MDS 3.0

v. 1.14 with October 2016 Updates

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N.C. Department of Health and Human Services

Objectives

Participants will be able to:

- Identify the key components of the Resident Assessment Instrument
- Gain understanding of the RAI Manual changes for version 1.14 October 2016
- Recognize the impact of documentation and coding inaccuracies
- Identify major changes to the Item Sets

MDS RAI Manual v1.14 effective Oct.1, 2016

The updated RAI Manual was posted to the CMS website in late September 2016

At:http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

Or

Go to www.qtso.com and click on MDS 3.0 and then click on MDS 3.0 RAI Manual

Overview of Changes

- Addition of Part A PPS Discharge Assessment
- Updates to the delirium assessment (CAM)
- Addition of Section GG: Functional Abilities and Goals
- Expected modification of injuries related to falls
- Determining "present on admission" for pressure ulcers
- Item set wording changes

Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014

SNF **Quality Reporting Program** (QRP)**adopted 3 QMs**

- Percent of Residents Experiencing One or More Falls with Major Injury
- Percent of Patients or Residents with Pressure Ulcers that are New or Worsened
- Percent of Long Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function

On the Web search **SNF QRP CMS**

SNF Quality Reporting Program

- Beginning with the FY 2018 payment determination, SNFs must report all of the data necessary to calculate the QM on at least 80% of the assessments submitted
- A SNF is compliant with the QRP if all of the data necessary to calculate QM has been submitted to fully calculate the QMs
- A measure cannot be calculated, for example, when the use of a dash [-] indicates the SNF was unable to perform a pressure ulcer assessment. Left blank, it also means no assessment was done for that Item

- The Annual Payment Update threshold for FY 2018 is not based on the final calculation of a quality measure, nor complete stays. Rather it is based on the determination of the completion of the items necessary to calculate the quality measure, which we note includes the risk adjustment items. The threshold is based on the completion of items on a record regardless of whether the stay has been completed.

For example, if a resident is admitted on December 20th, and the SNF has completed all items on the resident's 5-Day PPS assessment that is used to calculate the SNF QRP quality measures, then this record would be among those considered compliant. A provider must have 100% of all the items necessary to calculate the measure on at least 80% of the records submitted that would be used to calculate (and risk adjust) the quality measure.

MDS Focused Surveys Continue into 2017

National Results of FY 2015 MDS Focused Surveys

When items have a look-back period to the **prior assessment** (Admission/Entry, Reentry, or Prior OBRA or scheduled PPS assessment), staff must only consider those assessments that are required to be submitted to the QIES ASAP system

So....*PPS assessments completed for private insurance* and Medicare Advantage Plans must not be submitted to the QIES ASAP system and therefore *should not be considered when determining the "prior assessment."*

And the MDS Focused Surveys Continue

Most Frequently Cited Deficiencies

F278 – MDS Accuracy
F356 – Posted Staffing
F279 – Develop Comprehensive Care Plans
F329 – Free from Unnecessary Drugs
F314 – TX/Services to Prevent/Heal Pressure Ulcers
F315 – No Cath / Prevent UTI /Restore Bladder
F274 – Comprehensive Assessment after Sig Change

Common Errors with MDS Focused Surveys

Antipsychotics:
- Incorrect coding for residents with or without meds
- Incorrect coding on number of days administered

Restraints:
- Not identified and/or not coded

Falls:
- Not coded to reflect falls that had occurred

Common Errors continued

Continence/Catheters:
- Inconsistent with/without,
- No diagnosis, Inconsistent with actual continence

UTIs:
- Incorrect coding based on RAI Manual criteria

Pressure Ulcers:
- Inconsistent with/without,

Quarterly, Annual and SCSA:
- Not timely or not at all

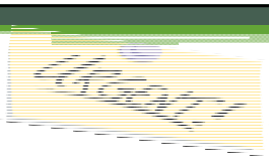
Coding Conventions

Reading the Manual is Essential

When items have a look-back period to the **prior assessment** (Admission/Entry, Reentry, or Prior OBRA or scheduled PPS assessment), staff must only consider those assessments that are required to be submitted to the QIES ASAP system

So....*PPS assessments completed for private insurance* and Medicare Advantage Plans must not be submitted to the QIES ASAP system and therefore *should not be considered when determining the "prior assessment."*

Important Reminder



It is ***never*** appropriate to code the MDS inaccurately simply because documentation may impact the MDS Validation Review, or for any other reason.

From the Myers & Stauffer Policy

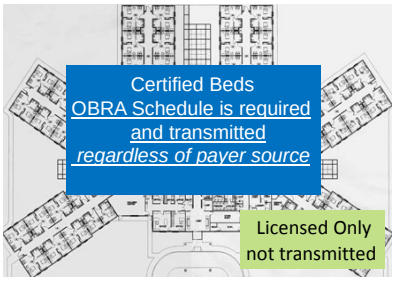
Recognizing that errors are inevitable, the Division of Medical Assistance has a Medical Record Correction Policy in place, allowing for documentation corrections to be made within 14 days of the ARD, but no later than the completion date of the MDS and before submission to the QIES ASAP system, using standard editing

Section A : Identifying Information

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.

A0310 A - OBRA Required Assessments

01. **Admission**
02. **Quarterly**
03. **Annual**
04. **SCSA**
05. Significant
06. Significant
99. None of the above



* A0310 F – Entry & Discharge are also OBRA required

OBRA Required Assessments - A310A

- Admission (comprehensive) A0310A = 01
- Quarterly A0310A = 02
- Annual (comprehensive) A0310A = 03
- Signif Change in Status Assess A0310A = 04
- Signif Correct to Prior Comp A0310A= 05
- Signif Correct to Prior Qtrly A0310A = 06

- **Discharge reporting assessments**
  - Return not anticipated A0310F = 10
  - Return anticipated A0310F = 11
  - Death in facility tracking A0310F= 12
- Entry record – tracking form A0310F = 01
- Planned or Unplanned Discharge A0310G

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A0310 F: Entry / Discharge Reporting

Entry Tracking Record

- Completed in 7 days when **admitted/readmitted**
- Submitted no later than the 14th calendar day after the entry (entry + 14 calendar days)

Death in Facility Tracking Record

- Completed when resident dies in the facility **OR**
- Dies in Ambulance in transit to hspital **OR**
- Dies in ED prior to admission to the hospital **OR**
- Dies while on Leave of Absence
- *Transmitted no later than date of death + 14days*

Chapter 2-16

RAI OBRA-required Assessment Summary

Assessment Type	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look Back) Consists Of	14-day Observation Period (Look Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than
Admission (Comprehensive)	A0310A= 01	14th calendar day of the resident's admission (admission date + 13 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day of the resident's admission (admission date + 13 calendar days)	14th calendar day of the resident's admission (admission date + 13 calendar days)	CAA(s) Completion Date + 7 calendar days
Annual (Comprehensive)	A0310A= 03	ARD of previous OBRA comprehensive assessment + 366	ARD + 6 previous calendar days	ARD +13 previous calendar days	ARD + 14 calendar days	ARD + 14 calendar days	CAA(s) Completion Date + 7 calendar

Significant Change In Status Assessment

Chapter 2-22

A SCSA is appropriate when:

— It is determined there has been a significant change (improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and

— The resident's condition is not expected to return to baseline within two weeks.

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Significant Change In Status Assessment

Decline in Two or More

*Decision-making changes

*Presence of a resident mood item not previously reported or increase in the symptom frequency

*Decline in an ADL where newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment

*Incontinence pattern changes or placement of a cath

*Unplanned wt loss (5% in 30 days or 10% in 180 days)

*New ulcer at Stage 2 or higher or worsening PU

*Begins to use a restraint or Overall deterioration

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Significant Change In Status Assessment

Improvement in Two or More

*Any improvement in an ADL physical functioning area where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment

*Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases

*Resident's decision making changes for the better

*Resident's incontinence pattern changes for better

*Overall improvement of resident's condition

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Hospice or Palliative by Outside Agency

Should a SCSA be completed? **Chapter 2-22**

"A SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare Hospice or other structured hospice)(Medicare-certified or State-licensed hospice provider) **or changes hospice providers** and remains a resident at the nursing home."

