MDS 3.0 Training
Payment Items and Documentation Requirements

Case Mix Team
October 2018

MDS 3.0 Training
Payment Items and Documentation

MDS 3.0 Training Agenda: Payment Items and Documentation

- Welcome and overview
- History
- Chapter 2
- Case Mix Implications
- Chapter 3 – section by section
- Section S – State only
- Section X – corrections
- Questions

MDS 3.0 Training
Payment Items and Documentation

MDS 3.0 History

MDS 3.0 Training
Payment Items and Documentation

Goals of the MDS 3.0

- Resident Voice – MDS 3.0 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.

MDS 3.0 Training
Payment Items and Documentation

CMS Resources for MDS 3.0

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html

RAI Manual: click on RAI manual on left, scroll down to bottom of page.

Item Set (MDS 3.0 Assessment tool): click on RAI technical information on left; scroll down to bottom of page.

MDS 3.0 Training
Payment Items and Documentation

Case Mix Implications for MDS 3.0

MDS 3.0 Training
Payment Items and Documentation

Case Mix Payment Items

Certain items coded as RUG III services, conditions, diagnoses and treatments on the MDS 3.0 assessment handout .

RUG IV refers to payment items for PPS services.

CATS refers to MDS items that "trigger" certain *care area assessment* items used - for developing an individualized, resident-specific care plan

MDS 3.0 Training
Payment Items and Documentation

MaineCare Case Mix

Maine uses a modified RUG III Code for Case Mix purposes.

PPS / Medicare uses RUG IV codes

Supporting Documentation for Case Mix payment items is required

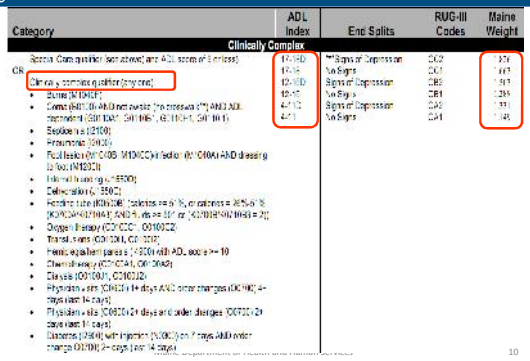
MDS 3.0 Training
Payment Items and Documentation

Case Mix Weights

There are 7 Categories:

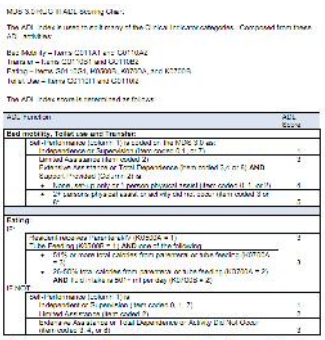
- Rehabilitation
- Extensive
- Special Care
- Clinically Complex
- Impaired Cognition
- Behavior
- Reduced Physical Function
- Default or Not Classified

MDS 3.0 Training
Payment Items and Documentation



Category	ADL Index	End Splits	RUG-III Codes	Maine Weight
Clinically Complex				
Clinically complex qualifier [any one]	12-16	No Signs	CC1	1.147
	12-16	Signs of Depression	CB1	1.313
	12-16	No Signs	CB1	1.283
	4-11	Signs of Depression	CA2	1.191
	4-11	No Signs	CA1	1.145

MDS 3.0 Training
Payment Items and Documentation



MDS 3.0 Training
Payment Items and Documentation

Case Mix Quality Assurance Review

About every 6 months, a Case Mix nurse reviews a sample of MDS 3.0 assessments and resident records to check the accuracy of the MDS 3.0 assessments.

Insufficient, inaccurate or lack of documentation to support information coded on the MDS 3.0 may lead to an error.

MDS 3.0 Training
Payment Items and Documentation

Poor Documentation could also mean…

Lower payment than the facility could be receiving,

OR

Overpayment which could lead to re-payment to the State (Sanctions). This is due to either overstating the care a resident received or insufficient documentation to support the care that was coded.

MDS 3.0 Training
Payment Items and Documentation

Sanctions:

2%	Error rate 34% or greater and less than 37%
5%	Error rate 37% or greater and less than 41%
7%	Error rate 41% or greater and less than 45%
10%	Error rate 45% or greater
10%	If requested reassessments not completed within 7 days

MDS 3.0 Training
Payment Items and Documentation

MaineCare Case Mix
Documentation

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

MDS 3.0 Training
Payment Items and Documentation

Visit the portal at:
www.Maine.gov/dhhs/dlrs/mds/training/index.shtml

MDS 3.0 Training
Payment Items and Documentation

Long Term Care Facility
Resident Assessment Instrument (RAI)
User's Manual

Chapter 2

Effective Oct 2018

MDS 3.0 Training
Payment Items and Documentation

Federal Requirements for the 3.0

- Initial and periodic assessments for **all** their residents residing in the facility for **14 or more days**.
- This includes hospice, respite, and special populations such as Pediatric and Psychiatric.

MDS 3.0 Training
Payment Items and Documentation

Responsibility of NF for Reproducing/Maintaining 3.0

Federal regulatory requirements at 42CFR483.20(d) requires NF to maintain all resident assessments completed within the previous **15 months** in the resident's active clinical record following the completion date for all assessments and correction requests.

MDS 3.0 Training
Payment Items and Documentation

Responsibility 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.

MDS 3.0 Training
Payment Items and Documentation

The Alphabet Soup of MDS

OBRA = Omnibus Budget Reconciliation Act
PPS = Prospective Payment System
OMRA = Other Medicare Required Assessments (SOT, EOT, COT)
ARD = Assessment Reference Date

MDS 3.0 Training
Payment Items and Documentation

Long Term Care Facility
Resident Assessment Instrument (RAI)
User's Manual

Chapter 3

Effective Oct 2018

MDS 3.0 Training
Payment Items and Documentation

Section A

Intent: The intent of this section is to obtain key information to uniquely identify each resident, the home in which he or she resides, and the reasons for assessment.

MDS 3.0 Training
Payment Items and Documentation

Coding Section A
A0050 - Type of Record

- Code 1 for a **new record** that has not been previously submitted and accepted in the QIES ASAP system
- Code 2 to **modify** the MDS items for a record that has been submitted and accepted in the QIES ASAP system
- Code 3 to **inactivate** a record that already has been submitted and accepted in the QIES ASAP system

MDS 3.0 Training
Payment Items and Documentation

Section A
A0310 Purpose

Documents the reason for completing the assessment

Identifies the required assessment content information (**determines item set**)

There are several subsections to A0310

MDS 3.0 Training
Payment Items and Documentation

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

MDS 3.0 Training
Payment Items and Documentation

Significant Change Criteria

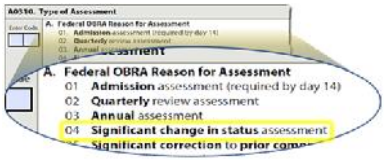
A **"significant change"** is a decline or improvement in a resident's status that:

1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not "self-limiting" (for declines only);
2. Impacts more than one area of the resident's health status; and
3. Requires interdisciplinary review and/or revision of the care plan.

MDS 3.0 Training
Payment Items and Documentation

A0310A Hospice Benefit

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



MDS 3.0 Training
Payment Items and Documentation

Significant Error

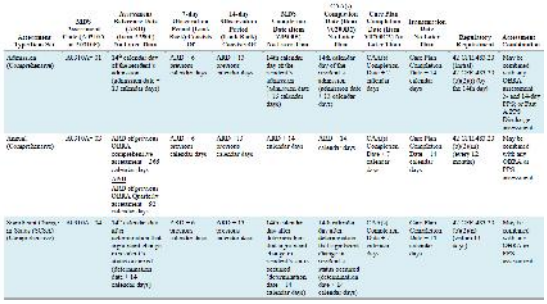
A **"significant error"** is an error in an assessment where:

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.

A significant error differs from a significant change because it reflects incorrect coding of the MDS and NOT an actual significant change in the resident's health status.

MDS 3.0 Training
Payment Items and Documentation

Assessment Scheduling



MDS 3.0 Training
Payment Items and Documentation

Section A: A0310B PPS Assessment

Includes scheduled and unscheduled assessments

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
PPS Unscheduled Assessments for a Medicare Part A Stay
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical chang
Not PPS Assessment
99. **None of the above**

MDS 3.0 Training
Payment Items and Documentation

Scheduled Medicare PPS Assessments

The SNF provider must complete the Medicare-required assessments according to the following schedule to assure compliance with the SNF PPS requirements.

Medicare MDS Scheduled Assessment Type	Reason for Assessment (A0310B code)	Assessment Reference Date	Assessment Reference Date Grace Days+	Applicable Standard Medicare Payment Days^
5-day	01	Days 1-5	6-8	1 through 14
14-day	02	Days 13-14	15-18	15 through 30
30-day	03	Days 27-29	30-33	31 through 60
60-day	04	Days 57-59	60-63	61 through 90
90-day	05	Days 87-89	90-93	91 through 100

+Grace Days: a specific number of days that can be added to the ARD window without penalty.

See RAI Manual page 2-43 for more information about use of grace days and Medicare payment days.

MDS 3.0 Training
Payment Items and Documentation

Medicare PPS Assessments

5 day
14 day
30 day
60 day
90 day

PPS Scheduled Assessments for a Medicare Part A Stay
RAI Manual, pages 2-49 to 2-50

Start of Therapy (SOT)
End of Therapy (EOT)
Both Start and End of Therapy
Change of Therapy (COT)

PPS Unscheduled Assessments: includes Other Medicare Required Assessment (OMRA), significant change and significant correction
RAI Manual, pages 2-50 to 2-58

MDS 3.0 Training
Payment Items and Documentation

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:

0. Not an OMRA assessment
1. Start of Therapy
2. End of Therapy when ARD is 1 - 3 days after last day of therapy services
3. Start and End of Therapy
4. Change of Therapy Assessment

MDS 3.0 Training
Payment Items and Documentation

Section A: A0310E Type of Assessment

Is This Assessment the First Assessment (OBRA, PPS, or Discharge) since the Most Recent Admission/Entry or Reentry?

