MDS ADL Coding and your QM's / RUGs

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QIPMO: QUALITY IMPROVEMENT PROGRAM FOR MO

MDS AND ADL CODING

- MDS Sections G and GG
  - Impact your Quality Measures/5 STAR report
  - Impacts your Medicare reimbursement
  - Impacts your staffing based on acuity

Section G

- This is the original MDS ADL section
- Written in language we are not accustomed to, which causes typically under coding (Not taking credit for the work we do)
- Ongoing education is required to:
  - Remind staff of the importance of taking credit for what they do
  - Staff turnover

Section G

- Column 1 ADL self performance
  - What the resident actually did
  - Measures what the resident actually did, not what he or she might be capable of doing, within each ADL category during the observation period according to a performance scale
- Column 2 ADL support provided
  - Measure the mot support provided by staff to complete each ADL activity
  - Document the most support provided even if it occurred only once

MDS Coding

- Record the **actual** resident self performance on each ADL
- Self performance may vary day to day, shift to shift, within shifts, 24 hours a day
- Consider the resident's performance when using adaptive device
- Do not include assistance provided by family or other visitors

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ADL Self Performance Rule of 3 Algorithm

Stop at the First code that Applies		
Did the activity occur at least a time	No	Code 8: Activity did not occur
Did the activity occur 3 or more times	No	Code 7 Activity occurred once or twice
Did the resident fully perform the ADL activity without ANY help or oversight from staff EVERY time?	Yes	Code 0; Independent
Did the resident fully perform the ADL activity without ANY help or oversight at least 3 times AND require help or oversight at any other level, but not 3 times at any other level? (Item 1 Rule of 3 with Independent* exception)	Yes	Code 1 Supervision STAND BY ASSIST
Did resident require Total Dependence EVERY time? (Item 1 Rule of 3, Total Dependence* exception)	Yes	Total Dependence

ADL Self Performance Rule of 3 Algorithm

Stop at the First code that Applies (cont.)		
Did the resident require Total Dependence 3 or more times, but not every time?	Yes	Code 3 Extensive Assistance MIN – MOD – MAX ASSIST
Did the resident require Extensive Assistance 3 or more times?	Yes	Code 3 Extensive Assistance
Did the resident require Limited Assistance 3 or more times?	Yes	Code 2 Limited Assistance CONTACT GUARD ASSIST
Did the resident require oversight, encouragement or cueing 3 or more times	Yes	Code 1 Supervision
Did the resident require a combination of total Dependence and Extensive Assistance 3 or more times but not 3 times at any one level (Item 3a Rule of 3)	Yes	Code 3 Extensive Assistance
Did the resident require a combination of total Dependence, Extensive assistance and/or Limited Assistance that total 3 or more times but not 3 times at any one level? (Item 3b Rule of 3)	Yes	Code 2 Limited Assistance

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G0110 ADL Support Provided

- Complete the ADL Self-Performance assessment for each ADL first.
- Measures the most support provided for each ADL over the look-back period.
- Most support provided may occur only once. Did the resident fall during the look back and you have documentation of a 2 person assisted. That would go on the MDS.
- Coded separately from the ADL Self-Performance assessment (column 1).
- Rule of 3 does not apply to Column 2.

G0110 ADL Support Provided
Coding Instructions

- Code **0.** if the resident completed the activity with no help or oversight.
- Code **1.** if the resident is provided materials or devices necessary to perform the ADL independently.
- Code **2.** if the resident was PHYSICAL assisted by one staff person.
- Code **3.** if the resident was assisted by two or more staff persons.
- Code **8.** if over the 7-day look-back period, the ADL activity did not occur. **Or family & or non-facility staff provided care 100% of the time for that activity over the entire 7 day period**

G0110 ADL Support Provided

- Complete the ADL Self-Performance assessment for each ADL first.
- Measures the most support provided for each ADL over the look-back period.
- Support provided may occur only once.
- Coded separately from the ADL Self-Performance assessment (column 1).
- Rule of 3 does not apply to Column 2.

