MDS Training for Social Services Directors
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Disclaimer

The MDS for Social Services was developed as an educational program and reference for long-term care staff. To the best of our knowledge, it reflects current federal regulations and practices. However, it cannot be considered absolute and universal. The information contained in this workshop must be considered in light of the individual organization and state regulations. The authors disclaim responsibility for any adverse effect resulting directly or indirectly from the use of the workshop material, from any undetected errors, and from the user’s misunderstanding of the material.

Disclaimer Continued

The authors put forth every effort to ensure that the content, including any policies, recommendations, and sample documents used in this training, were in agreement with current federal regulations, recommendations, and practices at the time of publication.

The information provided in this training is subject to revision based on future updates and clarifications by CMS.
MDS for Non-MDS Coordinators Objectives

- Understand where the MDS came from and why it must be completed.
- General MDS Assessment Scheduling and Look Back Periods
- The Role for Long-Term Care Staff in the MDS/Care Planning Process
- The importance of accurate documentation, observation reporting, changes and tasks performed.
- The MDS as it relates to reimbursement, Quality Measures, and the survey process.

Introduction

- CMS (The Centers for Medicare and Medicaid) is located in Baltimore, MD.
- It is a part of the Federal Government of the United States of America.
- Most facility’s beds are licensed for either Medicare, Medicaid or both.
- Federal regulation dictates that anyone residing in a bed that is licensed for either Medicare or Medicaid must have an MDS completed.

MDS History

- Prior to the MDS, there was no universal method for facilities to gather information on residents in long term care facilities.
- Further, there was not a good method for those facilities to be reimbursed for the care the residents were receiving.
- There was a high incidence of fraud and poor data collection.
In 1987, the Federal Government came up with a program designed to ensure that:

- Every resident would have the best chance to received the highest quality care from the day they enter the facility until they discharge, and,
- Reimbursements would reflect the actual care being given to a resident.
- This was called OBRA, which stands for the Omnibus Budget Reconciliation Act.

The MDS, which is a part of that program, has been so successful it is now used in over twenty countries and has been translated into 11 languages.

In late 2010, the MDS 3.0 Version was unveiled. It contains several additional areas which require assessments, resident interviews, and several areas of concern for the residents which assist in providing the appropriate, individual care needed by the resident.

IT IS NOT JUST FOR PAYMENT.
• However, in order for long-term care facilities to receive money from the government to pay for their care, there is a specialized database called MDS, which stands for Minimum Data Set.

• Information, by law, must be collected on every resident whose care or portions of their care, is being paid for by CMS who administers the funds for Medicare and Medicaid from the MDS items identified.

• Documentation must accurately reflect what is going on with each resident.

• Accurate Documentation must be available to support the coding on each MDS.

• The entire process is called the Resident Assessment Instrument (RAI) which the MDS is a part of, is complex and very detailed.

• The RAI process helps facilitate understanding of each resident’s physical, mental, emotional, and spiritual life.

• It may not be necessary for you to learn the entire RAI/MDS process, but it is important you understand the parts of it where you play a vital role.

• The RAI Process includes Care Area Assessments and the Care Plan.
The MDS

• The MDS 3.0 is entered into a data base where information is stored for each resident.

• A specially trained MDS Nurse collects all the resident data my means of:
  • Assessments
  • ADL Records
  • Behavior / Mood Records
  • Bowel and Bladder Records
  • Restorative Notes
  • Nurses Notes
  • Social Services Notes

The MDS

• Activity Notes
• Dietary Notes
• Intake Records
• Output Records
• Vital Signs Records
• Hospice Notes
• Resident Interviews

The MDS

• Staff Interviews
• Family Interviews
• Observations
• Medication Records
• Treatments Records
• ETC.........
The MDS

- that was obtained and documented by:
  - Nurses
  - Nursing Assistants
  - Medication Nurses
  - Social Services
  - Activities
  - Dietary Managers
  - Therapists
  - Restorative Nurses and Aides
  - Physicians
  - Hospital Charts
  - Physician Orders
  - Information obtained from the family
  - ETC

The MDS

- And that is only the beginning!
  - After the information is entered into the software, some of the information triggers Care Area Assessments.
  - There are 20 Care Area Assessments.
  - The information on the MDS and Care Area Assessments are used as the basis for forming an individualized Care Plan.
  - The Care Plan of course contains information regarding the resident in addition to the information triggered by the MDS.

The MDS

- Some of the information we are looking for covers everything from how often a resident likes to nap in a day, the time of day they like to nap
  - How they move about in their room, the hallway, on the unit, off the unit
  - How many staff members does it take to assist a resident to change positions or to get in or out of a chair?
  - What faith they are, who they lived with before they entered the facility, do they plan to return home, their likes & dislikes...
In fact almost every detail of their past and present life is included on the MDS.