Complete this item for all assessments

MDS 3.0 Training
Payment Items and Documentation

Coding Section A
A0310F Entry/ Discharge Reporting

01. Entry tracking record
10. Discharge assessment – **return not anticipated**
11. Discharge assessment – **return anticipated**
12. Death in facility tracking record
99. None of the above

MDS 3.0 Training
Payment Items and Documentation

Coding Section A
A0310G Type of Discharge

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

A discharge assessment is required for:
1. Discharge return not anticipated
2. Discharge return anticipated
3. Part A PPS Discharge

MDS 3.0 Training
Payment Items and Documentation

Section A: A0310H SNF Part A PPS Discharge

Part A PPS Discharge Assessment :
- completed when a resident's *Medicare Part A stay ends (A2400C)*, and the resident remains in the facility;

or
- may be combined with an OBRA Discharge (A0310F = 10) if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000). (Page A-7)

MDS 3.0 Training
Payment Items and Documentation

Discharge from facility and Part A:

Combined OBRA/Part A discharge MDS.

*If the End Date of the Most Recent Medicare Stay (**A2400C**) occurs **on the day of or one day before** the Discharge Date (**A2000**) of a **planned discharge** (**A0310G=1**), the OBRA Discharge assessment* and *Part A PPS Discharge assessment are both required and may be combined.*

*When the OBRA and Part A PPS Discharge assessments are **combined**, the ARD (**A2300**) must be equal to the Discharge Date (**A2000**).*

MDS 3.0 Training
Payment Items and Documentation

If the resident is **remaining** in the facility:

F. Entry/discharge reporting
01. **Entry** tracking record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** tracking record
99. None of the above

G. Type of discharge - Complete only if A0310F = 10 or 11
1. Planned
2. Unplanned

H. Is this a SNF Part A PPS Discharge Assessment?
0. No
1. Yes

- A0310F will be coded as '**99**', as this is not an OBRA discharge →
- Therefore, A0310G will be skipped, as this is completed only if A0310F = 10 or 11 →
- A0310H will be coded '**Yes**', for a Part A PPS discharge

MDS 3.0 Training
Payment Items and Documentation

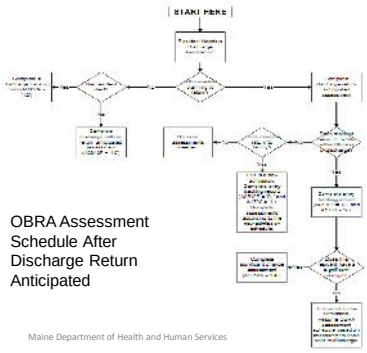
What if the resident doesn't go home until the next day?

Complete a Medicare Part A Discharge assessment, and complete an OBRA Discharge assessment

- A0310F = 10 (discharge, return not anticipated)
- A0310H = 1 (Part A PPS Discharge)

- A2000 = A2400 +1
- A2300 = A2000 (ARD = discharge date)
- A2400 = last covered day

MDS 3.0 Training
Payment Items and Documentation



OBRA Assessment Schedule After Discharge Return Anticipated

No new OBRA admission assessment required after *re-admission* from hospital. Submit entry tracking form and continue previously established OBRA schedule, or complete a significant change as appropriate.

MDS 3.0 Training
Payment Items and Documentation

A0410. Unit Certification or Licensure Designation

MDS 3.0 Training
Payment Items and Documentation

Section A
Resident Data

A0500 through A1300

Check and double check the accuracy of the name and all numbers - social security, Medicare and MaineCare numbers, Date of Birth

MDS 3.0 Training
Payment Items and Documentation

Section A
A1500 PASRR/ Medicaid

All individuals admitted to Medicaid certified NFs, regardless of payment source must have a Level I PASRR (Federal Requirement)

If the Level I screen is positive for known or suspected mental illness, intellectual disability, developmental disability, or "other related conditions," a Level II evaluation is performed

MDS 3.0 Training
Payment Items and Documentation

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

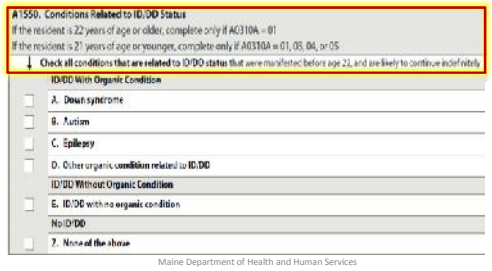
Completed only if admission (01), Annual (03), significant change (04), or significant correction to prior comprehensive assessment (05)

Level II Conditions:

- Serious mental illness
- Intellectual disability
- Other related condition

MDS 3.0 Training
Payment Items and Documentation

Section A
A1550- Level II Preadmission Screening and Resident Review (PASRR) Conditions



MDS 3.0 Training
Payment Items and Documentation

PASRR

https://www.ascendami.com/ami/Providers/YourState/MaineASAUserTools.aspx

MAXIMUS

Effective October 1, 2018, Maximus is now processing the assessments that were formerly done by KEPRO. The full name of Maximus is "Ascend Management Innovations."

Maximus will perform the standardized assessments that determine eligibility and communicate service options to individuals seeking State-funded and MaineCare program Long Term Care (LTC) services. In addition, ASA assessors conduct Preadmission Screening and Resident Review (PASRR) assessments for individuals suspected of having a mental disorder, intellectual disability or other related condition to determine the LOC services required.

48

MaineCare members can reach Maximus by phone at 833-525-5784 or email at ask-Maineasa@maximus.com.

MDS 3.0 Training
Payment Items and Documentation

A1600-A1800 Most Recent Admission/Entry or Reentry to the facility

A1900 Admission Date

A2000 Discharge Date

A2100 Discharge Status

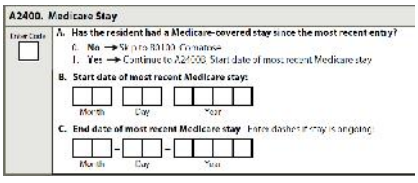
MDS 3.0 Training
Payment Items and Documentation

Section A
A2300 Assessment Reference Date (ARD)

- Designates the **end** of the look-back period so that all assessment items refer to the resident's status during the same period of time.
- Anything that happens after the ARD will not be captured on that MDS.
- The look-back period includes observations and events through the end of the day (midnight) of the ARD.

MDS 3.0 Training
Payment Items and Documentation

A2400



Medicare Stay End Date Algorithm RAI Manual, page A-37

MDS 3.0 Training
Payment Items and Documentation

Section S

This section is specific data requirements for the State of Maine only.

S0120 Residence Prior to Admission

Enter the zip code of the community address where the resident last resided prior to nursing facility admission. | | | | | |

MDS 3.0 Training
Payment Items and Documentation

S0170. Advanced Directive

A.	Guardian
B.	Durable power of attorney for health care
C.	Living will
D.	Do not resuscitate
E.	Do not hospitalize
F.	Do not intubate
G.	Feeding restrictions
H.	Other treatment restrictions
Z.	None of the above

MDS 3.0 Training
Payment Items and Documentation

S0510. PASRR Level I Screening

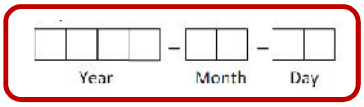
Was a PASRR Level I screening completed?

0. No → Skip to S3300 Weight-based Equipment Needed
1. Yes → Continue to S0511 PASRR Date
9. Unknown → Skip to S3300 Weight-based Equipment Needed

Note the skip patterns

MDS 3.0 Training
Payment Items and Documentation

S0511. PASRR Level I Date: (Complete only if S0510 = 1)



MDS 3.0 Training
Payment Items and Documentation

S0513. PASRR Level I Screening Outcome

What was the outcome of the PASRR Level I screen?

0. Screen was sent to the NF; no diagnosis, suspected diagnosis or need for specialized services
1. Screen was sent for determination of need for Level II screen due to diagnosis, suspected diagnosis or need for specialized services related to mental illness, intellectual disability, or other related condition

MDS 3.0 Training
Payment Items and Documentation

S3300. Weight-based Equipment Need

Did this resident require specialized equipment based on weight since last assessment?

0. No → Skip to S6020 Specialized Needs
1. Yes → Continue to S3305 Requirements for Weight

MDS 3.0 Training
Payment Items and Documentation

S3305. Requirements for Care, *Specifically related to Weight*

A. **Lifting device.** Since last assessment, was a specialized lifting device required?
B. **Wheelchair or mobility device.** Since last assessment, was an oversized, non-standard wheelchair or other mobility device required?
C. **Bed.** Since last assessment, was a specialized, non-standard bed required?
D. **Seating.** Since last assessment, was a specialized, non-standard seat required?
E. **More than 2 staff.** Since last assessment, was 3 or more staff required to provide assistance with ADL?
Y. **Other.** Since last assessment, was other specialized, non-standard equipment required? ☐

MDS 3.0 Training
Payment Items and Documentation

S6020. Specialized needs specifically related to a resident's need for a Ventilator/Respirator

A. **RN expertise.** Resident needs care by an RN with specialized expertise.
B. **CNA training.** Resident needs care by CNA staff with specialized training.
C. **Therapy (PT, OT, RT) expertise.** Resident needs therapy (PT, OT, RT) with specialized training or expertise.
D. **Equipment.** Resident needs specialized equipment.
Y. **Other.** Resident has other needs. ☐
Z. **None of the above**

MDS 3.0 Training
Payment Items and Documentation

S6022. Direct care by a Licensed Nurse

Enter a response for A, B, and C to indicate the number of **days** the resident required direct care described

A. **Number of days the resident required direct care by a licensed nurse on an hourly basis.** During the last 7 days or since admission/entry or reentry.
B. **Number of days the resident required direct care by a licensed nurse in 15-minute intervals.** During the last 7 days or since admission/entry or reentry.
C. **Number of days the resident required direct care by a licensed nurse in 5-minute intervals.** During the last 7 days or since admission/entry or reentry.

MDS 3.0 Training
Payment Items and Documentation

S6023. Direct Care by a CNA

A. **Number of days the resident required direct care by a CNA on an hourly basis.**
During the last 7 days or since admission/entry or reentry.

B. **Number of days the resident required direct care by a CNA in 15-minute intervals.**
During the last 7 days or since admission/entry or reentry.

C. **Number of days the resident required direct care by a CNA in 5-minute intervals.**
During the last 7 days or since admission/entry or reentry.

MDS 3.0 Training
Payment Items and Documentation

S6024. Direct Care by a Respiratory Therapist

A. **Number of days the resident required direct care by a licensed respiratory therapist on an hourly basis.**
During the last 7 days or since admission/entry or reentry.

B. **Number of days the resident required direct care by a licensed respiratory therapist in 15-minute intervals.**
During the last 7 days or since admission/entry or reentry.

C. **Number of days the resident required direct care by a licensed respiratory therapist in 5-minute intervals.**
During the last 7 days or since admission/entry or reentry.

