarantine alone in a separate room because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with a communicable disease, in an attempt to prevent spread of illness.

O0100M - If guests have the same infection can they be considered in strict isolation in a shared room?

No. Page O-4. Must be a separate room.

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If a resident goes to the ER and does not get admitted and gets IV medication while in the ER, is this coded as while a resident?

Yes.

If patient goes to ER and comes back do treatments count as "while a resident"?

If they were not admitted to the hospital and were not discharged from the nursing facility, then it is while a resident.

Resident is admitted, goes to hospital 10 days later, stays 5 days and has IV, then returns. On Readmission Return Assessment is IV "in facility"?

Not if they were discharged from the facility, and if they were gone for 5 days at the hospital, they should have been.

Can we code TPN given at HD facilities?

TPN doesn't matter where it is given. See Section K.

Would isolation/quarantine ever be marked for C-diff? C-diff is primarily body/fluid precautions so would a resident in a private room in isolation for c-diff be marked? Do not code this item if the "isolation" primarily consists of body/fluid precautions, because these types of precautions apply to everyone. Page O-4.

You need to look at the entire definition, but if the isolation primarily consists of body/fluid precautions, no.

O0250 - If not a "declared shortage" but unable to obtain, how do you code?

Page O-4. Either 5 – Not offered, if you haven't offered it, or 9 – None of the above, if you offered it, but do not have it to give.

Pneumonia vaccine - what is considered up to date?

See algorithm Page O-10.

What if therapy holds a resident due to medical reasons, do you have to do a EOT OMRA? They are not discharged.

Page 2-58, 2-59. Must do End of Therapy OMRA on days 1-3 after the last day therapy was furnished.

If on therapy one assessment but not on therapy the next assessment do you have to put in therapy end dates?

Page O-13. It will skip this per the skip pattern if there are no minutes entered.

Is the therapy end date the d/c from therapy date or the last treatment day?

Page O-16.

Therapy End Date—Record the date the most recent therapy regimen (since the most recent entry) ended. This is the last date the resident received skilled therapy treatment. Enter dashes if therapy is ongoing.

When calculating how many minutes a resident has for therapy - does the grouper divide group therapy minutes by 2, 3, or 4?

Group therapy is not divided. It is just limited to 25% of the total therapy minutes. Page O-15.

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If initial MDS, Therapy Start Date is the evaluation date, for subsequent MDS's is it still the evaluation date?

Yes. Page O-15. Therapy Start Date—Record the date the most recent therapy regimen (since the most recent entry) started. This is the date the initial therapy evaluation is conducted regardless if treatment was rendered or not.

Even though Therapy Start Date is the evaluation date - evaluation minutes are still not counted as therapy minutes?

Correct. Page O-16. The therapist's time spent on documentation or on initial evaluation is not included.

Therapy coding for strict Medicaid?

Uses same definitions. Page O-15, O-16.

Will concurrent therapy stay the same in Medicaid?

Uses same definitions. Page O-15, O-16.

I noticed that under the Restorative section of the MDS 3.0 the section where you could mark "other" Restorative programs as was on the 2.0, has been eliminated on this version. You could mark such things as more specialized programs under this "other category. Can you tell me what the reasoning was for this? And are there any other new changes or developments at all related to Restorative Programming that I need to be aware of in the 3.0?

I can not give a reason, but you now need to fit within one of the available categories. The entire MDS has changed and you should not try to compare the 2.0 to the 3.0. They are different assessments. Read pages O-26 through O-33 to see restorative specific coding instructions.

If resident has splint and ROM done to one joint only, together equaling at least 15 minutes but not 30 minutes. Is this only one program? Can it be coded as both ROM and splint program on the MDS?

The time provided for items O0500A-J must be coded separately, in time blocks of 15 minutes or more. Page O-29.

O0500A, Range of Motion (Passive)

Code provision of passive movements in order to maintain flexibility and useful motion in the joints of the body. These exercises must be individualized to the resident's needs, planned, monitored, evaluated and documented in the resident's medical record.

O0500B, Range of Motion (Active)

Code exercises performed by the resident, with cueing, supervision, or physical assist by staff that are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record. Include active ROM and active-assisted ROM.

