MDS 3.0 Training
Day 1

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MDS 3.0 Training Agenda: Day 1

- Welcome and overview
- History
- Chapter 2
- Case Mix Implications
- Chapter 3 – Clinical areas
- Sections Z, GG, G, M, N
- Sections I, J, L, H, O, P
- Questions and Wrap-up

MDS 3.0 History
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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.

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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.

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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 III** refers to payment items for PPS services.
- **CAS**: Refers to MDS items that “trigger” versus care area assessment items used for developing an individualized, resident-specific care plan.

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 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:

- 2% Error rate 54% or greater and less than 57%
- 6% Error rate 57% or greater and less than 61%
- 7% Error rate 61% or greater and less than 65%
- 10% Error rate 65% or greater
- 10% If requested reassessments not completed within 7 days

MaineCare Case Mix Documentation

- Resident interviews will be accepted as coded on the MDS 3.0—NO additional supporting documentation is required.

- Staff interviews must be documented in the resident’s record. If interviews are summarized in a narrative note, the interviewer must document the date of the interview, name of staff interviewed, and staff responses to scripted questions asked.

- Follow all “Steps for Assessment” in the RAI Manual, for the interview items.
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Introducing the Maine Division of Licensing and Regulatory Services (DLRS) Training Portal


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

Chapter 2

Effective Oct 2018

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Federal Requirements for the 3.0

- Initial and periodic assessments for all their residents residing in the facility for 14 or more days.
- This includes hospice, respite, and special populations such as Pediatric and Psychiatric.
Responsibility of NF for Reproducing/Maintaining 3.0

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

Responsibility of NF for Reproducing/Maintaining 3.0

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

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 Z
Assessment Administration

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

The majority of this section is completed by your software.

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

To check your final validation report:
https://sms.muskie.usm.maine.edu/
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Section Z
Assessment Administration

Z0400 Attestation Statement

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.

Z0500 Signature of RN Assessment Coordinator Verifying Assessment Completion

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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.

Coding Instructions

• All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed.

• If a staff member cannot sign Z0400 on the same day that he or she completed a section or portion of a section, when the staff member signs, use the date the item originally was completed.

• Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident’s status. Penalties may be applied for submitting false information.
FYI…
Chapter 110, Regulations Governing the Licensing and Function of Skilled Nursing Facilities and Nursing Facilities
http://www.maine.gov/sos/cec/rules/10/ch110.htm

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

Section GG
Intent: This section includes items about functional abilities and goals.
It includes items focused on prior function, admission performance, discharge goals, and discharge performance.
Functional status is assessed based on the need for assistance when performing self-care and mobility activities.

For the purposes of completing Section GG, a “helper” is defined as facility staff who are direct employees or facility-contracted employees (e.g., rehabilitation staff, nursing agency staff).
When helper assistance is required because a resident’s performance is unsafe or of poor quality, consider only facility staff when scoring according to the amount of assistance provided.
Admission: The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay.

- For the 5-Day PPS assessment, code the resident’s functional status based on a clinical assessment of the resident’s performance that occurs soon after the resident’s admission. This functional assessment must be completed within the first three days (3 calendar days of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay and the following two days, ending at 11:59 PM on day three). The assessment should occur, when possible, prior to the resident benefiting from treatment interventions in order to determine the resident’s true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.

For the discharge assessment (i.e., standalone Part A PPS or combined OBRA/Part A PPS), code the resident’s discharge functional status, based on a clinical assessment of the resident’s performance that occurs as close to the time of the resident’s discharge from Medicare Part A as possible. This functional assessment must be completed within the last three calendar days of the resident’s Medicare Part A stay, which includes the day of discharge from Medicare Part A and the two days prior to the day of discharge from Medicare Part A.

Definition: Usual Performance

A resident’s functional status can be impacted by the environment or situations encountered at the facility. Observing the resident’s interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident’s functional status. If the resident’s functional status varies, record the resident’s usual ability to perform each activity. Do not record the resident’s best performance and do not record the resident’s worst performance, but rather record the resident’s usual performance.

Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
At admission, when coding the resident’s usual performance, “effort” refers to the type and amount of assistance the helper provides in order for the activity to be completed. The 6-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.

On discharge, use the same 6-point scale or “activity was not attempted” codes that are used for the admission assessment to identify the resident’s usual performance on the discharge assessment.

Coding a dash (“-) in these items indicates “No information.” CMS expects dash use for SNF QRP items to be a rare occurrence. Use of dashes for these items may result in a 2% reduction in the annual payment update.

If the reason the item was not assessed was that the resident refused (code 07), the item is not applicable (code 09), or the activity was not attempted due to medical condition or safety concerns (code 88), use these codes instead of a dash (“-) .

Coding Reminders

Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident’s medical record. (RAI Manual, page GG-7)
Coping for GG0100 for admission and discharge assessments

Coding:
1. Instrumented: Resident completed the activities of daily living with the assistance of an aide or with an aide nearby in the room.
2. Needed Some Help: Resident received occasional assistance from another person during activities.
3. Unassisted: Resident completed the activities.
4. Unable to Perform
5. Not Applicable.

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Maine Department of Health and Human Services

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Coding for GG0130 and GG0170 for admission and discharge assessments

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10/12/2018
Assess the resident's self-care performance status based on:
- Direct observation
- The resident's self-report
- Reports from qualified clinicians, family and care staff

Observations and reports must be documented in the resident’s medical record during the three-day admission assessment period, starting with the date in A2400B, Start of most recent Medicare stay.
Eating: Ms. S has multiple sclerosis, affecting her endurance and strength. Ms. S prefers to feed herself as much as she is capable. During all meals, after eating three-fourths of the meal by herself, Ms. S usually becomes extremely fatigued and requests assistance from the certified nursing assistant to feed her the remainder of the meal.

• **Coding:** GG0130A. Eating would be coded 03, Partial/moderate assistance.
• **Rationale:** The certified nursing assistant provides less than half the effort for the resident to complete the activity of eating for all meals.

Oral hygiene: Mr. W is edentulous (without teeth) and his dentures no longer fit his gums. In the morning and evening, Mr. W begins to brush his upper gums after the helper applies toothpaste onto his toothbrush. He brushes his upper gums, but cannot finish due to fatigue. The certified nursing assistant completes the activity of oral hygiene by brushing his back upper gums and his lower gums.

• **Coding:** GG0130B. Oral hygiene would be coded 02, Substantial/maximal assistance.
• **Rationale:** The resident begins the activity. The helper completes the activity by performing more than half the effort.

Toileting hygiene: Mr. J is morbidly obese and has a diagnosis of debility. He requests the use of a bedpan when voiding or having bowel movements and requires two certified nursing assistants to pull down his pants and underwear and mobilize him onto and off the bedpan. Mr. J is unable to complete any of his perineal/perianal hygiene. Both certified nursing assistants help Mr. J pull up his underwear and pants.

• **Coding:** GG0130C. Toileting hygiene would be coded 01, Dependent.
• **Rationale:** The assistance of two helpers was needed to complete the activity of toileting hygiene.
The turns included in the items GG0170J and GG0170R (walking or wheeling 50 feet with 2 turns) are 90-degree turns.

- The turns may be in the same direction (two 90-degree turns to the right or two 90-degree turns to the left), or
- may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right).

The 90-degree turn should occur at the person’s ability level and can include use of an assistive device (for example, cane or wheelchair). (RAI Manual, Page GG-48)
Section GG: Summary

- The items in Section GG are used to calculate the SNF QRP Function quality measure.

- Section GG focuses on prior function, admission performance, discharge goals, and discharge performance.

- Functional status is assessed based on the need for assistance when performing self-care and mobility activities. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.