MDS 3.0 Training
Payment Items and Documentation

Resident Stays

S6200. Hospital Stays

Number of hospital stays. Record number of times resident was admitted to a hospital for an overnight stay in the last 90 days (or since last assessment if less than 90 days)

S6205. Observation Stays

Number of observation stays. Record number of times resident had at least one overnight stay without being admitted to the hospital since the last assessment.

S6210. Emergency Room (ER) Visits

Number of ER visits. Record number of times resident visited ER without an overnight stay in the last 90 days (or since last assessment if less than 90 days)

MDS 3.0 Training
Payment Items and Documentation

S8010 Payment Source – To determine payment source that covers the *daily per diem* or ancillary services for the resident's stay in the nursing facility, **as of the ARD date**.

- C3 – MaineCare per diem. Do not check if MaineCare is pending
- G3 MaineCare pays Medicare or insurance Co-pay

S8099 None of the above

MDS 3.0 Training
Payment Items and Documentation

S8510. MaineCare Therapeutic Leave Days


S8510. MaineCare Therapeutic Leave Days

A. MaineCare therapeutic leave days since last assessment. Enter the number of therapeutic leave days paid by MaineCare since the last assessment.

B. MaineCare therapeutic leave days state fiscal year-to-date. Enter the number of therapeutic leave days paid by MaineCare state fiscal year to date.

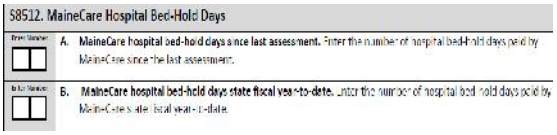
MDS 3.0 Training
Payment Items and Documentation

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

MDS 3.0 Training
Payment Items and Documentation

S8512. MaineCare Hospital Bed-Hold Days


S8512. MaineCare Hospital Bed-Hold Days

A. MaineCare hospital bed-hold days since last assessment. Enter the number of hospital bed-hold days paid by MaineCare since the last assessment.

B. MaineCare hospital bed-hold days state fiscal year-to-date. Enter the number of hospital bed-hold days paid by MaineCare state fiscal year-to-date.

MDS 3.0 Training
Payment Items and Documentation

Section B
Hearing, Speech, and Vision

Intent: The intent of items in this section is to document the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others and whether the resident experiences visual limitations or difficulties related to diseases common in aged persons.

MDS 3.0 Training
Payment Items and Documentation

Section B

B0100: Comatose
B0200: Ability to Hear (with hearing aid if normally used)
B0300: Hearing Aid
B0600: Speech Clarity
B0700: Makes Self Understood
B0800: Ability to Understand Others
B1000: Vision (with adequate light)
B1200: Corrective Lenses

MDS 3.0 Training
Payment Items and Documentation

Section B

B0700, page B-7: 4. Consult with the primary nurse assistants (over all shifts), and the resident's family, and speech-language pathologist.

Coding Tips and Special Populations

- *This item cannot be coded as Rarely/Never Understood if the resident completed any of the resident interviews,* as the interviews are conducted during the look-back period for this item and should be factored in when determining the residents' ability to make self understood during the entire 7-day look-back period.
- While B0700 and the resident interview items are not directly dependent upon one another, inconsistencies in coding among these items should be evaluated.

MDS 3.0 Training
Payment Items and Documentation

Section C
Cognitive Patterns

Intent: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions.

MDS 3.0 Training
Payment Items and Documentation

Section C

Steps for Assessment

1. Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.
2. Determine if the resident is rarely/never understood verbally, in writing, or using another method.

Coding Instructions

Code 0, **no**: if the interview should not be conducted because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available.

Code 1, yes: if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available.

MDS 3.0 Training
Payment Items and Documentation

Coding Tips

- Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.
- If the resident interview was not conducted within the look-back period (preferably the day before or the day of the ARD), item C0100 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items.
- Do not complete the Staff Assessment for Mental Status items (C0700-C1000) if the resident interview should have been conducted, but was not done.

MDS 3.0 Training
Payment Items and Documentation

Section C

C0200-C0500: BIMS resident interview questions (scripted interview)

Sock

Blue

Bed

MDS 3.0 Training
Payment Items and Documentation

Section C

C0600: Should the *staff* assessment be conducted?

C0700-C1000 Staff assessment:
C0700 Short-Term Memory
C0800 Long-Term Memory
C0900 Memory/Recall Ability
C1000 Cognitive Skills for Daily Decision Making

Documentation required to confirm responses

MDS 3.0 Training
Payment Items and Documentation

DEFINITION

DELIRIUM
A mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness or hallucinations.

DEFINITION

DISORGANIZED THINKING
Evidenced by rambling, irrelevant, or incoherent speech.

DEFINITIONS

INATTENTION
Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Resident seems unaware or out of touch with environment (e.g., dazed, fixated or darting attention).

FLUCTUATION
The behavior tends to come and go and/or increase or decrease in severity. The behavior may fluctuate over the course of the interview or during the 7-day look- back period. Fluctuating behavior may be noted by the interviewer, reported by staff or family or documented in the medical record.

DEFINITIONS

ALTERED LEVEL OF CONSCIOUSNESS
VIGILANT – startles easily to any sound or touch;
LETHARGIC – repeatedly dozes off when you are asking questions, but responds to voice or touch;
STUPOR – very difficult to arouse and keep aroused for the interview;
COMATOSE – cannot be arousec despite shaking and shouting.

MDS 3.0 Training
Payment Items and Documentation

C1310 Signs and Symptoms of Delirium

Delirium

C1310. Signs and Symptoms of Delirium (from CAM©)

Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

A. Acute Onset Mental Status Change

Enter Code: ☐ Is there evidence of an acute change in mental status from the resident's baseline?
0. No
1. Yes

Coding:
0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

↓ **Enter Codes in Boxes**

☐ **B. Inattention** - Did the resident have difficulty focusing attention, for example being easily distractible, or having difficulty keeping track of what was being said?

☐ **C. Disorganized thinking** - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?

☐ **D. Altered level of consciousness** - Did the resident have altered level of consciousness (as indicated by any of the following criteria)?
- **vigilant** - startled easily to any sound or touch
- **lethargic** - repeatedly dozes off when you are asking questions, but responds to voice or touch
- **stuporous** - very difficult to arouse and keep aroused for the interview
- **comatose** - could not be aroused

MDS 3.0 Training
Payment Items and Documentation

Section D
Mood

Intent: The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable.

MDS 3.0 Training
Payment Items and Documentation

Section D

D0100: Should Resident Mood Interview Be Conducted?

If yes…
D0200 (Resident Interview – PHQ9©)
Enter the frequency of symptoms for Column 2, Items A through I

Requires no further supporting documentation. Case mix nurses check for *timely completion* according to Z0400.

MDS 3.0 Changes
Effective 10/1/18

Section D

Steps for Assessment

1. Interact with the resident using his or her preferred language. *Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.*
2. *Determine if the resident is rarely/never understood verbally, in writing, or using another method.*

Coding Instructions

Code 0, **no**: if the interview should not be *conducted* because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed, but not available.

Code 1, yes: if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available.

MDS 3.0 Changes
Effective 10/1/18

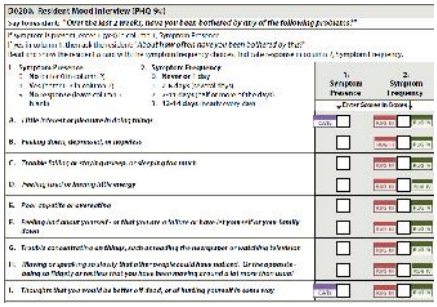
Section D

Coding Tips

- Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.
- If the resident interview was not conducted within the look-back period (preferably the day before or the day of)the ARD, item D0100 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items.
- Do not complete the Staff Assessment for Resident Mood items (D0500) if the resident interview should have been conducted, but was not done.

MDS 3.0 Training
Payment Items and Documentation

Section D D0200



Maine Department of Health and Human Services 82

MDS 3.0 Training
Payment Items and Documentation

Section D
D0300

D0300 Total Severity Score

A summary of the frequency scores that indicates the extent of potential depression symptoms. The score does not diagnose a mood disorder, but provides a standard of communication with clinicians and mental health specialists.

Total score must be between 00 and 27

Maine Department of Health and Human Services 83

MDS 3.0 Training
Payment Items and Documentation

Section D
D0500

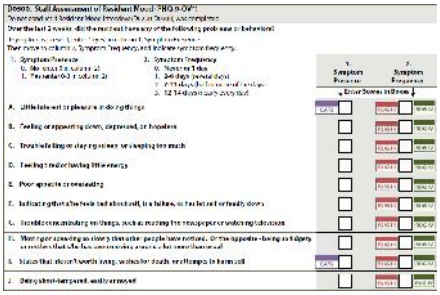
Staff Assessment of Resident Mood
Look-back period for this item is 14 days.

Interview staff from all shifts who know the resident best.

Supporting documentation is required

Maine Department of Health and Human Services 84

MDS 3.0 Training
Payment Items and Documentation



D0600 = Total Severity Score (Enter score of 00 to 30)

D0650 = safety notification if there is a possibility of resident self harm

MDS 3.0 Training
Payment Items and Documentation

Section E
Behavior

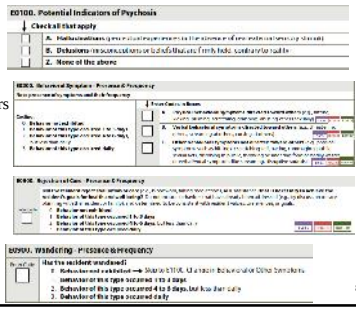
Intent: The items in this section identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment.

MDS 3.0 Training
Payment Items and Documentation

BEHAVIORAL SYMPTOMS

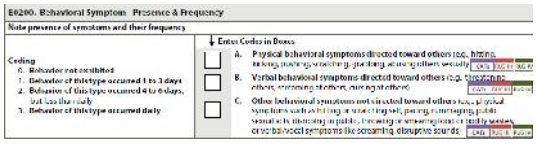
Payment Items

- **E0100A** Hallucinations
- **E0100B** Delusions
- **E0200A** Physical behaviors
- **E0200B** Verbal behaviors
- **E0200C** Other behaviors
- **E0800** Rejection of care
- **E0900** Wandering



MDS 3.0 Training
Payment Items and Documentation

Section E: E0200

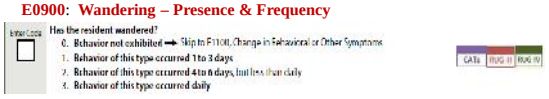


E0300: Overall Presence of Behavioral Symptoms
E0500: Impact on Resident
E0600: Impact on Others

MDS 3.0 Training
Payment Items and Documentation

Section E: E0800 and E0900

E0800: Rejection of Care – Presence & Frequency
E0900: Wandering – Presence & Frequency



E1000: Wandering – Impact
E1000A Risk to Self
E1000B Intrusion on others
E1100: Change in Behavior or Other Symptoms

MDS 3.0 Training
Payment Items and Documentation

Section G - Functional Status

Intent: Items in this section assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion.