Think about it – Knowing what the resident likes or dislikes, when do they like getting up in the morning or going to bed at night, and how much care do they require would ensure that all us are better equipped that the individual resident would get the very best care we can possibly give them.

Wouldn’t it be great to receive this information even before you started your shift? How do they transfer? How many people does the resident need to safely transfer? Do they use ambulation devices? Can they dress themselves / feed themselves? Are they incontinent and do they need a toileting schedule or incontinent products? Do they wear dentures, hearing aides, glasses, or prosthesis?

Wouldn’t it be great if you were made aware of why the resident was sad or chronically depressed? They’ve lost their independence, career, family doesn’t visit as often.
• Maybe some of the residents you are assigned to today has a form of dementia, or is deaf, has anger issues, wears dentures, recently broke a bone...
• Just about anything you can think of that makes up the “person” inside any resident can be found in their MDS.

Basic MDS Types

• There are:
  • OBRA Assessments (A0310A)
  • PPS Assessments (A0310B)
  • Other Medicare-Required Assessments (A0310C)
  • Swing-Bed Clinical Change Assessments (A0310D)

OBRA MDS Types

• The MDS consists of item sets of various “sizes”
• The “Comprehensive Assessments” are considered “Full Assessments” and require filling out Care Area Assessments.
• The Quarterly Assessments have fewer items to answer and do not require Care Area Assessments.
OBRA MDS Types

- Discharge Assessments
  - Discharge Return Anticipated
  - Discharge Return Not Anticipated
- Readmission/Return Tracking Forms
- Death in Facility Tracking Forms

The MDS Schedule

- The MDS is completed for any resident in a bed that is licensed for Medicare or Medicaid, regardless of the resident’s payer source.
- An MDS must be completed at least every 92 days for the average long term care resident.
- If a person is received Medicare A Services, an MDS must be completed more often

General Resident MDS Schedule:
- Admission Assessment
- Three Quarterly Assessments (within 92 days of the last assessment)
- Annual Assessment (within 365 days of the last Comprehensive Assessment)
- Significant Change Assessments are completed whenever a resident meets the criteria for Significant Change (page 2-22 of the RAI Manual)
PPS (Perspective Payment System, AKA Medicare A) MDS Schedule:
• 5 Day (if a new resident, combined with the Admission Assessment).
• 14 Day
• 30 Day
• 60 Day
• 90 Day (Usually combined with the Quarterly)

PPS Other Medicare Required Assessments:
• Start of Therapy (SOT)
• End of Therapy (EOT)
• Both Start and End of Therapy
• Change of Therapy (COT)

Assessment Reference Date (ARD)
• The Assessment Reference Date (ARD) is the date selected by the MDS Coordinator as the END DATE of the LOOK-BACK PERIOD.
• Data collection ends at midnight of the ARD
In accordance with the MDS User's Manual, AKA the RAI Manual, there are different “look-back” dates for different sections of the MDS.

Most of the look-back dates are 7 days.

Mood is 14 days.

Pain look back is 5 days.

Falls have a 30 day, 60 day, and 180 look back.

Special treatments & procedures, Section O0100 is 14 days.

UTI is 30 days look-back.

### 7 day Look-Back:

If the ARD was the 29th, the first day of the look back period would be the 23rd.

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### 14 day Look-Back:

If you were looking at a 14 day look back, the first day of the look-back period would be the 16th.

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Assessment Reference Date (ARD) & Interviews

- The RAI Manual states that the Mood and Pain interviews are to be conducted the day before or the day of the ARD.
- The BIMS (Section C) and Preferences for Customary Routine (Section F) can be conducted any time during the 7 day look back period.
- Interviews **must be attempted on every resident** unless they are in a coma (B01001), or are rarely/never understood (B07003).

Assessment Reference Date (ARD) and Research

- Because the last day of the ARD extends to midnight of that day, research should not be completed until the day after the ARD.

Assessment Reference Date (ARD) & Documentation

- In addition to the interviews, documentation must always support coding on MDS.
- It is extremely important that every staff member does their utmost to ensure accuracy in all their documentation, on every shift – even if it is not “your resident”.
- Even the slightest change in the resident’s functionality, mood, behavior, cognition, continence, pain levels, number of falls, skin issues, therapy and restorative status, can have a huge impact on resident care interventions and reimbursement.
In addition to documenting your findings, it is imperative you keep the Charge Nurse informed of those changes, even if it is outside the look back period.

As changes occur, the care plan should be updated to accurately represent the current status of the resident.

You may hear the nurses or other MDS team members talking about CAA’s. CAA’s are part of the MDS process.