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
   - The activity must be performed at least three times at one given level.
   - The activity must be performed at one given level at least three times.

2. ADL Supervision
   - The activity must be performed at least three times at one given level.
   - The activity must be performed at one given level at least three times.

List of ADL activities:
- Bathing
- Dressing
- Toileting
- Shaving
- Transfer
- Mobility
- Incontinence
- Eating
- Oral hygiene
- Transferring
- Ambulation

Instructions for Rule of 3

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent; exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all.
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance, and/or non-weight bearing assistance code limited assistance (2).
- If none of the above are met, code supervision.

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Coding Tips

- Do NOT include the emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag in G0110.

- Differentiating between guided maneuvering and weight-bearing assistance: determine who is supporting the weight of the resident’s extremity or body. For example, if the staff member supports some of the weight of the resident’s hand while helping the resident to eat (e.g., lifting a spoon or a cup to mouth), or performs part of the activity for the resident, this is “weight-bearing” assistance for this activity. If the resident can lift the utensil or cup, but staff assistance is needed to guide the resident’s hand to his or her mouth, this is guided maneuvering.

- Code Supervision for residents seated together or in close proximity of one another during a meal who receive individual supervision with eating.

- General supervision of a dining room is not the same as individual supervision of a resident and is not captured in the coding for Eating.

- Code extensive assistance (1 or 2 persons): if the resident with tube feeding, TPN, or IV fluids did not participate in management of this nutrition but did participate in receiving oral nutrition. This is the correct code because the staff completed a portion of the ADL activity for the resident (managing the tube feeding, TPN, or IV fluids).

- Code totally dependent in eating: only if resident was assisted in eating all food items and liquids at all meals and snacks (including tube feeding delivered totally by staff) and did not participate in any aspect of eating (e.g., did not pick up finger foods, did not give self tube feeding or assist with swallow or eating procedure).
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Coding activity did not occur, 8:
- **Toileting** would be coded 8, activity did not occur: only if elimination did not occur during the entire look-back period, or if family and/or non-facility staff toileted the resident 100% of the time over the entire 7-day look-back period.
- **Locomotion** would be coded 8, activity did not occur: if the resident was on bed rest and did not get out of bed, and there was no locomotion via bed, wheelchair, or other means during the look-back period, or if locomotion assistance was provided by family and/or non-facility staff 100% of the time over the entire 7-day look-back period.
- **Eating** would be coded 8, activity did not occur: if the resident received no nourishment by any route (oral, IV, TPN, enteral) during the 7-day look-back period, or if the resident was not fed by facility staff during the 7-day look-back period, or if family and/or non-facility staff fed the resident 100% of the time over the entire 7-day look-back period.

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Coding Scenario

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

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

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

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

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

The ADL Self-Performance coding level definitions for Codes 1, 3 and 4 did not apply directly to this scenario either.
The first Rule of 3 does not apply because even though the ADL activity occurred three or more times, the non-weight-bearing assistance occurred only twice.

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

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

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

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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 G0300 Balance During Transitions and Walking

**Skin Conditions**

Intent: The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.
DEFINITION: PRESSURE ULCER/INJURY
A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.

Section M

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

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

GRANULATION TISSUE
Red tissue with “cobblestone” or bumpy appearance; bleeds easily when injured.
CMS has further adapted the Section M guidelines to be more consistent with the National Pressure Ulcer Advisory Panel (NPUAP). Thus, all references to PRESSURE ULCER throughout Section M have been changed to PRESSURE ULCER/INJURY.

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

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

M0300B2, C2, and D2: Determine “Present on Admission”

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

Pressure Ulcers Present on Admission:

RAI Manual, Chapter 3, page M-7:

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

4. If the pressure ulcer/injury was present on admission/entry or reentry and becomes unstageable due to slough or eschar, during the resident’s stay, the pressure ulcer/injury is coded at M0300F and should not be coded as “present on admission.”
5. If the pressure ulcer/injury was unstageable on admission/entry or reentry, then becomes numerically stageable later, it should be considered as “present on admission” at the stage at which it first becomes numerically stageable. If it subsequently increases in numerical stage, that higher stage should not be coded as "present on admission."