Why?
Communication & Coordination & Care Plan

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ARD regarding Hospice

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

- When hospice election occurs after the Admission assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice election
- If hospice is discontinued prior to the ARD of the admission assessment, the facility should check item O0100K Hospice Care. Since hospice was discontinued prior the ARD, a SCSA is not required

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A1500—PASRR Overview

- PASRR is a preadmission screening process.
- Applies to the Medicaid unit of a facility only
- A positive screen indicates the resident has a mental illness, intellectual disability, or a related condition.
- A1500 documents whether a PASRR Level II determination has been issued.
- Reports on the results of the PASRR process
- Only completed on the OBRA comprehensive MDS

PASRR Help Desk 1-855-883-8018

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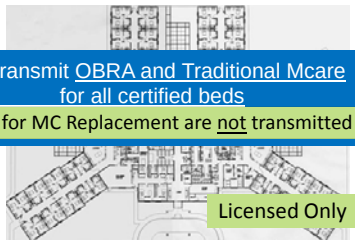
A0310 B - Scheduled PPS Assessments

01. **5 Day**
02. **14 Day**
03. **30 Day**
04. **60 Day**
05. **90 Day**



PPS Unscheduled for Medicare Part A

07. Unscheduled assessment used for PPS
99. None of the above

A0310 C – Other MCare Req. Assessments

Start of Therapy Optional

- Completed **only** to classify resident into a RUG IV Rehab plus Extensive Services or Rehab Group
- Completed **ONLY** if the resident isn't already in a RUG-IV Rehab Plus Extensive Services / Rehab Group
- ARD must be 5-7 days after start of **FIRST** therapy for ST, OT or PT, whichever is earlier.
  Day 1=therapy start date
- Medicare payment starts on first day of therapy

A0310 C - OMRAs

End of Therapy "Three Day" Policy

- EOT OMRA is completed when a beneficiary classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group did not receive any therapy services for three or more consecutive calendar days for any reason or weekend or holiday
- ARD for EOT OMRA must be set for day 1, 2, or 3 from the date of the resident's last therapy session

A0310 C - OMRAs

If therapy resumes > 5 days after last therapy date Then a new therapy evaluation(s) is required

- Resident may have new deficits and/or regressed
- Clinically must determine if plan of care and/or goals need to be modified

Establish new/current start of therapy date(s)

- This allows SOT OMRA to be completed if requirements are met (still optional)

New physician orders –determined case-by-case

- Plan of care/treatment regimen modified and may require new orders

A0310 C: OMRAs

EOT with Resumption (EOT-R)

- Used when the resident will resume at the same therapy level as prior to the discontinuation of therapy and Resumption must occur no more than 5 days after the last day of therapy provided

EOT Required or Not

If A2400C is prior to the third consecutive day of missed therapy services, then no EOT is required. If A2400C is on or after the third consecutive day of missed therapy services, then an EOT OMRA would be required.

A0310 C: OMRAs

Change of Therapy

- Required when the resident was receiving a sufficient level of rehabilitation therapy to qualify for an Ultra High, Very High, High, Medium, or Low Rehabilitation category and when the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) delivered, and other therapy qualifiers such as number of therapy days and disciplines providing therapy) changes to such a degree that it would no longer reflect the RUG-IV classification and payment assigned for a given SNF resident based on the most recent assessment used for Medicare payment.

A0310 C: OMRAs

Change of Therapy (COT)

- ARD is set for Day 7 of a COT observation period
- COT Observation Period: A successive 7-day window beginning the day following the ARD of the resident's last PPS assessment used for payment*

*In cases where the last assessment was an EOT-R, then the COT observation period begins on the resumption date listed in O0450B

A0310 C: OMRAs

When is the Change of Therapy required?

- In order to determine if a COT OMRA is required, providers should perform an informal **change of therapy evaluation** every **7 days**, that considers the intensity of the therapy the Patient received during the COT observation period

✓Total Reimbursable Therapy Minutes

✓Number of Therapy Disciplines

✓Number of Therapy Days

✓Restorative Nursing (for residents in a Rehab Low Category)

A COT OMRA is required in cases where the therapy received during the COT observation period would cause the patient to be classified into a different RUG category

A0310 C: COT OMRA to Reclassify

The COT OMRA may be completed when a resident is not currently classified into a RUG-IV therapy group, ***but only if both of the following conditions are met:***

1. Resident has been classified into a RUG-IV therapy group on a prior assessment during the resident's current Medicare Part A stay, **and**

2. No discontinuation of therapy services occurred between Day 1 of the COT observation period for the COT OMRA that classified the resident into his/her current non-therapy RUG-IV group and the ARD of the COT OMRA that reclassified the resident into a RUG-IV therapy group.

A0310 F: Entry / Discharge Reporting

Entry Record

- Completed within 7 days every time a person is **admitted or readmitted** into a nursing home (or swing bed facility)
- Submitted no later than the 14th calendar day after the entry (entry + 14 calendar days)
- Submit before the next assessment.
- Required in addition to the initial Admission assessment or other OBRA or PPS assessments that might be required
- Cannot be combined with an assessment

A0310 F: Entry / Discharge Reporting

Discharge *Assessments and Record*

- There are now 3 kinds of Discharge assessments
- **Not** associated with NH bed hold status or opening and closing of the medical record

A0310 F 10. Discharge assessment – return NOT anticipated

A0310 F 11. Discharge assessment – return anticipated

And now

A0310 H SNF PPS Part A Discharge (End of Stay) Assessment

A0310 H SNF PPS Part A Discharge (End of Stay) Assessment

- In order to collect admission data and discharge data for the new **Quality Measure: "Percentage of Long Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan that Addresses Function"**
- **A specific discharge assessment that effectively ends the Medicare Part A PPS stay of a resident when his/her Medicare stay ends but the resident remains in the facility**

A0310 H SNF PPS Part A Discharge (End of Stay) Assessment

- Consists of demographic administrative and clinical items
- The ARD (A2300) for the new Part A PPS Discharge assessment is always equal to the End Date of Most Recent Medicare Stay (A2400 C) The ARD can be coded on the assessment any time during the assessment completion period
- Must be completed within 14 days after the Most Recent MCare Stay (A2400 C + 14 calendar days)
- Section GG is only completed when the DC is **planned**

A0310 H SNF PPS Part A Discharge (End of Stay) Assessment

- The End Date of the Most Recent Stay may be earlier than the actual Discharge date (A2000) from the facility. If this occurs, the Part A PPS Discharge assessment is required.
- If the End Date of the Most Recent Part A Stay (A2400 C) occurs on the day of or one day before the Discharge Date (A2000), the OBRA Discharge and Part A Discharge assessments are both required. When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000)
- For a standalone Part A PPS Discharge , the End Date of the Medicare Stay (A2400 C) and the ARD (A2300) must be the same. The A2000 is left blank.

Measures for Beginning & End of Stay

- The Item Set for this discharge has **TWO section GGs- one for the START of the PPS stay, and one for the PPS discharge**
- On the Part A PPS Discharge assessment (A0310H = 1), the Self-Care items in GG0130 are completed only if the Type of Discharge is Planned (A0310G = 1)
- Your software vendor should populate the correct data fields

Unplanned Discharge Includes…..

- Acute care transfer of the resident to a hospital or an emergency department stay beyond 24 hours
- Resident leaves the facility against medical advice
- Resident unexpectedly deciding to go home or to another setting (e.g., resident decides to complete treatment in an alternate setting).
- For more information, please refer to Chapter 2 of the MDS 3.0 RAI Manual V1.14

Federal Regs for Section A

DF271 – F287

- F274 – 14 days after facility determines the resident has had a significant change
- F278 - *ACCURACY*
- F279 Comprehensive Care Plan
- F282 – Implementing the Care Plan
- F285 – PASRR Coordination
- F287 – Transmitting Data Timely

Section B : Hearing, Speech & 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.

Comatose Coding Instructions

Steps for Assessment

- Review the medical record for a neurological diagnosis of comatose or persistent vegetative state documented by a physician, NP, or PA

DEFINITION

COMATOSE (coma)
A pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; he/she does not open his/her eyes, does not speak and does not move his/her extremities on command or in response to noxious stimuli (e.g., pain).

B0200 - Hearing & B0300 - Hearing Aid

Determine if the Resident uses a hearing aid or other appliance prior to beginning assessment

- Check the medical record for evidence of a hearing appliance
- Ask the resident and/or family about the use of a hearing appliance
- Eliminate hall noises as much as possible

B0700 - Makes Self Understood

Ability to express ideas verbally and non-verbally

Take into account he entire 7day look-back

- Make sure the resident can hear you
- Use resident's preferred language and method of communication (verbal, sign language, etc)
- Unaddressed problems can be mistaken for confusion or cognitive impairment

This Item is ***not*** used to determine whether the interviews should be attempted

B1000 - Vision & B1200 - Corrective Lenses

*Determine if the Resident uses glasses or another vision aid before beginning the **Hearing Test***

- Test the accuracy of your findings
  - Ensure visual appliance(s) are in place
  - Ensure adequate lighting.
- For residents who cannot read out loud
  - Ask to read numbers.
  - Ask to name items in small pictures.

If all else fails - Check gross visual acuity

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.

Attempt Resident Interviews

All residents capable of any communication should be asked about what is important in their care

- Interviewing is a dynamic, collaborative process
- Basic approaches to make the interviews effective
  - Introduce yourself and find a quiet, private area
  - Be sure the resident can hear you
  - Is an interpreter needed?
  - Sit where the resident can see you clearly
- See Appendix D for more techniques and tools

Brief Interview for Mental Status (BIMS)

Introduce and explain the interview

> "I would like to ask you some questions. We ask everyone these same questions. This will help us provide you with better care. Some of the questions may seem very easy, while others may be more difficult."

- Complete the interview in one sitting, ask questions exactly as written and in the order provided
- Address any resident concerns
- Accept any refusal to answer / code as incorrect = 0
- Responses can be relevant, not necessarily correct

Stopping the BIMS Interview

Is the interview Complete or Incomplete?