O0500C, Splint or Brace Assistance

Code provision of (1) verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint; or (2) a scheduled program of applying and removing a splint or brace. These sessions are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

Is there anytime that orders on the day of admission are counted as a day new ones were received?

Yes. Page O-36. Orders written on the day of admission as a result for an 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.

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O0700 - Can rehab orders that are written for a rehab program (toileting, ROM) be counted as a physician order?

Restorative nursing orders do not count, because a physician's order is not required. Therapy orders do. Page O-35.

Can eye doctor be included as a physician visit?

Only if they are a MD, DO. Page O-34.

Can you count physician visits from 2 different doctors that occurred on the same day? Can you count all orders for the look back? Even if 2 or 3 were written on the same day?

No. Page O-36. If a resident has multiple physicians (e.g., surgeon, cardiologist, internal medicine), and they all visit and write orders on the same day, the MDS must be coded as 1 day during which a physician visited, and 1 day in which orders were changed.

Section P:

Question is if a pt. has side rails and uses them as enablers but cannot put the side rail down themselves, is it to be coded as a restraint even though it does not limit access to one's body?

Yes. PHYSICAL RESTRAINTS - Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body (State Operations Manual, Appendix PP). Bed rails used as positioning devices. If the use of bed rails (quarter-, half- or three-quarter, one or both, etc.) meets the definition of a physical restraint even though they may improve the resident's mobility in bed, the nursing home must code their use as a restraint at P0100A. Page P-1.

Question Section P0100 H other - We have a secure dementia unit would this be coded there? Also not all resident's wander some are immobile but all have a diagnosis of dementia. Would there be a difference in coding this section?

You should look into why you have individuals who are immobile on a locked unit. These would not qualify on the MDS as a restraint in this section because it is not attached or adjacent to the resident's body. But this is still a restraint per licensure. Page P-1.

If body alarm whether clipped on or sensor causes a person to stop from standing up does this constitute a restraint?

If it meets the definition then yes.

Is a perimeter defined mattress a restraint?

If it meets the definition then yes.

Is a pommel cushion a restraint?

If it meets the definition then yes.

If an item/device such as an alarm has not been assessed as a restraint, is it still to be coded as "other" or not at all? (Are only restraints to be coded?)

It must be determined to meet the definition of restraint for that resident to be coded here. This does not mean that this should not be care planned though.

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Section Q:

In section Q if the residents wants to return to the community and wants to talk with someone about this, but has a guardian and they will not support that how do we code that?

If the resident wants to talk to someone then you make the referral. It is up to the resident and the LCA would need to be involved in the final determination.

When a patient is admitted to a SNF, then sent to the hospital the next day and admitted, so we never met the patient, under Section Q we just put not assessed in all sections, correct? Is doing an MDS at discharge, or especially in this situation, being looked at for whether it is necessary? It just seems like extra paperwork with little/no info that can help provide care for the pt better, which is what the purpose of this new form is for.

Follow the skip patterns, and you will not be asking the question in section Q at discharge. Also I would hope that if a resident is in your facility for a day that someone has met that person.

Q0100B - Asks if family participated in assessment, does this mean just the MDS interview or in the social work assessment initially, Example: if care conference has been completed and family were present before the 14Day or 30Day MDS, then you would answer yes that family participated. But if 5Day and no family contact made yet, then put no, correct?

In order to code this, the family member or significant other has to actively participate in the MDS that it is being coded on.

Section Q - B and C, if guardian is also family/significant other should both be checked?

Yes.

What do you do with a resident on a secured/behavior unit who daily requests to go home? What if they have a guardian?

You follow the MDS and the skip patterns. You still need to ask them the question.

Q0400 Discharge plan - If a resident wants to return to the community but staff thinks that it is not feasible can you mark determined not to be feasible or if you can't what would you mark here? Also for those who have cognitive deficits can we use family's perception of discharge here?

You must ask the resident and refer to the LCA through marking Q0600 Yes. The LCA's input is needed to mark determined to be not feasible. Until you hear from them you would mark determination not made.

