



MaineCare Services

An Office of the
Department of Health and Human Services

MDS 3.0 Training



Case Mix Team

Office of MaineCare Services

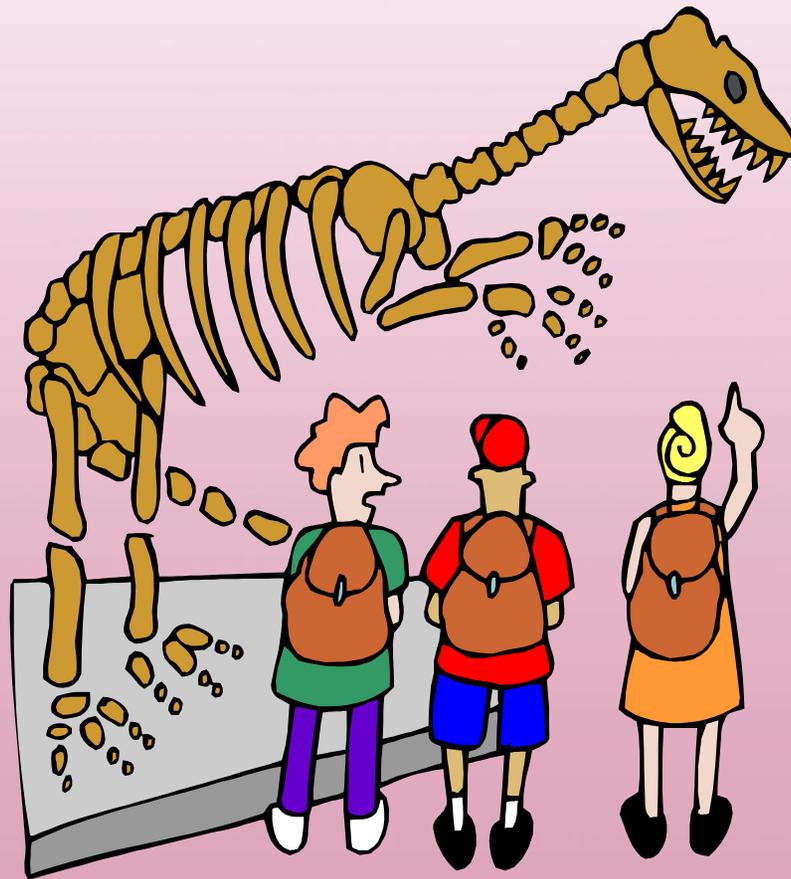
Updated October 2014

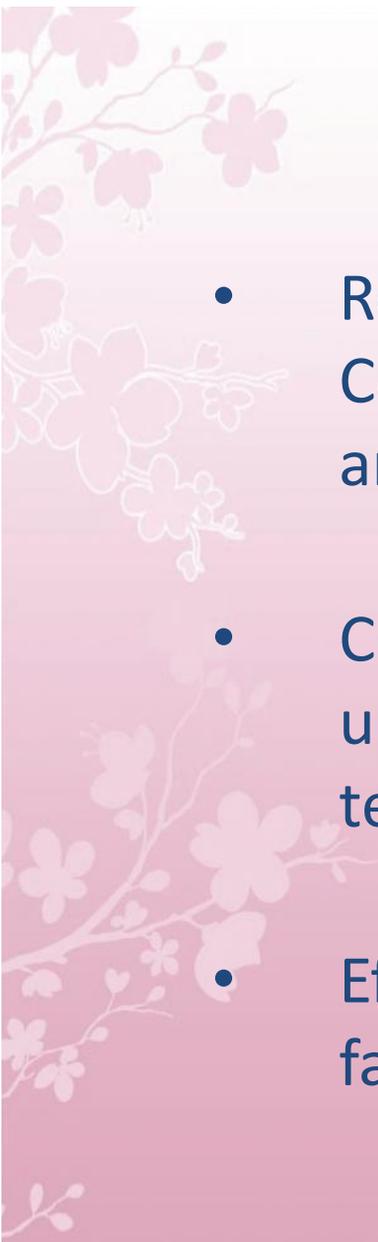
MDS 3.0 Training Agenda

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



MDS 3.0 History





Goals of the MDS 3.0

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

CMS Resources for MDS 3.0

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

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

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

Case Mix Implications for MDS 3.0





“While I can explain the meaning of life, I don’t dare try to explain how the Medicare system works.”

Case Mix Payment Items



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

RUG IV refers to payment items for PPS services.

MaineCare Case Mix

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

PPS / Medicare uses RUG IV codes

Supporting Documentation for Case Mix payment items is required

Case Mix Weights

There are 7 Categories:

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



Category	ADL Index	End Splits	RUG-III Codes	Maine Weight	
Clinically Complex					
OR	Special Care qualifier (see above) and ADL score of 6 or less)	17-18D	***Signs of Depression	CC2	1.826
		17-18	No Signs	CC1	1.663
	Clinically complex qualifier (any one):	12-16D	Signs of Depression	CB2	1.503
	• Burns (M1040F)	12-16	No Signs	CB1	1.389
	• Coma (B0100) AND not awake (no crosswalk**) AND ADL dependent (G0110A1, G0110B1, G0110H1, G0110I1)	4-11D	Signs of Depression	CA2	1.331
	4-11	No Signs	CA1	1.149	
• Septicemia (I2100)					
• Pneumonia (I2000)					
• Foot lesion (M1040B, M1040C)/infection (M1040A) AND dressing to foot (M1200I)					
• Internal bleeding (J1550D)					
• Dehydration (J1550C)					
• Feeding tube (K0500B) (calories >= 51%, or calories = 26%-51% (K0700A/K0710A3) AND fluids >= 501 cc (K0700B/K0710B3 = 2))					
• Oxygen therapy (O0100C1, O0100C2)					
• Transfusions (O0100I1, O0100I2)					
• Hemiplegia/hemiparesis (I4900) with ADL score >= 10					
• Chemotherapy (O0100A1, O0100A2)					
• Dialysis (O0100J1, O0100J2)					
• Physician visits (O0600) 1+ days AND order changes (O0700) 4+ days (last 14 days)					
• Physician visits (O0600) 2+ days and order changes (O0700) 2+ days (last 14 days)					
• Diabetes (I2900) with injection (N0300) on 7 days AND order change O0700) 2+ days (last 14 days)					

MDS 3.0 RUG III ADL Scoring Chart

The ADL index is used to split many of the Clinical Indicator categories. Composed from these ADL activities:

Bed Mobility – Items G011A1 and G0110A2

Transfer – Items G0110B1 and G0110B2

Eating – Items G0110G1, K0500B, K0700A, and K0700B

Toilet Use – Items G0110I1 and G0110I2

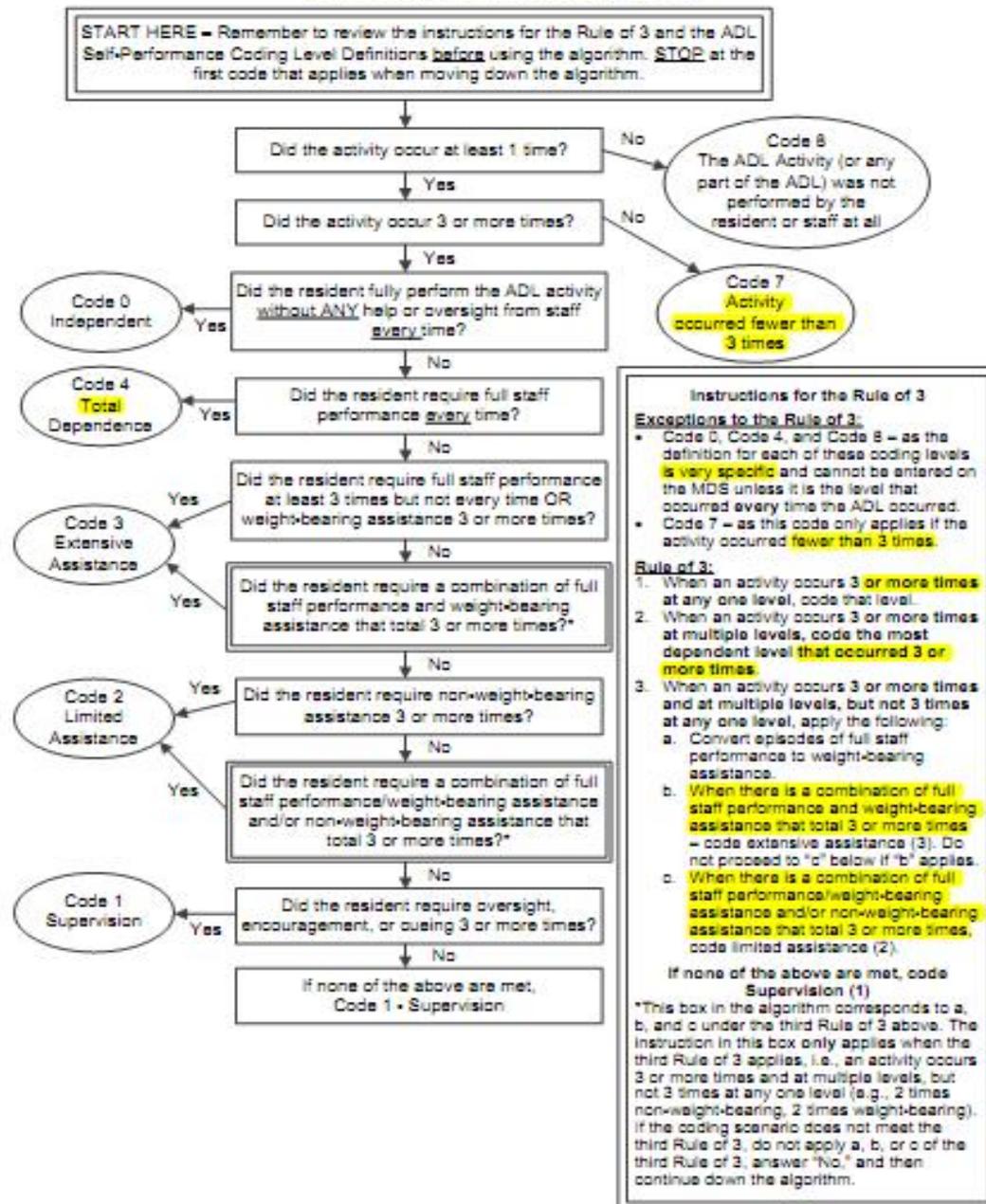
The ADL index score is determined as follows:

ADL Function	ADL Score
Bed mobility, Toilet use and Transfer:	
Self-Performance (column 1) is coded on the MDS 3.0 as:	
Independence or Supervision (item coded 0,1, or 7)	1
Limited Assistance (item coded 2)	3
Extensive Assistance or Total Dependence (item coded 3,4 or 8) AND Support Provided (Column 2) is:	
<ul style="list-style-type: none"> None, set-up only or 1 person physical assist (item coded 0, 1, or 2) 	4
<ul style="list-style-type: none"> 2+ persons physical assist or activity did not occur (item coded 3 or 8*) 	5
Eating:	
IF:	
Resident receives Parenteral/IV (K0500A = 1)	3
Tube Feeding (K0500B = 1) AND one of the following:	3
<ul style="list-style-type: none"> 51% or more total calories from parenteral or tube feeding (K0700A = 3) 26-50% total calories from parenteral or tube feeding (K0700A = 2) AND fluid intake is 501+ ml per day (K0700B = 2) 	
IF NOT:	
Self-Performance (column 1) is:	
Independent or Supervision (item coded 0, 1, 7)	1
Limited Assistance (item coded 2)	2
Extensive Assistance or Total Dependence or Activity Did Not Occur (item coded 3, 4, or 8)	3

The scores for each ADL variable are added to compute the ADL index score. The ADL Index score will range from 4 to 18 for each resident.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

ADL Self-Performance Algorithm



Case Mix Quality Assurance Review

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

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



Poor Documentation could also mean...



Lower payment than the facility could be receiving, OR

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



Sanctions:

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



MaineCare Case Mix

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

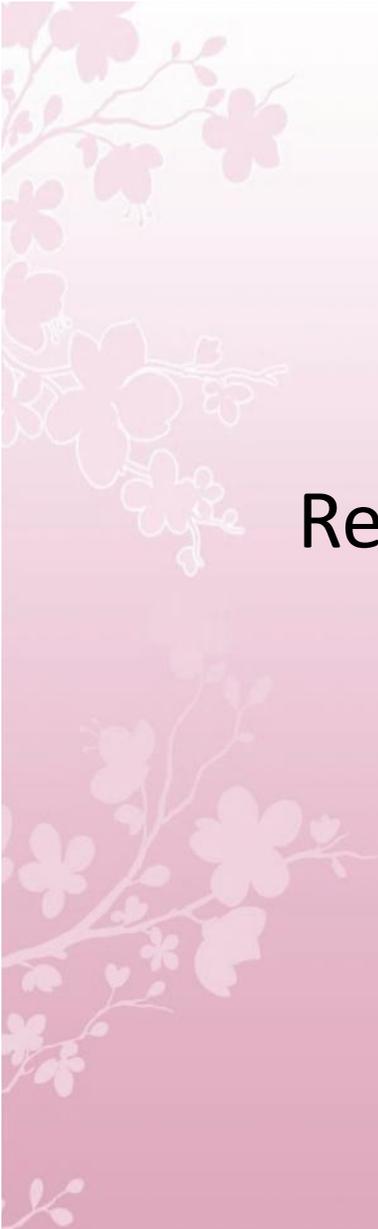


MDS 3.0

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

Chapter 2

Effective Oct 2014



MDS 3.0

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

Chapter 3

Effective Oct 2014



Requirement for the 3.0

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



Responsibility of NF for Reproducing/Maintaining 3.0

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



Responsibilities of NF for Reproducing/Maintaining 3.0

Nursing Homes may:

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



The Alphabet Soup of MDS

OBRA = Omnibus Budget Reconciliation Act

PPS = Prospective Payment System

OMRA = Other Medicare Required Assessments (SOT, EOT, COT)

ARD = Assessment Reference Date

Section	Title	Intent
A	Identification Information	Obtain key information to uniquely identify each resident, nursing home, type of record, and reasons for assessment.
B	Hearing, Speech, and Vision	Document the resident's ability to hear, understand, and communicate with others and whether the resident experiences visual, hearing or speech limitations and/or difficulties.
C	Cognitive Patterns	Determine the resident's attention, orientation, and ability to register and recall information.
D	Mood	Identify signs and symptoms of mood distress.
E	Behavior	Identify behavioral symptoms that may cause distress or are potentially harmful to the resident, or may be distressing or disruptive to facility residents, staff members or the environment.
F	Preferences for Customary Routine and Activities	Obtain information regarding the resident's preferences for his or her daily routine and activities.
G	Functional Status	Assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion.
H	Bladder and Bowel	Gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.
I	Active Disease Diagnosis	Code diseases that have a relationship to the resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death.
J	Health Conditions	Document health conditions that impact the resident's functional status and quality of life.
K	Swallowing/Nutritional Status	Assess conditions that could affect the resident's ability to maintain adequate nutrition and hydration.
L	Oral/Dental Status	Record any oral or dental problems present.
M	Skin Conditions	Document the risk, presence, appearance, and change of pressure ulcers as well as other skin ulcers, wounds or lesions. Also includes treatment categories related to skin injury or avoiding injury.
N	Medications	Record the number of days that any type of injection, insulin, and/or select medications was received by the resident.
O	Special Treatments and Procedures	Identify any special treatments, procedures, and programs that the resident received during the specified time periods.
P	Restraints	Record the frequency that the resident was restrained by any of the listed devices at any time during the day or night.
Q	Participation in Assessment and Goal Setting	Record the participation of the resident, family and/or significant others in the assessment, and to understand the resident's overall goals.
V	Care Area Assessment (CAA) Summary	Document triggered care areas, whether or not a care plan has been developed for each triggered area, and the location of care area assessment documentation.
X	Correction Request	Request to modify or inactivate a record already present in the QIES ASAP database.
Z	Assessment Administration	Provide billing information and signatures of persons completing the assessment.

Section A

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





Coding Section A

A0050 - Type of Record

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



Section A

A0310 Purpose

Documents the reason for completing the assessment

Identifies the required assessment content information (item set)

Section A

A0310A Federal OBRA Reason for Assessment

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

Significant Change Criteria



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

A0310A Hospice Benefit

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

A0310. Type of Assessment	
Enter Code	A. Federal OBRA Reason for Assessment
<input type="text"/>	01. Admission assessment (required by day 14)
<input type="text"/>	02. Quarterly review assessment
<input type="text"/>	03. Annual assessment
<input type="text"/>	04. Significant change in status assessment
<input type="text"/>	05. Significant correction to prior completion

Enter Code	A. Federal OBRA Reason for Assessment
<input type="text"/>	01 Admission assessment (required by day 14)
<input type="text"/>	02 Quarterly review assessment
<input type="text"/>	03 Annual assessment
<input type="text"/>	04 Significant change in status assessment
<input type="text"/>	05 Significant correction to prior completion



Significant Error

Significant Error – is an error in an assessment where:

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

Assessment Scheduling

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	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Admission (Comprehensive)	A0310A= 01	14 th 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	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (Initial) 42 CFR 483.20 (b)(2)(i) (by the 14th day)	May be combined with another assessment
Annual (Comprehensive)	A0310A= 03	ARD of previous OBRA comprehensive assessment + 366 calendar days <u>AND</u> ARD of previous OBRA Quarterly assessment + 92 calendar days	ARD + 6 previous calendar days	ARD + 13 previous calendar days	ARD + 14 calendar days	ARD + 14 calendar days	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(iii) (every 12 months)	May be combined with another assessment
Quarterly (Non-Comprehensive)	A0310A= 02	ARD of previous OBRA assessment of any type + 92 calendar days	ARD + 6 previous calendar days	ARD + 13 previous calendar days	ARD + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days	42 CFR 483.20(c) (every 3 months)	May be combined with another assessment

Section A

A0310B PPS Assessment

Includes scheduled and unscheduled assessments

PPS Assessment

PPS Scheduled Assessments for a Medicare Part A Stay

- 01. **5-day** scheduled assessment ←
- 02. **14-day** scheduled assessment
- 03. **30-day** scheduled assessment
- 04. **60-day** scheduled assessment
- 05. **90-day** scheduled assessment

PPS Unscheduled Assessments for a Medicare Part A Stay

- 07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change)

Not PPS Assessment

- 99. **None of the above**

Medicare PPS Assessments

5 day

14 day

30 day

60 day

90 day

Readmission/Return

SCSA

SCPA

Start of Therapy (SOT)

End of Therapy (EOT)

Both Start and End of Therapy

Change of Therapy (COT)

PPS Scheduled Assessments for a Medicare Part A Stay

PPS Unscheduled, OMRA used for a Medicare Part A Stay

PPS Unscheduled Assessments: Other Medicare Required Assessment (OMRA)