- To be **considered complete** the resident had to attempt and provide relevant answers to at least four of the questions included in C0200-C0400
- To be **considered incomplete**, a resident had to choose not to answer or give completely unrelated, nonsensical responses to four or more items
- **Staff Interview** - Staff will base their responses on observations they have made of the resident during care and activities

C1310 Signs and Symptoms of Delirium

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

Code **after completing** Brief Interview for Mental Status or Staff Assessment, a

A. Acute Onset Mental Status Change

☐ **Is there evidence of an acute change in mental status** from the reside
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 hav having difficulty keeping track of wh

☐ **C. Disorganized thinking**- Was the r conversation, unclear or illogical flo

☐ **D. Altered level of consciousness**- D any of the following criteria?
- **vigilant**- startled easily to a
- **lethargic**- repeatedly dozed
- **stuporous**- very difficult to
- **comatose**- could not be ar

And now C1310 triggers the Delirium CAA

CAM Assessment Scoring Methodology

The indication of delirium by the CAM requires the presence of:

Item A = 1 **OR** Item B, C or D = 2

AND

Item B = 1 OR 2

AND EITHER

Item C = 1 OR 2 **OR** Item D = 1 OR 2

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.

D0200 Mood Interview

Patient Health Questionnaire

- Validated Interview that screens for symptoms of depression 9 Items A - I
- Provides a standardized severity rating and score
- Has a 14-day look-back
- There are two parts for each Item
  - Symptom presence
  - Symptom frequency

D0200 Mood Interview

Patient Health Questionnaire

- Conduct interview as close to ARD as possible, during the look-back period
- Use interpreter if indicated
- May use paper form to assist in interview; the resident can respond verbally, pointing to a cue card, OR by writing out their answers
  - Symptom presence
  - Symptom frequency

Section E : Behavior

Intent: This section identifies behavioral symptoms in the last 7 days that may cause distress to the resident, or be disruptive to facility residents, staff or the environment. These behaviors may place the resident at risk for injury, isolation, and inactivity and may also indicate unrecognized needs, preferences or illness.

E0100 – Potential Indicators of Psychosis

May be associated with delirium, dementia, adverse drug effects, psychiatric disorders or hearing or vision impairment

- Hallucinations – the perception of the presence of something not actually there. May be auditory or visual, or involve taste, touch or smell
- Delusions - a fixed false belief not shared by others

E0200 – Behavioral Symptoms

Identify the presence and frequency of 3 groups of behaviors

A. Physical behavioral symptoms directed towards others (hitting, kicking, pushing, grabbing others)

B. Verbal behavioral symptoms directed towards others (threatening, screaming , cursing at others)

C. Other behavioral symptoms not directed toward others (scratching self, rummaging, disrobing, throwing or smearing food or bodily wastes, screaming or disruptive sounds)

E0500 & D0600 - Impact on Resident / Others

"Significant" refers to effects, results or consequences that are or are likely to affect

- Significant risk for illness or injury
- Interferes with the individual's care or privacy or activity of others
- Significantly interfere with participation in activities or social interactions

E0800 – Rejection of Care

Behavior that interrupts or interferes with the delivery of care

- Is it a matter of **choice**? Preferences do not have to appear logical and may not be consistent with "good judgement"
- Intent is to identify potential behavioral problems

E0900 – Wandering

Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place without a specified course or known direction

- Presence
- Frequency
- Impact

Determine the need for environmental modifications, and activities to reduce risk to the individual and reduce unwanted intrusions on other residents

Section F : Preference for Routine & Activities

Intent: This section obtains information regarding the resident's preferences for daily routine and activities. Nursing homes should use this as a guide to create an individualized plan based on the resident's preferences, and is not meant to be all-inclusive.

F0300 - Interview? & F0400 - Preferences

Daily Preferences and Quality of Life

- Explain the reason for the interview

  "I would like to ask you some questions about your daily routines. Staff would like to know what is important to you as it will help us plan your care around your preferences. Even if your stay is only for a few days, we want to make it as personal as possible."

- Stop interview and skip to F0700 if:
  - Resident gives 3 nonsensical responses to 3 questions **or,**
  - Resident has not responded to 3 questions

F0500 - Interview for Activity Preferences

Daily Preferences and Quality of Life

- As with the daily routines, responses may provide insights into perceived functional, emotional and sensory support needs
- Activities are a way for individuals to establish meaning in their lives and the need for enjoyable activities does not change on admission to a nursing home
- 8 items are evaluated using the same coding scale as in daily preferences

F0800 – Staff Interview for Preferences

Observations by staff across all shifts/departments

- Assessment is done by observing the resident when care, routines and activities specified in these items are available to the resident
- Conduct this interview only if resident or family interview cannot be conducted

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. In addition, on admission, resident and staff opinions regarding functional rehabilitation potential are noted.

G0110: ADL Assistance Coding Tips

Observation, Record Review & Interview - All Shifts

- Do not code ADLs based on the resident's potential ability, but on actual performance
- Include only assistance provided by individuals employed or under contract with the facility (not family, students, visitors or hospice staff)
- Consider each episode of an activity that occurred during the 7 day look-back period

G0110: ADL Assistance Coding Tips

Observation, Record Review & Interview - All Shifts

- Self-performance may vary from shift to shift in a 24 hour day
- Consider the resident's performance while using adaptive equipment
- Clarify your own understanding and observations about a resident's performance of an ADL activity

G0110: ADL Assistance (Column 1) Definitions

Self Performance

Code 0. Independent: if resident completed activity with no help or oversight **every time** during the 7-day look-back period and it occurred at least 3 times

Code 1. Supervision: if oversight, encouragement, or cueing was provided **3 or more times** in the last 7 days

Code 2. Limited assistance: if resident was highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight-bearing assistance **3 or more times** in the last 7 days

G0110: ADL Assistance Definitions continued

Code 3, extensive assistance: if the resident performed part of the activity over the last 7 days and help of the following type(s) was provided

- Weight-bearing support provided **3 or more times**

OR

- Full staff performance of an activity **3 or more times** during part but not all of the last 7 days

G0110: ADL Assistance Definitions

Code 4. Total dependence: if every time it occurred there was **full staff performance** of an activity with no participation by resident for any aspect of the ADL activity, and the activity occurred 3 or more times

Resident must be unwilling or unable to perform any part of the activity over the entire 7-day look-back period

Code 7. Activity only occurred once or twice: if the activity occurred fewer than 3 times in the last 7 days

Code 8. Activity did not occur: if the 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 look-back period

Coding with the Rule of 3

- Staff completing this section must fully understand the ADL Self Performance coding level definitions, the components of each ADL, and the steps to the Rule of 3
- In order to properly apply the Rule of 3, the facility must first note which ADL activities occurred, how many times each ADL activity occurred, what type and what level of support was required for each ADL activity over the entire 7-day look-back period

Exceptions to the Rule of 3

Code 0 - Independent
Code 4 - Total dependence
Code 8 - Activity did not occur
The definition for these coding levels are finite and cannot be entered on the MDS unless that level occurred **every** time the ADL occurred

Code 7 - Activity occurred only once or twice
Coded if the ADL activity occurred fewer than 3 times in the 7-day look back period

Instruction for the Rule of 3

- **Keep the ADL coding level Definitions and the Exceptions in mind**
- Use the first instruction encountered that meets the coding scenario
  (e.g., if #1 applies, stop and code that level)
- **The *Step* must apply before using the examples below the Step - as in 3a., 3b., or 3c.**
- When an ADL activity has occurred **3 or more times**, apply the following steps of the Rule of 3

Steps for the Rule of 3

1. When an activity occurs **3 or more times at any one level**, code that level
2. When an activity occurs **three or more times at multiple levels, code the most dependent level that occurred three or more times**

Steps for the Rule of 3

3. When an activity occurs at least 3 times, and at **multiple levels,** but not 3 times **at any one level**, apply the following:

a. See Self-Performance definition for Extensive

b. When there is a combination of full staff performance and weight-bearing assistance that total 3 or more times then code Extensive assistance

c. When there is a combination of full staff performance/weight-bearing assistance, and/or non-weight-bearing assistance that total 3 or more times then code Limited assistance

If none of the above are met, code supervision

Don't Rely on Your Software to be Correct!