MDS 3.0 Training
Payment Items and Documentation

Section G -
Payment Items

G0110A1, 2 Bed mobility: Self-performance & Support
G0110B1, 2 Transfer: Self-performance & Support
G0110I 1, 2 Toileting: Self-performance & Support
G0110H1 Eating: Self-performance Only

MDS 3.0 Training
Payment Items and Documentation

Section G - G0110

1. ADL Self-Performance
Code for resident's performance over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time.

Coding:
Activity Occurred 3 or More Times
0. Independent - no help or staff oversight at any time
1. Supervision - oversight, encouragement or cueing
2. Limited assistance - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight bearing assistance
3. Extensive assistance - resident involved in activity; staff provide weight bearing support
4. Total dependence - full staff performance every time during entire 7-day period
Activity Occurred 2 or Fewer Times
7. Activity occurred only once or twice - activity did occur but only once or twice
8. Activity did not occur - 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

1. ADL Support Provided
Code for most support provided over all shifts; code regardless of resident's self-performance classification

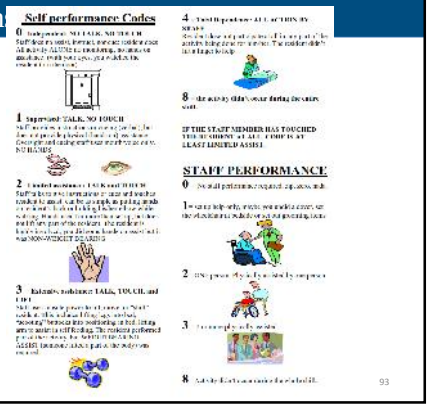
Coding:
0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur; family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

1. Self-Performance	2. Support

↓ Enter Codes in Boxes ↓

MDS 3.0 Training
Payment Item

ADL Documentation handout for CNAs



MDS 3.0 Training
Payment Items and Documentation

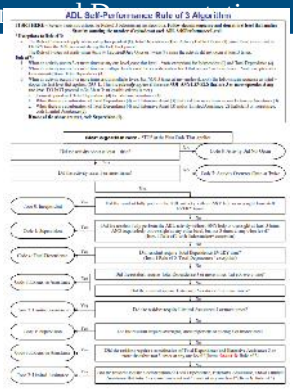
Section G Self Performance

Instructions for Rule of 3

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all.
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.

MDS 3.0 Training
Payment Ite



MDS 3.0 Training
Payment Items and Documentation

Coding Tips

- Do **NOT** include the emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag in G0110 I.
- **Differentiating between guided maneuvering and weight-bearing assistance:** determine **who** is supporting the weight of the resident's extremity or body. For example, if the staff member supports some of the weight of the resident's hand while helping the resident to eat (e.g., lifting a spoon or a cup to mouth), or performs part of the activity for the resident, this is "weight-bearing" assistance for this activity. If the resident can lift the utensil or cup, but staff assistance is needed to guide the resident's hand to his or her mouth, this is guided maneuvering.

MDS 3.0 Training
Payment Items and Documentation

- **Code Supervision** for residents seated together or in close proximity of one another during a meal who receive individual supervision with eating.
- General supervision of a dining room is not the same as individual supervision of a resident and **is not** captured in the coding for Eating.
- **Code extensive assistance (1 or 2 persons):** if the resident with tube feeding, TPN, or IV fluids did not participate in management of this nutrition but did participate in receiving oral nutrition. This is the correct code because the staff completed a portion of the ADL activity for the resident (managing the tube feeding, TPN, or IV fluids).
- **Code totally dependent in eating:** only if resident was assisted in eating all food items and liquids at all meals and snacks (including tube feeding delivered totally by staff) and did not participate in any aspect of eating (e.g., did not pick up finger foods, did not give self tube feeding or assist with swallow or eating procedure).

MDS 3.0 Training
Payment Items and Documentation

Coding activity did not occur, 8:

- **Toileting** would be **coded 8, activity did not occur**: only if elimination did not occur during the entire look-back period, or if family and/or non-facility staff toileted the resident 100% of the time over the entire 7-day look-back period.
- **Locomotion** would be **coded 8, activity did not occur**: if the resident was on bed rest and did not get out of bed, and there was no locomotion via bed, wheelchair, or other means during the look-back period or if locomotion assistance was provided by family and/or non-facility staff 100 % of the time over the entire 7-day look-back period.
- **Eating** would be **coded 8, activity did not occur**: if the resident received no nourishment by any route (oral, IV, TPN, enteral) during the 7-day look-back period, if the resident was not fed by facility staff during the 7-day look-back period, or if family and/or non-facility staff fed the resident 100% of the time over the entire 7-day look-back period.

MDS 3.0 Training
Payment Items and Documentation

Coding Scenario

During the look-back period, Mr. S was able to toilet independently without assistance **18** times. The other two times toileting occurred during the 7-day look-back period, he required the assistance of staff to pull the zipper up on his pants. This assistance is classified as non-weight-bearing assistance. The assessor determined that the appropriate code for G0100I, Toilet use was Code 1, Supervision. (RAI Manual, page G-23)

MDS 3.0 Training
Payment Items and Documentation

Rationale: Toilet use occurred 20 times during the look-back period. Non-weight bearing assistance was provided two times and 18 times the resident used the toilet independently.

Independent (i.e., Code 0) cannot be the code entered on the MDS for this ADL activity because in order to be coded as Independent (0), the resident must complete the ADL without any help or oversight from staff every time. Mr. S did require assistance to complete the ADL two times; therefore, the Code 0 does not apply.

Code 7, Activity occurred only once or twice, did not apply because even though assistance was provided twice during the look-back period, the activity itself actually occurred 20 times.

The assistance provided to the resident did not meet the definition for Limited Assistance (2) because even though the assistance was non-weight-bearing, it was only provided twice in the look-back period.

The ADL Self-Performance coding level definitions for Codes 1, 3 and 4 did not apply directly to this scenario either.

MDS 3.0 Training
Payment Items and Documentation

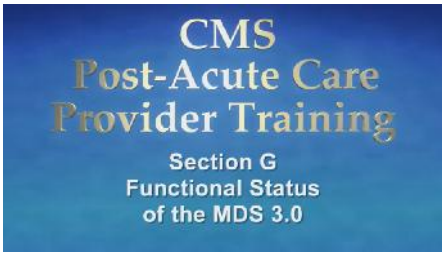
The first Rule of 3 does not apply because even though the ADL activity occurred three or more times, the non-weight-bearing assistance occurred only twice.

The second Rule of 3 does not apply because even though the ADL occurred three or more times, it did not occur three times at multiple levels.

The third Rule of 3 does not apply because the ADL occurred three or more times, at the independent level. Since the third Rule of 3 did not apply, the assessor knew not to apply any of the sub-items.

However, the final instruction to the provider is that when neither the Rule of 3 nor the ADL Self-Performance coding Level definitions apply, the appropriate code to enter in Column 1, ADL Self-Performance, is Supervision (1); therefore, in G0110I, Toilet use, the code Supervision (1) was entered.

MDS 3.0 Training
Payment Items and Documentation



https://youtu.be/t-6e5NV4j6k

MDS 3.0 Training
Payment Items and Documentation

Section G

G0120: Bathing
- A. Self-Performance
- B. Support

G0300: Balance During Transitions and Walking
G0400: Functional Limitation in Range of Motion
- A. Upper Extremity
- B. Lower Extremity

G0600: Mobility Devices (check all that apply)
G0900: Functional Rehabilitation Potential

MDS 3.0 Training
Payment Items and Documentation

Section G0300 Balance During Transitions and Walking

G0300. Balance During Transitions and Walking

After observing the resident, code the following walking and transition items for most dependent:

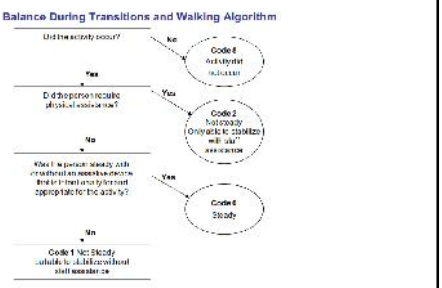
Coding:
0. Steady at all times
1. Not steady, but able to stabilize without staff assistance
2. Not steady, only able to stabilize with staff assistance
8. Activity did not occur

↓ Enter Codes in Boxes

- A. Moving from seated to standing position
- B. Walking (with assistive device if used)
- C. Turning around and facing the opposite direction while walking
- D. Moving on and off toilet
- E. Surface-to-surface transfer (transfer between bed and chair or wheelchair)

MDS 3.0 Training
Payment Items and Documentation

Section G0300 Balance During Transitions and Walking



MDS 3.0 Training
Payment Items and Documentation

Section H Bladder and Bowel

Intent: The intent of the items in this section is to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.

MDS 3.0 Training
Payment Items and Documentation

Section H

H0100: Appliances
H0200: Urinary Toileting Program
A: Trial of a toileting program?
B: Response to trial
C: Current toileting program or trial
H0300: Urinary Continence
H0400: Bowel Continence
H0500: Bowel Toileting Program
H0600: Bowel Patterns

H0200C and H0500 are part of the Restorative Nursing Program and will be reviewed with Section O

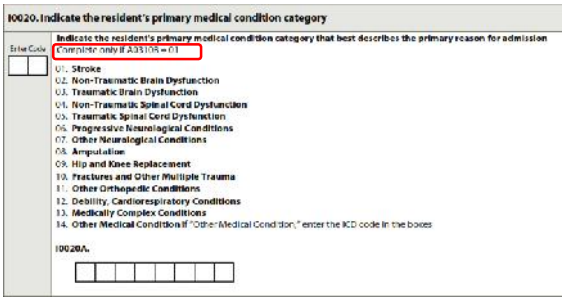
MDS 3.0 Training
Payment Items and Documentation

Section I Active Diagnoses

Intent: The items in this section are intended to code diseases that have a *direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death*. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status.

