

## MDS-RCA CASE MIX DOCUMENTATION REQUIREMENTS

For MDS-RCA form version 12/03

**Intent:** To document diagnoses that have a relationship to the resident's current ADL status, cognitive status, mood or behavior status, medical treatments, monitoring, or risk of death. In general, these are conditions that drive the current service plan. Do not include conditions that have been resolved or no longer affect the resident's functioning or service plan. In some facilities, staff and physicians neglect to update the list of resident's "active" diagnoses. There may also be a tendency to continue old diagnoses that are either resolved or no longer relevant to the resident's service plan. One of the important functions of the MDS-RCA assessment is to generate an updated, accurate picture of the resident's health status. **All diseases, conditions (not limited to those below) must have physician documented diagnosis in the clinical record.**

**"Current" means the diagnosis has been confirmed by the physician as being active (not a "history of") within the past 60 days and the resident is receiving active treatment for, or because of, this diagnosis.**

MDS RCA item and reference	Field	Documentation Requirement	Possible Locations in the resident record
<b>Clinically Complex</b>			
I1a and O4Ag pg. 69 and 90	Diabetes receiving daily insulin injections	<ul style="list-style-type: none"> <li>• Physician's diagnosis of diabetes, <b>and</b></li> <li>• receiving daily injections of insulin</li> </ul>	PD*, PPN, PO**, MAR
I1r, pg 64	Aphasia	<p>Definition: A speech or language disorder caused by disease or injury <u>to the brain</u> resulting in difficulty expressing thoughts (i.e., speaking, writing), or understanding spoken or written language.</p> <p>Documentation requirements:</p> <ul style="list-style-type: none"> <li>• difficulty must be noted in the resident chart</li> <li>• physician's diagnosis in the record</li> <li>• Current diagnosis and active treatment</li> </ul>	PD*, PPN, SP
I1s pg. 69	Cerebral Palsy	<ul style="list-style-type: none"> <li>• physician's diagnosis</li> <li>• Current diagnosis and active treatment</li> </ul>	PD*, PPN, SP
I1v	Hemiplegia/Hemiparesis	<ul style="list-style-type: none"> <li>• physician's diagnosis</li> <li>• Current diagnosis and active treatment</li> </ul>	PD*, PPN, SP

I1w	Multiple Sclerosis	<ul style="list-style-type: none"> <li>physician's diagnosis</li> <li>Current diagnosis and active treatment</li> </ul>	PD*, PPN, SP
I1ww	Explicit Terminal Prognosis	<ul style="list-style-type: none"> <li>A physician has put in the record that the resident is terminally ill and expected to have no more than 6 months to live.</li> <li>This should be substantiated with a documentation of diagnosis and deteriorating clinical condition</li> </ul>	PD*, PPN, NN, MS, SP
I1z	Quadriplegia	<ul style="list-style-type: none"> <li>A physician diagnosis of paralysis of all four limbs.</li> <li>Current diagnosis and active treatment</li> </ul>	PD*, PPN, SP
M1b	Burns – 2 <sup>nd</sup> or 3 <sup>rd</sup> degree	<ul style="list-style-type: none"> <li>Confirmation of the degree of the burn by the physician. In accordance with the Maine State Board of Nursing, the determination of degree of a burn must be documented by a physician.</li> <li>The status of a burn can be documented by a registered nurse or physician.</li> <li>Current diagnosis and active treatment</li> </ul>	PD*, NN, MS, PPN, SP, MAR
M2	Ulcers	<p>Ulcers must be staged by a registered nurse or physician, during the observation period for the MDS-RCA.</p> <ul style="list-style-type: none"> <li>Current diagnosis and active treatment</li> <li>Periodic evaluation by a Registered Nurse.</li> </ul> <p>Note: the definition of "ulcer" due to any cause means any lesion caused by pressure or decreased blood resulting in damage to underlying tissue.</p>	PD, NN, SP, PPN, TAR, MAR,
P1aa	Chemotherapy	<ul style="list-style-type: none"> <li>Any type of anti-cancer drug given by any route.</li> <li>Evidence in the resident record.</li> </ul> <p>Chemotherapy can only be coded if administered for a diagnosis of cancer.</p>	PD*, PO**, PPN, NN, MS, MAR, SP
P1aa	Radiation	<ul style="list-style-type: none"> <li>Radiation therapy or implant.</li> <li>Evidence in the resident record.</li> </ul> <p>Radiation therapy can only be coded if administered for a diagnosis of cancer.</p>	PD*, PO**, PPN, NN, MS, MAR, SP
P1ab	Oxygen	<ul style="list-style-type: none"> <li>physician's order</li> <li>administered during the past 14 days.</li> </ul>	PO**, PPN, NN, HHR, MAR, TAR