ADL Score

- Impacts your reimbursement/acuity specifically for these ADL's. The higher the amount care necessary increases your Medicare payment (for now)
  - Bed Mobility
  - Transfers
  - Eating
  - Toilet Use

ADL Score

- If the resident is getting therapy you need to be sure they also are needing help on the nurses unit.
- The last letter of the RUG score with few exceptions
  - A means they need very little help with ADL's
  - B means they need a moderate level of help with ADL's
  - C means the staff is doing a lot of care if not all

ADL Score and Skilling

- Ultra high, very high, etc. plus A for the ADL score, what questions should you ask:
  - What did the resident do prior to arrival at the facility
  - What is the goal for this resident
  - What is the living arrangements once they finish their Med A stay: home alone, intermittent supervision, or staying in the nursing home.
  - Clear documentation of prior function and goals

Section G/ADL and Quality Measures

- Claims based Quality Measures / MDS Co-variates.
- 5 STAR & Nursing Home Compare measures for Short Stay residents who
  - were re-hospitalized after a nursing home admission
  - have had an inpatient emergency department visit
  - who were successfully discharged to the community

Claims Based Measures

- **Percentage of short-stay residents who were re-hospitalized after a nursing home admission**
  - **What does this show you?** This shows you the percentage of short-stay residents who went to the nursing home from a hospital and then were readmitted to a hospital within 30 days for an unplanned stay. Planned readmissions aren't included.
  - **Lower percentages are better.**
  - **Why is it important?** Nursing homes help residents recover after being in the hospital and keep from going back to the hospital. Sometimes residents have to go back to the hospital. If nursing homes send many residents back to the hospital, it may be because the nursing homes aren't assessing or taking care of their residents well.

Claims Based Measures

- **Percentage of short-stay residents who had an outpatient emergency department visit**
- **What does this show you?** This shows you the percentage of short-stay residents who:
  - Went into or came back to the nursing home from a hospital.
  - Got care at an emergency department within 30 days of going into the nursing home.
  - Didn't need to have an inpatient or outpatient stay.
- **Lower percentages are better.**
- **Why is it important?** Emergency departments give necessary care for many residents of nursing homes. When nursing homes send many residents to the emergency room, it might be because the nursing homes aren't taking good care of their residents so they need emergency treatment.

Claims Based Measures

- **Rate of successful return to home and community from a short-stay**
- **What does this show you?** This shows you the percentage of all new admissions to a nursing home from a hospital where the resident:
  - Was discharged to the community within 100 calendar days of entering the nursing home
  - Didn't have an unplanned hospital stay
  - Wasn't readmitted to a nursing home and didn't die for 30 days
- **Higher percentages are better.**
- **Why is it important?** High rates of successful discharge, where a resident is able to stay in the community and out of a nursing home for at least a month, shows the nursing home may be helping to make a resident's function better so that he or she can successfully go back to the community.

Section G/ADL and Quality Measures

- Short Stay Measures
  - Residents with pressure ulcers that are new or worsened (Co-variate) (Low number better)
    - Bed mobility
  - Residents who made **_improvements_** in function (higher number is better)
    - Basic Transfer
    - Walk in corridor
   - Locomotion on unit

NEW

WARNING

Quality Measures

- Residents who made **_improvements_** in function (higher number is better)
- This is noted on the 5 STAR Report and on Nursing Home compare

CMS explanation in NHC

- **What does this show you?** This shows you the percentage of short-stay nursing home residents of all ages who got better at moving around during their stay. This shows improvements in:
    - Transferring (for example, from the bed to a chair)
    - Getting around the nursing home unit
    - Walking in the hallway
- **Higher percentages are better**
- **Why is it important?** Nursing homes can help residents make their physical functioning better. Short-stay residents admitted to a nursing home often have limited physical functioning because of illness, hospitalization, or surgery. For many short-stay residents, being able to go back to the community or home is most important. Residents who get better at moving independently are more likely to be able to go back home or the community.

Section GG
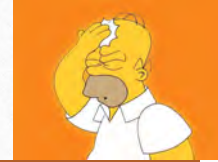
- Forget everything we just talked about in Section G
- Both sections are about ADL's BUT they have different coding and definitions.
- This section is only done for Traditional Medicare residents when they are being skilled.
- It is done during the first 3 days and last 3 days of the stay

Who does GG

- Definition of a Qualified Clinician: Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.
- Collaboration between therapy and licensed nurses. Much of this section is already being done by therapy in their initial eval.

Section GG?