MDS 3.0 Training
Payment Items and Documentation

Section I: Active Diagnoses



109

MDS 3.0 Training
Payment Items and Documentation

DIAGNOSES (Case Mix Items)

I2000 – Pneumonia
I2100 - Septicemia
I2900 - Diabetes (If N0300 = 7 and O0700 = 2 or more)
I4300 - Aphasia (and a feeding tube) **(RUG III only)**
I4400 - Cerebral palsy
I4900 - Hemiplegia/hemiparesis
I5100 - Quadriplegia
I5200 - Multiple Sclerosis
I5300 – Parkinson's Disease **(RUG IV only)**
I5500 - Traumatic brain injury (Maine only, **RUG III**)
I6200 - Asthma, COPD, or Chronic Lung Disease **(RUG IV only)**
I6300 – Respiratory Failure **(RUG IV only)**

MDS 3.0 Training
Payment Items and Documentation

Section I Active Diagnoses

1. Identify diagnoses in the last **60 days**
   - Must be **physician-documented**
2. Determine status of diagnosis
   - **7-day** look-back period,
   - Active diagnoses have a **direct relationship** to the resident's functional, cognitive, mood or behavior status, medical treatments or nursing monitoring or risk of death
   - Only active diagnoses should be coded

MDS 3.0 Training
Payment Items and Documentation

The following indicators may assist assessors in determining whether a diagnosis should be coded as active in the MDS:

There may be specific documentation in the medical record by a physician, nurse practitioner, physician assistant, or clinical nurse specialist of active diagnosis.

In the absence of specific documentation that a disease is active, the following indicators may be used to confirm active disease:

- Recent onset or acute exacerbation of the disease or condition indicated by a positive study, test or procedure, hospitalization for acute symptoms and/or recent change in therapy in the last 7 days.
- Symptoms and abnormal signs indicating ongoing or decompensated disease in the last 7 days.
- Listing a disease/diagnosis (e.g., arthritis) on the resident's medical record problem list is not sufficient for determining active or inactive status.
- Ongoing therapy with medications or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor potentially severe side effects in the last 7 days.

MDS 3.0 Training
Payment Items and Documentation

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** instead of 7 days

Code for a UTI **only if both** of the following criteria are met in the last 30 days:

1. It was determined that the resident had a UTI using evidence-based criteria such as McGeer, NHSN, or Loeb in the last 30 days,

AND

2. A physician documented UTI diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days.

MDS 3.0 Training
Payment Items and Documentation

Item I5100 Quadriplegia

Quadriplegia primarily refers to the paralysis of all four limbs, arms and legs, caused by spinal cord injury.

Coding I5100 Quadriplegia is limited to spinal cord injuries and must be a primary diagnosis and not the result of another condition.

Functional quadriplegia refers to complete immobility due to severe physical disability or frailty. Conditions such as cerebral palsy, stroke, contractures, brain disease, advanced dementia, etc. can also cause functional paralysis that may extend to all limbs hence, the diagnosis functional quadriplegia.

MDS 3.0 Training
Payment Items and Documentation

Section J

Intent: The intent of the items in this section is to document a number of health conditions that impact the resident's functional status and quality of life. The items include an assessment of pain which uses an interview with the resident or staff if the resident is unable to participate. The pain items assess the presence of pain, pain frequency, effect on function, intensity, management and control. Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, and falls.

MDS 3.0 Training
Payment Items and Documentation

J0100: Pain Management (5-Day Look Back)

MDS 3.0 Training
Payment Items and Documentation

DEFINITION

PAIN: Any type of physical pain or discomfort in any part of the body. It may be localized to one area or may be more generalized. It may be acute or chronic, continuous or intermittent, or occur at rest or with movement. Pain is very subjective; pain is whatever the experiencing person says it is and exists whenever he or she says it does.

Steps for Assessment: Basic Interview Instructions for Pain Assessment Interview (J0300-J0600): RAI Manual, pages J-7 and J-8

J0300 – J0600: Pain Interview

J0700: Should the Staff Assessment for Pain be Conducted?

J0800-J0850: Staff Assessment for Pain

MDS 3.0 Training
Payment Items and Documentation

Section J Problem Conditions

J1550:

A. Fever
B. Vomiting
C. Dehydrated (RUG III only)
D. Internal Bleeding (RUG III only)
Z. None of the above

Seven (7) day look-back period

MDS 3.0 Training
Payment Items and Documentation

Section J Health Conditions

J1700 Fall History (if A0310A = 1 or A0310E=1; 30 and 180 day look-back; fractures due to falls in the 6 months prior to admission)

J1800 Falls since Admission/Entry (yes or no)

J1900 Number of Falls since Admission

MDS 3.0 Training
Payment Items and Documentation

Definition of a Fall:

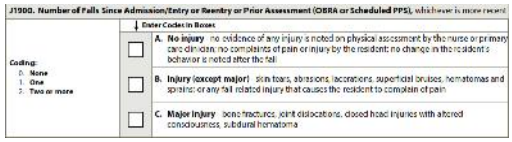
Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground.

Falls include any fall, whether it occurred at home, while out in the community, in an acute hospital or a nursing home. Falls are not a result of an *overwhelming external force* (e.g., a resident pushes another resident).

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.

MDS 3.0 Training
Payment Items and Documentation

J1900



It is important to ensure the accuracy of the level of injury resulting from a fall. Since injuries can present themselves later than the time of the fall, **the assessor may need to look beyond the ARD to obtain the accurate information for the complete picture of the fall that occurs in the look back of the MDS**.

121

MDS 3.0 Training
Payment Items and Documentation

Definition of **Injury Related to a Fall**:

Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

Steps for Assessment (RAI Manual, Chapter 3, page J-32):

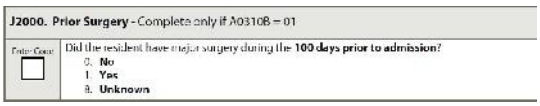
6. Review any follow-up medical information received pertaining to the fall, **even if this information is received after the ARD (e.g., emergency room x-ray, MRI, CT scan results), and ensure that this information is used to code the assessment.**

Coding Tip (RAI Manual, Chapter 3, page J-33)

If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to QIES ASAP, the assessment must be modified to update the level of injury that occurred with that fall

MDS 3.0 Training
Payment Items and Documentation

J2000: Prior Surgery



Generally, major surgery for item J2000 refers to a procedure that meets the following criteria:

1. The resident was an inpatient in an acute care hospital for at least one day in the 100 days prior to admission to the skilled nursing facility (SNF), **and**
2. The surgery carried some degree of risk to the resident's life or the potential for severe disability.

123

MDS 3.0 Training
Payment Items and Documentation

J2000: Prior Surgery

Examples:

1. Surgical removal of a skin tag from her neck a month and a half ago; the procedure was done as an outpatient.
2. Six months ago, a resident was admitted to the hospital for five days following a bowel resection (partial colectomy) for diverticulitis; no other surgeries since that time.
3. The resident was transferred to the facility immediately following a four-day acute care hospital stay related to dehiscence of a surgical wound subsequent to a complicated cholecystectomy. The attending physician also noted diagnoses of anxiety, diabetes, and morbid obesity in her medical record.

124

MDS 3.0 Training
Payment Items and Documentation

Section K
Swallowing/Nutritional Status

Intent: The items in this section are intended to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches. The assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately.

MDS 3.0 Training
Payment Items and Documentation

Section K: Weight Loss/Gain

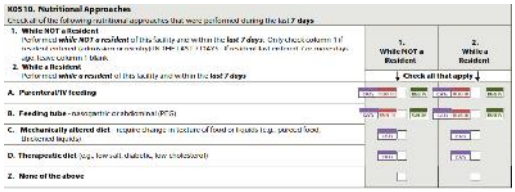
K0100: Swallowing disorder
K0200: Height and Weight
K0300: Weight Loss
K0310: Weight gain

MDS 3.0 Training
Payment Items and Documentation

Section K - Nutritional Approaches

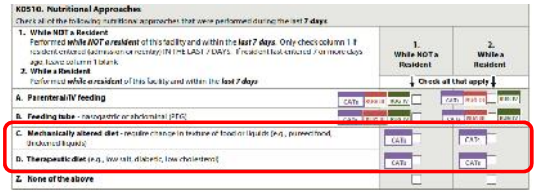
K0510: Approaches

- **A. Parenteral / IV Feeding**
- **B. Feeding Tube**
- C. Mechanically Altered Diet
- D. Therapeutic Diet
- Z. None of the above



127

MDS 3.0 Training
Payment Items and Documentation



Maine Department of Health and Human Services 128

MDS 3.0 Training
Payment Items and Documentation

K0510 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-10 through K-12

Maine Department of Health and Human Services 129

MDS 3.0 Training
Payment Items and Documentation

K0710 Percent Intake by Artificial Route

A. Proportion of total calories the resident received through parenteral or tube feeding
   1. 25% or less
   2. 26-50%
   3. 51% or more

B. Average fluid intake per day by IV or tube feeding
   1. 500 cc/day or less
   2. 501 cc/day or more

K0710B.3 is a payment item

If the resident took no food or fluids by mouth (NPO) or took just sips of fluid, stop here and code 3, 51% or more.

If the resident had more substantial oral intake than this, *consult with the dietician*.

MDS 3.0 Training
Payment Items and Documentation

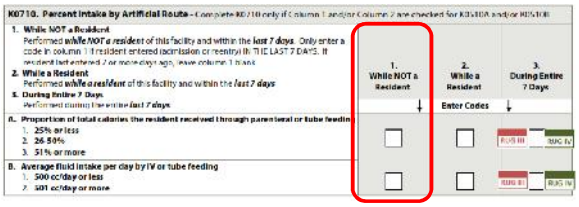
K0710B Average Fluid Intake per Day by IV or Tube Feeding

Code for the average number of cc per day of fluid the resident received via *IV or tube feeding*. Record what was actually received by the resident, not what was ordered.

- Code 1: 500 cc/day or less
- Code 2: 501 cc/day or more

K0710A and B (column 3) are payment items for residents receiving nutrition via IV or Tube Feeding

MDS 3.0 Training
Payment Items and Documentation



MDS 3.0 Training
Payment Items and Documentation

Section M
Skin Conditions

Intent: The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.

MDS 3.0 Training
Payment Items and Documentation

http://surveyortraining.cms.hhs.gov/Courses/126/SectionMVideo/SectionMVideo.mp4

MDS 3.0 Training
Payment Items and Documentation

DEFINITION:
PRESSURE ULCER/INJURY
A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.