When a problem, strength, or need is identified, the MDS document will automatically send up these indicators/red flags called CAA’s, which stands for Care Area Assessments.

CAA’s warn the MDS Coordinator and other MDS team members that they may need to create a specialized Plan Of Care to address this issue.

Plans of Care are usually referred to as “Care Plans.”
Care Area Assessments (CAA)

- There are 20 CAA’s
- Delirium
- Cognitive Loss/Dementia
- Visual Function
- Communication
- ADL Functional/Rehabilitation Potential
- Urinary Incontinence and Indwelling Catheter
- Psychosocial Well-Being
- Mood State
- Behavior Symptoms
- Activities

Care Area Assessments (CAA)

- Falls Nutritional Status
- Feeding Tube
- Dehydration/Fluid Maintenance
- Dental Care
- Pressure Ulcer
- Psychotropic Drug Use
- Physical Restraints
- Pain
- Return to Community Referral

CAA Process

- Understanding the causes and relationships between a resident’s clinical issues and needs and discovering the “whats” and “whys” of the residents clinical issues and needs;

- Finding out who the resident is and consideration for incorporating his or her needs, interests, and lifestyle choices in to the delivery of care, is key to this step of the process.
Using the results of the assessment can help the interdisciplinary team (IDT) and the resident and/or resident’s representative to identify areas of concern that:

- Warrant intervention;
- Affect the resident’s capacity to help identify and implement interventions to improve, stabilize, or maintain current level of function to the extent possible, based upon the resident’s condition and choices and preferences for interventions;
- Can help to minimize the onset or progression of impairments and disabilities; and
- Can help to address the need & desire for other specialized services (e.g., palliative care, including symptom relief and pain management).

CAA Process

CAA Documentation Criteria

- Nature of the Issue/Condition
- Causes, contributing/risk factors, complications
- Need for referrals and/or further evaluation
- Consideration factors in developing a care plan
- Resources used – facilities may have written policies/protocols/standards of practice.

Care Plan

- The Care Plan or Plan of Care is vital to improving the well-being and physical health of every resident.
- Every member of the team needs to know where the care plan is located and be able to tell the MDS Coordinator and Charge Nurse if anything needs changing or updated because it does not accurately reflect the resident anymore.
• The care plan is your instructional guide for how to best care for the resident.

• It is every staff member’s responsibility to know what is in the care plan for each resident.

• The care plan must address any CAA that is triggered on the MDS, if that CAA directly affects the day to day care of that resident.

• In addition to the CAA information, the Care Plan reflects any other issue that affects the resident.

• For instance, all medications, not just the psych drugs must be addressed, and their potential side effects, on the care plan.

• Diabetes and other diagnoses that pose daily problems/issues, must be addressed on the care plan.

• After each OBRA MDS is completed, the team gathers for a Care Plan Meeting.

• The resident and their family who is responsible for them are invited to that meeting.

• The team goes through the care plan and discusses any changes that need to be made to that care plan.

• Between MDS’, the Care Plan must be updated to be sure it is currently representing the care being given.
After each OBRA MDS is completed, the team gathers for a Care Plan Meeting. The resident and their family who is responsible for them are invited to that meeting. The team goes through the care plan and discusses any changes that need to be made to that care plan. Between MDS', the Care Plan must be updated to be sure it is currently representing the care being given.

There are 20 different sections of the MDS, A-Z, with some “letters” left out.

Section A: Identification Information:
• Need to verify the MDS type
• Need to double check the accuracy of SS numbers; Medicaid Numbers; Medicare Numbers;
• Need to verify the admission/re-entry status; ARD; Medicare Stay dates

Section B: Hearing Speech & vision
• B0700: Makes Self Understood:
  • Need to assess and verify whether or not the resident accurately reflects the definition of having the ability to understand.
  • This plays a huge role in the subsequent sections, especially the interviews.
Section C

- Section C: Cognitive Patterns
  - This is your first Interview Item
  - If B0700 is coded 3, or Rarely/Never understood, you skip to the Staff Assessment, C0700
  - If B0700 is not coded 3, the interview must be attempted.

- Stopping the interview:
  - Stop the interview after completing (C0300C) “Day of the Week” IF:
    - All responses have been nonsensical (i.e. any response that is unrelated, incomprehensible, or incoherent; not informative with respect to the item being rated);
    OR
    - There has been no verbal or written response to any of the questions up to this point,
    OR
    - There has been no verbal or written response to some questions up to this point and for all others, the resident has given a nonsensical response.