Coding Section A

A0310C PPS Other Medicare Required Assessment - OMRA

Indicates whether the assessment is related to therapy services

Complete this item for all assessments

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



Section A

A0310E Type of Assessment

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

Complete this item for all assessments

Coding Section A

A0310F Entry/ Discharge Reporting

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





Coding Section A

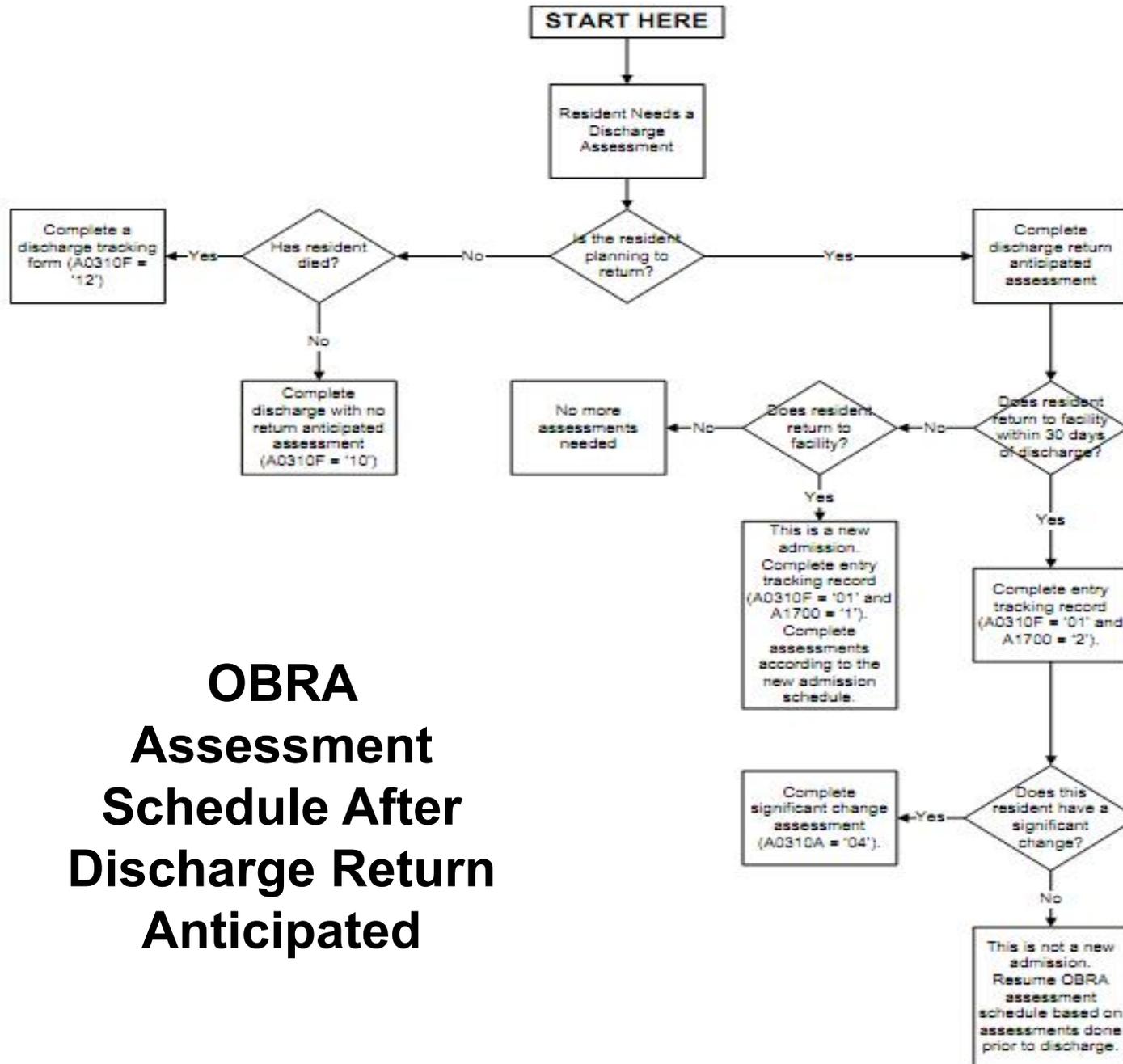
A0310G Type of Discharge

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

A discharge assessment is required for:

1. Discharge return not anticipated
2. Discharge return anticipated

OBRA Assessment Schedule After Discharge Return Anticipated



A0410. Unit Certification or Licensure Designation

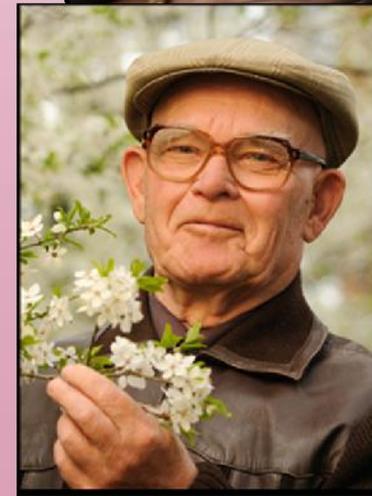
- 1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State**
- 2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State**
- 3. Unit is Medicare and/or Medicaid certified**

Section A

Resident Data

A0500 through A1300

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





Section A

A1500 PASRR/ Medicaid

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

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



Section A

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

Complete only if at A0310A, Type of Assessment, you have coded

- 01 admission;
- 03 annual;
- 04 significant change; or
- 05 significant correction to prior comprehensive assessment

Section A

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

A1550. Conditions Related to ID/DD Status

If the resident is 22 years of age or older, complete only if A0310A = 01

If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05

Check all conditions that are related to ID/DD status that were manifested before age 22, and are likely to continue indefinitely

ID/DD With Organic Condition

- A. Down syndrome
- B. Autism
- C. Epilepsy
- D. Other organic condition related to ID/DD

ID/DD Without Organic Condition

- E. ID/DD with no organic condition

No ID/DD

- Z. None of the above

PASRR

- http://www.qualitycareforme.com/MaineProvider_PASRR.htm

A1900

A1900. **Admission Date** (Date this episode of care in this facility began)

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

Episode vs Stay



Section A

A2300 Assessment Reference Date (ARD)

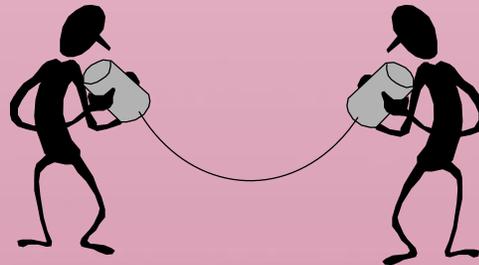
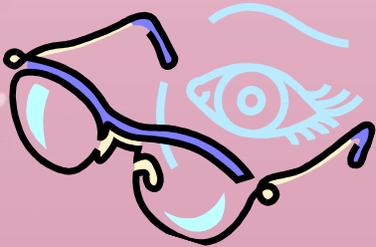
- Designates the **end** of the look-back period so that all assessment items refer to the resident's status during the same period of time.
- Anything that happens after the ARD will not be captured on that MDS.
- The look-back period includes observations and events through the end of the day (midnight)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

Section B

Hearing, Speech, and Vision



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



Section B

B0100: Comatose

B0200: Ability to Hear (with hearing aid if normally used)

B0300: Hearing Aid

B0600: Speech Clarity

B0700: Makes Self Understood

B0800: Ability to Understand Others

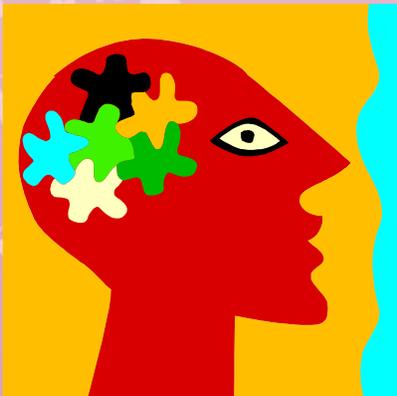
B1000: Vision (with adequate light)

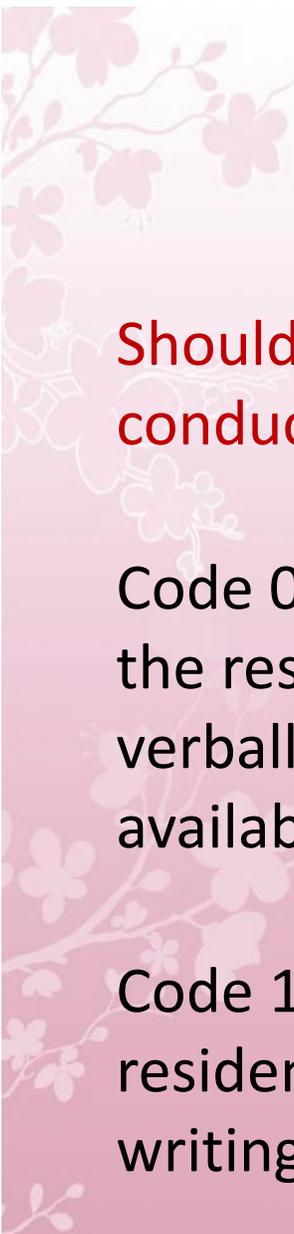
B1200: Corrective Lenses

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.