Q0500 - Does the facility have to pay for every skilled resident who plans to go home even when an admission is expected to be short term for rehab? What happens if we make a referral but the agency doesn't respond in the 10 days allowed due to staffing issues?

I do not understand this question as the facility does not have to pay anything related to this section. The LCA will not be responding within 10 days in Ohio. Contact ODJFS for questions. You need to continue to do discharge planning as you always have.

Where do we get information on what pamphlets we need to order to distribute to the families and residents in regard to asking resident if they would like referral to the community?

They are available on OHCA's website. You can also contact the home choice program or JFS.

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Q0600 - How would you prevent referral to only certain selected home care agencies or assisted living facilities? Patient/resident has right to select where they go.

This is for waiver services if it is general discharge planning you should be doing this as a facility with the resident.

Q0600 referral, if the resident says d/c and family says no - do we follow the resident's wishes? What if the resident has a legal guardian and there is a discrepancy?

Yes it is the patient that you ask.

Area agencies timeframe for referrals to community?

It is a staggered implementation timeframe depending on the category that the resident is placed in and no resident who has been in the SNF less than 90 days will have a referral.

Return to the community - is there no cognitive edit for the desire to be back in the community?

No, there is not.

Can the contact agency for the community be Home Care?

Home Choice is the coordinating intake agency.

Does the local contact agency have to be the local Department of Aging or can it be an independent agency?

ODJFS is coordinating the referrals.

Q0600 - If residents say they want to be discharged home what agency are we supposed to contact?

You just code Q0600 as a 2-Yes.

What if State does not respond in 10 days?

You are responsible for following up.

Section S:

What form will Ohio require Section S on?

On OBRA assessments. Not on PPS assessments because the state does not require PPS assessments.

Section V:

V0200B - Should this date be the same date as V0200C?

Not necessarily.

Can LPN sign section V0200C?

Signature of the staff person facilitating the care planning decision-making. Person signing does not have to be an RN.

Will CAA's need to be done with quarterly assessments?

No, only with comprehensive assessments.

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To work the CAA we can't just think through the process in our head we have to have an assessment "tool" for every CAA?

Correct.

The CAA resources that the medical director approves (expert endorsed) - How often do they need updated?

Do not need updated unless changed. Policy and procedure should be updated at that time as well.

In all the trainings the trainers discussed using Evidenced based and validated forms...For example a pressure ulcer risk form...The corporation I consult for is using a pressure ulcer risk form that was based on the Norton form (a validated form)....The adaption of a validated form changes its validation....Therefore would it be better to use the Norton form as written/validated or can we continue to use the form we created based on Norton information.... which I must say is good?

To use it as a pressure ulcer risk form is fine, but to use it for a CAA might not meet the definition. I would recommend using it only for the pressure ulcer risk form. See Chapter 4.

If our facility floor nurses complete a particular form (i.e. fall risk) quarterly, can we incorporate these findings in our CAAS or do we have to make an entry on the forms to coincide with the MDS data?

One can refer to the other.

Section X:

Let's say we have done a modification of our MDS 3.0 assessment that has been transmitted and accepted. Have made the correction to the MDS and re-transmitted it and the modification was accepted. What do you need to print and attach to your corrected MDS or do you reprint the entire MDS with the completed section X as part of the packet of assessment?

Chapter 5-10. A hard copy of the Correction Request items in Section X must be kept with the corrected paper copy of the MDS record in the clinical file to track the changes made with the modification. A hard copy of the Correction Request items (Section X) should also be kept with an inactivated record. Section X items are defined in the MDS 3.0 Data Specifications posted on the CMS web site at:

http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp

More detailed instructions and examples for the correction process are included in the "Provider Instructions and Examples for Making Corrections in MDS 3.0 Records", which will be made available in the future on the CMS web site at:

http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp

Is it true that reason for assessment can be modified or just reason for d/c?

You can only modify discharge assessments.

X0100 - Clarify what "add new record" is for?

Each new assessment is coded as -add a new record".

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Section Z:

In section Z.... do all scores need to be calculated before they are submitted (ie, have a score in each Z0100-Z0300)?

Yes. All scores should calculate on each new MDS.

What is ODH's rule on use of electronic signatures?