Section M

M0100: Determination of Pressure Ulcer Risk
M0150: Risk of Pressure Ulcers
M0210: Unhealed Pressure Ulcer(s)

MDS 3.0 Training
Payment Items and Documentation

Section M
M0300 Unhealed Pressure Ulcers

M0300A: Number of Stage 1
M0300B: Number of Stage 2
number present on admission
M0300C: Number of Stage 3
number present on admission
M0300D: Number of Stage 4
number present on admission

DEFINITIONS:
EPITHELIAL TISSUE
New skin that is light pink and shiny (even in persons with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and at the edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound.

GRANULATION TISSUE
Red tissue with "cobblestone" or bumpy appearance; bleeds easily when injured.

MDS 3.0 Training
Payment Items and Documentation

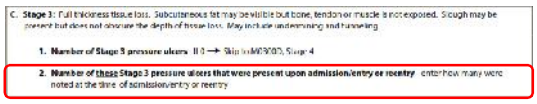
CMS has further adapted the Section M guidelines to be more consistent with the National Pressure Ulcer Advisory Panel (NPUAP). Thus, all references to **PRESSURE ULCER** throughout Section M have been changed to **PRESSURE ULCER/INJURY.**

The following items has been removed from the MDS as of 10/1/18:

- M0300B3. Date of the oldest Stage 2 Pressure Ulcer
- M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcer or Unstageable due to Eschar
- M0700. Most Severe Tissue Type for Any Pressure Ulcer
- M0800. Worsened in Pressure Ulcer Since Prior Assessment
- M0900. Healed Pressure ulcers

MDS 3.0 Training
Payment Items and Documentation

M0300B2, C2, and D2: Determine "Present on Admission"


C. **Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

1. **Number of Stage 3 pressure ulcers** 0 → Skip to M0300D, Stage 4

2. **Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry** enter how many were noted at the time of admission/entry or reentry

Was the pressure ulcer/injury present at the time of admission/entry or reentry and **not** acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement.

MDS 3.0 Training
Payment Items and Documentation

Pressure Ulcers Present on Admission:

RAI Manual, Chapter 3, page M-7:

3. If the pressure ulcer was present on admission/entry or reentry and subsequently increased in numerical stage during the resident's stay, the pressure ulcer is coded at that higher stage, and that higher stage **should not be considered as "present on admission."**

4. If the pressure ulcer/injury was present on admission/entry or reentry and becomes unstageable due to slough or eschar, during the resident's stay, the pressure ulcer/injury is coded at M0300F and **should not be coded as "present on admission."**

MDS 3.0 Training
Payment Items and Documentation

5. If the pressure ulcer/injury was unstageable on admission/entry or reentry, then becomes numerically stageable later, it should be considered as "present on admission" at the stage at which it first becomes numerically stageable. If it subsequently increases in numerical stage, that higher stage should not be coded as "present on admission."

6. If a resident who has a pressure ulcer/injury that was originally acquired in the facility is hospitalized and returns with that pressure ulcer/injury at the same numerical stage, the pressure ulcer/injury should not be coded as "present on admission" because it was present and acquired at the facility prior to the hospitalization.

MDS 3.0 Training
Payment Items and Documentation

7. If a resident who has a pressure ulcer/injury that was **"present on admission"** (not acquired in the facility) is hospitalized and returns with that pressure ulcer/injury at the same numerical stage, the pressure ulcer is **still coded as "present on admission"** because it was **originally acquired outside the facility** and has not changed in stage.

8. If a resident who has a pressure ulcer/injury is hospitalized and the ulcer/injury increases in numerical stage or becomes unstageable due to slough or eschar during the hospitalization, it **should be coded as "present on admission"** upon reentry.

MDS 3.0 Training
Payment Items and Documentation

9. If a pressure ulcer was numerically staged, then became unstageable, and is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the numerical stage has increased, code this pressure ulcer as **not present on admission.**

10. If two pressure ulcers merge, that were both "present on admission," continue to code the merged pressure ulcer as "present on admission." Although two merged pressure ulcers might increase the overall surface area of the ulcer, there needs to be an increase in numerical stage or a change to unstageable due to slough or eschar in order for it to be considered not "present on admission."

MDS 3.0 Training
Payment Items and Documentation

Pressure Ulcers/injuries are payment items if 2 or more treatments are required.

M1030: Number of Venous and Arterial Ulcers

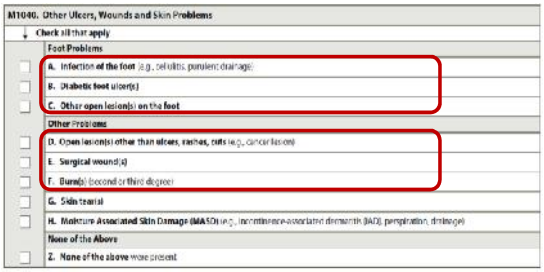
M1030: Definitions , RAI Manual, page M-26

VENOUS ULCERS: Ulcers caused by peripheral venous disease, 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 peripheral arterial disease, which commonly occur on the tips and tops of the toes, tops of the foot, or distal to the medial malleolus.

MDS 3.0 Training
Payment Items and Documentation

Section M: **M1040 Other Ulcers, Wounds, and Skin Problems**



MDS 3.0 Training
Payment Items and Documentation

M1200 Skin and Ulcer/Injury Treatments

A. Pressure reducing device for chair

B. Pressure reducing device for bed

- do **not** include egg crate cushions of any type, donut or ring devices for chairs

C. Turning/repositioning program

- *Specific* approaches for changing resident's position and re-aligning the body
- *Specific* intervention and frequency
- Requires supporting documentation of monitoring and periodic evaluation

D. Nutrition and hydration

MDS 3.0 Training
Payment Items and Documentation

M1200 Skin and Ulcer/Injury Treatments (continued)

E. Pressure Ulcer Care
F. Surgical Wound Care
G. Non-surgical Dressing (other than feet)
Do NOT include Band-Aids or steri-strips
H. Ointments/medications (other than feet)
I. Dressings to feet
Z. None of the above

MDS 3.0 Training
Payment Items and Documentation

Section N: Medications

Intent: The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and/or select medications were received by the resident.

In addition, an Antipsychotic Medication Review has been included. Including this information will assist facilities to evaluate the use and management of these medications.

MDS 3.0 Training
Payment Items and Documentation

Section N: INJECTIONS

N0300

Record the number of days (during the 7-day look-back period) that the resident received **any** type of medication, antigen, vaccine, etc.

Insulin injections are counted in this item as well as in Item N0350.

Note: N0300 is a RUG III payment item and N0350 is a RUG IV payment item for insulin injections.

MDS 3.0 Training
Payment Items and Documentation

Section N: INJECTIONS

N0350 Insulin: *Not a payment item for RUG III (MaineCare), but is a payment item for RUG IV (Medicare).*

A. Insulin Injections administered
B. Orders for insulin

MDS 3.0 Training
Payment Items and Documentation

Section N Medications

N0410 Medications Received
- A. Antipsychotic
- B. Antianxiety
- C. Antidepressant
- D. Hypnotic
- E. Anticoagulant
- F. Antibiotic
- G. Diuretic
- H. Opioid (new implications to CAAs)

MDS 3.0 Training
Payment Items and Documentation

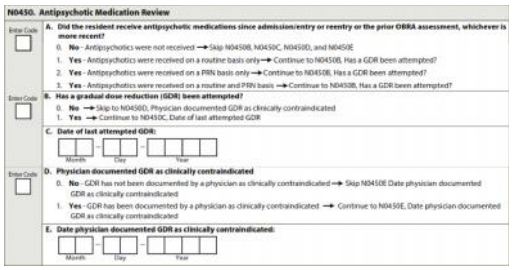
Section N New Drug References

The following resources and tools provide information on medications including classifications, warnings, appropriate dosing, drug interactions, and medication safety information.

- GlobalRPh Drug Reference, http://globalrph.com/drug-A.htm
- USP Pharmacological Classification of Drugs, http://www.usp.org/usp-healthcare-professionals/uspmedicare-model-guidelines/medicare-model-guidelinesv50-v40#Guidelines6 *Directions:* Scroll to the bottom of this webpage and click on the pdf download for "USP Medicare Model Guidelines (With Example Part D Drugs)"
- Medline Plus, https://www.nlm.nih.gov/medlineplus/druginformation.html

MDS 3.0 Training
Payment Items and Documentation

Section N0450 Antipsychotic Medication Review



N0450. Antipsychotic Medication Review

Enter Code — **A. Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent?**
0. **No** - Antipsychotics were not received → Skip N0450B, N0450C, N0450D, and N0450E
1. **Yes** - Antipsychotics were received on a routine basis only → Continue to N0450B, Has a GDR been attempted?
2. **Yes** - Antipsychotics were received on a PRN basis only → Continue to N0450B, Has a GDR been attempted?
3. **Yes** - Antipsychotics were received on a routine and PRN basis → Continue to N0450B, Has a GDR been attempted?

Enter Code — **B. Has a gradual dose reduction (GDR) been attempted?**
0. **No** → Skip to N0450D, Physician documented GDR as clinically contraindicated
1. **Yes** → Continue to N0450C, Date of last attempted GDR

C. Date of last attempted GDR:
Month – Day – Year

Enter Code — **D. Physician documented GDR as clinically contraindicated**
0. **No** - GDR has not been documented by a physician as clinically contraindicated → Skip N0450E Date physician documented GDR as clinically contraindicated
1. **Yes** - GDR has been documented by a physician as clinically contraindicated → Continue to N0450E, Date physician documented GDR as clinically contraindicated

E. Date physician documented GDR as clinically contraindicated:
Month – Day – Year

MDS 3.0 Training
Payment Items and Documentation

RAI Manual, page N14

- If the resident was admitted to the facility with a documented GDR attempt in progress and the resident received the last dose(s) of the antipsychotic medication of the GDR in the facility, then the GDR would be coded in N0450B and N0450C.

- Discontinuation of an antipsychotic medication, even without a GDR process, should be coded in N0450B and N0450C as a GDR, as the medication was discontinued. When an antipsychotic medication is discontinued without a gradual dose reduction, the date of the GDR in N0450C is the first day the resident did not receive the discontinued antipsychotic medication.

- The start date of the last attempted GDR should be entered in N0450C, Date of last attempted GDR. The GDR start date is the first day the resident received the reduced dose of the antipsychotic medication.

