MDS 3.0 Training

MDS 3.0 Training Agenda

- Welcome and overview
- History
- Chapter 2
- Case Mix Implications
- Chapter 3 – section by section
- Section 5 – State only
- Section X – corrections
- Questions

MDS 3.0 History
Goals of the MDS 3.0

- **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


**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
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
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:

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2%</td>
<td>Error rate 34% or greater and less than 37%</td>
</tr>
<tr>
<td>5%</td>
<td>Error rate 37% or greater and less than 41%</td>
</tr>
<tr>
<td>7%</td>
<td>Error rate 41% or greater and less than 45%</td>
</tr>
<tr>
<td>13%</td>
<td>Error rate 45% or greater</td>
</tr>
<tr>
<td>10%</td>
<td>If requested reassessments not completed within 7 days</td>
</tr>
</tbody>
</table>

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.

Introducing the Maine Division of Licensing and Regulatory Services (DLRS) Training Portal

Visit the portal at: [www.main.gov/dhhs/dlrs/provider/mds/training/](http://www.main.gov/dhhs/dlrs/provider/mds/training/)
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 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.

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
Section A
A0310B PPS Assessment

Includes scheduled and unscheduled assessments

<table>
<thead>
<tr>
<th>PPS Assessment</th>
<th>Medicare PPS Assessments for a Medicare Part A Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.</td>
<td>5-day scheduled assessment</td>
</tr>
<tr>
<td>01.</td>
<td>14-day scheduled assessment</td>
</tr>
<tr>
<td>02.</td>
<td>30-day scheduled assessment</td>
</tr>
<tr>
<td>03.</td>
<td>60-day scheduled assessment</td>
</tr>
<tr>
<td>04.</td>
<td>90-day scheduled assessment</td>
</tr>
</tbody>
</table>

PPS Unscheduled Assessments for a Medicare Part A Stay

05. Unscheduled assessment used for PPS (OMRA, significant or clinical risk)

Not PPS Assessment

06. 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 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 neither Medicare nor Medicaid certified; MDS data is not required by the State.
2. Unit neither Medicare nor Medicaid certified; 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

A155. Conditions Related to DiDD Status

If the resident is 22 years of age or older AND the resident is 022 or 022, complete this section.

- 0. Ongoing cognitive limitation
- 1. Autism
- 2. Epilepsy
- 3. Other significant co-morbidity requiring DDD
- 4. IDD without Cognitive Limitation
- 5. IDD without organic condition
- 6. Other

- 7. None of the above
PASRR

- [http://www.qualitycareforme.com/MaineProvider_PASRR.htm](http://www.qualitycareforme.com/MaineProvider_PASRR.htm)

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**A1900**

**Episode vs Stay**

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**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)
Section C

C1300 Signs and Symptoms of Delirium
C1600 Acute Onset Mental Status Change

DEFINITIONS

DELI RIU M
A mental disturbance characterized by new or
worsening confusion, or disorganized thinking,
expressed as delusions, hallucinations, disorganized speech,
or grossly disorganized behavior.

Section D
Mood

Intent: The items in this section address mood distress,
a serious condition that is underdiagnosed and
under-treated 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

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

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**

Section E E0200

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

**E0800 and E0900**

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

**E1000**: Wandering – Impact
- E1000A Risk to Self
- E1000B Intrusion on others
- E1100: Change in Behavior or Other Symptoms
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. **Self Performance**
   - Code if activity performance was partially or fully dependent on others during one or more attempts. Determination is made by the Team Leader, in consultation with the Team. If there are multiple attempts, code the highest level of dependence.

   **Rating**
   1. Independent
   2. Partially Dependent
   3. Total Dependence

   **Exceptions**
   - Activity occurred one or two times
   - Activity did not occur

   **Activity Occurred**
   - One or more times

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**
   - 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-documentated 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 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

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**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.**

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**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.

**Lesion Present**

- A. Nerve irritation caused by partial denture or bridge, created, unnatural, or foreign
- B. Neutrophic ulcer or soft-tissue necrosis (ischemia)
- C. Necrotic tissue in ulceration
- D. Odontogenic origin or local gingival infections
- E. Ulcer due to bleeding gums or hemorrhagic gums
- F. Ulcer due to distal bone, dry socket, or pocket disease
- G. Undetected lesion
- H. 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 sore, also called a **bed sore**, is a deep tissue injury at a site where the skin comes into constant pressure or friction against a hard, immobile object.
### Section M
#### M0300 Unhealed Pressure Ulcers

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>M0300A</td>
<td>Number of Stage 1</td>
<td>number present on admission</td>
</tr>
<tr>
<td>M0300B</td>
<td>Number of Stage 2</td>
<td>date of oldest stage 2 if known</td>
</tr>
<tr>
<td>M0300C</td>
<td>Number of Stage 3</td>
<td>number present on admission</td>
</tr>
<tr>
<td>M0300D</td>
<td>Number of Stage 4</td>
<td>number present on admission</td>
</tr>
</tbody>
</table>

#### 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

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### 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

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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

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

O0250: Influenza Vaccination
O0300: Pneumococcal Vaccination

Section O
Speech-Language Pathology and Audiology Services
Occupational Therapy
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

<table>
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<th>Services (restorative therapy)</th>
<th>Examples</th>
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<td>D. Generalized therapy</td>
<td>Activities of daily living, assistance with self-care, etc.</td>
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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

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Special Treatments, Procedures, and Programs

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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

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.