Example 1: **8, 4, 8, 3, 8, 8, 8, 4, 2, 8, 2, 0, 1, 8, 8, 8, 0, 8**

Total = two times Extensive = one time

Limited = two time Supervision = one time

Independent = two times

Example 2: **0, 8, 8, 1, 8, 0, 0, 1, 2, 0, 8, 4, 3, 3, 8, 4, 8, 8**

Total = two times Extensive = two times

Limited = one time Supervision = two times

Independent = 4 times

Example 3: **4, 4, 8, 8, 8, 4, 2, 2, 2, 2, 1, 2, 2, 2, 1, 2, 1, 0, 1**

Total = 3 times Limited = 8 times

Supervision = 4 times Independent = one time

G0110: ADL Support (Column 2)

Code for the **most support provided over all shifts**

Code 0 - no setup or physical help from staff

Code 1 - setup help only: resident is provided with materials or devices necessary to perform the ADL independently

Code 2 - one person physical assist: if the resident was assisted by one staff person

Code 3 - two+ person physical assist: if the resident was assisted by two or more staff persons

Code 8 - ADL activity did not occur during the entire period: if the 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

G0120: Bathing

Rule of 3 does not apply

- Codes for support provided are the same as for the other ADL's
- Code for maximum amount of assistance received during bathing

*Excludes washing back, hair

G0300: Balance Assessment

- Have assistive devices the resident normally uses
- Start with resident sitting on the edge of the bed, in a chair or in a wheelchair
- Ask the resident to stand up and stay still for 3-5 seconds (rate G0300A now)
- Ask resident to walk approximately 15 feet using his/her usual assistive device (rate G0300B now)
- Ask resident to turn around (rate G0300C now)

G0400: Functional Range of Motion

Intent to identify limitations that interfere with daily functioning or place the resident at risk of injury

- Assess ROM at the shoulder, elbow, wrist, hand, hip, knee, ankle, foot and other joints unless contraindicated (both sides of body)
- Ask resident to move each joint using verbal directions and demonstration. May actively assist the resident with ROM exercises

Question: G0400 - How is this coded for amputations?

Answer: Assess the resident to see the effect of the amputation upon the resident. If the resident had a prosthetic and it had no effect on ADL's, then this would not be coded as a limitation

Question: G0400 - How is this coded if the limitation isn't due to ROM limits, but cognitive deficits?

Answer: You would code this item "yes" if the effect was the same, and affected ADL's

Section GG : Functional Abilities & Goals

Intent: This section assesses the need for assistance with self-care and mobility activities at the beginning and end of a SNF PPS Stay.

GG: What and Why

- *Section GG is included in 2 item sets:*
  - The Medicare Part A 5-day MDS
  - The Medicare Part A Discharge assessment
- Combining either of these two item sets with an OBRA MDS is allowed, except for the Death In Facility item set

---

- Items focus on the resident's self-care mobility
  - Admission performance and Discharge goals and
  - Discharge performance

Section GG is TWICE as Much Fun as Section G

- Carefully review the coding guidelines and components of each of these ADL
- Consider which staff members will complete this section
  - If therapy will be provided, then therapy should be involved

Key Definition: Helper

*A **helper** is a paid or contracted staff member*

- So, when helper assistance is required because a resident's performance is unsafe, only consider facility staff when scoring for amount of assistance
- Safety impacts scoring
- And forget Section G

GG0130: Self-Care - Admission SNF Stay

- Done on SNF Part A 5d MDS assessments
- 3 ADLs- Eating, Oral hygiene, and Toileting hygiene
- 6 levels of coding, with '1' being most dependent and '6' being independent
- Columns for resident performance on admission and for discharge goals
- Assessment period is days 1-3 of the stay(based on A2400B)

GG0130: Self-Care – Coding Instructions

Steps for Assessment (page GG-2)

1. Assess the resident's self-care status based on direct observation, the resident's self-report, family reports, and direct care staff reports documented in the resident's medical record during the 3-day assessment period, which is days 1 through 3, starting with the date in A2400B, Start of most recent Medicare stay
2. Residents should be allowed to perform activities as independently as possible, as long as they are safe

GG0130: Self-Care – Assessment (cont.)

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

GG0130: Self-Care – Assessment (cont.)

4. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.

5. Residents should be coded performing activities based on their "usual performance," or baseline performance, which is identified as the resident's usual activity /performance for any of the self-care or mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if there's fluctuation in the performance of activities during the three-day assessment, the performance wouldn't be the worst, and it wouldn't be the best, but it would be what's "usual" for that individual.

Admission or Discharge Performance

Code 06, Independent: if the resident completes the activity by him/herself with no assistance from a helper

Code 05, Setup or clean-up assistance: if the helper SETS UP or CLEANS UP; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires assistance cutting up food or opening container, or requires setup of hygiene item(s) or assistive device(s)

Admission or Discharge Performance (cont.)

Code 04, Supervision or touching assistance: if the helper provides VERBAL CUES or TOUCHING/ STEADYING assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. The resident may require verbal cueing, coaxing, or general supervision for safety to complete activity; or may require only incidental help such as contact guard or steadying assist during the activity.

Code 03, Partial/moderate assistance: if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.

Admission or Discharge Performance (cont.)

Code 02, Substantial/maximal assistance: if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.

Code 01, Dependent: if the helper does ALL of the effort. Resident does none of the effort to complete the activity; or the assistance of two or more helpers is required for the resident to complete the activity.

Admission or Discharge Performance (cont.)

Code 07, Resident refused: if the resident refused to complete the activity

Code 09, Not applicable: if the resident did not perform this activity prior to the current illness, exacerbation, or injury

Code 88, Not attempted due to medical condition or safety concerns: if the activity was not attempted due to medical condition or safety concerns

Coding Tips (page GG-4)

- Do not record the staff's assessment of the resident's potential capability to perform the activity.
- If the resident does not attempt the activity and a helper does not complete the activity for the resident, code the reason the activity was not attempted. For example, code 07 if the resident refused to attempt the activity, code 09 if the activity is not applicable for the resident, or code 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.

Coding Tips (page GG-4)

- If two or more helpers are required to assist the resident to safely complete the activity, code as 01, Dependent
- Clarify your own understanding of the resident's performance of an activity, ask probing questions to staff about the resident, beginning with the general and proceeding to the more specific. See examples of probing questions at the end of section GG

Coding Tips (page GG-4)

Coding a *dash* ("-") in these items indicates *"No information."* CMS expects dash use for SNF QRP items to be a rare occurrence. Use of dashes for these items may result in a 2% reduction in the annual payment update. If the reason the item was not assessed was that the resident refused (code 07), the item is not applicable (code 09), or the activity was not attempted due to medical condition or safety concerns (code 88), **use these codes instead of a dash ("-").**

Hints Based on Practice

- Code the first column first, then the second column
- Start with the least assistance provided, then step through the levels until you reach one that matches the resident's USUAL performance
- Consider breaking the ADL down into percentages, to see which category applies

Discharge Goals

- These are determined by the IDT's professional judgement and resident input, taking into account the resident's prior status and anticipated progress
- Do not use codes 07, 09, or 88 for this column
- There must be at least one Discharge goal coded per resident stay on the 5-day PPS MDS

Discharge Goals – Coding Tip

From page GG-13:

- *Use the 6-point scale to code the resident's discharge goal(s). Do not use the "activity was not attempted" codes (07, 09, or 88) to code discharge goal(s). Use a dash (-) to indicate that a specific activity is not a goal. Of note, one goal must be indicated for either self-care or mobility.* ***Using the dash in this allowed instance does not affect APU determination****.*

Discharge Goal Considerations

- Is the resident expected to improve in these ADLs during the Part A stay? If so the code recorded as a goal will be higher than the Admission Performance column
- If the resident is expected to maintain the same level of ADL care, the codes will be equal
- If the resident is expected to decline, the code will be lower than the first column
- The goal can be higher, or the same, or lower

Discharge Goal - Column 2

- Licensed clinicians can establish goals at admission based on professional judgment and standards of practice as well as discussions with the resident and family. Goals should be established as part of the resident's care plan
- A minimum of one self-care or mobility goal must be coded per resident stay on the 5-day PPS assessment.
- Clinicians may code one goal for each self-care and mobility item included in Section GG at the time of the 5-day PPS assessment

Higher…Same…or Lower

Perhaps the resident has a progressive neurological condition. Rapid decline is expected but therapy services may slow the decline in function.

Toileting: Mrs. T's participation in skilled therapy is expected to slow down the pace of her anticipated functional deterioration. The resident's discharge goal code will be _____ than the 5-Day PPs admission performance code.

Well, what about……

CMS presenters were asked about the following scenario: a resident is wheeled to therapy even though she can propel her w/c, because she will be late for therapy without help.

- The response was that this is not a valid assessment of the resident's ability and should not be included in coding GG.

And this happens all the time……

The CMS presenters were asked about a resident who could ambulate with supervision, but required a staff member to follow in a wheelchair for safety

- CMS replied that if a second staff member is needed for safety, then the correct code is Dependent

GG0170 H1 Does the Resident Walk?

H1. Does the resident walk?

0.No, and walking goal is not clinically indicated → Skip to GG0170Q1, Does the resident use a wheelchair/scooter?

1.No, and walking goal **is** clinically indicated →Code the resident's discharge goal(s) for items GG0170J and GG0170K

2.Yes → Continue to **GG0170 J, Walk 50 feet with two turns**

GG0170H1 is done with Admission (Start of SNF PPS Stay)

Section GG: Summary

- The items in Section GG are used to calculate the SNF QRP Function quality measure.
- During a Medicare Part A SNF stay, residents may have self-care and mobility limitations on admission. In addition, residents may be at risk of further functional decline during their stay in the SNF.
- Section GG assesses the need for assistance with, and establishes goals for self-care and mobility activities. Outcomes are measured at discharge.

Section H : Bladder and Bowel Status

Intent: This section is to gathers information on the use of bowel and bladder appliances, patterns, response to toileting programs, and continence. Each resident who is incontinent or at risk of incontinence should be identified, assessed, and provided with individualized treatment and services to achieve or maintain as normal elimination function as possible.

