MDS-RCA Training: Mini-Series #3

Case Mix Team
October 2020

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MDS-RCA Training

MDS-RCA Training: Agenda

- Follow up from Session #1 and #2
- Section E
- Section J
- Section M
- Section P
- Section S - again
- Corrections
- Validation Reports - again
- Documentation requirements

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Questions??

From Mini-Series #1 or #2?

Other questions you want to make sure get answered?

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MDS-RCA Assessment Tool

Sections E, J, M, P and S

Means payment item

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Section E

Mood distress is a serious condition and is associated with declines in health and functional status. Associated factors include poor adjustment to the facility, functional impairment, resistance to daily care, inability to participate in or withdrawal from activities, isolation, increased risk of medical illness, cognitive impairment, and an increased sensitivity to physical pain. It is particularly important to identify signs and symptoms of mood distress among elderly residents because they are very treatable.

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28 day look back

SECTION E. MOOD and BEHAVIOR PATTERNS

1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	*(CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause)* 0. Not exhibited in last 30 days 1. This type of behavior exhibited up to 5 days a week (a minimum of 4 times per month). 2. This type of behavior exhibited daily or almost daily (6, 7 days/week)
		VERBAL EXPRESSIONS OF DISTRESS ___ a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die." ___ b. Repetitive questions—e.g., "Where do I go; What do I do?" ___ c. Repetitive verbalizations—e.g., calling out for help, ("God help me") ___ d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in facility; anger at care received ___ e. Self deprecation—e.g.,"I am nothing; I am of no use to anyone" ___ f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others ___ g. Recurrent statements that something terrible is about to happen —e.g., believes he or she is about to die, have a heart attack ___ h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions ___ i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues *(continued next page)*

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Section E: Mood and Behavior Patterns (cont.)

1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	*(CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause)* 0. Not exhibited in last 30 days 1. This type of behavior exhibited up to 5 days a week (a minimum of 4 times per month). 2. This type of behavior exhibited daily or almost daily (6, 7 days/week)
		SLEEP-CYCLE ISSUES ___ j. Unpleasant mood in morning ___ k. Insomnia/change in usual sleep pattern
		SAD, APATHETIC, ANXIOUS APPEARANCE ___ l. Sad, pained, worried facial expressions—e.g., furrowed brows ___ m. Crying, tearfulness ___ n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking
		LOSS OF INTEREST ___ o. Withdrawal from activities of interest—e.g., no interest in long-standing activities or being with family/friends ___ p. Reduced social interaction
		INDICATORS OF MANIA ___ q. Inflated self-worth, exaggerated self-opinion; inflated belief about one's own ability, etc. ___ r. Excited behavior, motor excitation (e.g., heightened physical activity; excited, loud or pressured speech; increased reactivity)

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Coding: For each indicator apply one of the following codes based on interactions with and observations of the resident in the last 28 days. Remember; code regardless of what you believe the cause to be. (3/1/18)

CODING: (3/1/18)

0. Indicator exhibited less than one day each week in last 28 days
1. Indicator exhibited one to five *days* per week during the past 28 days. Behavior must have occurred at least one day every week.
2. Indicator exhibited daily or almost daily (6 to 7 *days* each week) during the past 28 days **or** the average of the four weeks is 6.0 or greater.

NOTE**: Average is defined as the total of the values for each week in the look back period divided by number of weeks in the look back period.**

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	A5 date		E1 items, enter number of ***distinct days*** behavior occurred each week				
	weeks (7-day periods)		E1a	E1b	E1c	E1d	E1e
week 1	12/30/17	1/5/18	1	1			
week 2	1/6/18	1/12/18	2	2			
week 3	1/13/18	1/19/18	1	1			
week 4	1/20/18	1/26/18	3	3			
			1.8	1.8	#DIV/0!	#DIV/0!	#DIV/0!

code 0: if the behavior did not occur at least one day *every* week.
code 1: if the behavior occurred at least *one day every week*.
code 2: if the *average* is greater than or equal to 6.