Section C

C0100

Should the Brief Interview for Mental Status (BIMS) be conducted???

Code 0, no: if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status.

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

Section C

C0600: Should the staff assessment be conducted?

C0700-C1000 Staff assessment:

C0700 Short-Term Memory

C0800 Long-Term Memory

C0900 Memory/Recall Ability

C1000 Cognitive Skills for Daily Decision Making

Documentation required to confirm responses

Section C

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



IMPAIRED COGNITION CATEGORY

B0100- Comatose (requires supporting documentation)

AND



C0200

C0300

C0400

C0500

Resident Interview- BIMS

OR

B0700

C0700

C1000

Staff Assessment

Section C

C1300 Signs and Symptoms of Delirium

C1600 Acute Onset Mental Status Change



DEFINITIONS

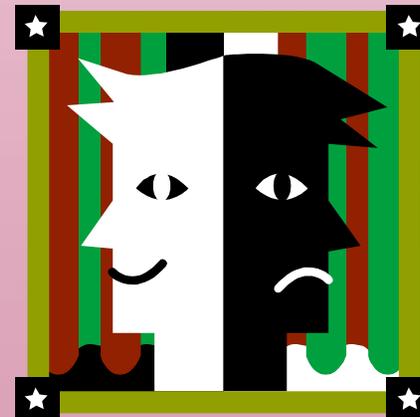
DELIRIUM

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

Section D

Mood

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



Section D

D0100: Should Resident Mood Interview Be Conducted?



If yes...

D0200 (Resident Interview – PHQ9[®])

Enter the frequency of symptoms for Column 2, Items A through I

Requires no further supporting documentation.

Section D

D0200

D0200. Resident Mood Interview (PHQ-9 [©])		
Say to resident: "Over the last 2 weeks, have you been bothered by any of the following problems?"		
If symptom is present, enter 1 (yes) in column 1, Symptom Presence. If yes in column 1, then ask the resident: "About <i>how often</i> have you been bothered by this?" Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.		
1. Symptom Presence	2. Symptom Frequency	
0. No (enter 0 in column 2)	0. Never or 1 day	
1. Yes (enter 0-3 in column 2)	1. 2-6 days (several days)	
9. No response (leave column 2 blank)	2. 7-11 days (half or more of the days)	
	3. 12-14 days (nearly every day)	
		1. Symptom Presence
		2. Symptom Frequency
		↓ Enter Scores in Boxes ↓
A. Little interest or pleasure in doing things		<input type="checkbox"/>
B. Feeling down, depressed, or hopeless		<input type="checkbox"/>
C. Trouble falling or staying asleep, or sleeping too much		<input type="checkbox"/>
D. Feeling tired or having little energy		<input type="checkbox"/>
E. Poor appetite or overeating		<input type="checkbox"/>
F. Feeling bad about yourself - or that you are a failure or have let yourself or your family down		<input type="checkbox"/>
G. Trouble concentrating on things, such as reading the newspaper or watching television		<input type="checkbox"/>
H. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual		<input type="checkbox"/>
I. Thoughts that you would be better off dead, or of hurting yourself in some way		<input type="checkbox"/>

Section D

D0300



D0300 Total Severity Score

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

Total score must be between 00 and 27

Section D

D0500

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



Interview staff from all shifts who know the resident best.

Supporting documentation is required

D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)		
Do not conduct if Resident Mood Interview (D0200-D0300) was completed		
Over the last 2 weeks, did the resident have any of the following problems or behaviors?		
If symptom is present, enter 1 (yes) in column 1, Symptom Presence. Then move to column 2, Symptom Frequency, and indicate symptom frequency.		
1. Symptom Presence	2. Symptom Frequency	
0. No (enter 0 in column 2)	0. Never or 1 day	
1. Yes (enter 0-3 in column 2)	1. 2-6 days (several days)	
	2. 7-11 days (half or more of the days)	
	3. 12-14 days (nearly every day)	
		↓ Enter Scores in Boxes ↓
A. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeling or appearing down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>
C. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>
D. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>
E. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down	<input type="checkbox"/>	<input type="checkbox"/>
G. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>
I. States that life isn't worth living, wishes for death, or attempts to harm self	<input type="checkbox"/>	<input type="checkbox"/>
J. Being short-tempered, easily annoyed	<input type="checkbox"/>	<input type="checkbox"/>

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

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

Section E

Behavior

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



BEHAVIORAL SYMPTOMS

Payment Items

E0100A Hallucinations

E0100B Delusions

E0200A Physical behaviors

E0200B Verbal behaviors

E0200C Other behaviors

E0800 Rejected care

E0900 Wandered



Section E

E0200

E0200. Behavioral Symptom - Presence & Frequency	
Note presence of symptoms and their frequency	
Coding: 0. Behavior not exhibited 1. Behavior of this type occurred 1 to 3 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily	↓ Enter Codes in Boxes
	<input type="checkbox"/> A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
	<input type="checkbox"/> B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others)
	<input type="checkbox"/> C. Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

E0300: Overall Presence of Behavioral Symptoms

E0500: Impact on Resident

E0600: Impact on Others

Section E

E0800 and E0900

E0800: Rejection of Care – Presence & Frequency

E0900: Wandering – Presence & Frequency

E0900. Wandering - Presence & Frequency	
Enter Code	Has the resident wandered?
<input type="checkbox"/>	<ul style="list-style-type: none">0. Behavior not exhibited → Skip to E1100, Change in Behavioral or Other Symptoms1. Behavior of this type occurred 1 to 3 days2. Behavior of this type occurred 4 to 6 days, but less than daily3. Behavior of this type occurred daily

E1000: Wandering – Impact

E1000A Risk to Self

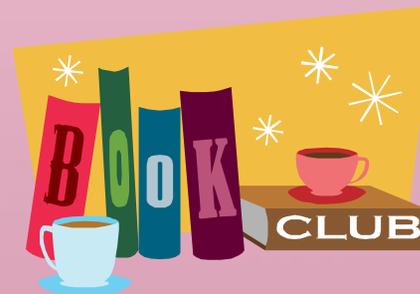
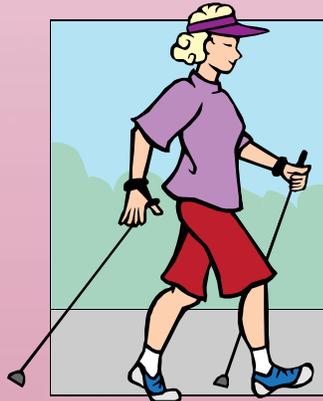
E1000B Intrusion on others

E1100: Change in Behavior or Other Symptoms

Section F

Preferences for Customary Routine and Activities

Intent: The intent of items in this section is to obtain information regarding the resident's preferences for his or her daily routine and activities.



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.



Section G

Payment Items

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



Section G

G0110

1. ADL Self-Performance

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

Coding:

Activity Occurred 3 or More Times

- 0. **Independent** - no help or staff oversight at any time
- 1. **Supervision** - oversight, encouragement or cueing
- 2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
- 3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
- 4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

- 7. **Activity occurred only once or twice** - activity did occur but only once or twice
- 8. **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

2. ADL Support Provided

Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:

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

1. Self-Performance	2. Support
↓ Enter Codes in Boxes ↓	



Section G

Self Performance

1. When an activity occurs 3 or more times at any one level, code that level.
2. When an activity occurs 3 or more times at multiple levels, follow the “Rule of 3” .

Exceptions to the Rule of 3:

0 Independent

4 Total Dependence

7 Activity occurred one or two times

8 Activity did not occur



Section G

G0120: Bathing

A. Self-Performance

B. Support

G0300: Balance During Transitions and Walking

G0400: Functional Limitation in Range of Motion

A. Upper Extremity

B. Lower Extremity

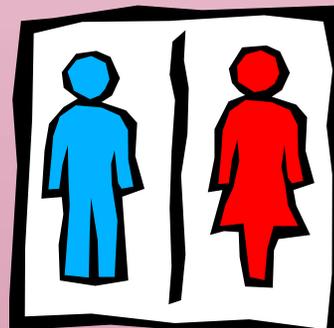
G0600: Mobility Devices (check all that apply)

G0900: Functional Rehabilitation Potential

Section H

Bladder and Bowel

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



Section H

H0100: Appliances

H0200: Urinary Toileting Program



A: Trial of a toileting program?

B: Response to trial

C: Current toileting program or trial

H0300: Urinary Continence

H0400: Bowel Continence

H0500: Bowel Toileting Program

H0600: Bowel Patterns

Scheduled Toileting/Retraining

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



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.





Section I Active Diagnoses

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



I2300 Urinary Tract Infections

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

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

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

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



DIAGNOSES (Case Mix Items)

I2000 – Pneumonia

I2100 - Septicemia

I2900 - Diabetes (If N0300 = 7 and O0700 = 2 or more)

14300 - Aphasia (and a feeding tube)

14400 - Cerebral palsy

14900 - Hemiplegia/hemiparesis

15100 - Quadriplegia

15200 - Multiple Sclerosis

15500 - Traumatic brain injury (Maine only)

Section J



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

Section J

Pain Assessment

J0100 Pain Management (5-day look-back)

J0200: Should Pain Assessment Interview be Conducted?

Pain Interview: J0300 – J0600

J0700: Should the Staff Assessment for Pain be Conducted?

J0800-J0850: Staff Assessment for Pain



Section J

Other Health Conditions

J1100 Shortness of Breath

J1300 Current Tobacco Use

J1400 Prognosis



Section J

Problem Conditions

J1550:

- A. Fever**
- B. Vomiting**
- C. Dehydrated**
- D. Internal Bleeding**
- Z. None of the above**

Seven (7) day look-back period



Section J

Health Conditions

J1700 Fall History

J1800 Falls since Admission/Entry

J1900 Number of Falls since Admission



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.



Section K

Weight Loss/Gain

K0100: Swallowing disorder

K0200: Height and Weight

K0300: Weight Loss

K0310: Weight gain



Section K

Nutritional Approaches

K0510: Approaches

A. Parenteral / IV Feeding

B. Feeding Tube

C. Mechanically Altered Diet

D. Therapeutic Diet

Z. None of the above

K0510. Nutritional Approaches		
Check all of the following nutritional approaches that were performed during the last 7 days		
1. While NOT a Resident Performed <i>while NOT a resident</i> of this facility and within the <i>last 7 days</i> . Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank	1. While NOT a Resident	2. While a Resident
2. While a Resident Performed <i>while a resident</i> of this facility and within the <i>last 7 days</i>	↓ Check all that apply ↓	
A. Parenteral/IV feeding	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeding tube - nasogastric or abdominal (PEG)	<input type="checkbox"/>	<input type="checkbox"/>
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	<input type="checkbox"/>	<input type="checkbox"/>
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>
Z. None of the above	<input type="checkbox"/>	<input type="checkbox"/>

K0510 Assessment Guidelines



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

- ✓ IV medications
- ✓ IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay
- ✓ IV fluids administered solely as flushes
- ✓ Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis

RAI Manual pages K-10 through K-12

K0710A Percent Intake by Artificial Route

A. Proportion of total calories the resident received through parenteral or tube feeding

1. 25% or less
2. 26-50%
3. 51% or more

B. Average fluid intake per day by IV or tube feeding

1. 500 cc/day or less
2. 501 cc/day or more

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

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

K0710B Average Fluid Intake per Day by IV or Tube Feeding



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

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

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

Section L



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

L0200. Dental	
↓ Check all that apply	
<input type="checkbox"/>	A. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose)
<input type="checkbox"/>	B. No natural teeth or tooth fragment(s) (edentulous)
<input type="checkbox"/>	C. Abnormal mouth tissue (ulcers, masses, oral lesions, including under denture or partial if one is worn)
<input type="checkbox"/>	D. Obvious or likely cavity or broken natural teeth
<input type="checkbox"/>	E. Inflamed or bleeding gums or loose natural teeth
<input type="checkbox"/>	F. Mouth or facial pain, discomfort or difficulty with chewing
<input type="checkbox"/>	G. Unable to examine
<input type="checkbox"/>	Z. None of the above were present

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. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.



Section M

M0100: Determination of Pressure Ulcer Risk

M0150: Risk of Pressure Ulcers

M0210: Unhealed Pressure Ulcer(s)



DEFINITIONS

PRESSURE ULCER

A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.

Section M

M0300 Unhealed Pressure Ulcers



M0300A: Number of Stage 1

M0300B: Number of Stage 2

number present on admission
date of oldest stage 2 if known

M0300C: Number of Stage 3

number present on admission

M0300D: Number of Stage 4

number present on admission

Section M

M0300 Unhealed Pressure Ulcers

M0300E: Unstageable Related to Non-removable dressing/device

number present on admission

M0300F: Unstageable – slough and/or eschar

number present on admission

M0300G: Unstageable – Deep Tissue

number present on admission

PRESSURE ULCERS (Guidelines)

Do not reverse stage

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

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



Section M

M0610: Dimensions of Unhealed Stage 3 or 4 or Eschar

M0700: Most Severe Tissue Type for any Ulcer

M0800: Worsening Pressure Ulcer Status

M0900: Healed Pressure Ulcers

M1030: Number of Venous and Arterial Ulcers



Section M

M1040 Other Ulcers, Wounds, and Skin Problems



M1040. Other Ulcers, Wounds and Skin Problems	
↓ Check all that apply	
Foot Problems	
<input type="checkbox"/>	A. Infection of the foot (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	B. Diabetic foot ulcer(s)
<input type="checkbox"/>	C. Other open lesion(s) on the foot
Other Problems	
<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
<input type="checkbox"/>	E. Surgical wound(s)
<input type="checkbox"/>	F. Burn(s) (second or third degree)
<input type="checkbox"/>	G. Skin tear(s)
<input type="checkbox"/>	H. Moisture Associated Skin Damage (MASD) (i.e. incontinence (IAD), perspiration, drainage)
None of the Above	
<input type="checkbox"/>	Z. None of the above were present



M1200 Skin and Ulcer Treatments



A. Pressure reducing device for chair

B. Pressure reducing device for bed

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

C. Turning/repositioning program

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

D. Nutrition and hydration



M1200 Skin and Ulcer Treatments



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

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.