H0100 – Appliances

Appliances used at any time during the past 7 days
Check all that apply

- H0100A = Indwelling catheter
- H0100B = External catheter
- H0100 C = Ostomy (Do not include intake ostomies)
- H0100 D Intermittent catheterization
- H0100 Z = None of the above

H0200 & H0500 – B&B Toileting Programs

A toileting trial or program refers to a specific approach

A. Has a trial of a toileting program been attempted at admission, re-entry or since incontinence was first noted?

B. Response?

C. Current toileting program?

- Bladder Training
- Prompted Voiding
- Habit Training

H0200 C Current Toileting Program

Look for documentation in the medical record showing the following 3 requirements are met:

- Implementation of a plan based on assessment of the resident's voiding pattern
- Evidence that the individualized program was communicated to staff and the resident through a care plan, flow records and documentation
- Resident's response to the program and any subsequent evaluations are documented

Question: A provider has a resident who self caths several times a day. The resident has been educated by staff, but does not follow a sterile technique. The definition for intermittent catheterization on page H-2 states: *Sterile insertion and removal of a catheter through the urethra for bladder drainage.* Since the resident is not using a sterile technique, how would the MDS be coded?

Answer: The intent of this item is to capture the use of appliances that are necessary to facilitate urinary elimination. The RAI manual currently states "*Sterile*" insertion and removal of a catheter through the urethra for bladder drainage, however it is important to capture this information on the MDS for a resident who is self-catheterizing in the facility, even if he/she is using clean technique. In this situation, item H0100D Intermittent Catheterization should be checked on the resident's MDS.

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.

I0100-I0800 Active Diagnosis

Two Look-back periods

- Diagnosis identification physician documentation of diagnosis **in last 60 days**
- Determination if diagnosis is active in **7-day window (except UTI)**

****If a disease or condition is not specifically listed then write in ICD-1- code at I8000. You may also be more specific at I8000*

Coding Tips

Do not include conditions that have been resolved, do not affect the resident's current status or do not drive the plan of care during the last 7 days

Special criteria for UTI:

- Physician Dx of UTI in last 30 days **and**
- Signs and symptoms attributed to UTI, **and**
- Positive test, study or procedure, **and**
- Current medication or treatment for UTI in last 30 days

Section J : Health Conditions

Intent: The intent of this section is to document health conditions that impact the resident's functional status and quality of life. The items include an assessment of pain using a resident or staff interview if the resident is unable to participate. Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, and falls.

J0100: Pain Management

Scheduled & PRN Pain Medication
Non-pharmacological Pain Interventions

- 5-day look back period
- Data to answer the 3 questions in this item come from medical record review and interviewing
- The interventions are included as part of a care plan
- There must be documentation that the intervention(s) were received and results assessed
- Interventions do not have to be successful to be counted

F309 in Appendix PP of the SOM - Pain Management Review

Non-Medication Pain Interventions?

Scheduled and implemented, non-pharmacological interventions include but are not limited to biofeedback, application of heat/cold, message, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electrical stimulation, ultrasound, and acupuncture

Herbal or alternative medicine products are not included in this category

J0300 –J0600: Resident Pain Interview

- Conduct this assessment close to the ARD date
- Ask the resident each item in J0300 thru J0600 in the order provided
- Use resident's terminology for pain – such as hurting, aching, burning
- Code for the presence or absence of pain regardless of pain management efforts
- *The resident's reported pain scale is independent of the medication received during the look-back*

J0800 –J0850: Staff Assessment for Pain

Complete only if Resident Interview was not done

- Review the medical record, interview staff and observe resident during cares/activities for past 5 days
- **Check** all indicators that apply
  - A = Non-verbal sounds (crying, whining, moans)
  - B = Vocal complaints of pain (ouch, it hurts, stop)
  - C = Facial expressions (grimaces, winces)
  - D = Protective body movements or postures
  - Z = None of these signs observed or documented (skip J0850)

J1100: Shortness of Breath (Dyspnea)

This can be an extremely distressing symptom and can lead to decreased interaction or quality of life

- Even residents with mild/moderate dementia may be able to provide information on their own symptoms
- Review the record, interview resident/staff/family
- Make your own observations
- If the resident avoids activity or is unable to engage in activity because of shortness of breath, then code this as present

J1300: Current Tobacco Use

The negative effects of smoking can shorten life expectancy and can create health problems that interfere with daily activities and adversely affect quality of life

Tobacco in any form

- This item opens the door to negotiation of a plan of care with the resident that includes support for smoking cessation
- If cessation is declined, a care plan that allows safe and environmental accommodation of resident preferences is needed

J1400: Prognosis

Coding Instructions

- **Code 0 - No:** if the medical record does not contain physician documentation that the resident is terminally ill and the resident is not receiving hospice services.
- **Code 1 - Yes:** if the medical record includes physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services

J1700: Fall History at Entry or Re-entry

Falls, especially a recent fall, recurrent falls, and falls with significant injury are the most important predictors of risk for future falls

- Ask the resident and family/significant other about falls in the last 6 month
- Review inter-facility transfer information
- Review all relevant medical records for evidence of one or more falls in the previous 6 months

J1800: Falls Since Admission or Prior Transmitted MDS

- If this is the first assessment/entry or reentry (A0310E = 1), review the medical record for the time period from the admission date to the ARD
- If this is not the first assessment/entry or reentry (A0310E = 0), review the day after the ARD of the last MDS assessment to the current ARD
- Any fall since the last MDS, even if it occurred while out in the community, in an acute hospital, or in the nursing home
- Review incident reports, fall logs and the medical record
- Ask the resident/family about falls during the look-back period even if not documented in the medical record

But What Are You Calling a FALL??

Definition:

- Unintentional change in position coming to rest on the ground, floor or onto the next lower surface
- Falls are not the result of an overwhelming external force
- An intercepted fall is still considered a fall
- A resident found on the floor or ground without knowledge of how they got there, is a fall

J1900: Falls Since Admission or Most Recent (Transmitted) MDS - Without or With Injury

J1900A-no injury
- no evidence of injury seen; no c/o pain or injury, no change in resident behavior after the fall

J1900B-injury not major
- Skin tears, abrasions, lacerations, superficial bruises, hematomas, sprains or fall-related injury that causes resident to have pain

J1900C-major injury
- Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematomas

Language Added at J01900

Please NOTE the new TEXT!!

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.

Language Added at J01900

More new TEXT!!

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.

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.

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.

K0100 Swallowing Disorder

Check All That Apply

- K0100A – loss of liquids/solids from mouth when eating or drinking
- K0100B – holding food in mouth/cheeks or residual food in mouth after meals
- K0100C – coughing or choking during meals or when swallowing medications
- K0100D – complaints of difficulty or pain with swallowing
- K0100Z – none of the above

K0200 A - Height

Current Ht. & Wt. to monitor nutrition & hydration

- On admission, measure and record height in inches – To The Nearest Whole Inch
- Use mathematical rounding (.1 to .4 inches round down, .5 or greater round up)
- Re-measure if last height was over a year ago
- If unable to stand, use other methods to measure the resident but have a policy for consistency

K0300 & K0310 Weight Loss & Gain

Most recent wt. compared to 30 and 180 days prior

- Weigh resident on admission
- On subsequent assessments, if last recorded weight was taken more than 30 days prior to ARD, or previous wt not available, weigh again
- If multiple wts in preceding month, record weight closest to the ARD

*To code **1, Yes**, the expressed goal of loss or gain must be physician ordered, including weight loss of edema by use of diuretics

K0510 A – Parenteral/IV

*Include **only** if given for nutrition or hydration and when there is supporting*

- IV or Hyper alimentation, including TPN given continuously or intermittently
- IV fluids running KVO(keep vein open)
- IV fluids in Piggybacks
- Hyperdermoclysis and subcutaneous ports in hydration therapy
- IV fluids can be coded in K0510A if needed to prevent dehydration as long as additional intake is clinically indicated and documented in the clinical record

K0510 A – Parenteral/IV

*Do **not** include the following:*

- IV Medications
- IV fluids used to reconstitute and/or dilute medications for IV administration
- IV fluids given as a routine part of an operative or diagnostic procedures, or in recovery room
- IV fluids given as solely as flushes
- Parenteral/IV fluids given in conjunction with chemotherapy or dialysis

Section L : Oral / Dental Status

Intent: This item is intended to record any dental **problems** present in the 7-day look-back period.

L0200 - Dental

Conduct an oral exam of lips and oral cavity

- L0200 A – broken or loose fitting dentures
- L0200 B – no natural teeth or tooth fragments
- L0200 C- abnormal mouth tissue
- L0200 D – likely cavity or broken teeth
- L0200 E – inflamed gums or loose teeth
- L0200 F – mouth pain with chewing
- L0200 G – unable to exam
- L0200 Z – none of the above

Section M : Skin Conditions

Intent: The items in this section document the risk, presence, appearance, and change of pressure ulcers. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury.

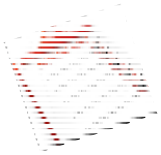
A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program.

