


MDS 3.0 Training
Day 2

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October 2018



MDS 3.0 Training
Day 2

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

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Any questions, comments, need for additional discussion related to any topics discuss on Day 1?

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Case Mix Implications for MDS 3.0

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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

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MaineCare Case Mix

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

PPS / Medicare uses RUG IV codes

Supporting Documentation for Case Mix payment items is required

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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



Visit the portal at:
www.Maine.gov/dhhs/dlrs/mds/training/index.shtml

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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.

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**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.

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**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..

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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

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

Chapter 3

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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.

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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

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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

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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

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Significant Change Criteria

A "significant change" is a decline or improvement in a resident's status that:

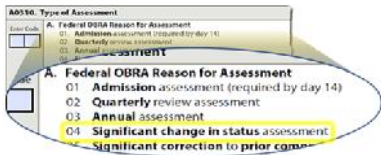
1. Will not normally resolve itself without intervention by staff or by implementing standard/disease-related clinical interventions, is not "self-limiting" (for declines only);
2. Impacts more than one area of the resident's health status; and
3. Requires interdisciplinary review and/or revision of the care plan.

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A0310A Hospice Benefit

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



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Significant Error

A "significant error" is an error in an assessment where:

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

A significant error differs from a significant change because it reflects incorrect coding of the MDS and NCI an actual significant change in the resident's health status

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Assessment Scheduling

Assessment Type	Assessment Schedule	Assessment Period	Assessment Frequency	Assessment Method	Assessment Location	Assessment Time	Assessment Duration	Assessment Staff	Assessment Cost	Assessment Notes
Initial (New Admissions)	ADMITTED	ADMITTED	ADMITTED	ADMITTED	ADMITTED	ADMITTED	ADMITTED	ADMITTED	ADMITTED	ADMITTED
Annual (Renewals)	ADMITTED	ADMITTED	ADMITTED	ADMITTED	ADMITTED	ADMITTED	ADMITTED	ADMITTED	ADMITTED	ADMITTED
Specialty (Specialty)	ADMITTED	ADMITTED	ADMITTED	ADMITTED	ADMITTED	ADMITTED	ADMITTED	ADMITTED	ADMITTED	ADMITTED

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Section A: A0310B PPS Assessment

Includes scheduled and unscheduled assessments

PPS Assessment

PPS Scheduled Assessments for a Medicare Part A Stay ←

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

PPS Unscheduled Assessments for a Medicare Part A Stay ←

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

Not PPS Assessment ←

99. None of the above

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Scheduled Medicare PPS Assessments

The SNF provider must complete the Medicare-required assessments according to the following schedule to assure compliance with the SNF PPS requirements.

Medicare MDS Scheduled Assessment Type	Reason for Assessment (A0310B code)	Assessment Reference Date	Assessment Reference Date Grace Days*	Applicable Standard Medicare Payment Days ¹
5-day	01	Days 1-5	6-8	1 through 11
14-day	02	Days 13-14	15-18	15 through 30
30-day	03	Days 27-29	30-33	31 through 60
60-day	04	Days 57-59	60-63	61 through 90
90-day	05	Days 87-89	90-93	91 through 100

*Grace Days: a specific number of days that can be added to the ARD window without penalty.

See RAI Manual page 2-43 for more information about use of grace days and Medicare payment days.

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Medicare PPS Assessments

5 day

14 day

30 day

60 day

90 day

Start of Therapy (SOT)

End of Therapy (EOT)

Both Start and End of Therapy

Change of Therapy (COT)

PPS Scheduled Assessments for a Medicare Part A Stay
RAI Manual, pages 2-49 to 2-50

PPS Unscheduled Assessments:
includes Other Medicare Required Assessment (OMRA), significant change and significant correction
RAI Manual, pages 2-50 to 2-58

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Coding Section A

A0310C PPS Other Medicare Required Assessment (OMRA)

Indicates whether the assessment is related to therapy services

Complete this item for *all* assessments:

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

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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

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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

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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

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Section A: A0310H SNF Part A PPS Discharge

H. Is this a SNF Part A PPS Discharge Assessment?
 0. No
 1. Yes

Part A PPS Discharge Assessment :

- completed when a resident's *Medicare Part A stay ends (A2400C)*, and the resident remains in the facility;
- or
- 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)

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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).*

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If the resident is remaining in the facility:

F. 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**

G. Type of discharge - Complete only if A0310F = 10 or 11

- 1. **Planned**
- 2. Unplanned

H. Is this a SNF Part A PPS Discharge Assessment?

- 0. No
- 1. **Yes**

- 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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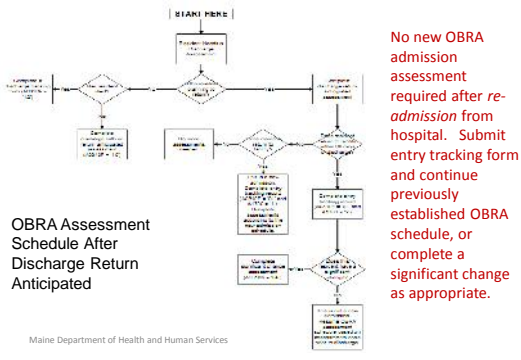
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What if the resident doesn't go home until the next day?

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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A0410. Unit Certification or Licensure Designation

A0410. Unit Certification or Licensure Designation

Fees (Y/N)

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

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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

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Section A
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

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Section A
A1510- Level II 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

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

A1550. Conditions Related to ID/DD Status
 If the resident is 22 years of age or older, complete only if AG310A = 01
 If the resident is 21 years of age or younger, complete only if AG310A = 01, 03, 04, or 05

↓ **Check all conditions that are related to ID/DD status that were manifested before age 21, and are likely to continue indefinitely.**

ID/DD With Organic Condition

A. Dementia syndrome

B. Autism

C. Epilepsy

D. Other organic condition related to ID/DD

ID/DD Without Organic Condition

E. ID/DD with no organic condition

No ID/DD

F. None of the above

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PASRR

<https://www.ascendami.com/ami/Providers/YourState/MaineASAUserTools.aspx>

MAXIMUS

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 LOC services required.

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

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A1600-A1800 Most Recent Admission/Entry or Reentry to the facility

A1900 Admission Date

A2000 Discharge Date

A2100 Discharge Status

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Section A
A2300 Assessment Reference Date (ARD)

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

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A2400

A2400. Medicare Stay

Has the resident had a Medicare-covered stay since the most recent entry?

E. No → 99 (to 83133) Continues

F. Yes → Continue to 22/230 Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

Month: Day: Year:

C. End date of most recent Medicare stay (Date dashed if stay is ongoing)

Month: Day: Year:

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

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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 restrictions
- H. Other treatment restrictions
- Z. None of the above

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S0510. PASRR Level I Screening

Was a PASRR Level I screening completed?

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

Note the skip patterns

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

Year **Month** **Day**

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S0513. PASRR Level I Screening Outcome

What was the outcome of the PASRR Level I screen?

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

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S3300. Weight-based Equipment Need

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

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

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S3305. Requirements for Care, Specifically related to Weight

- A. **Lifting device.** Since last assessment, was a specialized lifting device required?
- B. **Wheel chair or mobility device.** Since last assessment, was an oversized, non-standard wheelchair or other mobility device required?
- C. **Bed.** Since last assessment, was a specialized, non-standard bed required?
- D. **Seating.** Since last assessment, was a specialized, non-standard seat required?
- E. **More than 2 staff.** Since last assessment, was 3 or more staff required to provide assistance with ADL?
- F. **Other.** Since last assessment, was other specialized, non-standard equipment required? _____

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

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

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

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

D. **Equipment.** Resident needs specialized equipment.

Y. **Other.** Resident has other needs.

Z. **None of the above**

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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 an hourly basis.**
During the last 7 days or since admission/entry or reentry.

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

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

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S6023. Direct Care by a CNA

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

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

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

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S6024. Direct Care by a Respiratory Therapist

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

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

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

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Resident Stays

S6200. Hospital Stays
Record the number of times resident has been admitted to a hospital for an overnight stay in the last 90 days (or since last assessment if less than 90 days).

S6205. Observation Stays
Record number of times resident had at least one overnight stay without being admitted to the hospital since the last assessment.

S6210. Emergency Room (ER) Visits
Record number of times resident visited ER without an overnight stay in the last 90 days (or since last assessment if less than 90 days).

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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

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S8510. MaineCare Therapeutic Leave Days

S8510. MaineCare Therapeutic Leave Days

From Review **A. MaineCare therapeutic leave days since last assessment.** Enter the number of therapeutic leave days paid by MaineCare since the last assessment.

From Review **B. MaineCare therapeutic leave days state fiscal year-to-date.** Enter the number of therapeutic leave days paid by MaineCare state fiscal year-to-date.

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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

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S8512. MaineCare Hospital Bed-Hold Days

S8512. MaineCare Hospital Bed-Hold Days

From Review **A. MaineCare hospital bed-hold days since last assessment.** Enter the number of hospital bed-hold days paid by MaineCare since the last assessment.

From Review **B. MaineCare hospital bed-hold days state fiscal year-to-date.** Enter the number of hospital bed-hold days paid by MaineCare's state fiscal year-to-date.

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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.

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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

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Section B

B0700, page B-7: 4. Consult with the primary nurse assistants (over all shifts), and the resident's family, and speech-language pathologist.

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.

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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.

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Section C

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.

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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.

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Section C


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



Sock



Blue



Bed

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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

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<p>DEFINITION</p> <p>DELIRIUM A mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness or hallucinations.</p>	<p>DEFINITIONS</p> <p>INATTENTION Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Resident seems unaware or out of touch with environment (e.g., dazed, fixated or starting attention).</p> <p>FLUCTUATION The behavior tends to come and go and/or increase or decrease in severity. The behavior may fluctuate over the course of the interview or during the 7-day look-back period. Fluctuating behavior may be noted by the interviewer, reported by staff or family or documented in the medical record.</p>	<p>DEFINITIONS</p> <p>ALTERED LEVEL OF CONSCIOUSNESS VIGILANT – startles easily to any sound or touch; LETHARGIC – repeatedly dozes off when you are asking questions, but responds to voice or touch; STUPOR – very difficult to arouse and keep aroused for the interview; COMATOSE – cannot be aroused despite shaking and shouting.</p>
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C1310 Signs and Symptoms of Delirium

Delirium	
C1310. Signs and Symptoms of Delirium (From C/Ms)	
Code after completing Brief Interview for Mental Status or Staff Assessment and reviewing medical record.	
A. Acute Onset Mental Status Change	
Is there evidence of an acute change in mental status from the resident's baseline?	
<input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	
Enter Codes in Boxes	
Coding: 0. Behavior not present 1. Behavior consistently present, does not fluctuate 2. Behavior present, fluctuates (sometimes goes, changes in severity)	<input type="checkbox"/> B. Inattention - Did the resident have difficulty focusing attention, for example being easily distracted, or having difficulty keeping track of what was being said? <input type="checkbox"/> C. Disorganized thinking - Was the resident's thinking disorganized or illogical? (rambling or incoherent conversation, unclear or illogical flow of ideas, or unrelated ideas switching from a subject to subject?) <input type="checkbox"/> D. Altered level of consciousness - Did the resident have altered level of consciousness associated by any of the following events? • vigilant - started early to any sounds or touch • irritable - irritable or hostile when being approached or touched, and resistant to care or touch • inapparent - very difficult to wake and/or respond for the interview • comatose - could not be aroused

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Section D
Mood

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

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Day 2

Section D

D0100: Should Resident Mood Interview Be Conducted?

If yes...
D0200 (Resident Interview – PHQ9[®])
 Enter the frequency of symptoms for Column 2, Items A through I

Requires no further supporting documentation. Case mix nurses check for *timely completion* according to Z0400.

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MDS 3.0 Changes Effective 10/1/18

Section D

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.

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Section D

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.

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Section D D0200

D0200a. Resident Mood Interview (RMI) 9-1
 "Over the last 7 months, have you been bothered by any of the following problems?"

Performance is poorer than usual. 1. Symptoms Present 2. Symptoms Frequency

1. No or rarely bothered 2. Rarely 3. Sometimes 4. Often 5. Always

	1. Symptoms Present	2. Symptoms Frequency	1. Symptoms Present	2. Symptoms Frequency
A. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeling tired, exhausted, or sluggish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Trouble getting going in the morning or staying awake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Feeling restless or restless energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Feeling sad or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Feeling like a failure, guilty, or that you are a failure or have let your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Trouble concentrating, remembering things, or making decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Thinking or worrying too much about other people or the future. Have you made plans to "kill" or hurt yourself or have been having thoughts like this?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Thinking that you would do better off dead, or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Section D D0300

D0300 Total Severity Score

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

Total score must be between 00 and 27

MDS 3.0 Training Day 2

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

MDS 3.0 Training Day 2

D0600 - Staff Assessment of Resident Mood (MDS 3.0)
 Determine and document how frequently the resident has depression.
 Over the last 2 weeks, did the resident have any of the following problems or behaviors?
 If you check "often" or "always" for any of the following items, you must check "often" or "always" for item 1. Symptoms frequency.
 The first 3 columns (1, Symptoms frequency, and 2, Symptoms frequency) must be checked.

	1. Symptoms Frequency	2. Symptoms Frequency	3. Symptoms Frequency
A. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeling or appearing down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Things that usually bring you pleasure or a sense of accomplishment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Feeling guilty about not eating well, too much, or too little or about doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Moving or speaking so slowly that other people have noticed, or the opposite - being so busy or restless that others have noticed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Notice that you're either too restless or too tired to be usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Thinking about harming yourself or others, or thoughts of harming self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Other (do not check unless you are sure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D0600 = Total Severity Score (Enter score of 00 to 30)
D0650 = safety notification if there is a possibility of resident self harm

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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.

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BEHAVIORAL SYMPTOMS

Payment Items

- E0100A** Hallucinations
- E0100B** Delusions

- E0200A** Physical behaviors
- E0200B** Verbal behaviors
- E0200C** Other behaviors

- E0800** Rejection of care

- E0900** Wandering

E0100. Potential indicators of Psychosis

Check all that apply

1. Hallucinations (perceptions or sensations that occur in the absence of any external sensory stimulus)

2. Delusions (fixed beliefs or ideas that are not based on reality)

3. None of the above

E0200. Behavioral Symptom - Presence & Frequency

Code:

1. Behavior not exhibited

2. Behavior of this type occurred 1 to 3 days

3. Behavior of this type occurred 4 to 6 days

4. Behavior of this type occurred daily

Enter Codes in Boxes

A. Physical behavioral symptoms directed toward others (i.e., hitting, kicking, etc.)

B. Verbal behavioral symptoms directed toward others (i.e., shouting, screaming, cursing, etc.)

C. Other behavioral symptoms not included toward others (i.e., physical symptoms such as hitting or scratching self, pulling or tearing at clothing, etc.)

E0800. Rejection of Care - Presence & Frequency

1. Behavior not exhibited

2. Behavior of this type occurred 1 to 3 days

3. Behavior of this type occurred 4 to 6 days

4. Behavior of this type occurred daily

E0900. Wandering - Presence & Frequency

1. Behavior not exhibited

2. Behavior of this type occurred 1 to 3 days

3. Behavior of this type occurred 4 to 6 days

4. Behavior of this type occurred daily

MDS 3.0 Training Day 2

Section E: E0200

E0200. Behavioral Symptom - Presence & Frequency

Note presence of symptoms and their frequency

Code:

1. Behavior not exhibited

2. Behavior of this type occurred 1 to 3 days

3. Behavior of this type occurred 4 to 6 days

4. Behavior of this type occurred daily

Enter Codes in Boxes

A. Physical behavioral symptoms directed toward others (i.e., hitting, kicking, etc.)

B. Verbal behavioral symptoms directed toward others (i.e., shouting, screaming, cursing, etc.)

C. Other behavioral symptoms not included toward others (i.e., physical symptoms such as hitting or scratching self, pulling or tearing at clothing, etc.)

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

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Day 2

Section E: E0800 and E0900

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

Has the resident wandered?

0. Behavior not exhibited → Skip to E1100, Change in Behavioral or Other Symptoms

1. Behavior of this type occurred 1 to 3 days

2. Behavior of this type occurred 4 to 6 days, but less than daily

3. Behavior of this type occurred daily

E1000: Wandering – Impact
E1000A Risk to Self
E1000B Intrusion on others

E1100: Change in Behavior or Other Symptoms

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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.

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Section F

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

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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.

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Section K: Weight Loss/Gain

K0100: Swallowing disorder
K0200: Height and Weight
K0300: Weight Loss
K0310: Weight gain

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Section K - Nutritional Approaches

K0510: Approaches
A. Parenteral / IV Feeding
B. Feeding Tube
C. Mechanically Altered Diet
D. Therapeutic Diet
Z. None of the above

MDS 10. Nutritional Approaches
Check all of the following nutritional approaches that were performed during the last 7 days:

	1. While NOT a Resident	2. While a Resident
1. While NOT a resident <small>For use only while NOT a resident of this facility and within the last 7 days. Only check column 1 if resident received care and/or received care (e.g., IV, tube feeding, etc.) while not a resident. Do not check this column if resident is a resident.</small>	<input type="checkbox"/>	<input type="checkbox"/>
2. While a Resident <small>For use only while a resident of this facility and within the last 7 days.</small>	↓ Check all that apply ↓	
A. Parenteral/IV feeding	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeding tube - nasogastric or abdominal (PEG)	<input type="checkbox"/>	<input type="checkbox"/>
C. Mechanically altered diet - requires change in texture of food or liquids (e.g., pureed food, thickened liquids)	<input type="checkbox"/>	<input type="checkbox"/>
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>
Z. None of the above	<input type="checkbox"/>	<input type="checkbox"/>

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K0510: Nutritional Approaches
 Check all of the following nutritional approaches that were performed during the last 7 days

	1. While NOT a Resident	2. While a Resident
1. While NOT a Resident Permitted while NOT a resident of this facility and within the last 7 days. Only check column 1 if resident entered facility on resident/PT or labor orders. If resident had medical or nursing orders, leave column 1 blank.	<input type="checkbox"/>	<input type="checkbox"/>
2. While a Resident Permitted while a resident of this facility and within the last 7 days	Check all that apply ↓	
A. Parenteral/IV feeding	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeding tube - nasogastric or abdominal (PEG)	<input type="checkbox"/>	<input type="checkbox"/>
C. Mechanically altered diet - regular choice in texture of foods or liquids (e.g., pureed, thickened, liquid)	<input type="checkbox"/>	<input type="checkbox"/>
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)	<input type="checkbox"/>	<input type="checkbox"/>
Z. None of the above	<input type="checkbox"/>	<input type="checkbox"/>

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K0510 Assessment Guidelines

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

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

RAI Manual pages K-10 through K-12

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K0710 Percent Intake by Artificial Route

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

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

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

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

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.*

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K0710B Average Fluid Intake per Day by IV or Tube Feeding

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

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

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

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K0710. Percent Intake by Artificial Route

Code (column 3) is only if column 1 and/or column 2 are checked for K0710A and/or K0710B.

	1. While NOT a Resident	2. While a Resident	3. During Entire 7 Days
A. Proportion of total calories the resident received through parenteral or tube feeding			
1. 25% or less	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. 26-50%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. 51% or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Average fluid intake per day by IV or tube feeding			
1. 500 cc/day or less	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. 501 cc/day or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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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.

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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.

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Section Q - Participation in Assessment and Goal Setting

Q0300 Residents Overall Expectation

- Overall expectations
- Information source

Q0400 Discharge Plan

Q0490 Preference to Avoid Being Asked
Question Q0500B

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Day 2

Section Q - Participation in Assessment and Goal Setting

Q0500B Return to Community

Q0500. Return to Community

B. Ask the resident, or family or significant other, or resident or legally authorized representative if resident is unable to understand or respond: "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"

C. No
1. Yes
5. Unknown or uncertain

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

B. Indicate information source for Q0550A

1. Resident
2. If not resident, then family or significant other
3. If not resident, family or significant other, then guardian or legally authorized representative
9. None of the above

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Section Q - Participation in Assessment and Goal Setting

Q0600. Referral

Order Code **Has a referral been made to the Local Contact Agency?** (Document reasons in resident's clinical record)

0. No - referral not needed
1. No - referral is or may be needed (For more information see Appendix C, Care Area Assessment: Resources #20)
2. Yes - referral made

Who is the Local Contact Agency for Maine?

Long Term Care Ombudsman Program

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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.

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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

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.

Signature	Title	Signature	Date/Section Completed

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.

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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.

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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.

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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.**"

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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

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Section V: Care Area Assessment Summary

V0200: CAA and Care Planning

1. This is a summary of the findings of the assessment.

2. The underlying purpose of this summary is to provide a clear, concise, and accurate summary of the findings of the assessment to the care team.

3. The summary should be written in a clear, concise, and accurate manner.

4. The summary should be written in a clear, concise, and accurate manner.

5. The summary should be written in a clear, concise, and accurate manner.

6. The summary should be written in a clear, concise, and accurate manner.

7. The summary should be written in a clear, concise, and accurate manner.

8. The summary should be written in a clear, concise, and accurate manner.

9. The summary should be written in a clear, concise, and accurate manner.

10. The summary should be written in a clear, concise, and accurate manner.

Care Area	A. Assessment Triggered	B. Care Plan Decision	C. Care Plan Decision	Documentation Date of CAA Decision/Update
01. Delirium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
02. Communication/Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
03. Vision/Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
04. Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
05. ADL, Personal Hygiene/Personal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
06. Mobility/Transfer and Ambulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
07. Psychosocial Well-Being	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
08. Mood State	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
09. Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Falls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Pressure Ulcer/Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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Updates to Review of Indicators

- CAAs:
 - Delirium
 - Visual function
 - Communication
 - Activities of Daily living
 - Incontinence
 - Mood State
 - Falls
 - Dental Care
 - Pressure Ulcer/Injury

The use of opioids has been added as a consideration to each of these Care Area Assessments

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MDS 3.0 Training Day 2

9 BEHAVIORAL SYMPTOMS

Review of Individuals of Behavioral Symptoms

<p>Section 9 is for individuals who exhibit behaviors that are disruptive to the care of others or to the safety of the individual or others. It includes individuals who are violent, aggressive, or who engage in self-harm or suicidal ideation.</p> <p>Section 9 is for individuals who exhibit behaviors that are disruptive to the care of others or to the safety of the individual or others. It includes individuals who are violent, aggressive, or who engage in self-harm or suicidal ideation.</p>	<p>Section 9 is for individuals who exhibit behaviors that are disruptive to the care of others or to the safety of the individual or others. It includes individuals who are violent, aggressive, or who engage in self-harm or suicidal ideation.</p> <p>Section 9 is for individuals who exhibit behaviors that are disruptive to the care of others or to the safety of the individual or others. It includes individuals who are violent, aggressive, or who engage in self-harm or suicidal ideation.</p>	<p>Section 9 is for individuals who exhibit behaviors that are disruptive to the care of others or to the safety of the individual or others. It includes individuals who are violent, aggressive, or who engage in self-harm or suicidal ideation.</p> <p>Section 9 is for individuals who exhibit behaviors that are disruptive to the care of others or to the safety of the individual or others. It includes individuals who are violent, aggressive, or who engage in self-harm or suicidal ideation.</p>
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Factors that can cause or exacerbate the behavior (from observation, interview, record)

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

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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) ← has been added as a trigger
- Terminal condition (J1400)

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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.

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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

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Day 2

Section X: Correction Request

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

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Day 2

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.

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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

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Section X: Correction Request

- X0800 Correction number
- X0900 Reasons for Modification
- X1050 Reasons for Inactivation
- X1100 Name, Title, Signature, Attestation Date

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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

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RAI Manual Chapter 6
Medicare Skilled Nursing Facility
Prospective Payment System (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

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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.

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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!

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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.

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Case Mix Team
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/

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Questions?

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



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