MDS RCA item	Field	Documentation Requirement	Possible Locations in the resident record
P1bdA	Respiratory Therapy 5 or more days per week	<ul style="list-style-type: none"> <li>• Physician order</li> <li>• Performed by a qualified therapist.</li> <li>• Documentation of frequency, and the</li> <li>• Qualified professional must be with resident at least 15 minutes per day <b>and</b> at least 5 days per week.</li> </ul> <p>Includes only therapies based on a therapist's assessment and treatment plan that is documented in the resident's clinical record.</p>	PO**, PPN, NN, PN, MAR, SP, TAR
P3	Need for on-going monitoring	<ul style="list-style-type: none"> <li>• The need for monitoring must be determined, directed and documented by a physician or a registered nurse.</li> <li>• The need for on-going monitoring for: <ul style="list-style-type: none"> <li>○ An acute condition,</li> <li>○ A chronic condition that exacerbated into an acute episode</li> <li>○ A new treatment or medication</li> </ul> </li> <li>• Documentation that monitoring has been provided by the person responsible within the look back period.</li> </ul>	PPN, NN, HHR, SP, PO
P10	4 or more order change days	<ul style="list-style-type: none"> <li>• Code the <b>number of days</b> on which physician orders were changed.</li> <li>• Written, telephone, fax, or consultation orders for new or altered treatment.</li> <li>• Does NOT include admission orders, return admission orders, clarifying, or renewal orders without changes.</li> </ul>	PO**, PPN

MDS RCA item and reference	Field	Documentation Requirement	Possible Locations in the resident record
<b>Impaired Cognition</b>			
B3, pg 29	Cognitive Skills for Daily Decision Making	Documentation of the resident's <i>actual</i> performance in making everyday decisions about tasks or activities of daily living within the look back period. Documentation must support the coding selected.	PPN, NN, SSN, FS

MDS RCA item	Field	Documentation Requirement	Possible Locations in the resident record
<b>Problem Behavior and Conditions</b>			
E1a-E1r, pg 34	Indicators of Depression	Evidence and observation of the identified indicators must be present in the resident record within the look back period.	NN, MS, PPN, SSN, FS
J1e, pg 68	Delusions	Documentation in the resident record should describe examples of <i>fixed, false beliefs, not shared by others even when there is obvious proof or evidence to the contrary</i> , that occurred within the look back period.	PPN, NN, SP, SSN, FS
J1f, pg 68	Hallucinations	Documentation in the resident record should describe examples of <i>tactile, auditory, visual, gustatory, olfactory false perceptions in the absence of any real stimuli</i> that occurred within the look back period.	PPN, NN, SP, SSN, FS
P2a – P2j	Intervention Programs for Mood, Behavior, Cognitive Loss	Documentation that the resident has received any intervention and/or strategies in the last seven days. Service plan should include the evaluation for and the provision of these services as well as the outcomes of treatment.	PPN, NN, MS, SP, SSN, FS

MDS RCA item	Field	Documentation Requirement	Possible Locations in the resident record
<b>Physical</b>			
G1aA	Bed mobility	Documentation in the record must reflect the resident's ADL self-performance over the 7 day period, 24 hours per day. Only self-performance counts towards the ADL score.	PN, SP, FS
G1bA	Transfer		
G1cA	Locomotion		
G1dA	Dressing		
G1eA	Eating		
G1fA	Toilet Use		
G1gA	Personal Hygiene		

**Key for Possible Record Locations**

HHR – Home Health Record

MAR – Medication Administration Record

MS – Monthly Summary

NN – Nurses Notes

PD - Physician's Diagnosis

TAR -Treatment Record

PN – Provider Notes

PO - Physician's Orders

PPN - Physician's Progress Notes

SSN - Social Service Notes

SP - Service Plan

FS – Flowsheet

**PD\*** - The **bold PD** indicates this element is required

**PO\*\*** - The **bold PO** indicates this element is required in the physician's orders