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

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

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

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

10. If two pressure ulcers merge, that were both "present on admission," continue to code the merged pressure ulcer as "present on admission." Although two merged pressure ulcers might increase the overall surface area of the ulcer, there needs to be an increase in numerical stage or a change to unstageable due to slough or eschar in order for it to be considered not “present on admission.”
Pressure Ulcers/injuries are payment items if 2 or more treatments are required.

**M1030: Number of Venous and Arterial Ulcers**

**VENOUS ULCERS:** Ulcers caused by peripheral venous disease, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg.

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

**M1040 Other Ulcers, Wounds, and Skin Problems**

- 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
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M1200 Skin and Ulcer/Injury Treatments (continued)

E. Pressure Ulcer Care
F. Surgical Wound Care
G. Non-surgical Dressing (other than feet)
   Do NOT include Band-Aids or steri-strips
H. Ointments/medications (other than feet)
I. Dressings to feet
J. 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, insulin, and/or select medications were received by the resident.

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

Section N: INJECTIONS

N0300
Record the number of days (during the 7-day look-back period) that the resident received any type of medication, antigen, vaccine, etc.

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

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

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

A. Insulin Injections administered
B. Orders for insulin

Section N Medications

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

Section N New Drug References

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

Section N0450 Antipsychotic Medication Review

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

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

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

Three (3) new items: Drug Regimen Review

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<th>Assessed on:</th>
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<td>N2001. Drug Regimen Review (DRR)</td>
<td>Admission (5-day)</td>
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<td>N2003. Medication Follow-up</td>
<td>Admission (5-day)</td>
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<tr>
<td>N2005. Medication Intervention</td>
<td>PFS Discharge</td>
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N2001 Drug Regimen Review

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

**Steps for Assessment**

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

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

**Potential or Actual Clinically Significant Medication Issue**

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

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

Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the purpose of the drug regimen review items.
3. Clinically significant medication issues may include, but are not limited to:

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

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

  (cont.)

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

Definition: Medication Follow-Up

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

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

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

Definition: Contact with Physician

• Communication with the physician to convey an identified potential or actual clinically significant medication issue, and a response from the physician to convey prescribed/recommended actions in response to the medication issue.

• Communication can be in person, by telephone, voice mail, electronic means, facsimile, or any other means that appropriately conveys the resident’s status.

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

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

DIAGNOSES (Case Mix Items)

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

1. Identify diagnoses in the last 60 days
   - Must be physician-documented

2. Determine status of diagnosis
   - 7-day look-back period,
   - Active diagnoses have a direct relationship to the resident’s functional, cognitive, mood or behavior status, medical treatments or nursing monitoring or risk of death
   - Only active diagnoses should be coded

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

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

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

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

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

- Look-back period to determine an active diagnosis of a UTI is 30 days instead of 7 days

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

1. It was determined that the resident had a UTI using evidence-based criteria such as McGee, NHSN, or Loeb in the last 30 days,
2. A physician documented UTI diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days.
Quadriplegia primarily refers to the paralysis of all four limbs, arms and legs, caused by spinal cord injury.

