



MDS 3.0
10/1/2010





MDS 3.0 Training

o Updated April 2012



Goals of the MDS 3.0

- Resident Voice – MDS 3.0 now includes interviews for cognitive function, Mood, Personal Preferences, and Pain.
- Clinical Relevancy – MDS 3.0 Items are based upon clinically useful and validated assessment techniques.
- Efficiency – MDS 3.0 sections are formatted to facilitate usability and minimize staff burden.



Requirement for the 3.0

- The OBRA regulations require Nursing Homes that are Medicare certified, Medicaid Certified, or both, to conduct initial and periodic assessments for all their residents.
- The MDS 3.0 is part of that assessment process and is required by CMS.



Responsibilities of NF for Completing MDS 3.0

- An RAI (MDS, and CAA Process) must be completed for any resident residing more than 14d in the facility, including:
 1. All residents of Title 18 (SNF) and Title 19 (NF) regardless of payment source.
 2. Hospice Residents
 3. Respite Residents
 4. Special Populations such as Pedi and Psyche



Responsibility of NF for Reproducing/Maintaining 3.0

- Federal regulatory requirements at 42cfr483.20(d) requires NH to maintain all resident assessments completed within the previous 15 months in the resident's active clinical record

Responsibilities of NF for Reproducing/Maintaining 3.0

- Nursing Homes may:
 1. Use electronic signatures for the MDS
 2. Maintain the MDS electronically
 3. Maintain the MDS and Care Plans in a separate binder in a location that is easily and readily accessible to staff, Surveyors, CMS etc.

Item Sets

The various MDS 3.0 Assessments are called Item Sets.

There are 10 Nursing Home Item Sets

1. Comprehensive Item Set (**NC**)
2. Quarterly Item Set (**NQ**)
3. PPS Item Set (**NP**)
4. OMRA-Start of Therapy Item Set (**NS**)

Item Sets

5. OMRA-Start of Therapy and Discharge Item Set (**NSD**)
6. OMRA Item Set (**NO**) Used for COT
7. OMRA Discharge Item Set (**NOD**)
8. Discharge Item Set (**ND**)
9. Tracking Item Set Entry/Death in Facility(**NT**)
10. Inactivation Request Item Set (**XX**)



Comprehensive Assessments

- Comprehensive MDS – Includes both the completion of the MDS and the CAAs and is done on:
 1. Admission
 2. Annually
 3. Significant Change (SCSA)
 4. Significant Correction to Prior Comprehensive Assessment (SCPA)



Comprehensive Assessments

- Please review Assessment Management Requirements/Tips for Comprehensive Assessments in the 3.0 RAI User's Manual on Pg. 2-17.

Comprehensive Assessments Admission

- Admission refers to the date a person enters the facility and is admitted as a resident.
- An admission assessment must be completed (MDS Z0500B+CAAs V0200B2) within 14 days from the date of admission.
- The Care Plan must be completed (V0200C2) within 7 days of the CAAs completion date (V0200B2)
- Transmission within 14 days of Care Plan Completion date (V0200C2)



Admission Assessment Situations

1. A new resident who has never been admitted to the facility before
2. A resident who was previously admitted and then discharged prior to completion of the OBRA assessment.
3. A resident who was previously admitted and then discharged return not anticipated.
4. A resident who was previously admitted and then discharged return anticipated and did not return within 30 days.

Comprehensive Assessments

Annual Assessment

- No more than 366 days between the ARD of the previous OBRA comprehensive assessment and the ARD of the Annual Assessment
- No more than 92 days between the ARD of the previous OBRA Quarterly and the ARD of the Annual Assessment
- Completed by ARD + 14d
- CAAs completion date(V0200B2) same as MDS completion date (Z0500B)
- Care Plan completion (V0200C2) within 7days of CAAs completion date (V0200B2)
- Transmission within 14days from the Care Plan completion date (V0200C)

Comprehensive Assessment Significant Change in Status

- Must be completed (MDS Z0500B + CAAs V0200B2) within 14 days from the onset of a significant change in a resident's condition
- Resets the clock for the next Quarterly and Annual Assessments
- Care Plan must be completed (V0200C2) within 7d of the completion of the CAAs (V0200B2)
- Transmitted within 14 days of the care plan completion date (V0200C2)

Significant Change Criteria



- MAJOR change
- Not Self-limiting
- 2 or more areas of decline/improvement (CMS 3.0 manual, pgs. 2-20 through 2-27)
- Requires IDT review and/or revision of Care Plan

A0310A Hospice Benefit

- Electing or revoking the hospice benefit requires a significant change in status assessment

A0310. Type of Assessment

Enter Code

A. Federal OBRA Reason for Assessment	
01	Admission assessment (required by day 14)
02	Quarterly review assessment
03	Annual assessment
04	Significant change in status assessment
05	Significant correction to prior completion

Significant Correction to Prior Comprehensive Assessment

- Must be completed (MDS Z0500B + CAAs V0200B2) by the 14th day after determination that significant error in prior comprehensive assessment occurred
- Care Plan must be completed (V0200C2) within 7 days of CAAs completion (V0200B2)
- Transmission within 14 days from care plan completion date (V0200C2)



Significant Error

Significant Error – is an error in an assessment where:

1. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment; and
2. The error has not been corrected via submission of a more recent assessment.



Non-Comprehensive Assessments

- **Non-Comprehensive MDS –**
 - does not require the completion of the CAAs
- **Non-Comprehensive MDS**
 - Quarterly
 - Significant Correction of Prior Quarterly (SCQA)
 - Discharge Assessment
 - Return Anticipated
 - Return Not Anticipated

Non Comprehensive Assessments Quarterly

- ARD must be set within 92 days of the ARD of the previous OBRA assessment of any type
- Completion date (Z0500B) within 14 days of the ARD
- Transmission within 14 days of the completion date (Z0500B)



Non Comprehensive Assessments **Significant Correction to Prior Quarterly**

- Must be completed (Z0500B) by the 14th day after determination that a significant error in a prior quarterly assessment occurred.
- Must be transmitted within 14d of completion date

Non Comprehensive Assessments

Discharge Assessment

Discharge- refers to the date a resident leaves the facility for anything other than a temporary LOA.

Discharge Assessment- refers to an assessment required upon resident discharge

- A discharge assessment is required for:
 1. Discharge return anticipated
 2. Discharge return not anticipated

Non Comprehensive Assessments

Discharge Assessment

- A discharge assessment must be completed (Z0500B) within 14 days from the date of discharge.
- A discharge assessment must be transmitted within 14 days from the date of completion.

Non Comprehensive Assessments

Discharge Assessment

- For Unexpected/Emergency Discharge:
 - Complete all items possible on the assessment & code with “-” if unable to obtain the information
 - CMS expects Staff Interviews to be done when the resident is discharged before he/she can be interviewed.
 - CMS expects that there will be as few items as possible coded with “-”

Non Comprehensive Assessments Discharge

- Per CMS: No longer have to submit a “Return NOT anticipated” when the resident was initially discharged as a “Return anticipated”, but then they don’t return. The computer program will automatically remove the resident from the list of recent assessments if no new assessments are submitted by day 30 from the date of discharge—“Return anticipated.”