Section N

INJECTIONS



N0300

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



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

Section N Medications

N0350 Insulin: *Not a payment item for RUG III (MaineCare).*

- A. Insulin Injections administered
- B. Orders for insulin





Section N

Medications

N0410 Medications Received

- A. Antipsychotic
- B. Antianxiety
- C. Antidepressant
- D. Hypnotic
- E. Anticoagulant
- F. Antibiotic
- G. Diuretic

Section O

Special Treatments, Procedures and Programs



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



Section O

Special Treatments, Procedures, and Programs



O0100. Special Treatments, Procedures, and Programs		
Check all of the following treatments, procedures, and programs that were performed during the last 14 days		
1. While NOT a Resident Performed <i>while NOT a resident</i> of this facility and within the <i>last 14 days</i> . Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank 2. While a Resident Performed <i>while a resident</i> of this facility and within the <i>last 14 days</i>	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
Cancer Treatments		
A. Chemotherapy	RUG III <input type="checkbox"/>	RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>
B. Radiation	RUG III <input type="checkbox"/>	RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>
Respiratory Treatments		
C. Oxygen therapy	RUG III <input type="checkbox"/>	RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>
D. Suctioning	RUG III <input type="checkbox"/>	RUG III <input type="checkbox"/>
E. Tracheostomy care	RUG III <input type="checkbox"/>	RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>
F. Ventilator or respirator	RUG III <input type="checkbox"/>	RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>
G. BiPAP/CPAP	<input type="checkbox"/>	<input type="checkbox"/>
Other		
H. IV medications	RUG III <input type="checkbox"/>	RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>
I. Transfusions	RUG III <input type="checkbox"/>	RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>
J. Dialysis	RUG III <input type="checkbox"/>	RUG III <input type="checkbox"/> RUG IV <input type="checkbox"/>
K. Hospice care	<input type="checkbox"/>	<input type="checkbox"/>
L. Respite care		<input type="checkbox"/>
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	<input type="checkbox"/>	<input type="checkbox"/> RUG IV <input type="checkbox"/>

Section O

Special Treatments, Procedures, and Programs

00250: Influenza Vaccination

00300: Pneumococcal Vaccination



Section O

Special Treatments, Procedures, and Programs

O0400A. Speech-Language Pathology and Audiology Services

O0400B. Occupational Therapy

O0400C. Physical Therapy

Individual minutes

Concurrent minutes

Group minutes

Co-treatment minutes

Number of Days

Start date

End date



Section O

Special Treatments, Procedures, and Programs



00400D Respiratory Therapy

Total minutes

**Days therapy was administered
at least 15 minutes**

00400E Psychological Therapy

00400F Recreational Therapy

Section O

Special Treatments, Procedures, and Programs

00420 Distinct Days of Therapy

00450 Resumption of Therapy





Section O

Restorative Nursing Programs

00500. Restorative Nursing Programs

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

Number of Days	Technique
<input type="checkbox"/>	A. Range of motion (passive)
<input type="checkbox"/>	B. Range of motion (active)
<input type="checkbox"/>	C. Splint or brace assistance
Number of Days	Training and Skill Practice In:
<input type="checkbox"/>	D. Bed mobility
<input type="checkbox"/>	E. Transfer
<input type="checkbox"/>	F. Walking
<input type="checkbox"/>	G. Dressing and/or grooming
<input type="checkbox"/>	H. Eating and/or swallowing
<input type="checkbox"/>	I. Amputation/prostheses care
<input type="checkbox"/>	J. Communication

Section O

Restorative Nursing Programs

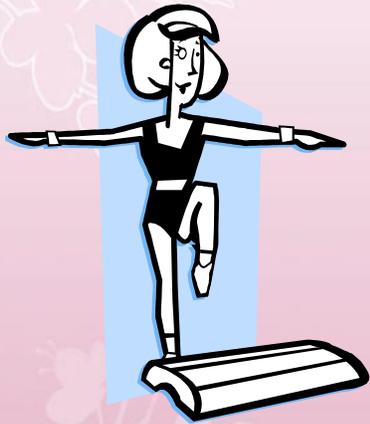


Nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible.

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

Section O

Restorative Nursing Programs



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

Section O

Restorative Nursing Programs



H0200C Current toileting program

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

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

Section O

Restorative Nursing Programs



H0500 Bowel Training Program

Three requirements:

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

00600 Physician Examination Days Assessment Guidelines



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

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

Do **not** include:

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



00700 Physician Order Change Days Assessment Guidelines



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

Do **not** include the following:

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



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.

Assessors will evaluate whether or not a device meets the definition of a physical restraint and code only the devices that meet the definition in the appropriate categories of Item P0100.



Section P

Restraints

P0100. Physical 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

Coding:

- 0. Not used
- 1. Used less than daily
- 2. Used daily

↓ Enter Codes in Boxes

Used in Bed

A. Bed rail

B. Trunk restraint

C. Limb restraint

D. Other

Used in Chair or Out of Bed

E. Trunk restraint

F. Limb restraint

G. Chair prevents rising

H. Other

Section Q

Participation in Assessment 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. Discharge planning follow-up is already a regulatory requirement (CFR 483.20 (i)(3)). Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.



Section Q

Participation in Assessment and Goal Setting

Q0100 Participation in Assessment:

Who participated??

Whenever possible, the resident should be actively involved-except in unusual circumstances such as if the individual is unable to understand the proceedings or is comatose.



Section Q

Participation in Assessment and Goal Setting

Q0300 Residents Overall Expectation

- Overall expectations
- Information source

Q0400 Discharge Plan

Q0490 Preference to Avoid Being Asked

Question Q0500B

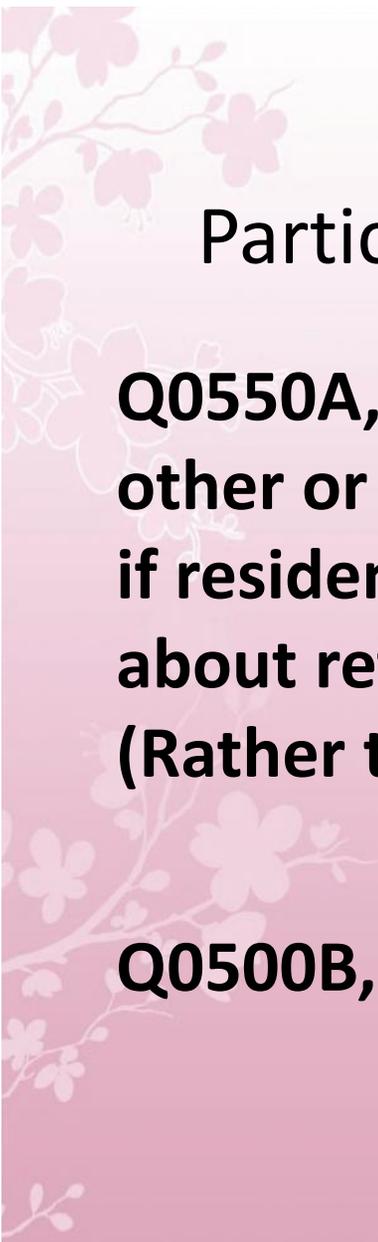
Section Q

Participation in Assessment and Goal Setting

Q0500B Return to Community

Q0500. Return to Community	
Enter Code <input type="checkbox"/>	B. Ask the resident (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?" 0. No 1. Yes 9. Unknown or uncertain

The goal of follow-up action is to initiate and maintain collaboration between the nursing home and the local contact agency to support the resident's expressed interest in being transitioned to community living.



Section Q

Participation in Assessment and Goal Setting

Q0550A, Does the resident, (or family or significant other or guardian or legally authorized representative if resident is unable to respond) want to be asked about returning to the community on all assessments? (Rather than only on comprehensive assessments.)

Q0500B, what is the source of the information?

Section Q

Participation in Assessment and Goal Setting

Q0600. Referral	
Enter Code <input type="checkbox"/>	Has a referral been made to the Local Contact Agency? (Document reasons in resident's clinical record) 0. No - referral not needed 1. No - referral is or may be needed (For more information see Appendix C, Care Area Assessment Resources #20) 2. Yes - referral made

**Who is the Local Contact Agency for Maine?
Long Term Care Ombudsman Program**

Section S

This section applies to the State of Maine specific data requirements.



S0120 Residence Prior to Admission

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

--	--	--	--	--

S0170. Advanced Directive

- A. Guardian**

- B. Durable power of attorney for health care**

- C. Living will**

- D. Do not resuscitate**

- E. Do not hospitalize**

- F. Do not intubate**

- G. Feeding restrictions**

- H. Other treatment restrictions**

- Z. None of the above**

S0510. PASRR Level I Screening

Was a PASRR Level I screening completed?

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

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>
Year					Month			Day	

S0513. PASRR Level I Screening Outcome

What was the outcome of the PASRR Level I screen?

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

S3300. Weight-based Equipment Need

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

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



S3305. Requirements for Care, Specifically related to Weight

A. **Lifting device.** Since last assessment, was a specialized lifting device required?

B. **Wheelchair or mobility device.** Since last assessment, was an oversized, non-standard wheelchair or other mobility device required?

C. **Bed.** Since last assessment, was a specialized, non-standard bed required?

D. **Seating.** Since last assessment, was a specialized, non-standard seat required?

E. **More than 2 staff.** Since last assessment, was 3 or more staff required to provide assistance with ADL?

Y. **Other.** Since last assessment, was other specialized, non-standard equipment required? _____

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

A. RN expertise. Resident needs care by an RN with specialized expertise.

B. CNA training. Resident needs care by CNA staff with specialized training.

C. Therapy (PT, OT, RT) expertise. Resident needs therapy (PT, OT, RT) with specialized training or expertise.

D. Equipment. Resident needs specialized equipment.

Y. Other. Resident has other needs.

Z. None of the above

S6022. Direct care by a Licensed Nurse

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

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

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

Enter a response for A, B, and C

S6023. Direct Care by a CNA

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

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

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

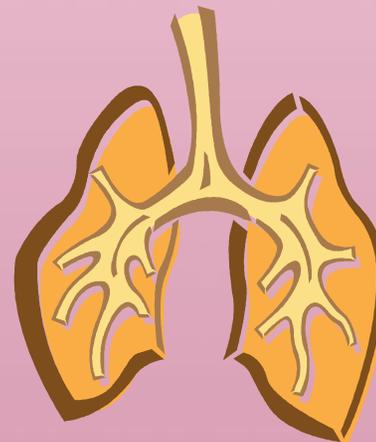


S6024. Direct Care by a Respiratory Therapist

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

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

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



Resident Stays Outside of the Facility:

S6200. Hospital Stays

S6205. Observation Stays

S6210. Emergency Room (ER) Visits



Resident Stays

Enter Number

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

S6205. Observation Stays

Enter Number

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

S6210. Emergency Room (ER) Visits

Enter Number

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



S8010 Payment Source – To determine payment source(s) that covers the daily per diem or ancillary services for the resident's stay in the nursing facility over the last 30 days.

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

S8099 None of the above

S8510. MaineCare Therapeutic Leave Days

- A. **MaineCare therapeutic leave days since last assessment.** Enter the number of therapeutic leave days paid by MaineCare since the last assessment.
-
- B. **MaineCare therapeutic leave days fiscal year-to-date.** Enter the number of therapeutic leave days paid by MaineCare for State fiscal year-to-date (beginning July 1).





Leave of Absence, or LOA, refers to:

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

S8512. MaineCare Hospital Bed-Hold Days

- A. **MaineCare hospital bed-hold days since last assessment.** Enter the number of hospital bed-hold days paid by MaineCare since the last assessment.
-
- B. **MaineCare hospital bed-hold days fiscal year-to-date.** Enter the number of hospital bed-hold days paid by MaineCare for State fiscal year-to-date (beginning July 1).



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.

... and CATS





Section V

Care Area Assessment Summary

V0100 Items from Most Recent Prior OBRA or PPS Assessment

- Reason for assessment (A0310A and/or A0310B)
- Prior ARD (A2300)
- Prior BIMS score (C0500)
- Prior PHQ-9 (C0300 or C0600)

V0200: CAAs and Care Planning

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

Majority of this section is completed by your software.

Z0100 Medicare Part A Billing

Z0150 Medicare Part A Non-Therapy

Z0200 State Medicaid Billing

Z0250 Alternate State Medicaid Billing

Z0300 Insurance Billing

Section Z

Assessment Administration

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

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

Section Z

Assessment Administration

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

Z0500 Signature of RN Assessment Coordinator Verifying Assessment Completion





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.



Section X

Correction Request

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

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

Section X

Correction Request

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



Section X

Correction Request: Manual Deletion



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

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



Section X

Correction Request

X0150 Type of Provider

X0200 Name of Resident

X0300 Gender

X0400 Date of Birth

X0500 Social Security Number

X0600 Type of Assessment

X0700 Date on existing record





Section X

Correction Request

X0800 Correction number

X0900 Reasons for Modification

X1050 Reasons for Inactivation

X1100 Name, Title, Signature, Attestation Date



Chapter 5

Submission and Correction of MDS

5.1 Transmitting MDS Data:

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

5.2 Timeliness Criteria

5.3 Validation Edits

5.4 Additional Medicare Submission Requirements that Impact Billing Under SNF PPS



It's **QUESTION TIME!!**



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