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

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

**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.

**J0100: Pain Management (5-Day Look Back)**

1. Is there a resident management plan for pain?
   - No
   - Yes

2. Are residents with chronic pain receiving medication management?
   - No
   - Yes

3. Are residents with acute pain receiving appropriate medication?
   - No
   - Yes

4. Do residents with chronic pain have an accurate pain assessment?
   - No
   - Yes

5. Do patients with acute pain have an accurate pain assessment?
   - No
   - Yes

6. Are pain interventions being evaluated effectively?
   - No
   - Yes

7. Is the resident satisfied with the pain management plan?
   - No
   - Yes

8. Are residents with chronic pain educated on pain management?
   - No
   - Yes

9. Are residents with acute pain educated on pain management?
   - No
   - Yes

10. Are residents with chronic pain educated on pain control techniques?
    - No
    - Yes

11. Are residents with acute pain educated on pain control techniques?
    - No
    - Yes

12. Are residents with chronic pain educated on pain self-care?
    - No
    - Yes

13. Are residents with acute pain educated on pain self-care?
    - No
    - Yes
DEFINITION
PAIN: Any type of physical pain or discomfort in any part of the body. It may be localized to one area or may be more generalized. It may be acute or chronic, continuous or intermittent, or occur at rest or with movement. Pain is very subjective; pain is whatever the experiencing person says it is and exists whenever he or she says it does.

Steps for Assessment: Basic Interview Instructions for Pain Assessment
Interview (J0300–J0600): RAI Manual, pages 3-7 and 3-8
J0300 – J0600: Pain Interview
J0700: Should the Staff Assessment for Pain be Conducted?
J0800–J0850: Staff Assessment for Pain

Section J Other Health Conditions
J1100 Shortness of Breath, 7 day look-back, check all that apply
J1300 Current Tobacco Use, in any form
J1400 Prognosis, If the physician states that the resident’s life expectancy may be less than 6 months, request that he or she document this in the medical record. Do not code until there is documentation in the medical record.

Section J Problem Conditions
J1550:
A. Fever
B. Vomiting
C. Dehydrated (RUG III only)
D. Internal Bleeding (RUG III only)
Z. None of the above

Seven (7) day look-back period
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Section J Health Conditions

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

J1800 Falls since Admission/Entry (yes or no)

J1900 Number of Falls since Admission

Definition of a Fall:

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

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

An intercepted fall occurs when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person—this is still considered a fall.

It is important to ensure the accuracy of the level of injury resulting from a fall. Since injuries can present themselves later than the time of the fall, the assessor may need to look beyond the ARD to obtain the accurate information for the complete picture of the fall that occurs in the look back of the MDS.
Definition of Injury Related to a Fall:
Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

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

Coding Tip (RAI Manual, Chapter 3, page J-33)
If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to QIES ASAP, the assessment must be modified to update the level of injury that occurred with that fall.

J2000: Prior Surgery

Generally, major surgery for item J2000 refers to a procedure that meets the following criteria:
1. The resident was an inpatient in an acute care hospital for at least one day in the 100 days prior to admission to the skilled nursing facility (SNF), and
2. The surgery carried some degree of risk to the resident’s life or the potential for severe disability.

Examples:
1. Surgical removal of a skin tag from her neck a month and a half ago; the procedure was done as an outpatient.
2. Six months ago, a resident was admitted to the hospital for five days following a bowel resection (partial colectomy) for diverticulitis; no other surgeries since that time.
3. The resident was transferred to the facility immediately following a four-day acute care hospital stay related to dehiscence of a surgical wound subsequent to a complicated cholecystectomy. The attending physician also noted diagnoses of anxiety, diabetes, and morbid obesity in her medical record.
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Section L
Intent: This item is intended to record any dental problems present in the 7-day look-back period.

<table>
<thead>
<tr>
<th>D200: Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Missing upper right tooth, or partial dentures</td>
</tr>
<tr>
<td>3. Missing upper left tooth, or partial dentures</td>
</tr>
<tr>
<td>5. Missing upper middle tooth, or partial dentures</td>
</tr>
<tr>
<td>7. Missing upper front tooth, or partial dentures</td>
</tr>
<tr>
<td>9. Missing upper back tooth, or partial dentures</td>
</tr>
<tr>
<td>11. Difficulty eating due to dentures or partials</td>
</tr>
<tr>
<td>12. Difficulty speaking due to dentures or partials</td>
</tr>
<tr>
<td>13. Difficulty breathing due to dentures or partials</td>
</tr>
</tbody>
</table>

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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.

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Section H

H0100: Appliances

H0200: Urinary Toileting Program
  A: Trial of a toileting program?
  B: Response to trial
  C: Current toileting program or trial

H0300: Urinary Continence

H0400: Bowel Continence

H0500: Bowel Toileting Program

H0600: Bowel Patterns

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

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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.

Example:
Ms. J was diagnosed with estrogen receptor–positive breast cancer and was treated with chemotherapy and radiation. After her cancer treatment, Ms. J was prescribed tamoxifen (a selective estrogen receptor modulator) to decrease the risk of recurrence and/or decrease the growth rate of cancer cells. Since the hormonal agent is being administered to decrease the risk of cancer recurrence, it cannot be coded as chemotherapy.
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O0100F, Invasive Mechanical Ventilator (ventilator or respirator)

Code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become (such as during weaning attempts) unable to support his or her own respiration in this item.
During invasive mechanical ventilation the resident’s breathing is controlled by the ventilator. Residents receiving closed-system ventilation include those residents receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) or tracheostomy. A resident who has been weaned off of a respirator or ventilator in the last 14 days, or is currently being weaned off a respirator or ventilator, should also be coded here. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.

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

Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle.
The BiPAP/CPAP mask/device enables the individual to support his or her own spontaneous respiration by providing enough pressure when the individual inhales to keep his or her airways open, unlike ventilators that “breathe” for the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes his/her own BiPAP/CPAP mask/device.

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Section O Special Treatments, Procedures, and Programs

Influenza vaccine is contraindicated for a resident with severe reaction (e.g., respiratory distress) to a previous dose of influenza vaccine or to a vaccine component. Precautions for influenza vaccine include moderate to severe acute illness with or without fever (influenza vaccine can be administered after the acute illness) and history of Guillain-Barré Syndrome within six weeks after previous influenza vaccination.
Specific guidance about pneumococcal vaccine recommendations and timing for adults can be found at https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccinetiming.pdf.

Section O: Special Treatments, Procedures, and Programs

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

- **O0400D** Respiratory Therapy
  - Total minutes
  - Days therapy was administered at least 15 minutes

- **O0400E** Psychological Therapy
- **O0400F** Recreational Therapy

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

- 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
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.

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

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

**O0600 and O0700 Examination Days and Order Days Guidelines**

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

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

**Section P: Restraints and Alarms**

Intent: The intent of this section is to record the frequency that the resident was restrained by any of the listed devices at any time during the day or night, during the 7-day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definition in the appropriate categories.
Coding Tips for Alarms and Restraints:

- When coding this section, do not consider as a restraint a locked/secured unit or building in which the resident has the freedom to move about the locked/secured unit or building. Additional guidance regarding locked/secured units is provided in the section “Considerations Involving Secured/Locked Areas” of F603 in Appendix PP of the State Operations Manual.

- When an alarm is used as an intervention in the resident’s safety strategy, the effect the alarm has on the resident must be evaluated individually for that resident.

- When determining whether the use of an alarm also meets the criteria of a restraint, refer to the section “Determination of the Use of Position Change Alarms as Restraints” of F604 in Appendix PP of the State Operations Manual.
MDS 3.0 Training Day 1

Questions?

Forum call for Nursing Facilities
1st Thursday of the month in February, May, August and November, 1:00-2:00
Call the MDS Help Desk to register!

Reminder!

- This completes Day 1 of the MDS 3.0 training.
- Don’t forget to come back for part 2 of our exciting journey.

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

Contact Information:
- MDS Help Desk: 624-4019 or toll-free: 1-844-288-1612
  MDS3.0.DHHS@maine.gov
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  Suzanne.Pinette@maine.gov

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

Sue Pinette RN, RAC-CT
Case Mix Manager / State RAI Coordinator
Contact Information
207-287-3933

Maine Department of Health and Human Services

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