Interactive Training Video on Section M

MDS 3.0 Training Update: An interactive training video on Section M: Skin Conditions is now available under Related Links below and at: http://surveyortraining.cms.hhs.gov/Courses/126/SectionMVideo/SectionMVideo.html

Presentation by Elizabeth Ayello, PhD, focuses on staging pressure ulcers correctly and accurately coding pressure ulcers and other skin conditions on the MDS 3.0. The video contains interactive polling and quiz questions.

Planning for Pressure Ulcer Prevention Care



- Stabilize, reduce, or remove underlying risk factors
- Tensile strength of healed pressure ulcers is only 80% of normal skin tensile strength
- Use preventative measures to mitigate opening of a closed ulcer due to fragility of the tissue
- Monitor the area carefully and document the impact of the interventions

M0210 – Unhealed Pressure Ulcers

- Conduct a full body assessment and focus in key areas for pressure ulcer development
- If the resident had a pressure ulcer on the last assessment and it is now healed, complete M0900 Healed Pressure Ulcers
- If a pressure ulcer healed during the look-back period, and was not present on prior assessment, code “0” indicating resident did not have one or more unhealed pressure ulcer(s) at Stage 1 or higher, and skip to M0900

Identify the Kind of Wound Correctly

If it is pressure related….

Step 1: Determine deepest anatomical stage

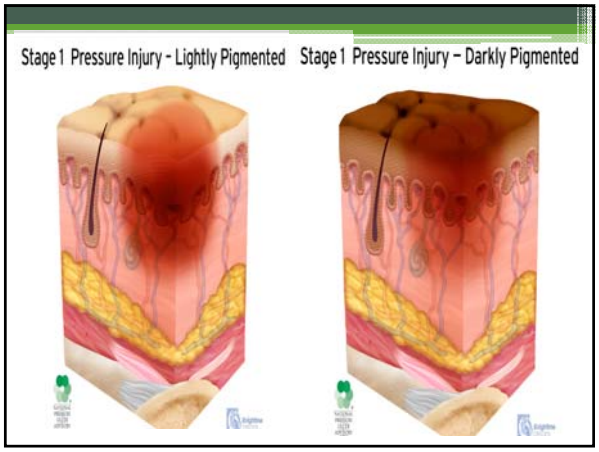
- Do not reverse or back-stage
- If the ulcer has ever been classified at a higher stage than now, it continues at the higher stage
- If an ulcer is from a **combination of factors** which are ***primarily caused by pressure***, then it should be coded as a pressure ulcer

Step 2: Identify unstageable pressure ulcers

Step 3: Determine "present on admission"

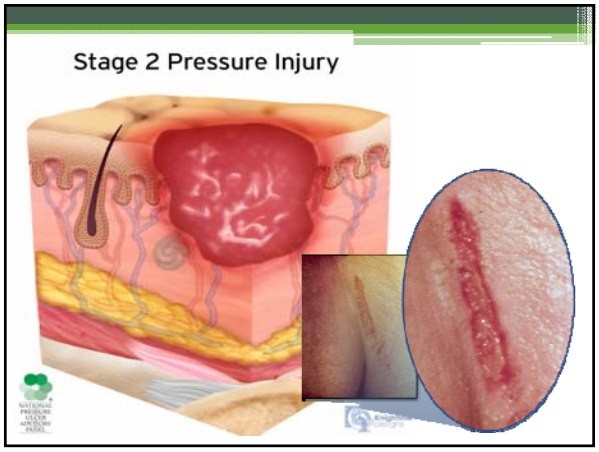
Pressure Ulcer Present on Admission

- If a resident with a facility acquired pressure ulcer is hospitalized and returns with that pressure ulcer at the same stage, the pressure ulcer **should not be coded as "present on admission"** because it was **acquired at the facility** prior to the hospitalization
- If a current pressure ulcer worsens to a higher stage during a hospitalization, it is coded at the higher stage upon re-entry and **should be coded as "present on admission"**



Stage 2 Pressure Ulcer Definition

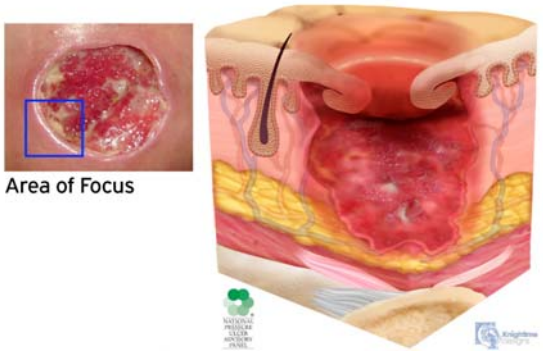
- Partial thickness loss of dermis presenting as a shallow open crater with a red-pink wound bed, without slough
  - May also appear as an intact or open/ruptured blister
  - Do not include skin tears, tape burns, perineal dermatitis, maceration, excoriation, or suspected deep tissue injury
- Stage 2 pressure ulcers should not be coded as having granulation, slough, or necrotic tissue as by definition they do not have this extent of tissue damage. All Stage 2 pressure ulcers should be coded as 1 for M0700



Stage 3 Pressure Ulcer Definition

- Stage 3 -Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to underlying fascia
  - Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed
  - Presents as deep crater with/without undermining but on areas that do not have subcutaneous tissue (bridge of nose, ear, occipital, malleolus) may be shallow

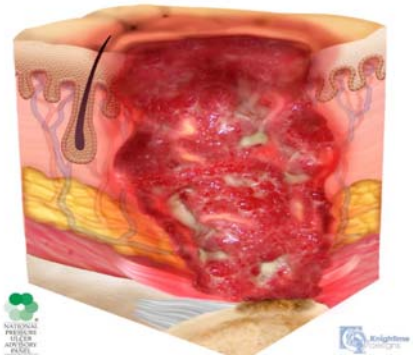
Stage 3 Pressure Injury with Epibole



Stage 4 Pressure Ulcer Definition

- Full thickness tissue loss with **exposed bone, tendon or muscle**
- Slough or eschar may be present on some parts of the wound bed
- Often includes undermining and tunneling
- Depth varies by anatomical location (bridge of nose, ear, occiput, and malleolus ulcers can be shallow)

Stage 4 Pressure Injury



Unstageable - Non-Removeable Dressing

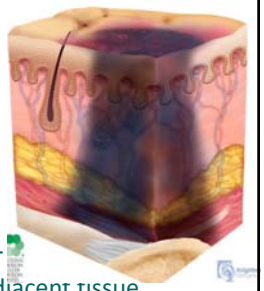
Examples:
- primary surgical dressing that cannot be removed
- orthopaedic device
- cast

Unstageable due to Slough/Eschar

- **Known** but not stageable because of inability to visualize wound bed
- Full thickness tissue loss
- Base of ulcer covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown or black) in the wound bed

Suspected Deep Tissue Injury Definition

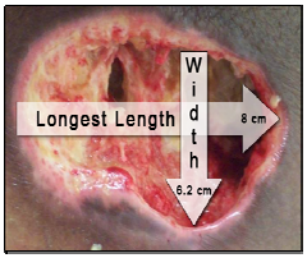
- Purple or maroon area of discolored intact skin due to damage of underlying soft tissue
- The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue



Suspected Deep Tissue Injury

M0610-Dimensions of Unhealed Stage 3 or 4

Identify highest stage pressure ulcer with the largest surface area



M0700 – Most Severe Tissue Type

Code this item with a "9" in the following situations

- Stage 1 pressure ulcer
- Stage 2 pressure ulcer with intact blister
- Unstageable pressure ulcer due to non-removable dressing/device
- Unstageable related to deep tissue injury

- The "9" is used in these instances because the wound bed cannot be visualized and therefore cannot be assessed

M0800 Worsening PU since Prior MDS

- This item captures ulcers that progress to a higher numerical stage – not those that simply cover more surface area
- Look-back for this item is back to the ARD of the prior MDS. If no prior MDS, skip to M1030
- Enter the number of current ulcers that are new or have worsened since last MDS for each stage
- If a pressure ulcer becomes unstageable due to slough or eschar, do not code as worsened

M0900 – Healed Pressure Ulcers

- Look-back period is the ARD of the prior MDS to the current ARD (do not consider MCare replacement)

M0900: Were pressure ulcers present on the prior assessment?

- 0 = No (includes healed but not on prior assessment
- 1 = Yes, continue with items B through D

M0900B: Enter the number of Stage 2 ulcers
M0900C: Enter the number of Stage 3 ulcers
M0900D: Enter the number of Stage 4 ulcers

M1030 – Number of Venous & Arterial

Typically not found over bony prominences

Venous

Arterial

M1040 – Other Skin Problems

Check all that apply in last 7 days

- **Foot Problems**
  - Infection of foot
  - Diabetic foot ulcer
  - Open lesion on foot
- **Other Problems**
  - Open lesions
  - Surgical wounds
  - Burns
  - skin tears
  - Moisture associated damage

Diabetic Foot Ulcer

M1200 – Skin and Ulcer Treatments

Any specific or generic treatments in last 7 days

- M1200 A - Pressure reducing device for chair
- M1200 B - Pressure reducing device for bed
- M1200 C - Turning /repositioning program
- M1200 D - Nutrition or hydration intervention
- M1200 E - Pressure ulcer care
- M1200 F - Surgical wound care
- M1200 G - Application of non-surgical dressing
- M1200 H - Applications of ointments/medications
- M1200 I - Applications of dressing to feet

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 (subcutaneous, intramuscular or intradermal), insulin, and/or select medications were received by the resident.