Section D

- Section D: Mood
  - This is the second Interview
  - Many of the same criteria is implemented as was in Section C.
  - The lookback reference period in this interview is 14 days.
Section E

• Section E: Behavior
  • This Section relies on documentation in a 7 day lookback.
  • Documentation must be reviewed for all shifts during the lookback period.
  • In order to code this section, we must have the documentation to support the coding.
  • E0100, E0200, E0800, and E0900 affect reimbursement

Section F

• Section F: Preferences for Customary Routine and Activities
  • This Section is an interview that is conducted with the resident OR family OR Significant Other.
  • It is only completed with each Comprehensive Assessment – for now.
  • There is no set lookback period for this section.
  • If the interview cannot be completed, one skips to Section F0800, the staff assessment

Section G

• Section G: Functional Status
  • ADL’s affect Medicare Payment hundreds of dollars per day per Medicare resident
  • The ADL score can also mean the difference of 50 to 100 dollars per day for a Medicaid resident.
  • Accuracy not only affects the reimbursement, it affects resident care.
  • ADL Score, or acuity level, dictates staffing in many facilities.
Inaccurate documentation of ADL’s will not accurately reflect the plan of care, and can ultimately result in a deficiency during survey. A resident’s ADL’s acuity can change at any time: sometimes between shifts, sometimes within a shift. ADL coding on the MDS has become more complicated. Accurate coding depends on the accuracy of the documentation during the 7 day lookback.

The phrase, “to attain and maintain the resident’s highest practicable physical, mental, or psychosocial well-being” is repeated throughout the Federal State Operations Manual (SOM). Accurate ADL Coding can assist in helping the resident maintain the highest practicable level of functioning & wellbeing. Coding ADL’s accurately can assist the nurse with monitoring & trending resident function.

ADL decline can prompt the Nurse to take a look at resident’s medications, urine output, hydration issues, are they recovering from an acute illness, fall, UTI, depression, etc. Respiratory, cardiac, and metabolic disorders can interfere with physical functioning. Pain, adverse side effects from medications and cognitive and mood disorders also have the potential to impair self performance of ADL’s.
Section G

• Any person, including surveyors & Medicare Auditors, who review the resident’s medical record (paper or electronic) should be able to come to the same coding decisions by looking at the same data the MDS Coordinator did.
• CMS does not require specific documentation procedures.
• However, it is good clinical practice for documentation to contribute to identification & communication of a resident’s problems, needs, & strengths.

Section G

• Most often ADL’s are under-coded rather than over-coded.
• There are a few unscrupulous facilities that purposely over-code ADL’s, and are often prosecuted for fraud.
• Frankly, it is fraudulent practices of those people who are partly responsible for the decreased Medicare/Medicaid reimbursement payments.

Section G

• Take credit for what you do – not because you have to, but because it is the right thing to do. As any nurse, nurse aide, or other staff members know, documentation is a part of our job.
• Does it take away from time spent with the resident? – Yes sometimes, but we are still mandated to do it & do it accurately.
• In a business that is as federally regulated as nursing homes, documentation can make or break one in a court of law.
Section G

• Record how much the resident actually did for themselves, with or without help.
• Record what the resident actually did, not what he/she might be capable of doing.
• Do not record the type and level of assistance the resident “should” receive.

Section G

• There are 11 ADL’s in Section G, including Bathing.
• This section has a lookback of 7 days.
• There are only 4 ADL’s that count toward the ADL Score.
• They are referred to as “Late Loss ADL’s” and they are typically the “last abilities” most residents lose.
  • Bed Mobility
  • Transfers
  • Eating
  • Toileting

MDS Coding Rules for Section G

• The ADL coding is categorized in 2 sections:
  • ADL Self Performance (what the resident is able to do)
  • ADL Support Provided (what the staff does)
• Self Performance:
  • Independent
  • Supervision
  • Limited Assistance
  • Extensive Assistance
  • Total Assistance
  • Activity occurred only one or twice
  • Activity did not occur
MDS Coding Rules for Section G

**INDEPENDENT (0) NO TALK NO TOUCH**
- No help or oversight from staff (physical or verbal). Staff does not assist, instruct, or cue.
- Resident is able to perform the activity with or without setup from staff. No monitoring, no hands-on assistance.
- The resident does all of activity itself ALONE
- Code only if resident did ADL totally on own during the 7 day look back.

MDS Coding Rules for Section G

**SUPERVISION (1) TALK NO TOUCH**
- Use of eyes (oversight) or mouth (verbal cueing)
- Resident able to complete the activity but required supervision, oversight, clues to do the task, encouragement, monitoring, verbal prompting, or cueing.
- Staff provides instructions or cueing, but does not provide physical (hands on) assistance (do not touch), only oversight and cuing.

MDS Coding Rules for Section G

**LIMITED ASSIST: (2) TALK AND TOUCH**
- Physically prompting or physically guiding.
- Resident highly involved in activity, received physical help in guided maneuvering of limbs or other non-weight bearing assistance.
- Resident very involved in helping self but staff assistedguided activity.
**MDS Coding** Rules for Section G

**EXTENSIVE ASSISTANCE (3) TALK, TOUCH, & LIFT**

- Staff providing physical weight-bearing assistance for resident to help complete task.
- When the resident **helps in the activity**, staff provide some partial physical support of the resident. In this case, the resident is not totally dependent on the staff to do the activity.
- Resident helped very little and staff provided weight-bearing assistance (carried any part of resident weight).

**MDS Coding** Rules for Section G

**TOTAL DEPENDENCE (4) ALL ACTION BY STAFF.**

- Full staff performance of the activity throughout the entire 7 days.
- Complete non-participation by the resident in all aspects of the ADL task.
- Staff performs/completes **entire** ADL task for resident.

**MDS Coding** Rules for Section G

**ACTIVITY OCCURRED ONLY ONCE OR TWICE (7)**

- Activity occurred only once or twice
- Remember this is MDS coding, not day to day, shift to shift coding.
MDS Coding Rules for Section G

ACTIVITY DID NOT OCCUR (8)

• Activity did not occur OR FAMILY AND/OR NON-FACILITY STAFF PROVIDED CARE 100% OF THE TIME for that activity over the entire 7 days.

• Note: Bed Mobility should never be coded “Activity did not occur” on the MDS.

ADL Support Provided: code for the most support provided over all shifts; code regardless of resident’s self-performance classification.

• 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 or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7 day period.

MDS Coding Rules for Section G

• For the purposes of completing Section G, “facility staff” pertains to direct employees and facility-contracted employees (e.g. rehabilitation staff, nursing agency staff)

• Thus does not include individuals outside of the facility’s management & administration.

• Facility staff does not include, for example, Hospice staff, Nursing/CNA Students, etc.
• 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. Example, three times extensive assistance (3) and three times limited assistance (2); code extensive assistance.

• Instructions for Rule of 3, cont.
  • 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)

• Additional areas in section G are:
  • Balance During Transitions and Walking
  • Functional limitation in Range of Motion
  • Mobility Devices
  • Functional Rehabilitation Potential
Section GG

• Coming to a Skilled Nursing Facility near you October 1, 2018.............

• Yet additional Criteria to Assess for Section GG

• This section will be completed for Medicare A residents only.

Section GG

• It will be completed on their 5 day assessment & discharge “end of stay” assessment.

• “A SNF PPS Part A Discharge [End of Stay] Assessment” is also a new coding choice beginning October 1st.

• This MDS collects resident performance the first 3 days of the Medicare A stay and compares it to their performance at the end of their Medicare A Stay.

Section H

• Section H: Bladder & Bowel
  • Appliances
  • Urinary Toileting program
  • Urinary Incontinence
  • Bowel Incontinence
  • Bowel Toileting Program
  • Bowel Patterns
Section I

• Section I: Active Diagnoses
  • Sections I0100 through I7900 are the list of diagnoses
  • Some are your reimbursement items for either or both RUG III and RUG IV. (We’ll get to RUG’s a little later)
  • Each diagnosis must be active diagnoses in the last 7 days
  • UTI has a 30 day lookback
  • I8000 is where additional ICD-9 codes can be entered that reflect diagnoses active during the last 7 days that are not on the list.

Section J

• Section J: Health Conditions
  • First comes the coding for Pain Management.
  • Then comes the 4th interview – PAIN!
  • Some of the same criteria for conducting the interview apply (B0700)
  • Interview should be completed the day before or the day of the ARD.
  • Only do a staff assessment if unable to complete the interview.

Section J

• Section J: Health Conditions, cont.
  • Other health conditions
    • Shortness of Breath
    • Current Tobacco use (does NOT include marijuana or electronic cigarettes)
    • Prognosis
    • Problem conditions
Section J

- Section J: Health Conditions, cont.
  - FALLS! This section has a 30 day, 60 day, and 180 day lookback!
  - Also asks about the number of falls since the most recent Admission/Entry/Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is most recent.
  - And whether or not there was an injury and was it major or minor.

Section K

- Section K: Swallowing & Nutritional
  - Swallowing Disorder
  - Height & Weight
  - Weight Loss: whether or not on Physician Prescribed weight loss
  - Weight Gain: whether or not on Physician Prescribed weight gain.
  - Nutritional approaches
  - Percent Intake by artificial route

Section L

- Section L: Oral Dental Status
Section M

• Section M: Skin Conditions
  • Determination of Pressure Ulcer Risk
  • Risk of Pressure Ulcer
  • Unhealed Pressure Ulcer
  • Current Number of Unhealed Pressure Ulcers at each stage
  • Dimensions of unhealed Stage 3 or 4 Pressure Ulcers or Eschar
  • Most Severe Tissue Type for any Pressure Ulcer
  • Worsening in pressure ulcer status since prior assessment (OBRA or scheduled PPS) or last admission/entry/reentry.

• Section M: Skin Conditions, cont.
  • Healed Pressure Ulcers
  • Number of Venous and Arterial Ulcers
  • Other ulcers, wounds and skin problems.
    • 3/2014 Dan Taylor, Nebraska RAI coordinator, clarified that a cut/laceration is not a skin tear and cannot be coded on the MDS Section M1040G
  • Skin & Ulcer Treatments

Section N

• Section N: Medications
  • Injections
  • Insulin: Injections and orders for insulin in the last 7 days
  • Medications received:
    • Antipsychotic
    • Antianxiety
    • Antidepressant
    • Hypnotic
    • Anticoagulant
    • Antibiotic
    • Diuretic
    • Opioid
Section N

• Section N: Medications
  • Antipsychotic Medication Review
  • Gradual Dose Reduction – Yes or No
  • If attempted, date of the last attempt.
  • Physician documented GDR as clinically contraindicated
  • Did a complete Drug Regimen Review identify potential clinically significant medication issues?
  • Medication Follow-up
  • Medication Intervention

Section O

• Section O: Special Treatments, Procedures, and Programs
  • Special Treatments Procedures/Programs: Several reimbursable items in this section for RUG III, and 1 item for RUG IV
  • Influenza Vaccine
  • Pneumococcal Vaccine
  • THERAPIES: PT/OT/SLP/Respiratory/Psychological Therapy/Recreational therapy
  • Distinct calendar days of therapy
  • Resumption of therapy

• Section O: Special Treatments, Procedures, and Programs
  • Restorative Programs
  • Physician Examinations
  • Physician Orders
Section P

• Section P: Restraints
  • Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body.

Section P

• Physical Restraints Used in Bed
  • Bed Rail
  • Trunk Restraint
  • Limb Restraint
  • Other

• Physical Restraints Used in Chair or Out of Bed
  • Trunk Restraint
  • Limb Restraint
  • Chair prevents Rising
  • Other

Section P

• Alarms
  • Bed Alarm
  • Chair Alarm
  • Floor Mat Alarm
  • Motion Sensor Alarm
  • Wander/eloement Alarm
  • Other Alarm
Section P

- Alarms
  - You would code alarms as a restraint if the alarm deters the resident from evening moving in bed or chair.
  - If they are afraid to move because it might set the alarm off, it is a restraint.
  - Follow the criteria in the MDS 3.0 Manual

Section Q

- Section Q: Participation in Assessment and goal Setting
  - This is not a structured interview
  - The first section wants to know if the resident participated in the assessment: this means the entire MDS.

- Section Q: Participation in Assessment and goal Setting, cont.
  - The person conducting the assessment (most often the Social Services person) and gathering the data from the resident, must ask the questions using the verbiage on the MDS.
  - The resident, family, significant other, guardian, or legally authorized representative of the resident can participate in this section.
Section Q

- Section Q: Participation in Assessment and goal Setting, cont.
- One of the most upsetting questions to staff and residents alike is Section Q0500: "Ask the resident (or family or significant other, or guardian, or legal authorized representative if the resident is unable to respond) 'Do you want to talk to someone about the possibility to leaving this facility and returning to live & receive services in the community?'"
Section X

- Section X: Correction Request
  - Boo Boo Section!
  - Modification
  - Inactivation

Section Z

- Section Z: Assessment Administration
  - Medicare Part A Billing Information
  - Medicare Part A Non-Therapy Billing Information
  - State Medicaid Billing Information
  - Alternate State Medicaid Billing Information
  - Insurance Billing Information
  - Signature of Persons Completing the assessment or Entry/Death Reporting
  - 20500 Signature of RN Assessment Coordinator Verifying Assessment Completion

Changes are Coming 10/01/18 – Again! We’ll know for sure when it is released

- Section A: A0600B: New Medicare Numbers
- Section F: F010: Oh Good Night Nurse!
- Section J: J0200 Prior Surgery – 100 days.
- Section M: additions and clarifications in wording of some of the current coding choices.
- Section N: Multiple Additions
- Drafts of the 2018 MDS 3.0 revisions are available at CMS.gov
The Art of the Interview

• All residents capable of any communication should be asked to provide information regarding what they consider to be the most important facets of their lives.

• There are several MDS 3.0 sections that require direct interview of the resident as the primary source of information (e.g., mood, preferences, pain).

The Art of the Interview

• CMS put out the VIVE Video when MDS 3.0 came out in 2010. I recommend you watch this video when you have access to a computer.


The Art of the Interview

• Self-report is the single most reliable indicator of these topics.

• Staff should actively seek information from the resident regarding these specific topic areas; however, resident interview/inquiry should become part of a supportive care environment that helps residents fulfill their choices over aspects of their lives.
• In addition, a simple performance-based assessment of cognitive function can quickly clarify a resident's cognitive status.

• The majority of residents, even those with moderate to severe cognitive impairment, are able to answer some simple questions about these topics.

• Even simple scripted interviews like those in MDS 3.0 involve a dynamic, collaborative process.

• There are some basic approaches that can make interviews simpler and more effective.
The Art of the Interview

• **Introduce yourself** to the resident.

• **Be sure the resident can hear what you are saying.**
  
  • Do not mumble or rush.
  
  • Articulate words clearly.

The Art of the Interview

• Ask the resident if he or she uses or owns a hearing aid or other communication device.

• Help him or her get the aid or device in place before starting the interview.

• The assessor may need to offer an assistive device (headphones).

• If the resident is using a hearing aid or other communication device make sure that it is operational.

The Art of the Interview

• Ask whether the resident would like an interpreter (language or signing).

• Find a quiet, private area where you are not likely to be interrupted or overheard.

• Sit where the resident can see you clearly and you can see his or her expressions.
• Establish rapport and respect.
• Explain the purpose of the questions to the resident.
• Say and show the item responses.
• Ask the questions as they appear in the questionnaire.
• Break the question apart if necessary.

If the resident has difficulty understanding, requests clarification, or seems hesitant, you can employ unfolding or disentangling techniques. *(Do not, however, use these techniques for the memory test).*
The Art of the Interview

- Unfolding:
  - Refers to the use of a general question about the symptom followed by a sequence of more specific questions if the symptom is reported as present.
  - This approach walks the resident through the steps needed to think through the question.

Example:

- Read the item (or part of the item) to the resident, then ask, “Do you have this at all?” If yes, then ask, “Do you have it every day?” If no, then ask, “Did you have it at least half the days in the past 2 weeks?”
• Disentangling:
  • Refers to separating items with several parts into manageable pieces.
  • The type of items that lend themselves to this approach are those that include a list and phrases such as “and” or “or.”

• Disentangling, cont:
  • The resident is given a chance to respond to each piece separately.
  • If a resident responds positively to more than one component of a complex item, obtain a frequency rating for each positive response and score that item using the frequency of the component that occurred most often.

• Example:
  • An item asks about “Poor appetite or overeating.” Disentangle this item by asking, “Poor appetite?”; pause for a response and then ask, “Or overeating?”
  • If neither part is rated positively by the resident, mark no.
  • If either or both are rated positively, then mark yes.
The Art of the Interview

- Clarify using echoing.

- **Echoing** means simply restating part of the resident’s response.

- This is often extremely helpful during clinical interviews.

The Art of the Interview

- If the resident provides a related response but does not use the provided response scale or fails to directly answer the question, then help clarify the best response by repeating the resident’s own comment and then asking the related response options again.

- This interview approach frequently helps the resident clarify which response option he or she prefers.

The Art of the Interview

- Repeat the response options as needed. Some residents might need to have response choices repeated for each item on a given list.

- Move on to another question if the resident is unable to answer.

- Even if the interview item cannot be completed the time spent is not wasted. The observation of resident behaviors and attention during the interview attempt provide important insights into delirium, cognition, mood, etc.
• Break up the interview if the resident becomes tired or needs to leave for rehabilitation, etc.

• Do not try to talk a resident out of an answer. If the resident expresses strong emotions, be nonjudgmental, and listen.

• Record the resident's response, not what you believe he or she should have said.

The Art of the Interview

• If the resident becomes deeply sorrowful or agitated, sympathetically respond to his or her feelings.

• Allowing emotional expression—even when it is uncomfortable for you as the interviewer—recognizes its validity and provides cathartic support to residents.

• If the resident remains agitated or overly emotional and does not want to continue, respond to his or her needs.

• This is more important than finishing the interview at that moment.

• You can complete this and other sections at a later point in time.
The Art of the Interview

- Resident preferences may be influenced by many factors in a resident’s physical, psychological and environmental state, and can be challenging to truly discern.

Resource Utilization Group

RUG’s

- We’ve eluded to reimbursement and RUG’s
- RUG IV 66 Grouper is the version currently being utilized by the Federal Government in regard to Medicare A payment.
- RUG III 34 Grouper is the version currently being utilized by the State of Nebraska for the Medicaid payment.

Resource Utilization Group

RUG’s

- RUG IV 66 Grouper has the following categories:
  - Rehabilitation + Extensive Services
  - Rehabilitation
  - Extensive Services
  - Special Care High
  - Special Care Low
  - Clinically complex
  - Behavior symptoms and Cognitive Performance
  - Reduced Physical Function
  - Restorative Nursing Programs
RUG III 34 Grouper has the following categories:

- Rehabilitation
- Extensive Services
- Special Care (ADL Score <7 Clinically Complex)
- Clinically Complex
- Impaired Cognition
- Short Stay Residents
- Behavior Problems with ADL Score of <=10
- Reduced Physical Function

The ADL score can literally make or break your reimbursement.

- The ADL’s must be documented accurately in order to be coded correctly on the MDS.
- For MDS 3.0, the ADL Score can range from 0-16
- RUG III ADL’s are based on MDS 2.0 (cross-walked to MDS 3.0 coding) and the scores can range from 4-18.

Regardless of how we chart, the facility must still provide the ordered care/therapy, etc. But without the documentation, subsequent coding on the MDS, you won’t get paid.
Resource Utilization Group
RUG’s

- Mr. Little is an elderly gentleman receiving Medicare A Services (RUG IV) who needs assistance with all his ADL’s except eating. During the day he is able to transfer with 1 assist and a gait belt, but the nurse needs to help him stand by lifting him with that gait belt.
- On the Evening & Night shifts, he needs 2 people to help him stand with the gait belt.
- The only thing documented on the ADL Sheet was Extensive assistance with 1. That what was coded on the MDS

Resource Utilization Group
RUG’s

- During the day he is able to get off the toilet with 1 assist and a gait belt.
- On the Evening & Night shifts, he needs 2 people to help him stand with the gait belt.
- The only thing documented on the ADL Sheet was Extensive assistance with 1. That what was coded on the MDS.
- He was able to feed himself and needed limited assistance with turning and sitting on the side of the bed.
- He is receiving 325 minutes of therapy during the 7 day look back so is at a High rehab RUG

Calculating ADL Scores

- MDS Coding for Mr. Little:
  - Bed Mobility: Self Performance: 2 Support 2 = 1
  - Transfer: Self Performance: 3 Support 2 = 2
  - Eating: Self Performance: 1 Support 1 = 0
  - Toileting: Self Performance 3 Support 2 = 2
    Total Score: 5
- Rehab High with an ADL Score of 5 (RHA) = $324.66/day
• Actual ADL Score for Mr. Little:
  - Bed Mobility: Self Performance: 2 Support 2 = 1
  - Transfer: Self Performance: 3 Support 3 = 4
  - Eating: Self Performance: 1 Support 1 = 0
  - Toileting: Self Performance: 3 Support 3 = 4
  Total Score: 9

If the facility would have documented ADL’s accurately, reflecting what level of care he was actually receiving, his ADL score would have been 9.

RUG IV

• Rehab High with an ADL Score of 9 (RHB) = $365.49/day

• That is a difference of $40.83/day that was left on the table.
• Say this was a 30 day assessment and no Change of therapy MDS was completed.
• Billing period for the 30 day is day 31 through day 60 (29 days)
• $40.83 x 29 = $1184.07 in LOST REVENUE!

RUG III

• Rug III
• How many RUG PA1, PA2, PB1, PB2 do you have in your building
• Those RUG levels pay the Assisted Living Rate.
• Inaccurate coding for ADL’s, Behaviors, Restorative, Impaired cognition [not completing the interviews in the proper fashion] can cost you a lot of money.
• The example RUG III Sheet states that PA1 – PB2 pay $75.48/day
• Miss coding behaviors that ACTUALLY happened in the 7 day look back can really cost you.
• ADL Score 5 with Wandering 4 or more days has a payment of $129.23/day
• If you had a PA1 due to miss-coding, you’re receiving $75.48/day
• $129.23-$75.48 = $53.75/day lost
• MDS’ are completed every 92 days.
• $53.75 X 92 days = $4945.00 lost.

• Now let’s say you have 4 residents in your building on Medicaid at PA1 with instances where behavior documentation was missed:
  • $19780.00 left on the table.

ACCURACY

• Remember, staff need to document what ACTUALLY happened. Accuracy is the name of the game
• There is no room for fraud (over – coding) and inaccuracy (under-coding)
• We are only taking credit for what accurately reflects the resident.
• Behaviors need to be documented, even if it is “normal” for them.
• If the resident is on a psych drug, behaviors need to be documented to accurately reflect the resident for the entire 24 hours – not just the day shift

• Accuracy applies to all aspects of the resident’s care.

• MDS also populates your Quality Measures, has a part in your Four Star status, and of course your Survey process.
Thank you for your attention.

References:

MDS 3.0 Manual V1.15, 10/01/2017