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4.	BEHAVIORAL SYMPTOMS	(COLUMN A CODES: Record the appropriate code for the frequency of the symptom in last 7 days) 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days but less than daily 3. Behavior of this type occurred daily (COLUMN C CODES: History of this behavior in the last 6 months) 0. No 1. Yes (COLUMN B CODES: Alterability of behavioral symptoms in last 7 days) 0. Not present or easily altered 1. Behavior not easily altered	A FREQUENCY	B ALTERABILITY	C HISTORY
a.	WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)				
b.	VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)				
c.	PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused, gross physical assault)				
d.	SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, sexual behavior, disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings, stealing, self-abusive acts, substance abuse, self-mutilation)				
e.	RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)				
f.	INTIMIDATING BEHAVIOR (made others feel unsafe, at risk, privacy invaded)				
g.	ELOPEMENT				
h.	Dangerous non-violent behavior (e.g., falling asleep while smoking)				
i.	Dangerous violent behavior				
j.	FIRE SETTING				
5.	SUICIDAL IDEATION	Resident demonstrated suicidal thoughts or actions in **the last 30 days**: ☐ 0. No ☐ 1. Yes			
6.	SLEEP PROBLEMS	Check all present on 2 or more days during last 7 days ☐ a. Inability to awaken when desired ☐ b. Difficulty falling asleep ☐ c. Restless or non-restful sleep ☐ d. Interrupted sleep ☐ e. *NONE OF ABOVE*			
7.	INSIGHT INTO MENTAL HEALTH	Resident has insight about his/her mental problem ☐ 0. No ☐ 1. Yes ☐ 2. No mental health problems			
8.	BEHAVIORS (Check only one.)	Resident's current behavior status compared to resident's status 180 days ago (or since admission if less than 180 days): ☐ 0. No change ☐ 1. Improved ☐ 2. Declined			

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Section J covers Health Conditions and Possible Medication Side Effects…

A lot of territory!

- J1. Problem conditions
- J2. Extrapyramidal signs and symptoms
- J3 and 4. Pain Symptoms and location
- J5 and 6. Pain interference and management
- J7. Accidents
- J8. Fall risk

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Section J. Health Conditions and Possible Medication Side Effects

SECTION J. HEALTH CONDITIONS AND POSSIBLE MEDICATION SIDE EFFECTS

1.	PROBLEM CONDITIONS	*(Check all problems present in last 7 days unless other time frame is indicated)*	
		☐ a. Inability to lie flat due to shortness of breath	☐ i. Headache
		☐ b. Shortness of breath	☐ j. Numbness/tingling
		☐ c. Edema	☐ k. Blurred vision
		☐ d. Dizziness/vertigo	☐ l. Dry mouth
		☐ e. Delusions	☐ m. Excessive salivation or drooling
		☐ f. Hallucinations	☐ n. Change in normal appetite
		☐ g. Hostility	☐ o. Other *(specify)* _____
		☐ h. Suspiciousness	☐ p. *NONE OF ABOVE*

Delusions and Hallucinations are both Items that can contribute to the Behavioral Health RUG groups. **Descriptive documentation required**

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Section M: Skin Condition

If **M1b** is checked, it will contribute to a clinically complex RUG group

SECTION M. SKIN CONDITION

1.	SKIN PROBLEMS (Check all that apply.)	Any troubling skin conditions or changes in the **last 7 days?** ☐ a. Abrasions (scrapes) or cuts ☐ e. Open sores or lesions ☐ b. Burns (2nd or 3rd degree) ☐ f. Other (specify) _____ ☐ c. Bruises ☐ d. Rashes, itchiness, body lice ☐ g. NONE OF ABOVE
2.	ULCERS (Due to any cause.)	(Record the number of ulcers at each ulcer stage–regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during **last 7 days**. Code 9=9 or more.) Requires full body exam. — Number at Stage a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues–presents as a deep crater with or without undermining adjacent tissue. d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

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Section M: Skin Condition

If **M2a, b, c, or d** is coded greater than 0, this item will contribute to a clinically complex RUG group

SECTION M. SKIN CONDITION

1.	SKIN PROBLEMS (Check all that apply.)	Any troubling skin conditions or changes in the **last 7 days?** ☐ a. Abrasions (scrapes) or cuts ☐ e. Open sores or lesions ☐ b. Burns (2nd or 3rd degree) ☐ f. Other (specify) _____ ☐ c. Bruises ☐ d. Rashes, itchiness, body lice ☐ g. NONE OF ABOVE
2.	ULCERS (Due to any cause.)	(Record the number of ulcers at each ulcer stage–regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during **last 7 days**. Code 9=9 or more.) Requires full body exam. — Number at Stage a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues–presents as a deep crater with or without undermining adjacent tissue. d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.
3.	FOOT PROBLEMS	a. Resident or someone else inspects resident's feet on a regular basis? ☐ 0. No ☐ 1. Yes b. One or more foot problems or infections such as corns, calluses, bunions, hammer toes, overlapping toes, pain, structural problems, gangrene toe, foot fungus, enlarged toe in last 7 days? ☐ 0. No ☐ 1. Yes

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Section P: Special Treatments and Procedures

These items will contribute to the clinically complex RUG group

SECTION P. SPECIAL TREATMENTS and PROCEDURES

1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

a. SPECIAL CARE–*Check treatments or programs received during the last 14 days* [Note–count only post admission treatments]

TREATMENTS

- ☐ a. Chemotherapy or radiation
- ☐ b. Oxygen therapy
- ☐ c. Dialysis

PROGRAMS

- ☐ d. Alcohol/drug treatment program
- ☐ e. Alzheimer's/dementia special care unit
- ☐ f. Hospice care
- ☐ g. Home health
- ☐ h. Home care
- ☐ i. Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)
- ☐ j. Case management
- ☐ k. Day treatment program
- ☐ l. Sheltered workshop/employment
- ☐ m. Job training
- ☐ n. Transportation
- ☐ o. Psychological rehabilitation
- ☐ p. Formal education
- ☐ q. *NONE OF ABOVE*

b. THERAPIES–*Record the number of days each of the following therapies was administered (for at least 15 minutes a day) in the* ***last 7 calendar days*** *(Enter 0 if none or less than 15 min. a day)*

(Note-count only post admission therapies)
(A) = # of days administered for 15 minutes or more
Check B if therapy was received at home or in facility
Check C if therapy was received out-of-home or facility

	Days (A)	ON SITE (B)	OFF SITE (C)
a. Speech-language pathology and auditory services			
b. Occupational therapy			
c. Physical therapy			
d. Respiratory therapy			
e. Psychological therapy (by any licensed mental health professional)			

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Section P: Special Treatments and Procedures (cont..)

2. INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS

(Check all interventions or strategies used in the last 7 days unless other time specified–no matter where received)

- ☐ a. Special behavior symptom evaluation program
- ☐ b. Special behavior management program
- ☐ c. Evaluation by a licensed mental health specialist in last 90 days
- ☐ d. Group therapy
- ☐ e. Resident-specific deliberate changes in the environment to address mood/behavior patterns–e.g., providing bureau in which to rummage
- ☐ f. Reorientation–e.g., cueing
- ☐ g. Validation/Redirection
- ☐ h. Crisis intervention in facility
- ☐ i. Crisis stabilization unit in last 90 days
- ☐ j. Other *(specify)* _____
- ☐ k. *NONE OF ABOVE*

These items will contribute to a Behavioral Health RUG group if *three (3) or more* items in P2A – P2J are checked

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Section P: Special Treatments and Procedures (cont..)

3.	NEED FOR ON-GOING MONITORING	(Code for person responsible for monitoring) 0. No monitoring required 1. RCF nurse 2. RCF Other Staff 3. Home health nurse
		____ a. Acute physical or psychiatric condition - not chronic ____ b. New treatment/medication

These items will contribute to a Clinically Complex RUG group

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POP QUIZ!

Can Acute Monitoring be Coded??

1. Resident has another urinary tract infection (UTI) and has been prescribed Bactrim again.

2. Resident has diabetes. He has had vague complaints of not feeling well and his blood sugar has been elevated for the past week. Insulin was increased, but blood sugars are still elevated.

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POP QUIZ!

Can Acute Monitoring be Coded??

3. Resident has had arthritis with pain and a history of stomach ulcers for many years. Recently, she had a fall. There was no fracture, but her pain has increased and she was started on a new arthritis medication that can cause GI problems.

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POP QUIZ!

Can Acute Monitoring be Coded??

4. Resident has diabetes, needs to have fingerstick blood sugars done 4 times per day, and takes insulin 2 times per day and as needed based on blood sugar.

5. Resident has been on Coumadin for years and has a blood test done every month. With his most recent blood test, he had to go to the ER for an injection of Vit K, his dose was changed and he had another blood test in 3 days with another dose change.

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Section P: Special Treatments and Procedures (cont..)

P4. Rehab / Restorative care (7 days)

P5. Skill Training (30 days)

P6. Adherence With Treatments/Therapies Programs (P2 Items, 6 months)

P7. General Hospital Stays (6 months)

P8. Emergency Room (ER) Visits (6 months)

P9. Physician Visits (6 months)

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Section P: Special Treatments and Procedures (cont.)

10.	PHYSICIAN ORDERS	In the **last 14 days** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter "0" if none)	

Note: Code the number of **days** the physician changed the resident's orders, not including order renewals without change or clarification of orders, within the 14-day look back.

This item will contribute to the Clinically Complex RUG group if coded as **4 or more**

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Section P: Special Treatments and Procedures (cont..)

P11. Abnormal Lab Values (90 days)

P12. Psychiatric Hospital Stays (6 months)

P13. Outpatient Surgery (6 months)

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Section S: Assessment Information and Signatures

SECTION S. ASSESSMENT INFORMATION

1.	PARTICIPATION IN ASSESSMENT	a. Resident: ☐ 0. No ☐ 1. Yes b. Family: ☐ 0. No ☐ 1. Yes ☐ 2. No Family c. Other Non-Staff: ☐ 0. No ☐ 1. Yes ☐ 2. None
2.	SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:	a. Signature of Assessment Coordinator (sign on line above) b. Date Assessment Coordinator signed as complete ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year) c. Other Signatures / Title / Sections / Date d. / Date e. / Date
3.	CASE MIX GROUP	☐☐☐☐☐

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MDS-RCA Training: Corrections

Correction Request Form

Purpose of this form:
To request correction of errors in an assessment or tracking form that has **already been accepted into the database**.

- To modify a record in the database
- To inactivate a record in the database

It is important that the information in the State database be correct.

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Correction Request Form

Intent:
To INACTIVATE a record in the State database

1. Complete this correction request form
2. Create an electronic record of the form
3. Place a hard copy of the documents in the Clinical record
4. Electronically submit this request.

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Correction Request Form: **Prior Record Section**

PRIOR RECORD SECTION:
THIS SECTION IDENTIFIES THE ASSESSMENT OR TRACKING FORM THAT IS IN ERROR. (In this section, reproduce the information EXACTLY as it appeared in the erroneous record, even if the information is wrong. This information is necessary in order to locate the record in the State database.)

Prior AA1	RESIDENT NAME	a.(First) b.(Middle Initial) c.(Last) d.(Jr/Sr)
Prior AA2	GENDER	1. Male 2. Female
Prior AA3	BIRTHDATE	Month – Day – Year
Prior AA5a	SOCIAL SECURITY	a. Social Security Number
Prior A6 OR D1.8	REASON FOR ASSESSMENT	ASSESSMENT 1. Admission assessment 2. Annual assessment 3. Significant change in status assessment 4. Semi-Annual 5. Other DISCHARGE TRACKING 6. Discharged 7. Discharged prior to completing initial assessment
	PRIOR DATE	PRIOR DATE (Complete one only) Complete Prior A5 if Primary Reason (Prior A6) equals 1,2,3,4 or 5 Complete Prior D3.2 if Primary Reason (Prior D1.8) equals 6 or 7
Prior A5	ASSESSMENT DATE	a. *Last day of MDS observation period* Month – Day – Year
Prior D3.2	DISCHARGE DATE	*Date of Discharge* Month – