MDS 3.0 Training
Day 2

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October 2018

MDS 3.0 Training Agenda: Day 2
- Welcome and overview
- History
- Chapter 2
- Case Mix Implications
- Chapter 3 – Multi-Disciplinary Areas
  - Sections A, S, B, C, D, E
  - Sections F, K, Q, Z, V, X
  - RAI Manual Chapters 4, 5, and 6
- Questions and Wrap-up

Any questions, comments, need for additional discussion related to any topics discuss on Day 1?
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.
- CATS refers to MDS items that “trigger” certain 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 transfer is required.
**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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**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.

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

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

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

Chapter 3

Effective Oct 2018
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 (determines item set)

There are several subsections to A0310
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

Maine Department of Health and Human Services

Significant Change Criteria

A "significant change" is a decline or improvement in a resident's status that:
1. Will not usually resolve itself without intervention or change in care being provided
2. Could lead to harm to the resident
3. Requires interdisciplinary review and revision of the care plan

Maine Department of Health and Human Services

A0310A Hospice Benefit

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

Maine Department of Health and Human Services
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Significant Error

A *significant error* is an error in an assessment where:
1. The error is a serious deviation from the usual, expected, or required format or method. AND
2. The error is not connected to a violation of a specific code or rule.

Significant errors differ from a significant vaccination because a significant vaccination is a record error triggered by a significant event in the patient’s health status.

Assessment Scheduling

Section A: A0310B PPS Assessment

Includes scheduled and unscheduled assessments

PPS Assessment
- PPS Scheduled Assessments for a Medication Part A Stay
  - 3-day scheduled assessment
  - 14-day scheduled assessment
  - 30-day scheduled assessment
  - 60-day scheduled assessment
- PPS Unscheduled Assessments for a Medication Part A Stay
  - Unscheduled assessment used for PPS CINRN, significant or clinical event
  - Not PPS Assessment
  - None of the above
Scheduled Medicare PPS Assessments

The Medicare PPS require that the MDS be completed within the following timeframe:

- Day 1: Assessment Start Date
- Day 1: Review Date
- Day 1 to 14: Assessment End Date
- Day 15: Review Date

Medicare PPS Scheduled Assessments

- 5 days
- 14 days
- 30 days
- 60 days
- 90 days

Medicare PPS Unscheduled Assessments:

- Includes Other Medicare Required Assessment (OMRA), significant change, and significant correction

Coding Section A

A0310C PPS Other Medicare Required Assessment (OMRA)

Indicates whether the assessment is related to therapy services:

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
3. Part A PPS Discharge
Section A: A0310H SNF Part A PPS Discharge

Part A PPS Discharge Assessment:
- completed when a resident's Medicare Part A stay ends (A2400C), and the resident remains in the facility;
- may be combined with an OBRA Discharge (A0310F = 10) if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000). (Page A-7)

Discharge from facility and Part A:

Combined OBRA/Part A discharge MDS

If the End Date of the Most Recent Medicare Stay (A2400C) occurs on the day of or one day before the Discharge Date (A2000) of a planned discharge (A0310G=1), the OBRA Discharge assessment and Part A PPS Discharge assessment are both required and may be combined.

When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000).

If the resident is remaining in the facility:
- A0310F will be coded as ‘99’, as this is not an OBRA discharge →
- Therefore, A0310G will be skipped, as this is completed only if A0310F = 10 or 11 →
- A0310H will be coded ‘Yes’, for a Part A PPS discharge
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What if the resident doesn’t go home until the next day?

Complete a Medicare Part A Discharge assessment, and complete an OBRA Discharge assessment

- A0310F = 10 (discharge, return not anticipated)
- A0310H = 1 (Part A PPS Discharge)

- A2000 = A2400 +1
- A2300 = A2000 (ARD = discharge date)
- A2400 = last covered day

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OBRA Assessment
Schedule After Discharge Return
Anticipated

No new OBRA admission assessment required after re-admission from hospital. Submit entry tracking form and continue previously established OBRA schedule, or complete a significant change as appropriate.

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A0410. Unit Certification or Licensure Designation

- A0410: Unit Certification or Licensure Designation

- A0410A: Unit Certification or Licensure Designation

- A0410B: Unit Certification or Licensure Designation

- A0410C: Unit Certification or Licensure Designation

- A0410D: Unit Certification or Licensure Designation
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
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A1500 PASRR/ Medicaid

All individuals admitted to Medicaid certified NFs, regardless of payment source must have a Level I PASRR (Federal Requirement)

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
MDS 3.0 Training Day 2

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

Completed only if admission (01), Annual (03), significant change (04), or significant correction to prior comprehensive assessment (05)

Level II Conditions:
• Serious mental illness
• Intellectual disability
• Other related condition
Effective October 1, 2018, Maximus is now processing the assessments that were formerly done by KEPRO. The full name of Maximus is “Ascend Management Innovations.”

Maximus will perform the standardized assessments that determine eligibility and communicate service options to individuals seeking State-funded and MaineCare program Long Term Care (LTC) services. In addition, ASA assessors conduct Preadmission Screening and Resident Review (PASRR) assessments for individuals suspected of having a mental disorder, intellectual disability or other related condition to determine the Level of Care (LOC) services required.

MaineCare members can reach Maximus by phone at 833-525-5784 or email at askMaineasa@maximus.com.
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.

Medicare Stay End Date Algorithm RAI Manual, page A-37

Section S
This section is specific data requirements for the State of Maine only.

S0120 Residence Prior to Admission
Enter the zip code of the community address where the resident last resided prior to nursing facility admission.

[ ] [ ] [ ]
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S0170. Advanced Directive
A. Guardian
B. Durable power of attorney for health care
C. Living will
D. Do not resuscitate
E. Do not hospitalize
F. Do not intubate
G. Feeding instractions
H. Other treatment restrictions
I. None of the above

Maine Department of Health and Human Services

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S0510. PASRR Level I Screening
Was a PASRR Level I screening completed?
0. No → Skip to S0510, Weight-based Equipmen Needed
1. Yes → Continue to S0511 PASRR Date
9. Unknown → Skip to S0510, Weight-based Equipment Needed

Note the skip patterns

Maine Department of Health and Human Services

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

- - -
Year Month Day

Maine Department of Health and Human Services
S0513. PASRR Level I Screening Outcome

What was the outcome of the PASRR level I screening?

- Screen was sent to the MD/ID (or medical staff) for determination of need for Level II/Level III service
- Screen was sent to the MD/ID for determination of need for Level II/Level III service

S3300. Weight-based Equipment Need

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

- No
- Yes – Continue to S3305 Requirements for Weight

S3305. Requirements for Care, Specifically related to Weight

- A. Lifting tools, such as assistive, lift or special bed
- B. Weight-based equipment required
- C. Dietary or nutrition assessment (See ADRS or USDA-ARS)
- D. Other – (Specify)

Maine Department of Health and Human Services
S6022. Direct care by a Licensed Nurse

Enter a response for A, B, and C to indicate the number of days the resident required direct care described.

A. Number of days the resident required direct care by a licensed nurse on each shift,
   During the last 7 days or since admittance if less than 7 days.

B. Number of days the resident required direct care by a licensed nurse in 35 minute intervals,
   During the last 7 days or since admittance if less than 7 days.

C. Number of days the resident required direct care by a licensed nurse in 5-minute intervals,
   During the last 7 days or since admittance if less than 7 days.

S6023. Direct Care by a CNA

A. Number of days the resident required direct care by a CNA on each shift,
   During the last 7 days or since admittance if less than 7 days.

B. Number of days the resident required direct care by a CNA in 15-minute intervals,
   During the last 7 days or since admittance if less than 7 days.

C. Number of days the resident required direct care by a CNA in 5-minute intervals,
   During the last 7 days or since admittance if less than 7 days.
S6024. Direct Care by a Respiratory Therapist

1. Number of days the resident required direct care by a licensed respiratory therapist on an hourly basis. Indicate “3” if care occurred in a facility that is not a nursing facility.

2. Number of days the resident required direct care by a licensed respiratory therapist in 15-minute intervals. Indicate “3” if care occurred in a facility that is not a nursing facility.

3. Number of days the resident required direct care by a licensed respiratory therapist in 30-minute intervals. Indicate “3” if care occurred in a facility that is not a nursing facility.

Resident Stays

S8010 Payment Source – To determine payment source that covers the daily per diem or ancillary services for the resident’s stay in the nursing facility, as of the ARD date.

- C3 – MaineCare per diem. Do not check if MaineCare is pending
- G3 MaineCare pays Medicare or insurance Co-pay
- S8099 None of the above
### S8510. MaineCare Therapeutic Leave Days

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Therapeutic leave day where resident is not admitted to hospital</td>
</tr>
</tbody>
</table>

*MaineCare Therapeutic Leave Days refers to:

- Temporary home visit
- Temporary therapeutic leave
- Hospital observation stay of less than 24h

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**Leave of Absence, or LOA, refers to:**

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

### S8512. MaineCare Hospital Bed-Hold Days

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Hospital bed held for diagnostic and treatment purposes</td>
</tr>
<tr>
<td>B</td>
<td>Hospital bed held due to medical necessity</td>
</tr>
</tbody>
</table>

*MaineCare Hospital Bed-Hold Days refer to:

- Hospital bed held for diagnostic and treatment purposes
- Hospital bed held due to medical necessity
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

Coding Tips and Special Populations

• This item cannot be coded as Rarely/Never Understood if the resident completed any of the resident interviews, as the interviews are conducted during the look-back period for this item and should be factored in when determining the residents' ability to make self understood during the entire 7-day look-back period.

• While B0700 and the resident interview items are not directly dependent upon one another, inconsistencies in coding among these items should be evaluated.
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.

Steps for Assessment
1. Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.

2. Determine if the resident is rarely/never understood verbally, in writing, or using another method.

Coding Instructions
Code 0, no: if the interview should not be conducted because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available.

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

Coding Tips
• Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.

• If the resident interview was not conducted within the look-back period (preferably the day before or the day of the ARD), item C0100 must be coded 1, Yes, and the standard “no information” code (a dash “-”) entered in the resident interview items.

• Do not complete the Staff Assessment for Mental Status items (C0700-C1000) if the resident interview should have been conducted, but was not done.
Section C

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

Sock  Blue  Bed

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

DEFINITIONS

**DELIRIUM**
A mental disturbance characterized by a rapidly worsening confusion, disorientation, disorganization, agitation, and change in level of consciousness.

**DISORGANIZED THINKING**
Exaggerated by speaking, imposter, or incoherent speech.

**ALTERED LEVEL OF CONSCIOUSNESS**
VIGILANT - alert and able to respond to verbal or written commands.
LETHARGIC - unable to answer simple, written or verbal commands.
STUPOR - unable to answer questions, but may follow simple commands.
COMATOSE - unable to follow commands.

DEFINITION

**FLUCTUATION**
The state of a patient's condition and the change over a short period of time, fluctuating between stable and unstable.
Intent: The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable.

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. Case mix nurses check for timely completion according to Z0400.
Steps for Assessment

1. Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.

2. Determine if the resident is rarely/never understood verbally, in writing, or using another method.

Coding Instructions

Code 0, no: if the interview should not be conducted because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed, but not available.

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

MDS 3.0 Changes
Effective 10/1/18

Coding Tips

• Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.

• If the resident interview was not conducted within the look-back period (preferably the day before or the day of the ARD), item D0100 must be coded 1, Yes, and the standard "no information" code (a dash "-" ) entered in the resident interview items.

• Do not complete the Staff Assessment for Resident Mood items (D0500) if the resident interview should have been conducted, but was not done.
Section D
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.
Section E: E0800 and E0900

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

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.

Steps for Assessment

1. Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.
2. Determine if the resident is rarely/never understood verbally, in writing, or using another method. If the resident is rarely or never understood, attempt to conduct the interview with a family member or significant other.
3. If resident is rarely/never understood and a family member or significant other is not available, skip to item F0800, Staff Assessment of Daily and Activity Preferences.

Code 0 = no
Code 1 = yes
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

K0530: Approaches
A. Parenteral / IV Feeding
B. Feeding Tube
C. Mechanically Altered Diet
D. Therapeutic Diet
E. 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

K0710 Percent Intake by Artificial Route

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

1. 0-25%
2. 26-50%
3. 51% or more

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

1. 300 cal/day or less
2. 301-500 cal/day or more

K0710B.3 is a payment item

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

If the resident had more substantial oral intake than this, consult with the dietician.
K0710B Average Fluid Intake per Day by IV or Tube Feeding

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

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

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

Section 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 483.21 (c)(1)). This is also a civil right for all residents. 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.

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 talking to someone about the possibility of leaving the facility and returning to live and receive services in the community.
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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.)

Q0550B, what is the source of the information?

1. Resident
2. Most resident, then family or significant other
3. Most resident, then legal representative, then guardian or legally authorized representative
4. None of the above

Who is the Local Contact Agency for Maine?

Long Term Care Ombudsman Program

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Section Z

Assessment Administration

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

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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Z0400 Attestation Statement  

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.  

Z0500 Assessment Complete  

“Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete”  

“Verify that all items on this assessment or tracking record are complete.”  

“Verify that Item Z0400 contains attestation for all MDS sections”  

“... use the actual date that the MDS was completed, reviewed and signed as complete by the RN assessment coordinator (generally later than the date(s) at Z0400)…”  

“... If for some reason the MDS cannot be signed by the RN assessment coordinator on the date it is completed, the RN assessment coordinator should use the actual date that it is signed.”
This chapter provides information about the Care Area Assessments (CAAs), Care Area Triggers (CATs), and the process for care plan development for nursing home residents.

Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs, in relation to a number of specified areas (e.g., customary routine, vision, and continence). The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive plan of care.

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

CAAs are not required for Medicare PPS assessments. They are required only for OBRA comprehensive assessments (Admission, Annual, Significant Change in Status, or Significant Correction of a Prior Comprehensive). However, when a Medicare PPS assessment is combined with an OBRA comprehensive assessment, the CAAs must be completed in order to meet the requirements of the OBRA comprehensive assessment.

Table 1. Care Area Assessments in the Resident Assessment Instrument, Version 3.0

<table>
<thead>
<tr>
<th>No.</th>
<th>CAAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Orientation</td>
</tr>
<tr>
<td>2</td>
<td>Cognitive Loss/Dementia</td>
</tr>
<tr>
<td>3</td>
<td>Visual Problem</td>
</tr>
<tr>
<td>4</td>
<td>Communication</td>
</tr>
<tr>
<td>5</td>
<td>Anxiety/Grief (or Clinical Depression)</td>
</tr>
<tr>
<td>6</td>
<td>Incontinence and/or Urinary Retention</td>
</tr>
<tr>
<td>7</td>
<td>Eye Vision and/or Hearing</td>
</tr>
<tr>
<td>8</td>
<td>Mood/Pace</td>
</tr>
<tr>
<td>9</td>
<td>Behavioral Aggressiveness</td>
</tr>
<tr>
<td>10</td>
<td>swallow</td>
</tr>
<tr>
<td>11</td>
<td>Incontinence of Stool</td>
</tr>
<tr>
<td>12</td>
<td>Incontinence of Urine</td>
</tr>
<tr>
<td>13</td>
<td>Falling</td>
</tr>
<tr>
<td>14</td>
<td>Dizziness/Unsteady Gait</td>
</tr>
<tr>
<td>15</td>
<td>Sleep/Fatigue</td>
</tr>
<tr>
<td>16</td>
<td>Pressure Ulcer</td>
</tr>
<tr>
<td>17</td>
<td>Psychotropic Medication Use</td>
</tr>
<tr>
<td>18</td>
<td>Physical Restraint</td>
</tr>
<tr>
<td>19</td>
<td>Falls</td>
</tr>
<tr>
<td>20</td>
<td>Return to Community Referral</td>
</tr>
</tbody>
</table>
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

Updates to Review of Indicators

- CAAs:
  - Delirium
  - Visual function
  - Communication
  - Activities of Daily living
  - Incontinence
  - Mood State
  - Falls
  - Dental Care
  - Pressure Ulcer/Injury
Factors that can cause or exacerbate the behavior (from observation, interview, record)

- Alarm Use (P0200) (has been added as a trigger)

14. Dehydration/Fluid Maintenance
Diseases and conditions that predispose to limitations in maintaining normal fluid balance
- Malnutrition (I5600) has been added as a trigger

16. Pressure Ulcer/Injury(s)
Diagnoses and conditions that present complications or increase risk for pressure ulcer/injury
- Alarm use (P0200)
- Terminal condition (J1400) has been added as a trigger

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.

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
6.2 Using the MDS in the Medicare PPS System
6.3 Resource Utilization Groups (RUG) IV
6.4 Relationship Between the Assessment and the Claim
6.5 SNF PPS Eligibility Criteria
6.6 RUG IV Calculation Worksheets
6.7 SNF PPS Policies
6.8 Non-compliance with the SNF PPS Assessment Schedule

SNF-QRP: two handouts available in the lower right corner:

Technical Specs for Reporting Assessment-Based Measures for FY2019: Items Necessary to Calculate the Measures (shows the impact of a dash on certain items in Sections GG, J, M)

And

Overview of Data Elements Used for Reporting Assessment-Based Quality Measures Affecting FY2020 Annual Payment Update Determination.
MDS 3.0 Training Day 2

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!

Reminders!

• This completes Day 2 of the MDS 3.0 training. Thank you for attending.
• Ask questions!
• Ask more question!!
• Use your resources (other MDS coordinators, case mix staff, MDS Help Desk, Forum Calls etc.)
• Attend training as often as you need.

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
• Lois Bourque, RN 592-5909
  Lois.Bourque@maine.gov
• Darlene Scott-Rairdon, RN 215-4797
  Darlene.Scott@maine.gov
• Maxima Corriveau, RN 215-3589
  Maxima.Corriveau@maine.gov
• Deb Poland, RN 215-9675
  Debra.Poland@maine.gov
• Sue Pinette, RN 287-3933 or 215-4504 (cell)
  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