- Section GG: Functional Abilities and Goals assesses the need for assistance with self-care and mobility activities; it is **collected at the start of a Medicare Part A stay on the 5-Day PPS assessment and is also collected at the end of the stay on the Part A PPS Discharge assessment**

- It is important to note that data collection for Section GG **does not substitute** for the data collected in Section G because of the difference in rating scales, item definitions, and type of data collected. Therefore, providers are required to collect data for **both Section GG and Section G.**

Section GG Includes

- Prior Functioning: Everyday Activities
    - Self Care
    - Indoor mobility (ambulation)
    - Stairs
    - Functional cognition

Section GG Includes

- Prior Device use
  - Manual wheelchair
  - Motorized wheelchair and or scooter
  - Mechanical lift
  - Walker
  - Orthotics / Prosthetics

From the Top
Intent and Steps for Assessment

- **Prior Functioning: Everyday Activities**
- **Intent:** This section includes items about functional abilities and goals. It includes items focused on **prior functioning**, admission performance, discharge goals, and discharge performance. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.
- **Item Rationale**
  - Knowledge of the resident's functioning prior to the current illness, exacerbation, or injury may inform treatment goals.
- **Steps for Assessment**
  - 1. Ask the resident or his or her family about, or review the resident's medical records describing, the resident's prior functioning with everyday activities
- Carol: prior level of function

Self Care

- Eating
- Oral hygiene
- Toileting hygiene
- Shower/bathe sell
- Upper body dressing
- Lower body dressing
- Putting on/taking off footwear

Mobility

- Roll left and right
- Sit to lying
- Lying to sitting on side of bed
- Sit to stand
- Chair/bed to chair transfer
- Car transfer
- Walk 10 feet
- Walk 50 feet with two turns
- Walk 150 feet

Mobility

- Walking 10 feet on uneven surfaces
- 1 step curb
- 4 steps
- 12 steps
- Picking up object
- Wheelchair (Manual or motorized)
  - Wheel 50 feet with 2 turns
  - Wheel 150 feet

Steps for Assessment

- Should be coded based on the resident's "usual performance" or baseline performance, which is identified as the resident's usual activity/performance for any of the self care or mobility activities, not the most independent performance and not the most dependent performance over the assessment period

Chapter 3   Section GG
Steps for Assessment

Assess the resident's self-care status based on direct observation, the resident's self-report, family reports, and direct care staff reports documented in the resident's medical record during the assessment period,. For Section GG, *the admission assessment period is the first three days of the Part A stay* starting with the date in A2400B, *which is the* Start of most recent Medicare stay. *On admission, these items are completed only when A0310B = 01 (5-Day PPS assessment).*

Section GG coding on admission should reflect the person's baseline admission functional status, and is based on a clinical assessment that occurs soon after the resident's admission.

Chapter 3   Section GG
Steps for Assessment

- The admission functional assessment, when possible, should be conducted prior to the person benefitting from treatment interventions in order to determine a true baseline functional status on admission. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. **Treatment should not be withheld in order to conduct the functional assessment.**

- If the resident performs the activity more than once during the assessment period and the resident's performance varies, coding in Section GG should be based on their resident's "usual performance," which is identified as the resident's usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the resident's Self-Care performance varies during the assessment period, report the resident's usual performance, not the resident's most independent performance and not the resident's most dependent performance. A provider may need to use the entire 3-day assessment period to obtain the resident's usual performance.

Chapter 3 Section GG
Admission or Discharge Performance Coding Tips

- **Discharge:** The Part A PPS Discharge assessment is required to be completed when the resident's Medicare Part A Stay ends (as documented in A2400C, End of Most Recent Medicare Stay), either as a standalone assessment when the resident's Medicare Part A stay ends, but the resident remains in the facility; or may be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or one day before the resident's Discharge Date (A2000). Please see Chapter 2 and Section A of the RAI Manual for additional details regarding the Part A PPS Discharge assessment.

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Chapter 3 Section GG
Admission or Discharge Performance Coding Tips

- For the Discharge assessment (i.e., standalone Part A PPS or combined OBRA/Part A PPS), code the resident's discharge functional status, based on clinical assessment of the resident's performance that occurs as close to the time of the resident's discharge from Medicare Part A as possible. This functional assessment must be completed within the last three calendar days of the resident's Medicare Part A stay, which includes the day of discharge from Medicare Part A and the two days prior to the day of discharge from Medicare Part A.

Section GG! When?

- Complete section GG with EACH five day assessment
- Three days look back (ARD) period:
  - from day 1 through 3 of the PPS stay, starting the day of most recent Medicare stay (A2400b)
  - Last 3 days of SNF PPS stay ending with day recorded in A2400c
- Complete on end of stay for ALL part A discharge whether the resident stays in the facility or not

Coding-How?

WARNING

Using 6-point scale to code: from Dependent to Independent

- **Code "01"** for Dependent, helper does ALL of the effort. If two or more helpers are required to assist the resident to complete the activity
- **Code "02"** for Substantial/maximal assistance. *(does MORE THAN HALF the effort , lifts or holds trunk or limbs and provides more than half the effort)*
- **Code "03"** for Partial/moderate assistance. LESS THAN HALF the assistance effort *(lifts, holds, or supports trunk or limbs, but provides less than half the effort.)*
- **Code "04"** for Supervision or touching assistance. VERBAL CUES or TOUCHING/ STEADYING assistance *(Assistance may be provided throughout the activity or intermittently)*
- **Code "05"** for Setup or clean-up assistance: *Helper assists only prior to or following the activity, but not during the activity*
- **Code "06"** for Independent: *if the resident completes the activity by him/herself with no assistance from a helper.*

Coding-How?

- **Code 07, Resident refused:** if the resident refused to complete the activity
- **Code 09, Not applicable:** if the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- • **Code 88, Not attempted** due to medical condition or safety concern
- **Code 10, Not attempted due to environmental limitations:** if the resident did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.

So, just start ASKING the question ….Does the resident need assistance to complete the activities?

Coding-What?

- Record the resident's usual ability to perform each activity.

- **Do not record the resident's best performance** and **do not record the resident's worst performance**, but rather **record the resident's usual performance**.

- **Do not record the staff's assessment** of the resident's potential capability to perform the activity.

Coding-What?

- Coding a *dash* ("-") in these items indicates *"No information."* CMS expects dash use for SNF QRP items to be a rare occurrence. **Use of dashes for these items may result in a 2% reduction in the annual payment update (Actual performance scores on admission and discharge not the goal column)**

Dash

- Do not use a dash ("-") if the item was not assessed because:
  - Patient refused (code 07)
  - Item is not applicable (code 09)
  - Activity was not attempted due to medical condition or safety concerns (code 88)
  - Code 10, Not attempted due to environmental limitations: if the resident did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.

Dash

- Use of dashes for Admission and Discharge Performance items may result in a payment reduction

- Completion of at least **one** discharge goal is required for one of the self care or mobility items for each patient

- While a dash should be a rare occurrence the use of the dash in the coding of a **discharge goal** is permitted

- Using the dash in this allowed instance does not affect Annual Payment Update (APU) determination

CODING TIPS

- Review documentation in the medical record for the 3-day assessment period.
- Talk with direct care staff.
- Use probing questions.
- Observe the resident as he/she performs each self-care activity.
- Be specific in evaluating each component.
- Record the resident's **actual** ability to perform each activity.
- Score will be based on the amount of assistance/effort provided.
- Activities may be completed with or without assistive devices.

"Helper" ?

For the purposes of completing Section GG, a "helper" is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). Thus, does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration such as hospice staff, nursing/certified nursing assistant students, etc. Therefore, when helper assistance is required because a resident's performance is unsafe or of poor quality, only consider facility staff when scoring according to amount of assistance provided.

Discharge Goal

- Use the 6-point scale to code the resident's discharge goal(s). **Do not use** codes 07, 09, or 88 to code discharge goal(s).

- Establish a resident's discharge goal(s) at the time of admission based on the 5-Day PPS assessment, Goals should be established as part of the resident's care plan.

- May code one goal for each self-care and mobility item included in Section GG at the time of the 5-Day PPS assessment

- For the cross-setting quality measure, a minimum of one self-care or mobility goal must be coded per resident stay on the 5-Day PPS assessment

Discharge Goal

Discharge Goal Code Is

❖ *Higher* than 5-Day PPS Assessment Admission Performance Code

❖ *Lower* than 5-Day PPS Assessment Admission Performance Code

❖ *Same* as 5-Day PPS Assessment Admission Performance Code

At least one Discharge goal is required for one of the Self-Care or Mobility Items. In other words, one self-care or one mobility item must have a Discharge goal

Resources

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