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

O0600 Physician Examination Days
Assessment Guidelines

Over the last 14 days, on how many days did the physician examine the resident?
Examinations can occur in the facility or in the physician’s office.
Do not include:
• Examinations that occurred prior to admission/readmission to the facility
• Examinations that occurred during an ER visit or hospital observation stay

O0700 Physician Order Change Days
Assessment Guidelines

Over the last 14 days, on how many days did the physician change the resident’s orders?
Do not include the following:
• Admission or re-admission orders
• Renewal of an existing order
• Clarifying orders without changes
• Orders prior to the date of admission
• Sliding scale dosage schedule
• Activation of a PRN order
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 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

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?

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

- Guardian
- Durable power of attorney for health care
- Living will
- Do not resuscitate
- Do not hospitalized
- Do not intubate
- Feeding restrictions
- Other treatment restrictions
- None of the above

S0510. PASRR Level I Screening

Was a PASRR Level I screening completed?

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

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

Year Month Day
S0513. PASRR Level I Screening Outcome

What was the outcome of the PASRR Level I screen?

- 0. The resident was not found to have a level I screening diagnosis.
- 1. The resident was found to have a level I screening diagnosis.

- 2. The resident was found to have a level II screening diagnosis.

S3300. Weight-based Equipment Need

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

- 0. No
- 1. Yes

S3305. Requirements for Care, Specifically related to Weight

- A. Lifting device. Is the resident a weight of 150 lbs or more?
- B. Wheelchair or bed lift needed. Is the resident a weight of 50 lbs or more?
- C. Bed. Is the resident a weight of 40 lbs or more?
- D. Bedding. Is the resident a weight of 30 lbs or more?
- E. More than 10 lbs. Is the resident a weight of 10 lbs or more?
- F. Other. Should the resident receive special care?
S6020. Specialized needs specifically related to a resident’s need for a Ventilator/Respirator

A. The care plan, resident care plan, or other written notes of resident needs specifically related to a resident’s need for a Ventilator/Respirator include:
B. Other procedures, meetings, or other written notes of resident needs specifically related to a resident’s need for a Ventilator/Respirator include:
C. Other factors:
1. Other factors related to the resident’s need for a Ventilator/Respirator:
2. None of the above

S6022. Direct care by a Licensed Nurse

A. Number of days the resident received direct care by a licensed nurse in the nursing home:
B. Number of days the resident received direct care by a licensed nurse in the facility:
C. Number of days the resident received direct care by a licensed nurse in the nursing home during the last 7 days or since the last assessment:
Enter a response for A, B, and C

S6023. Direct Care by a CNA

A. Number of days the resident received direct care by a CNA on the nursing unit:
B. Number of days the resident received direct care by a CNA in the facility:
C. Number of days the resident received direct care by a CNA on the nursing unit during the last 7 days or since the last assessment:
S6024. Direct Care by a Respiratory Therapist

A. Number of days the resident received direct care by a licensed respiratory therapist or his/her delegate. 
B. Number of days the resident received direct care by a respiratory therapist and physical therapist. 
C. Number of days the resident received direct care by a licensed respiratory therapist and occupational therapist.

Resident Stays Outside of the Facility:

S6200. Hospital Stays
S6205. Observation Stays
S6210. Emergency Room (ER) Visits

Resident Stays
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 are used by the long-term care facility to recover from some illness or injury. The resident is not admitted to the hospital.
B. MaineCare therapeutic leave days may be used for leave of absence, or LOA, for the resident to return to their home environment for temporary home visit.

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
Section V
Care Area Assessment Summary

CAAs

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.

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

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

RAI Manual Chapter 5
Submission and Correction of MDS
5.1 Transmitting MDS Data:
The provider indicates the submission authority for a record in item A0410, Submission Requirement.
5.2 Timeliness Criteria
5.3 Validation Edits
5.4 Additional Medicare Submission Requirements that Impact Billing Under SNF PPS
Contact Information

- MDS Help Desk: 624-4019 or
toll-free: 1-844-288-1612
  MDS3.0.DHHS@maine.gov
- Lois Bourque RN: 592-5909
  Lois.Bourque@maine.gov
- Heidi Coombe RN: 441-6754
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www.maine.gov/dhhs/dlrs/provider/mds/training/