Electronic Signatures are allowed in Ohio, but the facility has to have P&P to ensure the privacy and integrity of the record and to ensure that access to clinical records is made available to surveyors and others who are authorized by law. The use of the electronic signature does not require that the entire record be made electronically.

Our software (ECS) keeps old signatures and dates in section AB, what will be section Z. Should these dates and signatures just be for the current assessment?

Yes, they should only be for the current assessment.

If you have a "Portion Assessment" that you have to keep, does that get submitted to the database?

No. Only completed MDS can be submitted.

If we do not submit within 14 day requirement what happens? What about corrections done after 14 days?

If you do not submit within 14 days you are out of compliance and can get cited during survey. Also, the score will not count in Medicaid case mix score. Corrections must be submitted within 14 days of completing the correction.

If no electronic signatures in electronic records do we have to print only section Z and sign? Not whole MDS?

We have not been given this answer yet. Will update in Newsbites when available.

Managed Care:

How do you code a Medicare replacement plan resident? What is your opinion on doing/not doing PPS assessments on Insurance Payors? How do we code in A0310 A, B, or C for the managed care companies to get the RUG scores they want? When a resident has Medicare replacement Insurance, whether 3 day stay required or not, some say they pay according to RUGS other a contract rate, what should I code this assessment?

Managed Care assessments, should not be submitted as PPS assessments regardless of whether they follow RUGs or not. You should complete and print but not submit.

How long do you have to complete and set the ARD for a Hospice patient?

ARD must be within 14 days of electing Hospice, submitted within 14 days of completion date.

Does Hospice include palliative care?

Hospice Services = A program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.

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Have our managed care insurances had any input? Are they continuing to follow CMS PPS schedule?
Each Managed Care insurance company makes their own policies.

Medicaid:

Is Ohio Medicaid ever going to use RUG IV?
Yes the next time they rebase the prices, you will have lots of advance notice.

How does the state Medicaid system get MDS information from federal submission?
CMS sends it to them in a file.

If Medicaid is retroactive, do we need to go back to retro date and do an attestation or just put it (MDC #) on the next MDS?
No, just add the Medicaid # to the next MDS that you do.

Can the OH Medicaid RUGs be calculated using the MDS 3.0 to 2.0 RUGs crosswalk published by CMS?
Yes.

Are additional fields/data/calculations needed?
No.

When using "judgment" as to whether or not discharge with return anticipated or not anticipated on Medicaid patients, could this not skew case mix since return anticipated are considered to be part of case mix and billing is not charging?
If you code as return anticipated and they never come back, Ohio will require a modification.

Interview:

Is there a certain date for the BIMS, depression, and activity interviews that you should do the interview during the assessment dates?
PHQ-9 should be as close to the ARD date as possible.

It was suggested at one in service not to take a clipboard with us during interviews, how do you suggest we do the interview and remember what the resident responses are?
If you need to use a clipboard you should. It is better if you make it less clinical for the resident. Try not to make them feel tested.

What if what the staff reports is not what they are charting?
You need to inservice your staff on proper documentation per your facilities documentation policy and procedure.

If staff interview needs to be done and with all shifts, are those to be done by hand and names applied with shift and attached to the MDS?
Documentation is necessary to ensure accuracy. What documentation policy you implement is up to your facility.

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Can a nursing assistant do any part of the interviews?

Yes. They can answer the staff portion and they can ask the resident questions as well. Any staff can conduct the interviews as long as they are trained.

If there are discrepancies between what the resident states in their interview and what staff see and document can you synthesize answers from other sources to that section?

No, these are resident interviews and you must use their answers.

If the MDS is based on Resident Interview, why do assessments prior? Contradictions?

The MDS 3.0 adds resident's voice. It is ok and probable with some individuals that some areas will contradict others. This is okay.

What happens if a resident is admitted on Friday evening and is discharged prior to being interviewed?

You will put dashes in the resident interview and interview staff if the discharge is unplanned and you were not able to interview. If this is a planned discharge you should have someone interview before they leave.

How do you complete an interview on a discharge assessment if they were sent out on 3-11 or 11-7 or on a weekend when the MDS nurses aren't there?