Entry and Discharge Reporting Entry Tracking Record

- An entry tracking record must be completed every time a resident is
 - admitted for the first time
 - readmitted after discharge prior to completion of OBRA admission assessment
 - readmitted after discharge return not anticipated, or return anticipated but did not return within 30days



Entry and Discharge Reporting Entry Tracking Record

- An entry tracking record must be completed within 7 days of the entry date
- An entry tracking record must be transmitted within 14 days of the entry date.



Entry and Discharge Reporting Death in Facility Tracking Record

Death in Facility -refers to when a resident dies in the facility or dies while on a LOA.

-The facility must complete a Death in Facility tracking record.

-A discharge assessment is not required.



Assessment Definitions

Leave of Absence

Leave of Absence, or LOA,
refers to:

- Temporary home visit
- Temporary therapeutic leave
- Hospital observation stay of less than 24h where resident is not admitted to hospital



Assessment Definitions

Leave of Absence

Leave of Absence or LOA, does not require completion of either discharge assessment or any entry tracking record.



Assessment Definitions

Assessment Reference Date (ARD)

- The ARD refers to the last day of the observation (or “look back”) period that the assessment covers for the resident.
- Since a day begins at 12:00 AM and ends at 11:59 PM, the ARD must cover this period
- The facility is required to set the ARD within the appropriate timeframe of the assessment type being completed.
- **ARD should not be the same as the completion date**

Assessment Definitions

Observation Period

- **Observation (Look Back) period** The period of time over which the resident's condition or status is captured by the MDS Assessment
 - **The "Look Back" period is 7 days unless otherwise stated on the MDS 3.0 Item Set**
 - **If it did not occur during the look back period, it is not coded on the MDS.**



Assessment Definitions

Assessment Combination

- Assessment Combination refers to the use of one assessment to satisfy both OBRA and PPS assessment requirements when time frames required for both assessments coincide.



Assessment Definitions

Assessment Completion

- Assessment Completion refers to the date that all info needed has been collected and recorded for a particular assessment type, and staff have signed and dated that the assessment is complete.



Assessment Definitions

Assessment Scheduling

- Assessment Scheduling refers to the period of time during which assessments take place, setting the ARD, timing, completion, submission, and other observation periods required to complete the MDS items.



Assessment Definitions

Assessment Submission

- Assessment Submission refers to electronic MDS data being in record and file formats that are capable of being transmitted to CMS

Assessment Definitions

Transmission

- Assessment Transmission refers to electronic transmission of submission files to the QIES Assessment Submission and Processing (ASAP) System using the Medicare Data Communication Network.

Assessment Definitions

Transmission

- Transmission (submitted and accepted into MDS database) electronically no later than **14 days** after Completion;
- V0200C2, for comprehensive assessment
- Z0500 for non-comprehensive assessment.



Assessment Definitions

MDS Assessment Codes

MDS Assessment Codes -refer to the values that correspond to the OBRA and PPS required assessments in items A0310A, A0310B, A0310C, and A0310F on the MDS 3.0.



Assessment Definitions

Medicare PPS Assessments

- 5 day**
- 14 day**
- 30 day**
- 90 day**
- Readmission/Return**
- SCSA - SCPA**
- Swing Bed Clinical Change**
- Start of Therapy (SOT) - End of Therapy (EOT)**
- Both Start and End of Therapy OMRA**
- Change of Therapy (COT) OMRA**

MaineCare Case Mix

Maine will continue to use the RUG III Codes for Case Mix purposes. This has been calculated for the MDS 3.0 based on the CMS Translator.

- Maine will continue with the brain injury modification

Supporting Documentation for Case Mix payment items continues to be required

MaineCare Case Mix (continued)

- Resident interviews **only** will be accepted as coded on the MDS 3.0—NO supporting documentation required.
- Staff interviews **must be documented** in the residents record. If the interviews are summarized in a narrative note, the interviewer must document the date of the interview, name of staff interviewed staff responses to questions asked.
- Follow all “Steps for Assessment” in the RAI Manual, for the interview items



Coding Section A

A0050- Type of Record

- This is a new item on the April 2012, MDS 3.0. Please refer to pgs A1&2 of Chapter 3 for more info
- Code 1 if this is a new record that has not been previously submitted and accepted in the QIES ASAP system
- Code 2 if this is a request to modify the MDS items for a record that has been submitted and accepted in the QIES ASAP system
- Code 3 if this is a request to inactivate a record that already has been submitted and accepted in the QIES ASAP system

Coding Section A

A0100 Facility Provider Numbers & A0200 Provider Type

Allows identification of the nursing home submitting the assessment.

- Note the National Provider Number (NPI) and CMS Certification Number (CCN) (formerly the Medicare/Medicaid Provider Number)
- State of Maine will code the **NPI plus 3** – location indicator

A0200 Provider Type

- Note the type of provider
- This is a new item for the MDS 3.0

Coding Section A

A0310 Purpose

Identifies the information required to complete the type of assessment

May be completed for more than one reason

- All requirements for each type of assessment must be met

Determines what items set must be completed (see bottom of MDS 3.0 Form—NC, ND, NQ, etc.)



Coding Section A

A0310A Federal OBRA Reason for Assessment

01. Admission
02. Quarterly
03. Annual
04. Significant change in status
05. Significant correction to prior comprehensive
06. Significant correction to prior quarterly
99. Not OBRA required

Coding Section A

A0310B PPS Assessment

Includes scheduled and unscheduled assessments

Enter Code <input type="text"/>	B. PPS Assessment
	PPS Scheduled Assessments for a Medicare Part A Stay
	01. 5-day scheduled assessment
	02. 14-day scheduled assessment
	03. 30-day scheduled assessment
	04. 60-day scheduled assessment
	05. 90-day scheduled assessment
	06. Readmission/return assessment
	PPS Unscheduled Assessments for a Medicare Part A Stay
	07. Unscheduled assessment used for a Medicare Part A Stay
Not PPS Assessment	
99. Not PPS assessment	

<input type="text"/>	B. PPS Assessment
	PPS Scheduled Assessments for a Medicare Part A Stay
	01. 5-day scheduled assessment
	02. 14-day scheduled assessment
	03. 30-day scheduled assessment
	04. 60-day scheduled assessment
	05. 90-day scheduled assessment
	06. Readmission/return assessment
	PPS Unscheduled Assessments for a Medicare Part A Stay
	07. Unscheduled assessment used for a Medicare Part A Stay
Not PPS Assessment	
99. Not PPS assessment	

PPS Other Medicare Re...