N0300 & N0350 – Injections & Insulin

Injections

- Count the number of days that the resident received any type of injection while a resident of the nursing home

Insulin - since admit/re-entry if less than 7 days

- Number of days (in the last 7) that insulin was received
- Number of days the physician changed insulin orders

N0410 – Medications Received

*By **pharmacological classification***

- N0410 A - Antipsychotic
- N0410 B - Antianxiety
- N0410 C- Antidepressant
- N0410 D - Hypnotic
- N0410 E - Anticoagulant
- N0410 F - Antibiotic
- N0410 G - Diuretic
- N0410 Z – none of the above

Enter the number of days each of the medications listed were received In the last 7 days

Section O : Special Tx, Procedures, 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.

O0100 – Special Tx, Procedures & Programs

Do not code services that were provided solely in conjunction with a surgical or diagnostic procedure

- A. Chemotherapy – any route / used for cancer Tx
- B. Radiation – even via implant
- C. Oxygen therapy – BiPAP / CPAP
- D. Suctioning – tracheal / nasopharyngeal – not oral
- E. Tracheostomy care – trach and/or cannula
- F. Ventilator or Respiratory – via endotracheal tube

O0100 – Special Tx, Procedures & Programs

- G. BiPAP / CPAP – or ventilator used as BiPAP
- H. IV Meds – do not code flushes or IVs sans meds
- I. Transfusions – blood or blood products
- J. Dialysis – even in the nursing home
- K. Hospice – state licensed or MCare certified
- L. Respite Care – only short-term
- M. Isolation

Strict Isolation

1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
2. Precautions are over and above standard precautions. (contact, droplet, and/or airborne precautions must be in effect)
3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation
4. The resident must remain in his/her room. All services must be brought to the resident (e.g. rehabilitation, activities, dining)

O0100M – Isolation or quarantine

- Code **only** when the resident **requires** strict isolation or quarantine alone in a separate room because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with a communicable disease
- **Do not** code this item if the resident only has a history of infectious disease (e.g., MRSA or C-Diff with no active symptoms), but facility policy requires cohorting of similar infectious disease conditions.
- **Do not** code this item if the "isolation" primarily consists of body/fluid precautions, because these precautions apply to everyone.

Examples of when the isolation criterion would not apply include urinary tract infections, encapsulated pneumonia, and wound infections

O0250: Influenza Vaccine

Did resident influenza vaccine **in this facility** for this year's flu season?

- **Code O** = no, resident did not receive influenza vaccine in this facility during this year's flu season (Skip to item C, leaving B blank)
- **Code 1** = yes, record date in item B

- O0250B: Date vaccine received
  - MMDDYYY

This value is carried forward until the new flu season begins

O0300: Pneumococcal Vaccine

Is the resident's pneumococcal Vaccine up to date?

- Refer to CDC flow chart to determine whether or not resident should receive the vaccine
- **Code 0** = no, vaccine status is not current or cannot be determined (proceed to item B)
- **Code 1** = Yes the vaccine status is current

- O0300B: If Pneumococcal Vaccine not received, state reason
  - **Code 1** = Not eligible
  - **Code 2** = Offered and declined
  - **Code 3** = Not offered

PCV13 and/or the PPSV23 pneumococcal vaccinations

Question: The CDC recommends that adults 65 years and older receive both the PCV13 and the PPSV23 pneumococcal vaccinations one year apart. For MDS coding purposes, if the resident has received only one of the vaccines, can O0300A be checked "yes, up to date"?

Answer: The Coding Instructions for O0300 A do not differentiate between PCV13 and PPSV23, nor does it state that both vaccines must be given. If the resident received either vaccination at the age of 65 or older and is not immunocompromised then the person is considered "up to date" and the correct response is: **Code 1, yes.** If the person was less than 65 years of age and/or immunocompromised, and 5 years has elapsed since the first dose, then another vaccine is indicated and the response is **Code 0, no**. The current coding instructions should be followed for coding purposes, but the current ACIP recommendations should be followed when assessing the need for further vaccination. It is recommended that providers now use two pneumococcal vaccines for adults aged ≥65. These vaccinations are 13-Valent Pneumococcal Conjugate Vaccine (PCV13) and 23-Valent Pneumococcal Polysaccharide Vaccine (PPSV23). CMS 2/2016

O0400: Therapies

Captures medically necessary therapies that occurred after admit/readmit in the past 7 days

Therapy can occur inside or outside facility

- **All** Therapies must be:
  - Ordered by a physician (or approved extender)
  - Performed by a qualified therapist
  - Based on a therapist's assessment and treatment plan
  - Documented in the resident's medical record
  - Care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective

O0400: Therapies – Coding Tips

- Include only therapies provided after resident admitted to the nursing home
- If a resident returns from a hospital stay, an initial evaluation must be done again after reentry and only those therapies that occurred since reentry can be coded on the MDS
- Therapist time
  - Do not count initial evaluation or documentation time
  - Can count subsequent re-evaluation time if part of the treatment process

O0500: Restorative Nursing

Techniques provided by restorative nursing staff

- O0500A: Range of Motion (Passive)
- O0500B: Range of Motion (Active)
- O0500C: Splint or Brace Assistance

All techniques must be planned, monitored, evaluated and documented in the resident's medical record

Cannot claim techniques that therapists claim under O0400A,B or C.

O0500: Restorative Nursing

*Must meet specific criteria **prior** to coding*

- Measurable objectives and interventions documented in the care plan and medical record
- Periodic evaluation by licensed nurse in medical record
- Nursing assistants/aides must be trained in the techniques that promote resident involvement
- A nurse must supervise the activities in a nursing restorative program
- Groups no larger than 4 residents per staff

O0600: Physician Examinations

- Enter number of days that a physician has **examined** resident in last 14 days (or since being admitted, if less than 14 days ago)
- Includes MDs, DOs, Podiatrists, Dentists and authorized Physician Assistants, Nurse Practitioners or Clinical Nurse Specialists working in collaboration with the physician
- Examination (full or partial) can occur in facility or in physician's office
- Psychological therapy visits by a licensed psychologist (PhD) should be recorded in O0400E, Psychological Therapy, and should not be included as a physician visit in this section

O0700: Physician Orders Examinations

- Enter number of days that a physician has **examined** resident in last 14 days (or since being admitted, if less than 14 days ago)
- Includes MDs, DOs, Podiatrists, Dentists and authorized Physician Assistants, Nurse Practitioners or Clinical Nurse Specialists working in collaboration with the physician
- Examination (full or partial) can occur in facility or in physician's office
- Psychological therapy visits by a licensed psychologist (PhD) should be recorded in O0400E, Psychological Therapy, and should not be included as a physician visit in this section

Section P : Restraints

Intent: The intent of this section is to record the frequency over the 7-day look-back period that the resident was restrained by any of the listed devices at any time during the day or night.

P0100 Physical Restraints

Definition: "Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the resident cannot remove easily, which restricts freedom of movement or normal access to one's body"

- Record the frequency that the resident was restrained by any of the listed devices at any time, day or night, over the last 7 days

More Definitions

Removes easily
- Residents intentionally remove, in the same manner as they were applied by staff

Freedom of movement
- Any change in place or position for the body or any part of the body that the person is able to control or access

Medical symptom/diagnoses
- Must have clear link between restraint use and how it benefits the resident by addressing the specific medical symptom

Does It Meet The Definition?

- Must assess each resident to determine need for the device, then evaluate the **effect** the device has on the resident not the type, the intent or reason for use
- Evaluate whether the resident can easily and voluntarily remove the device, material or equipment
- If resident cannot easily and voluntarily remove the restraint, continue with assessment to determine whether it restricts freedom of movement or access to his/her body

If it Meets the Definition

Any device, material, or equipment that meets the definition of a physical restraint must have:
- Physician documentation of a medical symptom that supports the use of the restraint
- A physician's order for the type of restraint and parameters of use
- A care plan and a process in place for systematic and gradual restraint reduction (and/or elimination, if possible), as appropriate

Federal Tags:
- F221 – Physical restrains without medical justification/staff convenience
- F323 – Accident hazards (bed rails entrapment issues)

Section Q : Participation and Goal Setting

Intent: The items in this section are intended to record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals. Section Q ensures all individuals have the opportunity to learn about home and community-based services and to receive long term care in the least restrictive setting possible.

Office of Civil Rights - May 2016 guidance to SNFs

Section 504 of the Rehabilitation Act prohibits discrimination based on disability.

Are you using Section Q appropriately?

Is your facility making referrals?

Do you know your LCA??