MDS 3.0 Training
Payment Items and Documentation

Section N

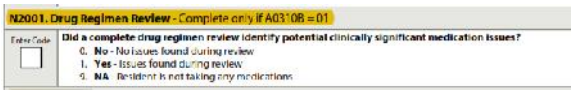
Three (3) new items: **Drug Regimen Review**

Item	Assessed on:
N2001. Drug Regimen Review (DRR)	Admission (5-day)
N2003. Medication Follow - up	Admission (5-day)
N2005. Medication Intervention	PPS Discharge

MDS 3.0 Training
Payment Items and Documentation

N2001 Drug Regimen Review

Intent: The intent of the drug regimen review items is to document whether a drug regimen review was conducted upon the resident's admission (start of Skilled Nursing Facility [SNF] Prospective Payment System [PPS] stay) and throughout the resident's stay (through Part A PPS discharge) and whether any clinically significant medication issues identified were addressed in a timely manner.



MDS 3.0 Training
Payment Items and Documentation

N2001: Drug Regimen Review (cont.)

Steps for Assessment

Complete if A0310B = 01.

1. Complete a drug regimen review upon admission (start of SNF PPS stay) or as close to the actual time of admission as possible to identify any potential or actual clinically significant medication issues.

2. Review medical record documentation to determine whether a drug regimen review was conducted upon admission (start of SNF PPS stay), or as close to the actual time of admission as possible, to identify any potential or actual clinically significant medication issues.

MDS 3.0 Training
Payment Items and Documentation

Potential or Actual Clinically Significant Medication Issue

A clinically significant medication issue is a *potential or actual* issue that, in the clinician's professional judgment, warrants physician (or physician-designee) communication and completion of prescribed/recommended actions by midnight of the next calendar day at the latest.

"Clinically significant" means effects, results, or consequences that materially affect or are likely to affect an individual's mental, physical, or psychosocial well-being, either positively, by preventing a condition or reducing a risk, or negatively, by exacerbating, causing, or contributing to a symptom, illness, or decline in status.

Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the purpose of the drug regimen review items.

MDS 3.0 Training
Payment Items and Documentation

3. Clinically significant medication issues may include, but are not limited to:

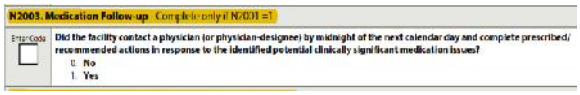
- Medication prescribed despite documented medication allergy or prior adverse reaction.
- Excessive or inadequate dose.
- Adverse reactions to medication.
- Ineffective drug therapy.
- Drug interactions (serious drug-drug, drug-food, and drug-disease interactions).
- Duplicate therapy (for example, generic-name and brand-name equivalent drugs are co-prescribed).
- Wrong resident, drug, dose, route, and time errors.
- (continued)

MDS 3.0 Training
Payment Items and Documentation

3. Clinically significant medication issues may include, but are not limited to: (cont.)

- Medication dose, frequency, route, or duration not consistent with resident's condition, manufacturer's instructions, or applicable standards of practice.
- Use of a medication without evidence of adequate indication for use.
- Presence of a medical condition that may warrant medication therapy (e.g., a resident with primary hypertension does not have an antihypertensive medication prescribed).
- Omissions (medications missing from a prescribed regimen).
- Nonadherence (purposeful or accidental).

MDS 3.0 Training
Payment Items and Documentation


N2003. Medication Follow-up Complete only if N2001 = 1

Enter Code

Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

0. No
1. Yes

Definition: Medication Follow-Up

The process of contacting a physician to communicate an identified medication issue and completing all physician-prescribed/recommended actions by midnight of the next calendar day at the latest.

This item is completed if one or more potential or actual clinically significant medication issues were identified during the admission drug regimen review (N2001 = 1).

MDS 3.0 Training
Payment Items and Documentation

Steps for Assessment

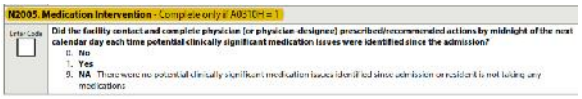
1. Review the resident's medical record to determine whether the following criteria were met for any potential or actual clinically significant medication issues that were identified upon admission:
   - Two-way communication between the clinician(s) and the physician was completed by midnight of the next calendar day, AND
   - All physician-prescribed/-recommended actions were completed by midnight of the next calendar day.

MDS 3.0 Training
Payment Items and Documentation

Definition: Contact with Physician

- Communication with the physician to convey an identified potential or actual clinically significant medication issue, *and a response* from the physician to convey prescribed/recommended actions in response to the medication issue.
- Communication can be in person, by telephone, voice mail, electronic means, facsimile, or any other means that appropriately conveys the resident's status.

MDS 3.0 Training
Payment Items and Documentation


N2005. Medication Intervention - Complete only if A0310H = 1

Did the facility contact and complete physician [or physician designee] prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?

0. No
1. Yes
9. NA - There were no potential clinically significant medication issues identified since admission or resident is not taking any medications

Every time a potential or actual clinically significant medication issue is identified throughout the resident's stay, it must be communicated to a physician, and the physician-prescribed/-recommended actions must be completed by the clinician in a time frame that maximizes the reduction in risk for medication errors and resident harm.

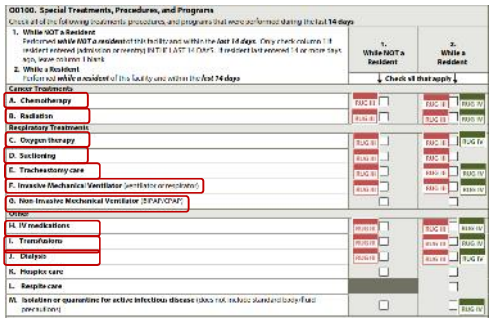
The observation period for this item is from the date of admission (start of SNF PPS stay) through discharge (Part A PPS discharge).

MDS 3.0 Training
Payment Items and Documentation

Section O Special Treatments, Procedures and Programs

Intent: The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received during the specified time periods.

MDS 3.0 Training
Payment Items and Documentation


O0100. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the last 14 days

1. While NOT a Resident
Performed while NOT a resident of this facility and within the last 14 days. Only check columns 1-3 if resident entered (admission or reentry) INTO LAST 14 DAYS. If resident had entered 14 or more days ago, leave column 1 blank

2. While a Resident
Performed while a resident of this facility and within the last 14 days

	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
Cancer Treatments		
A. Chemotherapy		
B. Radiation		
Respiratory Treatments		
C. Oxygen therapy		
D. Suctioning		
E. Tracheostomy care		
F. Invasive Mechanical Ventilator (ventilator or respirator)		
G. Non-Invasive Mechanical Ventilator (BiPAP/CPAP)		
Other		
H. IV medications		
I. Transfusions		
J. Dialysis		
K. Hospice care		
L. Respite care		
M. Isolation or quarantine for active infectious disease (does not include standard/droplet/fluid precautions)		

MDS 3.0 Training
Payment Items and Documentation

O0100A, Chemotherapy

Medications coded here are those actually used for cancer treatment. Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer should not be coded in this item, as they are not considered chemotherapy for the purpose of coding the MDS.

Example: Ms. J was diagnosed with estrogen receptor–positive breast cancer and was treated with chemotherapy and radiation. After her cancer treatment, Ms. J was prescribed tamoxifen (a selective estrogen receptor modulator) to decrease the risk of recurrence and/or decrease the growth rate of cancer cells. Since the hormonal agent is being administered to decrease the risk of cancer recurrence, it cannot be coded as chemotherapy.

MDS 3.0 Training
Payment Items and Documentation

O0100F, Invasive Mechanical Ventilator (ventilator or respirator)

Code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become (such as during weaning attempts) **unable to support his or her own respiration in this item.**

During invasive mechanical ventilation the resident's breathing is controlled by the ventilator. Residents receiving closed-system ventilation include those residents receiving *ventilation via an endotracheal tube (e.g., nasally or orally intubated) or tracheostomy*. A resident who has been weaned off of a respirator or ventilator in the last 14 days, or is currently being weaned off a respirator or ventilator, should also be coded here. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.

MDS 3.0 Training
Payment Items and Documentation

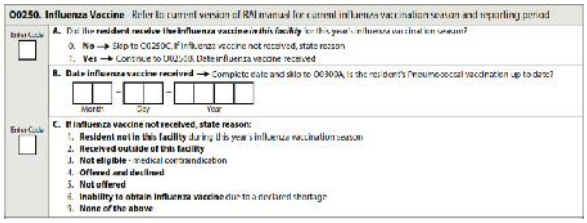
O0100G, Non-invasive Mechanical Ventilator (BiPAP/CPAP)

Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle.

The BiPAP/CPAP mask/device enables the individual to **support his or her own spontaneous respiration** by *providing enough pressure when the individual inhales to keep his or her airways open*, unlike ventilators that "breathe" for the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes his/her own BiPAP/CPAP mask/device.

MDS 3.0 Training
Payment Items and Documentation

Section O Special Treatments, Procedures, and Programs


O0250. Influenza Vaccine – Refer to current version of RAI manual for current influenza vaccination season and reporting period

Enter Code
A. Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season?
0. No → Skip to O0250C, If influenza vaccine not received, state reason
1. Yes → Continue to O0250B, Date influenza vaccine received

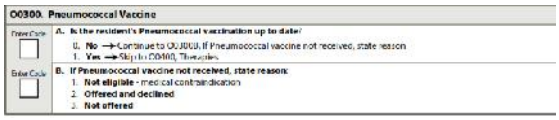
B. Date influenza vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?
Month – Day – Year

Enter Code
C. If influenza vaccine not received, state reason:
1. Resident not in this facility during the year's influenza vaccination season
2. Received outside of this facility
3. Not eligible - medical contraindication
4. Offered and declined
5. Not offered
6. Inability to obtain influenza vaccine due to a declared shortage
9. None of the above

Influenza vaccine is contraindicated for a resident with severe reaction (e.g., respiratory distress) to a previous dose of influenza vaccine or to a vaccine component. Precautions for influenza vaccine include moderate to severe acute illness with or without fever (influenza vaccine can be administered after the acute illness) and history of Guillain-Barré Syndrome within six weeks after previous influenza vaccination.