Coding Section A

A0310C PPS Other Medicare Required Assessment - OMRA

Indicates whether the assessment is related to therapy services

Complete this item for all assessments

- **Code 0.** Not an OMRA assessment
- **Code 1.** Start of Therapy when ARD is 5 - 7 days after first day of therapy services
- **Code 2.** End of Therapy when ARD is 1 - 3 days after last day of therapy services
- **Code 3.** Start and End of Therapy when ARD meets both therapy criteria
- **Code 4.** Change of Therapy Assessment

Coding Section A

A0310D Swing Bed Clinical Change Assessment

Complete only if A0200 is coded 2 to designate a swing bed provider

Enter Code <input type="checkbox"/>	D. Is this a Swing Bed clinical change assessment? Co 0. No 1. Yes
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A0200. Type of Provider	
Enter Code <input type="checkbox"/>	Type of provider
<input type="checkbox"/>	1. Nursing home (SNF/NF)
<input checked="" type="checkbox"/>	2. Swing Bed



Coding Section A

A0310E First Assessment Since Most Recent Admission

Indicate whether this is the first OBRA, PPS, or discharge assessment since the most recent admission

- Entry of any kind – admission or reentry

Complete this item for all assessments

Coding Section A

A0310F Entry/ Discharge Reporting

Indicate an entry or discharge reason for assessment or tracking record

Code 01 Entry Record – tracking form

Code 10 Discharge assessment – return not anticipated – requires clinical assessment

Code 11 Discharge assessment – return anticipated – requires clinical assessment

Code 12 Death in facility record – tracking form



Coding Section A

A0310G Type of Discharge

- This is a new item on the April 2012, MDS 3.0
- Complete only if A0310F = 10 or 11
- Code 1 for a planned discharge
- Code 2 for an unplanned discharge

Coding Section A

A0410 Submission Requirement

Designates the submission authority for the resident assessment

Must be a federal or state authority to submit the MDS assessment to the QIES ASAP system

Maine has both a state and federal requirement – code 03 Federal required

Coding Section A

Resident Data

A0500 through A1300

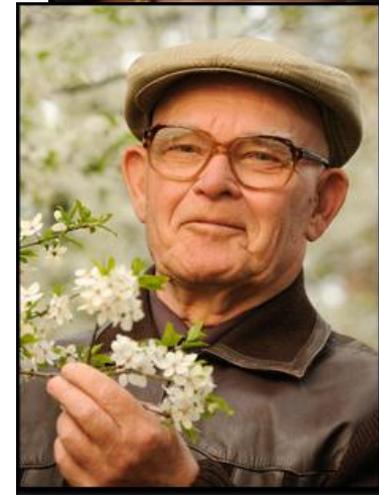
- Personal data

A1500 and A1550

- Mental Illness/ Mental Retardation (MI/MR) status
- Mental Retardation/ Developmental Disability (MR/DD) status

A1600 through A2400

- Entry and discharge data
- Assessment Reference Date
- Medicare stay



Coding Section A

A1300 Optional Resident Items

- Document data helpful to the facility.
- Track resident data.
- Improve resident interaction and care.

A1300. Optional Resident Items	
A. Medical record number:	<input type="text"/>
B. Room number:	<input type="text"/>
C. Name by which resident prefers to be addressed:	<input type="text"/>
D. Lifetime occupation(s) - put "/" between two occupations:	<input type="text"/>



Coding Section A

A1500 PASRR Overview

PASRR is a preadmission screening process

A positive screen indicates that resident has a mental illness, mental retardation, or a related condition

A1500 documents whether a PASRR Level II determination has been issued

Does not call for judgment about an individual's mental illness, mental retardation, or a related condition

Only reports on the results of the PASRR process



Coding Section A 1500 PASRR/ Medicaid

All individuals admitted to Medicaid certified NFs must complete a Level I PASRR

If the Level I screen is positive, a Level II evaluation is performed

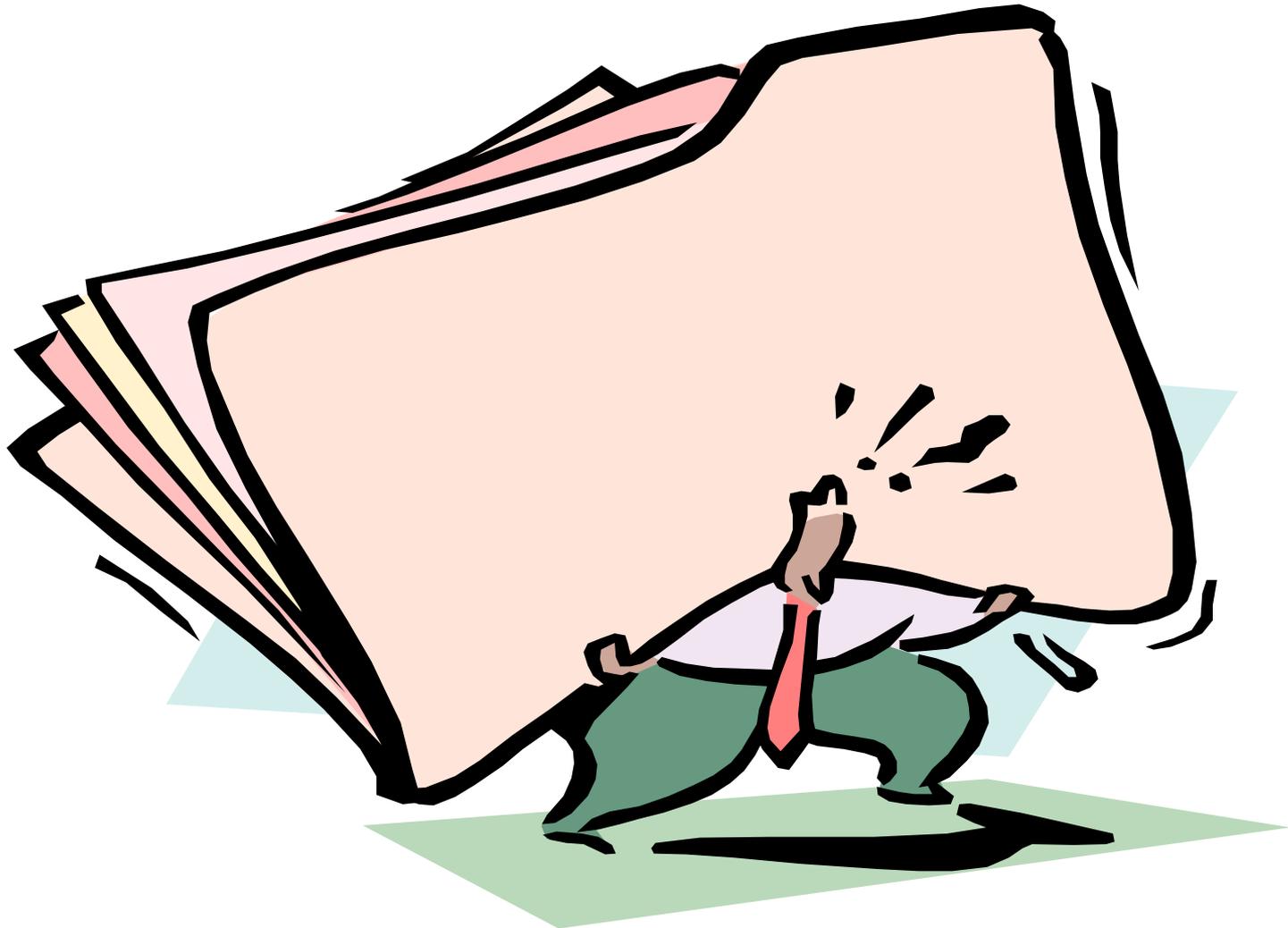
Individuals suspected to have MI/ MR or a related condition may not be admitted unless approved through a Level II PASRR determination

Coding Section A

A1510- Level II Preadmission Screening and Resident Review (PASRR) Conditions

- This is a new item on the April 2012, MDS 3.0
- Complete only if at A0310A, Type of Assessment, you have coded 01 admission; 03 annual; 04 significant change; or 05 significant correction to prior comprehensive assessment
- Check all that apply

FULL “ITEM SET” FORM



CASE MIX PAYMENT ITEMS

- Certain services, conditions, diagnoses and treatments that are on the MDS 3.0



MDS 3.0 ITEM BY ITEM

Mostly Payment and
New Items- Unless
there are
questions about
other Sections



IMPAIRED COGNITION

Items

-B0100- Commatose
(requires supporting documentation)

-C0200

-C0300A,B,C

-C0400A,B,C

(Resident Interview- BIMS stands
alone)

Or

-B0700

-C0700

-C1000

(Staff Assessment requires supporting
documentation)



Depression Indicators

Resident Interview (PHQ-9)

- Items D02002A through D02002I
- Requires no further documentation



Depression Indicators



Staff Interview (PHQ-9-OV)

- Items D05002A through J

******Supporting
Documentation
Required******

BEHAVIORAL SYMPTOMS

Items



- E0100A Hallucinations
- E0100B Delusions
- E0200A Physical behaviors
- E0200B Verbal behaviors
- E0200C Other behaviors
- E0800 Rejected care
- E0900 Wandered

Section G

New on 3.0 for Self Performance

- **Added a code of 7 for when the Activity occurred only once or twice**
- **Code Independent (0), only if “Independent” level of self-performance occurred EVERY TIME the activity occurred.**
- **Code 7 if activity occurred only once or twice**
- **Code 8 if activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period**



Section G

April Change for Support Provided

- April 2012, 3.0 changed the wording in Section G0110A2, for code of 8, as follows:

ADL Activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.

Section G

ADL'S

Self-performance & Number of Support Persons:

G011A1,2 Bed mobility

G0110B1, 2 Transfer

G0110I, Toileting

Self-performance Only:

G0110H1 Eating



Section G

ADL's (continued)

- Rule of Three, except for:
 - "0" Independent
 - "4" Total dependence
 - "8" Activity did not occur

H0300 Urinary Continence

If intermittent catheterization is used to drain the bladder, code continence level based on continence between catheterizations

Code 9: if resident has a catheter or no urine output for 7 days or urinary ostomy

Residents with indwelling catheters are no longer coded as continent

H0400 Bowel Continence

Select the one category that best describes the resident

Look back period is 7 days

Code 9: if resident has an ostomy or did not have a bowel movement for entire 7 days

- If no BM for 7 days, this is a **sentinel event**

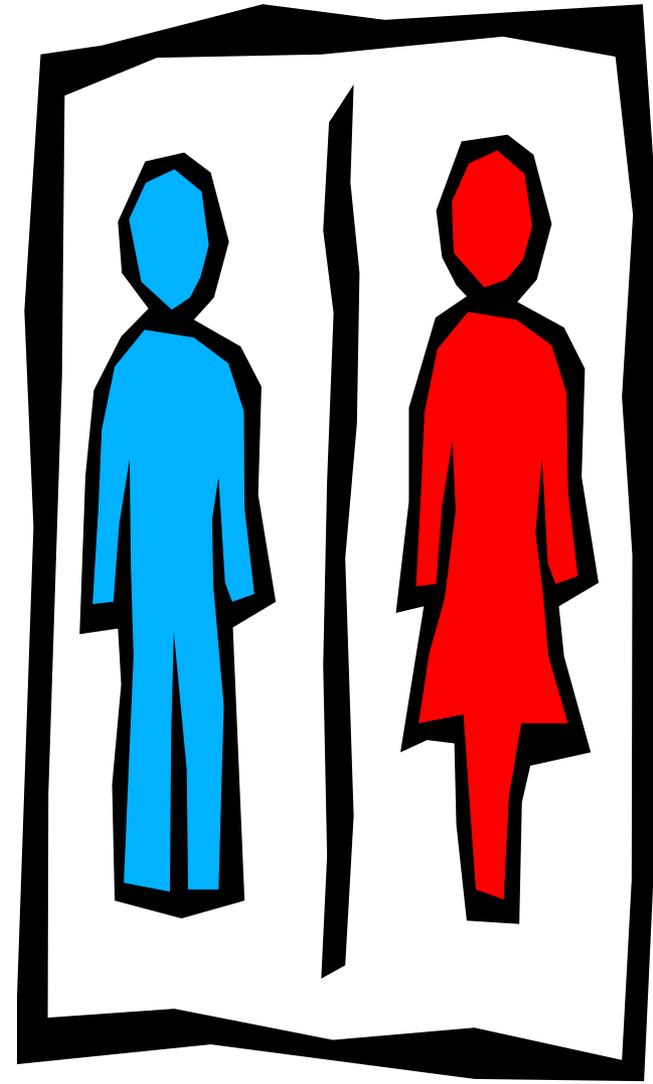
RAI manual reference pages H-9 through H-11

H0600 Bowel Patterns

- The term “fecal impaction” has been eliminated from MDS 3.0 item set
- Constipation is yes or no
- RAI manual reference pages H-12 through H-13 for definitions of constipation and fecal impaction

Scheduled Toileting/Retraining

This is part of
Nursing Rehab /
Restorative so we
will review Items
H0200C & H0500
when we review
Items O0500A -
O0500J.



Section I Active Diagnoses

1. Identify diagnoses

- Requires **documented** physician's diagnoses
- Identify any diagnoses made in the last **60 days**

2. Determine diagnosis status

- Using a 7-day look-back period, determine if diagnosis is active or inactive
- Active diagnoses have a direct relationship to the resident's functional or cognitive status, mood or behavior, medical treatments (including medication to manage the disease/condition), nursing monitoring, or risk of death during the look back period

DIAGNOSES (Case Mix Items)

- 12900-** Diabetes (N0300 must = 7 and O0700 must = 2 or more)
- 14300-** Aphasia (must be with a feeding tube)
- 14400-** Cerebral palsy
- 14900-** Hemiplegia/hemiparesis
- 15100-** Quadriplegia
- 15200-** Multiple Sclerosis
- 15500-** Traumatic brain injury
(Maine only)

Infections

- I2000-** Pneumonia
- I2100-** Septicemia

I2300 Urinary Tract Infections

The look-back period for UTI (I2300) differs from other items

- **Look-back period to determine an active diagnosis of a UTI is 30 days**

Code for a UTI **only if all** of the following criteria are met:

- Diagnosis of a UTI in last 30 days
- Signs and symptoms attributed to UTI
- Positive test, study, or procedure confirming a UTI
- Current medication or treatment for UTI



J0100 through J0850 Pain

Types of Management

Determine if pain assessment **interview** should be conducted with Resident or Staff

Conduct pain assessment **interview**

Pain Assessment Interview Guidelines

The look-back period for all pain interview items is 5 days

- Conduct the interview close to the end of the 5-day look-back period
- Skip to the Staff Assessment if the resident is unable to answer J0300 Pain Presence (coded 9)
- Stop the interview and skip to the Staff Assessment if the resident is unable to answer J0400 Pain Frequency (coded 9)

J1100 Shortness of Breath (Dyspnea)

Document any evidence of the presence of a symptom of shortness of breath

There are now 3 symptom choices. A resident may have any combination of the symptoms listed in **J1100**—**check all that apply.**

J1300 Current Tobacco Use

- Ask the resident if he/she used tobacco **in any form** during the look-back period.
- Review the medical record and interview staff about indications of tobacco use if:
 - Resident is unable to answer, or
 - Resident indicates that he or she did **not** use tobacco during the 7 day look-back period



J1400 Prognosis

Life expectancy less than 6 months

Review medical record for documentation of:

- Condition or chronic disease that may result in life expectancy of less than 6 months
- Terminal illness
- Indication of hospice services

Request documentation in the medical record if physician (or other authorized, licensed staff as permitted by State law) states that resident life expectancy is less than 6 months



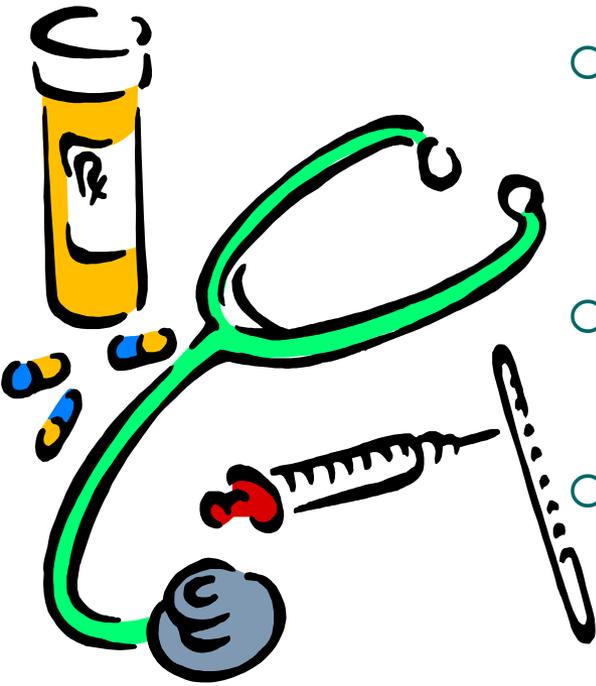
J1550 Problem Conditions

- A. Fever
- B Vomiting
- C Dehydration
- D Internal bleeding

J1550 PROBLEM CONDITIONS

(continued)

- **J1550A(fever)**—must be at least 2.4F >baseline (“**should** be established prior to the ARD”) (must be other condition as well—see Maine MDS RUG III Codes)
- **J1550B(vomiting)**—episode must be W/I the 7 days (Must also be a fever)
- **J1550C(dehydration)**—must be 2 or more clinical indicators (pg. J-26)
- **J1550D(internal bleeding)**—must be clinical indicator W/I the 7 days.



J1550 (Continued)

- A (Fever) The resident's baseline temperature **should be** established prior to the ARD.
- C (dehydration) Follow guidelines in Manual
- D (Internal bleeding) Guidelines:
 - May be frank or occult
 - Observe clinical indicators
 - **Do not code as internal bleeding:**
 - Nosebleeds that are easily controlled
 - Menses
 - Urinalysis that shows a **small** amount of red blood cells

Definition of a Fall

“Unintentional change in position coming to rest on the ground, floor, or next lower surface”

- May be witnessed, reported by resident or identified by finding resident on the floor or ground
- May occur in any setting
- Not a result of overwhelming external force
- Intercepted fall where resident catches himself or herself or is intercepted by another person **is still considered a fall**

J1700 Fall History on Admission

- o **Complete this item only for an Admission Assessment**

(A0310A = 01 or A0310E = 1)

- o Timeframes prior to admission are different for each item in J1700
 - One month for A
 - Two to six months for B
 - Last six months for C

J1800 Any Falls Since Admission or Prior Assessment

- Code whether the resident had any falls during the look-back period
- Skip to K0100 Swallowing Disorder if **0. No**

J1800. Any Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), whichever is more recent	
Enter Code <input type="checkbox"/>	Has the resident had any falls since admission or the prior assessment (OBRA, PPS, or Discharge), whichever is more recent? 0. No → Skip to K0100, Swallowing Disorder 1. Yes → Continue to J1900, Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge)

K0100 Coding Instructions

- Check all items that apply during the 7-day look-back period

K0100. Swallowing Disorder	
Signs and symptoms of possible swallowing disorder	
↓ Check all that apply	
<input type="checkbox"/>	A. Loss of liquids/solids from mouth when eating or drinking
<input checked="" type="checkbox"/>	B. Holding food in mouth/cheeks or residual food in mouth after meals
<input type="checkbox"/>	C. Coughing or choking during meals or when swallowing medications
<input checked="" type="checkbox"/>	D. Complaints of difficulty or pain with swallowing
<input type="checkbox"/>	Z. None of the above

K0200A & B Height & Weight

- Measure and record height in inches on admission
- Measure height & weight consistently over time in accordance with facility policy and procedure
- Check the medical record for subsequent assessments
- Measure and record height again if last measurement is more than one year old

K0200 Height/Weight

- Record height/weight to the nearest whole unit
- Use mathematical rounding for height and weight
 - Record a height of 62.5 inches as 63 inches
 - Record a weight of 100.4 pounds as 100 pounds

K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up

6	3
---	---

inches

A. Height (in inches). Record most recent height measure since admission

1	0	0
---	---	---

pounds

B. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently in facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)

K0300 - WEIGHT LOSS (Case Mix Item)

- K0300 (must be in combination with fever (J1550A) for payment).

Codes have been expanded to indicate whether the resident is on a physician-prescribed weight-loss regimen or not

- Loss of 5% or more in the last month
- Loss of 10% or more in the last six months



K0310 – Weight Gain

- This is a new item on the April 2012, 3.0
- Gain of 5% or more in the last month or gain of 10% or more in last 6 months
- Code 0 for No or unknown
- Code 1 for yes, on physician prescribed weight gain regimen
- Code 2 for yes, not on a physician prescribed weight gain regimen

K0510 Nutritional Approaches

- New to the April 2012, 3.0 – K0500 is replaced by K0510
- K0510 is split in to two columns
 1. While NOT a Resident
 2. While a Resident
- Items A,B, C, D, and Z remain the same
- Timeframe remains the last 7 days

K0510 Assessment Guidelines

Reminder: Code only items that were administered for nutrition or hydration

- "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."
 - Per the MDS 3.0 RAI Manual updates of September 2010

K0500 Assessment Guidelines

○The following items are **NOT** coded in K0510A:

- IV medications
- 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

○RAI Manual pages K-8 through K-10

K0700 Percent Intake by Artificial Route

**Complete K0700 only if
column 1 and/or column 2
are checked for K0510A or
K0510B**

CALORIE/FLUID INTAKE

- **K0700A** (parenteral/enteral portion of total calories)
 - “Review intake records to determine actual intake. . .”
 - “If the resident had more substantial oral intake than just sips of fluid, consult with the dietician.”



- **K0700B** (parenteral/enteral fluid intake average)
 - Review intake records from the last 7 days. Add up the total TF/IV fluid intake and divide by 7

Section K

Case Mix Payment Items

- **K0510A** IV fluids
 - **K0510B** Feeding tube
 - **K0700A** TF/IV calories
 - **K0700B** TF/IV fluid amount average
- See Maine MDS RUG III Codes



Section M: Skin Conditions

- Intent: to document the risk, presence, appearance and/or change of pressure ulcers and other skin ulcers, wounds or lesions and some treatments.
- CMS **adapted** (not adopted) the NPUAP 2007 definitions of Pressure Ulcer Stages, “therefore, you cannot use the NPUAP definitions to code the MDS. You must code the MDS according to the instructions in this (RAI) Manual.”

Pressure Ulcer: CMS Definition

- “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.”



PRESSURE ULCERS (Guidelines)

Do not reverse stage

○ “If the pressure ulcer has ever been classified at a **deeper stage** than what is observed now, it should continue to be classified at the deeper stage”

- Determine the deepest anatomical stage of each pressure ulcer
- Enter number of pressure ulcers for each stage
- **Pressure Ulcers are Case Mix items**
 - 2+ Treatments required



Item MO300A

Stage I Pressure Ulcers

“An observable, pressure-related alteration of **intact** skin, whose indicators, as compared to an adjacent or opposite area on the body, may include changes in one or more of the following parameters: Skin temperature (warm or cool), tissue consistency (firm or boggy), sensation and/or a defined area of persistent (non-blanchable) redness. . .in darker skin tones. . .red, blue or purple hues.”



Item M0300B

Stage 2 Pressure Ulcers

“Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, **without slough**. May also present as an intact or open / ruptured blister” (regardless of what material the blister is filled with).

Item MO300C

Stage 3 Pressure Ulcers

“Full thickness tissue loss. Subcutaneous fat may be visible but **bone, tendon or muscle are not exposed.** Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.”



Item MO300D

Stage 4 Pressure Ulcers

“Full thickness tissue loss **with exposed bone, tendon or muscle**. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.”

Item MO300E-Unstageable Pressure Ulcers (non-removable dressings)

- “Includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast.”
- Not a Case Mix Item

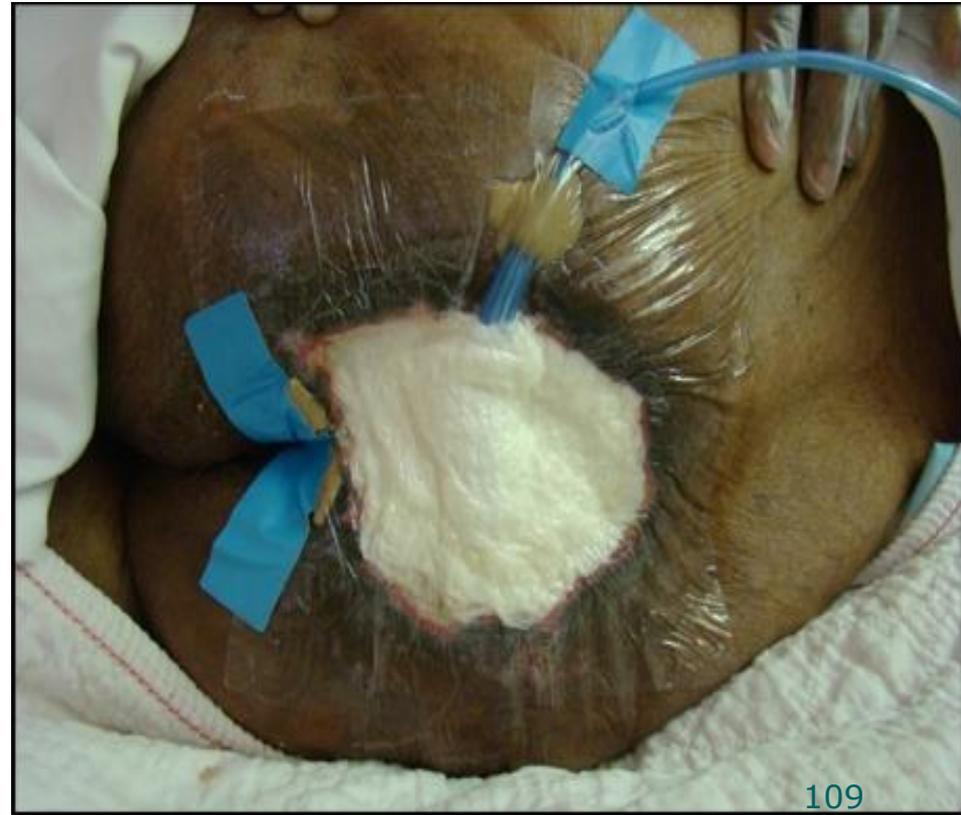
M0300E Unstageable Non-Removable Device (Continued)

- **Ulcer covered with eschar under plaster cast**
 - **Known but not stageable because of the non-removable device**



M0300E Unstageable Non-Removable Dressing (continued)

- **Known** but not stageable because of the non-removable dressing



Item M0300F Unstageable Related to Slough and/or Eschar

“Although the wound bed cannot be visualized, and hence cannot be staged, the pressure ulcer may affect quality of life for residents because it may limit activity, may be painful, and may require time-consuming treatments and dressing changes.”

✓ **This is a Case Mix item**

CMS Definitions

- Slough tissue: “Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough **may be adherent** to the base of the wound or present in clumps throughout the wound bed.”

CMS Definitions

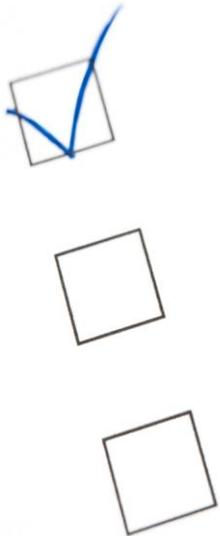
- Eschar tissue: “Dead or devitalized tissue that is hard or soft in texture; usually black brown or tan in color, and may appear scab-like. Necrotic tissue and eschar are **usually firmly adherent** to the base of the wound and often the sides/edges of the wound”

Item MO300G Unstageable related to Suspected Deep Tissue Injury

- CMS Definition: “Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.”
- “Once the suspected deep tissue injury has opened to an ulcer, reclassify the ulcer into the appropriate stage. . . .”
- Not a Case Mix Item

MO900 Healed Pressure Ulcers

- CMS Definition: “Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, even if the area continues to have some surface discoloration.”
- Look-back period is back to the ARD of the prior assessment.
- Skip this item ONLY IF there is NO prior assessment.
- Not a Case Mix item.



M1030 Venous and Arterial Ulcers

- Definitions per CMS
 - Venous ulcers: “Ulcers cause by PVD, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg.”
 - Arterial ulcers: “Ulcers caused by PAD, which commonly occur on the tips and tops of the toes, tops of the foot, or distal to the medial malleolus.”
- **This is a Case Mix item (2+ treatments)**

M1040 Other Ulcers Wounds and Skin Problems

- **Foot problems** – check **all** that apply
 - A. Infection of the foot (“cellulitis, purulent drainage”)
 - B. Diabetic foot ulcer (“ulcers caused by the neuropathic and small blood vessel complications of diabetes”). Documentation must support this.
 - C. Other **open** lesion(s) on the foot (e.g. cuts, fissures)



M1040 Other Skin Problems (continued)

- M1040D Open Lesion(s) other than ulcers, rashes, cuts (most typically skin ulcers that develop as a result of diseases and conditions such as syphilis and cancer).
- Must be documentation of “open” in the 7 day look-back period.

M1040 Other Skin Problems (continued)

- M1040E Surgical wound(s)-- Do **not** include: Healed sites, healed stomas, lacerations with butterfly closures, PICC sites, Central line sites, peripheral IV sites or surgically debrided pressure ulcers (these should continue to be coded as pressure ulcers).



M1040 Other Skin Problems (continued)

- M1040F Burn(s)
(Second or third degree): Skin and tissue injury caused by heat or chemicals and may be in ANY stage of healing.
- Do NOT include first degree burns (changes in skin color only).



M1040 G Skin Tears

- This is a new item on the April 2012, 3.0
- Code all skin tears here even if they have already been coded at J1900B

M1040H – Moisture Associated Skin Damage (MASD)

- This is new to the April 2012, 3.0
- Code here for skin damage due to moisture such as Incontinence Dermatitis, perspiration, or drainage

M1040 Other Skin Problems (continued)

- To qualify for Case Mix RUG placement, there must be application of a specific treatment within the 7-day look-back period (see handout, Maine MDS RUG III Codes, Model Version 5.12 ME for MDS 3.0).

M1200 Skin and Ulcer Treatments

- A & B-Pressure relieving devices **do not** include:
- Egg crate cushions of any type, donut or ring devices for chairs (The use of donut or ring devices violate current Standard of Practice)
- C. -Turning/repositioning program
- Specific approaches for changing resident's position and realigning the body
 - Program should specify intervention and frequency
 - Requires supporting documentation
- D. -Nutrition and hydration
- High calorie diets with added supplements to prevent skin breakdown
 - High protein supplements for wound healing

SKIN & ULCER TREATMENTS (continued)

○ M1200 (continued)

- E. Ulcer care
- F. Surgical wound care
- G. Non-surgical dressing other than to feet (with/without topical meds)
- H. Ointment/meds other than to feet
- I. Dressings to feet (with/without topical meds)

- Must be a physician's order, Care Plan or Facility policy/protocol for each item coded
- Must be documentation of use in the 7 day-day look-back period.
- As of 4/1/12, DO NOT code "G" or "H" for Pressure Ulcers (RAI Manual, pgs. M-35, 36)



Section M (Ulcers & Other Skin Problems) Case Mix Payment Items

- M0300A,B1, C1, D1, F1 & M1030 (Ulcers) with 2+ Treatments: M1200A, B, C, D, E, G, H
- M1040E (surgical site) or M1040D (open lesion) with M1200F, G or H
- M1040A, B, C (foot problems) with M1200I (foot dressing)
- M101F (burns—2nd or 3rd degree)



INJECTIONS

○ Item N0300

- code number of **days** injections were received in the last 7 days or since admission/re-entry
- Subcutaneous (for SC pumps, include only days that the SC injection site was started/restarted)
- Intramuscular
- Intradermal
- Insulin is counted here as well as at item N0350A (Insulin injections)
- DO NOT CODE I.V. access, meds or fluids here



N0300- Injections

- This is a Case Mix Item when the number of days administered = 7
AND:
 - Physician documentation in the resident's record stating a diagnosis of diabetes (Item I2900)
 - Physician order change days = 2+ (Item O0700)

NO410 Medication Received

- This is a new item to the April 2012, 3.0
- N0400 was replaced by N0410
- Items N0410 A through G remain the same.
- Item N0410Z, none of the above, was added
- You must now enter the **# of DAYS** each listed medication was received in the last 7 days, or since admission/entry if less than 7days

00100 Special Treatment, Procedures, and Programs

Column 1 Coding Instructions

- Document treatments received **before** becoming a resident of the facility
- 1. Check all treatments received by the resident:
 - **Prior** to admission/ reentry to the facility
 - **Within** the 14-day look-back period
- 2. Check **Z**. None of the above if resident:
 - Was admitted/ reentered during the look-back period
AND
 - Did not receive any of the treatments listed
- 3. Leave Column 1 **blank** if resident was admitted or reentered facility more than 14 days ago

00100 Special Treatments, Procedures, and Programs

Column 2 Coding Instructions

- Document treatments received **after** becoming a resident of the facility
- Check all treatments received by the resident:
 - **After** admission/reentry to the facility
 - **Within** the 14-day look-back period
- Check **Z**. None of the above if none of the treatments apply during the look-back period
- **Do not leave this column blank**

00100 Special Treatments

- Items H and I: IV medication, and blood transfusions administered during dialysis or chemotherapy are considered part of the procedure and are **not coded under items O0100H (IV medications) and O0100I (transfusions)**. This also includes **Item K0500A (Parenteral/ IV)**

Treatments

Case Mix Payment Items

- **00100A1,2** (Chemotherapy)—Must be used for documented diagnosis of cancer.
- **00100B1,2** (Radiation)
- **0100C1,2** (Oxygen)
- **00100D1,2** (Suctioning)—NOT oral.
- **00100E1,2** (Trach. Care)—Ostomy and/or cannula
- **00100F1,2** (Ventilator)
- **00100H1,2** (IV/epidural meds)
- **00100I1,2** (Transfusions)—NOT when administered during dialysis or chemo.
- **00100J1,2** (Dialysis)



Item O0250

Influenza Vaccine

- **Not a payment item**
- Influenza season set every year by the CDC (-Per the AHFSA RAI Panel, distributed by CMS, June 2011, (Current flu season) “should be thought of as did the resident receive the influenza vaccine in this facility for this year’s influenza season `or the most recent influenza season.””)

Administer the vaccination according to standards of clinical practice if vaccine status cannot be determined

00400 Determine Applicable Therapies

- Count only therapies that occurred since admission or reentry and after the initial evaluation
- Do **NOT** include therapies that occurred while the resident was:
 - An inpatient at a hospital or recuperative/rehabilitation center or a different long-term care facility
 - The recipient of home care or community-based services

00400 Determine Applicable Therapies

- Speech/language, occupational, physical, respiratory, psychological and recreational therapy must meet the requirements for skilled therapy outlined in Chapter 3 and Appendix A of the RAI Manual
- Include services provided by a qualified physical/occupational therapy assistant employed by the facility only if under the direction of a qualified therapist
- Do **not** include therapeutic services that are not specifically listed in the RAI Manual or on the MDS item set even if provided by specialists

Do not include non-skilled services

- Services provided at the request of the resident or family that are not medically necessary
- Maintenance treatments or supervision of aides performing maintenance services
- Services provided after a resident has been discharged from rehabilitation

Modes of Therapy

- Three modes of therapy:
 - Individual (one resident with one therapist or assistant's full attention)
 - Concurrent
 - as defined for Medicare Part A
 - Medicare Part B has NO Concurrent therapy-Code 0
- Group (as defined for Medicare Part A and Part B)
- Documentation in the record must support MDS 3.0 coding for each mode of therapy

O0400 Therapies

- Respiratory therapy
 - Code MDS 3.0 for the total number of minutes
 - Code MDS 3.0 for the number of days therapy by a qualified professional was provided for 15 minutes or more
 - Does not include hand-held medication dispensers
- Recreational & psychological therapy
 - Not Case Mix payment items
 - Coding as above for respiratory therapy

Parameters for Coding Therapies

- Skilled therapy only by a “qualified professional” (see RAI Manual, Appendix A, pages A-14, 16, 17, 18, 19, 20)
- Therapies must be ordered by a physician/PCP “based on a qualified therapist’s assessment (Case Mix will accept Care Planning in lieu of “therapist’s assessment” for respiratory therapy only).
- Included on the Care Plan
- Periodic evaluation for effectiveness

NURSING REHABILITATION

- O0500A, B, C, I (assistance)
- O0500D, E, F, G, H, J (training & skill practice)
- H0200C (scheduled urinary toileting program)
- H0500 (scheduled bowel toileting program)
 - all documentation required for Items O500A-J is also required for urinary & bowel toileting programs



Nursing Rehabilitation

- Restorative care **must meet** the following criteria:
 - Measureable objective(s) and intervention(s) documented in the care plan and medical record
 - Evidence of periodic evaluation by the licensed nurse must be present in the medical record
 - Nursing assistants/ aides must be trained in techniques that promote resident involvement in the activity
 - A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a nursing restorative program



Importance of O0500

- **Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible**
 - **Does not require a physician's order**
 - **A signature from an RN or LPN is required if therapy recommendations are being utilized**
- **This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning**

00500 Assessment Guidelines

- Technique, training or skill practice must take place at least 15 minutes during the 24-hour period
 - Code each type of restorative care separately
 - Total minutes of care provided across the 24-hour period
 - Cannot combine time across item categories
- Does **not** include groups with **more than four residents** per supervising helper or caregiver

H0200 Urinary Toileting Program

- **H0200 captures three aspects of a resident's urinary toileting program:**
 - **H0200A Toileting Program Trial: Whether a toileting program has been attempted**
 - **H0200B Toileting Program Trial Response: Resident's response to any trial program**
 - **H0200C Current Toileting Program: Whether a current toileting program is being used to manage a resident's incontinence**
- **See RAI manual pages H-1 through H-7**

H0200 Urinary Toileting Program

- Definition of a urinary toileting program remains the same as the MDS 2.0
- Urinary toileting program does not refer to:
 - Simply tracking continence status
 - Changing pads or wet garments
 - Random assistance with toileting or hygiene

H0500 Bowel Toileting Program

- Bowel toileting program refers to a specific approach:
 - Organized, planned, documented, monitored, and evaluated
 - Has measurable objectives and interventions
 - Consistent with nursing home policies and procedures and current standards of practice
- RAI manual reference pages H-11 through H-12

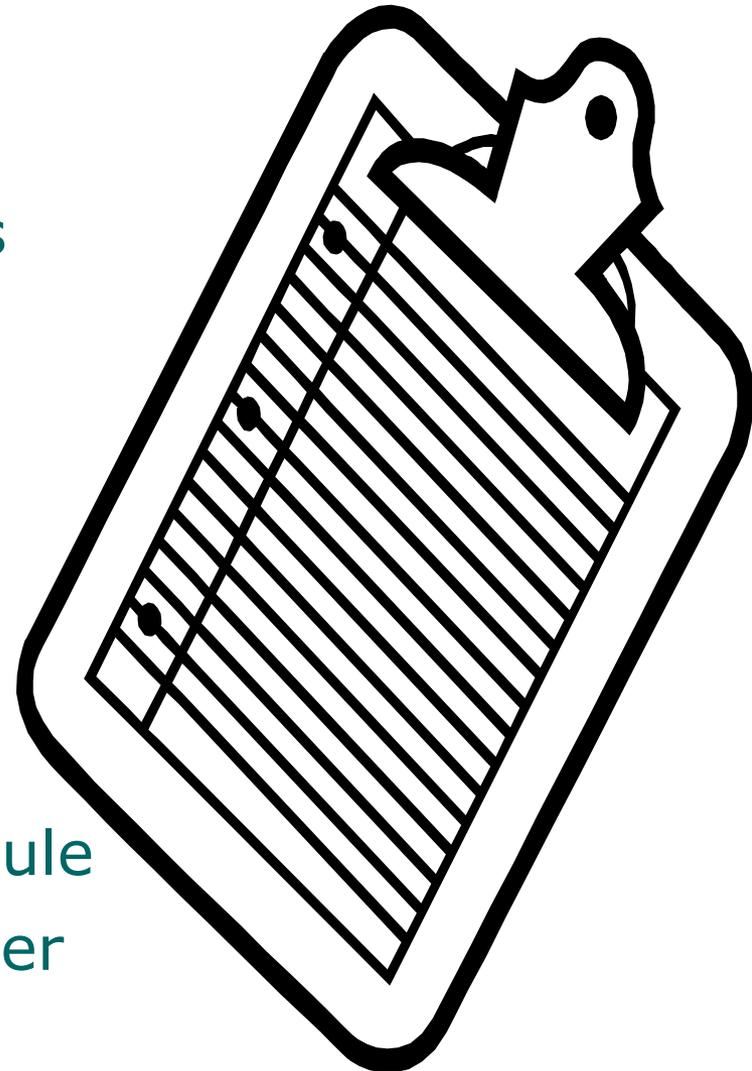
00600 Physician Examinations Assessment Guidelines



- Examination can occur in the facility or in the physician's office
 - May be a partial or full examination
 - Documentation required
- **Do not** include:
 - Examinations that occurred prior to admission/ readmission to the facility
 - Examinations that occurred during an ER visit or hospital observation stay
 - Visits made by Medicine Men

00700 Physician Orders Assessment Guidelines

- Do **not** include the following:
 - Standard admission orders
 - Return admission orders
 - Renewal orders
 - Clarifying orders without changes
 - Orders prior to the date of admission/re-entry
 - Sliding scale dosage schedule
 - Notification that a PRN order was activated



00700- Physician Orders Assessment Guidelines

- Do not include the following (continued):
 - Monthly Medicare Certification
 - Orders only written to increase the resident's RUG classification and facility payment
 - Orders for transfer of care to another physician
 - Orders written by a pharmacist
- An order written on last day of the MDS observation period for a consultation planned 3-6 months in the future should be carefully reviewed



Section Q- Participation in Assessment and Goal Setting

New on the April 2012, MDS 3.0 were the changes to section Q.

- Sections Q0400B and Q0500A were deleted



Section Q Participation in Assessment and Goal Setting

- Section Q0490, Resident's Preference to Avoid Being Asked Question, has been added on the April 2012, 3.0.
 - Please read the directions carefully here.
 - This item is completed only if A0310 is coded as 02, 06, or 99
 - There is a skip pattern here as well

Section Q Participation in Assessment and Goal Setting

- Sections Q0500A and Q0500B have been added on the April 2012, 3.0
- Q0500A asks if the resident (or family or sig other or guardian, if resident unable to respond) want to be asked about returning to the community on **ALL** assessments.
- Code 0 = No (documentation is required)
- Code 1 = yes
- Code 9 = information not available

Section Q Participation in Assessment and Goal Setting

- Section Q0500B, Indicate information source for Q0500A
 - Code 1 **Resident**
 - Code 2 if not resident then **family or sig other**
 - Code 3 if not resident, family or sig other, **then guardian or legally authorized representative**
 - Code 8 **No information source available**

Section X



The purpose of section X is to indicate whether an MDS record is a new record to be added to the QIES ASAP system or a request to modify or inactivate a record already present in the database

Section X (continued)

Section A Errors

**Please read pgs 5-10 & 5-11 of
Chapter 5 of the 3.0 User's
Manual**

**An Inactivation of the existing
record followed by submission
of a new corrected record is
required to correct Errors in
section A.**