You still need to complete the interview if it was a planned discharge. Other staff can complete the interviews.

Do you need to document who you interview?

The more information you can capture is always better but it will depend on your facilities policy and procedure.

Do you think the staff interview areas will be on the care systems (the computerized care trackers) for our staff to answer when completing it? Will it be acceptable?

This depends on your computer programs.

QI/QM:

Will the new MDS 3.0 generate different QI/QM areas? If so, how soon will the new areas be reflected in the 5 star rating system?

At least 2 years before the new QI's are finalized, in the meantime no decision has been made on the 5 star.

Will the sentinel events stay the same?

No, fecal impaction is not a question anymore, but they have not been released.

PASRR:

Do you need to do a PASRR Level 2 after each admission to a psych facility?

Yes

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Surveyors:

How much training are surveyors getting on the new MDS 3.0?

Surveyors are going to the same training that CMS provided train the trainers.

General and Timing:

When do we use a Start of Therapy OMRA? Heard that 5 day and 14 day can sometimes be combined for Start of Therapy OMRA. Don't understand due to 5 day and 14 day having different reference periods.

Depends on when therapy starts, a SOT OMRA could be combined with any scheduled PPS assessment or it could stand alone.

If someone is admitted and goes back out to the hospital the same day, do we still need to do an MDS to avoid default rates?

Yes.

If in the building 8 hours I thought they could be billed?

That relates to Medicaid residents.

Is there a way to do an overnight "therapeutic leave" during a Medicare stay?

Yes. You can not bill that midnight though.

Should MDS 2.0 or 3.0 schedule guidelines be used to schedule the first MDS 3.0 for a continuing stay resident?

If the most recent prior quarterly or comprehensive assessment is an MDS 3.0 assessment, then the ARD of the next MDS 3.0 quarterly or comprehensive assessment must be within 92 days of the ARD of the prior assessment.

If the most recent prior quarterly or comprehensive assessment is an MDS 2.0 assessment, then the ARD of the first MDS 3.0 quarterly or comprehensive assessment must be within 92 days of the R2B date of the prior assessment.

If therapy knows that on day 8, a patient has met all goals and is independent in all areas of ADL's (i.e. patient referred to us was skilled for IV's), therapy notifies the facility that patient will be discharged on day 11. Can day 11 be used for the 14 day in order to capture a rehab RUG for days 15-20, or should the MDS nurse choose an ARD that is truly reflective of what the resident needs for days 15-30?

Due to the EOT requirement you can not get a rehab score for days after rehab discharges.

Short Stay - Therapy continued through D/C day, did therapy have to be delivered that day?

Not delivered but must have continued through. No order to discharge before that day.

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Reference Material:

How can we figure RUGS categories and Case Mix?

Handouts were in the appendix tabs of your handout book (Not MDS manual). Also in chapter 6 of the MDS Manual.

What ADL's count towards the RUG scores and how do we add up the total points?

See handout in the appendix tab of your handouts or chapter 6 of the MDS Manual.

How do we figure the HIPPS Code?

See chapter 6 of the MDS Manual, Page 6-7 through 6-12.

Please address the RUGS categories and what qualifies for each category?

See chapter 6 of the MDS Manual and the handout in the appendix tab of the handout book.

What are some resource agencies for interpreter's especially rural counties?

http://www.manta.com/mb_45_AA1857OH_36/translation_services/ohio?show_all_cities=1

What is the difference between code 9 and (-)?

9 means resident couldn't answer (-) means you didn't assess it at all.

How do we download the skin and dental assessment videos?

http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp

Can you give websites to check for updates?

http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp

Is there time study data available on expected completion times for sections?

No, only total MDS.

Where can we find the new HIPPS Codes?

Chapter 6. Or http://www.ohca.org/component/option,com_docman/task,doc_download/gid,1828/

How will this change to the MDS 3.0 affect the CMS 672 & 802 forms?

Most software companies made it so that data pulls from the MDS.

What is overall objective of MDS 3.0 vs. MDS 2.0 by CMS?

It is a stronger use of the resident's voice, increase the clinical relevance, increase the accuracy and clarity, and decrease the completion time.

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