MDS 3.0 Training
Payment Items and Documentation

O0300: Pneumococcal Vaccine


O0300. Pneumococcal Vaccine

Enter Code
A. Is the resident's Pneumococcal vaccination up to date?
0. No → Continue to O0300B, If Pneumococcal vaccine not received, state reason
1. Yes → Skip to O0400, Therapies

Enter Code
B. If Pneumococcal vaccine not received, state reason:
1. Not eligible - medical contraindication
2. Offered and declined
3. Not offered

Specific guidance about pneumococcal vaccine recommendations and timing for adults can be found at
https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccinetiming.pdf

MDS 3.0 Training
Payment Items and Documentation

Section O: Special Treatments, Procedures, and Programs

O0400A. Speech-Language Pathology and Audiology Services
O0400B. Occupational Therapy
O0400C. Physical Therapy
- **Individual minutes**
- **Concurrent minutes**
- **Group minutes**
- Co-treatment minutes
- **Number of Days**
- Start date (RUG IV only)
- End date (RUG IV only)

MDS 3.0 Training
Payment Items and Documentation

Section O: Special Treatments, Procedures, and Programs

O0400D Respiratory Therapy
Total minutes
 # Days therapy was administered at least 15 minutes
O0400E Psychological Therapy
O0400F Recreational Therapy

O0420 Distinct Days of Therapy (RUG IV only)
O0450 Resumption of Therapy (RUG IV only)

MDS 3.0 Training
Payment Items and Documentation

Section O: Restorative Nursing Programs

O0500. Restorative Nursing Programs

Record the number of days each of the following restorative programs was performed for at least 15 minutes a day in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)

Number of Days	Technique
	A. Range of motion (passive)
	B. Range of motion (active)
	C. Splint or brace assistance
Number of Days	Training and Skill Practice in:
	D. Bed mobility
	E. Transfer
	F. Walking
	G. Dressing and/or grooming
	H. Eating and/or swallowing
	I. Amputation/prosthesis care
	J. Communication

MDS 3.0 Training
Payment Items and Documentation

Section O: Restorative Nursing Programs

***Nursing interventions* that promote the resident's ability to adapt and adjust to living as independently and safely as possible.**

- Measureable objectives and interventions
- Periodic evaluation by a licensed nurse
- CNAs must be trained in the techniques
- Does not require a physician's order, but a licensed nurse must supervise the activities

MDS 3.0 Training
Payment Items and Documentation

Section O: Restorative Nursing Programs

- Nursing staff are responsible for coordination and supervision
- Does not include groups with more than 4 residents
- Code *number of days* a resident received 15 minutes or more in each category
- Remember that persons with dementia learn skills best through repetition that occurs multiple times per day.

175

MDS 3.0 Training
Payment Items and Documentation

Section O: Restorative Nursing Programs

H0200C Current toileting program

An individualized, resident-centered toileting program may decrease or prevent urinary incontinence, minimizing or avoiding the negative consequences of incontinence.

The look-back period for this item is since the most recent admission/entry or reentry or since urinary incontinence was first noted within the facility.

176

MDS 3.0 Training
Payment Items and Documentation

Section O: Restorative Nursing Programs

H0500 Bowel Training Program

Three requirements:

- Implementation of an individualized, resident-specific bowel toileting program.
- Evidence that the program was communicated to staff and resident through care plans, flow sheets, etc.
- Documentation of the response to the toileting program and periodic evaluation

177

MDS 3.0 Training
Payment Items and Documentation

O0600: Physician Examination Days Assessment Guidelines

Over the last **14 days**, on how many ***days*** did the physician examine the resident?

Examinations can occur in the facility or in the physician's office.

Do **not** include:

- Examinations that occurred prior to admission/readmission to the facility
- Examinations that occurred during an ER visit or hospital observation stay

178

MDS 3.0 Training
Payment Items and Documentation

O0700: Physician Order Change Days Assessment Guidelines

Over the last **14 days**, on how many ***days*** did the physician change the resident's orders?

Do **not** include the following:

- Admission or re-admission orders
- Renewal of an existing order
- Clarifying orders without changes
- Orders prior to the date of admission
- Sliding scale dosage schedule
- Activation of a PRN order

179

MDS 3.0 Training
Payment Items and Documentation

O0600 and O0700 Examination Days and Order Days Guidelines

Maine will continue to require O0600 and O0700 as they may be payment items for clinically complex RUG groups.

If you leave this item blank, that would be an invalid value and CMS would reject the assessment. If enter a dash, as recommended by CMS, it would be a valid value but would count as a zero (0) and would not contribute towards clinically complex RUG scoring. Check your final validation report to confirm it was submitted the way you wanted it to be filled out.

180

MDS 3.0 Training
Payment Items and Documentation

Section X: Correction Request

Intent: The purpose of Section X is to identify an MDS record to be modified or inactivated. Section X is only completed if Item A0050, Type of Record, is coded a 2 (***Modify*** existing record) or a 3 (***Inactivate*** existing record).

In Section X, the facility must reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

MDS 3.0 Training
Payment Items and Documentation

Section X: Correction Request

A **modification** request is used to correct a QIES ASAP record containing incorrect MDS item values due to:

- transcription errors,
- data entry errors,
- software product errors,
- item coding errors, and/or
- other error requiring modification

MDS 3.0 Training
Payment Items and Documentation

Section X: Correction Request

An inactivation request is used to move an existing record in the QIES ASAP database from the active file to an archive (history file) *so that it will not be used for reporting purposes*.

MDS 3.0 Training
Payment Items and Documentation

Section X: Correction Request: Manual Deletion

A Manual Deletion Request is required **only in the following three cases:**

1. Item A0410 Submission Requirement is incorrect.
2. Inappropriate submission of a test record as a production record.
3. Record was submitted for the wrong facility.

MDS 3.0 Training
Payment Items and Documentation

Section X: Correction Request

X0150 Type of Provider
X0200 Name of Resident
X0300 Gender
X0400 Date of Birth
X0500 Social Security Number
X0600 Type of Assessment
X0700 Date on existing record

MDS 3.0 Training
Payment Items and Documentation

Section X: Correction Request

X0800 Correction number
X0900 Reasons for Modification
X1050 Reasons for Inactivation
X1100 Name, Title, Signature, Attestation Date

MDS 3.0 Training
Payment Items and Documentation

Section Z
Assessment Administration

Intent: The intent of the items in this section is to provide billing information and signatures of persons completing the assessment.

MDS 3.0 Training
Payment Items and Documentation

Section Z
Assessment Administration

The majority of this section is completed by your software.

Z0100 Medicare Part A Billing **(RUG IV)**
Z0150 Medicare Part A Non-Therapy **(RUG IV)**
Z0200 **State Medicaid Billing** **(RUG III)**
Z0250 Alternate State Medicaid Billing
Z0300 Insurance Billing

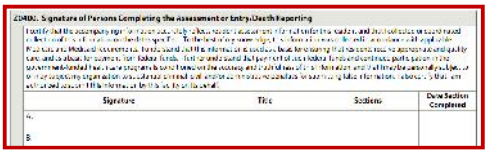
****

To check your final validation report:
https://sms.muskie.usm.maine.edu/

MDS 3.0 Training
Payment Items and Documentation

Section Z
Assessment Administration

Z0400 Attestation Statement



Z0500 Signature of RN Assessment Coordinator Verifying Assessment Completion

MDS 3.0 Training
Payment Items and Documentation

Section Z - Assessment Administration

Z0400 Signature of Persons Completing the Assessment or Entry/Death Reporting.

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. ***I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information.*** I also certify that I am authorized to submit this information by this facility on its behalf.

MDS 3.0 Training
Payment Items and Documentation

Z0400 Attestation Statement

Coding Instructions

- All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed.
- If a staff member cannot sign Z0400 on the same day that he or she completed a section or portion of a section, when the staff member signs, use the date the item originally was completed.
- Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident's status. Penalties may be applied for submitting false information.

MDS 3.0 Training
Payment Items and Documentation

FYI…

Chapter 110, Regulations Governing the Licensing and Function of Skilled Nursing Facilities and Nursing Facilities
http://www.maine.gov/sos/cec/rules/10/ch110.htm

Chapter 2.B.1.b Comprehensive Assessment (page 2)
b. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

MDS 3.0 Training
Payment Items and Documentation

Z0500 Assessment Complete

"Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete"

--"Verify that all items on this assessment or tracking record are complete."

--"Verify that Item Z0400 contains attestation for all MDS sections"

--". . .**use the actual date that the MDS was completed, reviewed and signed as complete by the RN assessment coordinator** (generally later than the date(s) at Z0400. . ."

--"If for some reason the MDS cannot be signed by the RN assessment coordinator on the date it is completed, the RN assessment coordinator should **use the actual date that it is signed**."

MDS 3.0 Training
Payment Items and Documentation

RAI Manual Chapter 4
Care Area Assessment and Care Planning

This chapter provides information about the Care Area Assessments (CAAs), Care Area Triggers (CATs), and the process for care plan development for nursing home residents.

Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs, in relation to a number of specified areas (e.g., customary routine, vision, and continence). The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive plan of care.

MDS 3.0 Training
Payment Items and Documentation

RAI Manual Chapter 5
Submission and Correction of MDS

5.1 Transmitting MDS Data:

The provider indicates the submission authority for a record in item A0410, Submission Requirement.

5.2 Timeliness Criteria

5.3 Validation Edits

5.4 Additional Medicare Submission Requirements that Impact Billing Under SNF PPS

MDS 3.0 Training
Payment Items and Documentation

Questions?

Forum call for Nursing Facilities
1st Thursday of the month in February, May, August and November, 1:00-2:00

Call the MDS Help Desk to register!

MDS 3.0 Training
Payment Items and Documentation

Reminder!

- This completes *Payment Items and Documentation* of the MDS 3.0 training.
- Ask questions!
- Ask more question!!
- Use your resources (other MDS coordinators, case mix staff, MDS Help Desk, Forum Calls etc.)
- Attend training as often as you need.

Please complete your evaluations to help us to continually improve training to best meet your needs.

Case Mix Team
Contact Information

- **MDS Help Desk**: 624-4019 or toll-free: 1-844-288-1612
  MDS3.0.DHHS@maine.gov
- **Lois Bourque, RN**: 592-5909
  Lois.Bourque@maine.gov
- **Darlene Scott-Rairdon, RN**: 215-4797
  Darlene.Scott@maine.gov
- **Maxima Corriveau, RN**: 215-3589
  Maxima.Corriveau@maine.gov
- **Deb Poland, RN**: 215-9675
  Debra.Poland@maine.gov
- **Sue Pinette, RN**: 287-3933 or 215-4504 (cell)
  Suzanne.Pinette@maine.gov

Training Portal: www.maine.gov/dhhs/dlrs/mds/training/

Questions?

Case Mix Team
Sue Pinette RN, RAC-CT
207-287-3933

MDS 3.0 Training
Payment Items and Documentation