Discharge Planning Collaboration

- Nursing home staff expected to contact Local Contact Agencies for those residents who express a desire to learn about possible transition back to the community and what care options and supports are available
- Local Contact Agencies expected to respond to nursing home staff referrals by providing information to residents about available community-based, long-term care supports and services
- Nursing home staff and Local Contact Agencies expected to meaningfully engage residents in their discharge and transition plan, and collaboratively work to arrange for all of the necessary community-based, long-term care services

Q0400: Discharge Plan

?-Is ***ACTIVE*** discharge planning already occurring for the resident to return to the community**?**

- The current CP has goals specific to discharge
- **Discharge is in the near future** (within 3 months)
- Staff are taking active steps to accomplish discharge

But if special equipment, money, etc. is needed then a referral may still be necessary
Or
Skip pattern if this is an easy / expected discharge

Q0500: Do You Want to Talk to Someone…?

Intent: Provide an opportunity for the resident to get more information and explore the possibility of different settings for receiving care

0. No = nothing in the chart about Q0500 preference

1. Yes = there is documentation in the record so don't ask again about Return to Community until the next comprehensive > skip to Q0600, Referral

Q0600:
Has a referral been made to the LCA?

Return to Community CAA Referral Resource

CMS's RAI Version 3.0 Manual — Appendix C: CAA Resources

20. RETURN TO COMMUNITY REFERRAL

Review of Return to Community Referral

✓	Steps in the Process
☐	1. Document in the care plan whether the individual indicated a desire to talk to someone about the possibility of returning to the community or not (Q0500B).
☐	2. Interview the individual and his or her family to identify potential barriers to transition planning.

For additional guidance, see CMS'
Planning for Your Discharge: A checklist for patients and caregivers preparing to leave a hospital, nursing home, or other health care setting.
Available at
http://www.medicare.gov/Publications/Pubs/pdf/11376.pdf https://www.medicare.gov/Pubs/pdf/11376.pdf

The Office of Civil Rights Recommends…..

- *Review/Revise/Develop policies/procedures on Discharge Planning, MDS administration, and LCA referral process*
- *Train all members of the IDT on Section Q, and what the area LCA has to offer*
- *Invite the LCA and community-based service systems in to provide training*

For NC statewide LCA questions:
contact Lorrie Roth
NC Community Living Coordinator at
919-855-4986
lorrie.roth@dhhs.nc.gov

Or
To make a referral
Care Link at 1-866-271-4894

Section V : Care Area Assessment Summary

Intent: The MDS does not constitute a comprehensive assessment. Rather, it is a preliminary assessment to identify potential resident problems, strengths, and preferences. Care Areas are triggered by MDS item responses that indicate the need for additional assessment based on problem identification, known as "triggered care areas," which form a critical link between the MDS and decisions about care planning.

V0200: CAAs and Care Planning

The information in the MDS constitutes the core of the required State-specified Resident Assessment Instrument (RAI)

The Care Area Assessments help identify whether the findings represent a problem or risk requiring further intervention

The assessment of the causes and contributing factors gives the interdisciplinary team additional information to help them develop a comprehensive plan of care

The CAA Process Should…..

- Consider each resident as a whole, with unique characteristics and strengths that affect his or her capacity to function
- Identify areas that may warrant interventions
- Help develop interventions to help improve, stabilize, or prevent decline in physical, functional, and psychosocial well-being, choices, and preferences for interventions

Key to Writing Good CAAs

- Paint a picture of the resident's status
- Talk about the resident's individual condition because the care plan must be individualized
- The better all staff "know" the resident, the better able they will be to provide and monitor adequate care and services to help that individual reach their highest practicable level of well-being

Documentation for Each Triggered CAA Should Describe

The issue/problem for this resident and why is it a problem

- Complications affecting or caused by the care area
- Risk factors related to the presence of the condition
- Factors to be considered in developing individualized care plan interventions
- The need for additional evaluation as appropriate
- The resource(s), or assessment tool(s) used for decision-making, and conclusions that arose from performing the CAA

V0200 CAAs and Care Planning

V0200. CAAs and Care Planning

1. Check column A if Care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and CAAs). Check column B if the triggered care area is addressed in the care plan.
3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks, and any referrals for this resident for this care area.

A. CAA Results

Care Area	A. Care Area Triggered	B. Care Planning Decision	Location and Date of CAA documentation
	↓ Check all that apply ↓		
01. Delirium	☐	☐	
02. Cognitive Loss/Dementia	☐	☐	
03. Visual Function	☐	☐	
04. Communication	☐	☐	
05. ADL Functional/Rehabilitation Potential	☐	☐	
06. Urinary Incontinence and Indwelling Catheter	☐	☐	
07. Psychosocial Well-Being	☐	☐	
08. Mood State	☐	☐	
09. Behavioral Symptoms	☐	☐	
10. Activities	☐	☐	
11. Falls	☐	☐	
12. Nutritional Status	☐	☐	

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.

Check Your Validation Reports

Accepted Data with warnings may indicate

- Missed assessments
- Error(s) in the record
- Duplicate files

Who signs at Z0400 for Section A at your facility?

Major vs Minor Errors

- **Significant Error** is an error in an assessment where:
  1. The resident's overall clinical status is not accurately represented and
  2. The error has not been corrected via submission of a more recent assessment
- **Minor errors** are all other errors related to coding the MDS

Correcting Significant Errors

When any *significant error is discovered in an OBRA comprehensive or Quarterly assessment in the QIES ASAP system, the nursing home must take the following actions to correct the OBRA assessment:*

1. Create a corrected record with all items included, not just the items in error
2. Complete the required Correction Request Section X items and include with the corrected record. Item A0050 should have a value of 2, indicating a modification request
3. Submit this modification request record
4. Perform a ***new Significant Correction to Prior Assessment or Significant Change in Status Assessment and update the care plan as necessary***

Inactivations vs. Modifications

Modification – can be used for most items

- Target Date (A0310F = 1)
- Discharge Date (A0310F = 10, 11, 12)
- ARD (A2300) >>> When it was a typographical error
- Type of Assessment (A0310)>>If it doesn't change the item set

Inactivation - followed by a new record with a new ARD is required for: Type of Provider (Item A0200)

Correction/Deletion Request is required to correct:

- Unit Certification or Licensure Designation (A0410)
- State-assigned facility submission ID (FAC_ID)

A0050: Modifications

- Create a corrected MDS record with all items included – not just the items in error
- Complete Section X (correction request) to identify the record that needs to be modified, and include with the corrected record (never make changes to Section X)
- Submit both the Section X and the corrected record to the QIES ASAP
- A hard copy of the Section X must be kept with corrected paper copies of the MDS record in the clinical file to track the changes. A hard copy of Section X should also be kept with any inactivated record

Special Manual Record Correction Request

- A few error types cannot be corrected with an automated modification or inactivation request
  - Test record submitted as production
  - Wrong submission requirement in A0410
  - Wrong facility id in control item FAC_ID
- Facility must submit a **written request** to the state MDS Coordinator to have these problems fixed – see Chapter 5 pages 13-14 for more information

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.

Section Z Assessment Administration

- **Z0400**: Signatures of persons completing Assessment or Entry/Death Reporting
  - Signatures certify accuracy of sections completed
- **Z0500**: Signature of RN Assessment Coordinator
  - Signature certifies completion of assessment

Z0400 and the Interview Dates

When filling in the information for Z0400, any staff member who has completed a sub-set of item within a section should identify which item(s) he/she completed within that section. If a staff member cannot sign Z0400 on the same day a section or portion of a section is completed, when the staff member signs, the date used should be the same date the item originally was completed. When signing at Z0400 for a particular section that included an interview, the date of the interview should also be included.

Should we expect anything else in 2017??

In the FY 2017 SNF PPS final rule, three additional measures *affecting FY 2018 payment* determination were finalized for adoption into the SNF QRP, including:

- Discharge to Community – Post Acute Care (PAC) Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
- Potentially Preventable 30-Days Post-Discharge Readmission Measure for Skilled Nursing Facility (SNF) Quality Reporting Program (QRP)
- and Medicare Spending Per Beneficiary – Post-Acute Care (PAC) Skilled Nursing Facility Measure

Updated Resident Assessment Regulations coming October 2017…

- Assessments must include:
  - * Observations and interviews with the resident
  - * Interviews with licensed/non-Lic staff - all shifts
- PASARR
  - * PASARR level II determination and PASARR evaluation report/recommendations must be incorporated into resident's assessment, *care planning*, and transitions of care

- New, Baseline Care Plans

  * The facility must develop and implement a baseline care plan within 48 hours from admission for each resident including instructions needed to provide effective and person-centered care

  * The Care Plan Team must include a NA responsible for the resident's care

  * The Baseline Care Plan must include at least:

    (A) Initial goals based on admission orders
    (B) Physician orders
    (C) Dietary orders
    (D) Therapy services
    (E) Social services
    (F) PASARR recommendation, if applicable

- Discharge Planning Process should…

  * Identify the needs and goals of ***this*** resident

  * Include the resident as an active partner

  * Emphasize value in moving back to the community

  * Ensure a referral is made to the LCA if the resident indicates interest

  * Include documentation if discharge to the community is not feasible
    Who decided/Why

  * Be re-evaluated and updated as necessary

Questions?

Let's Find the Answers in the Manual

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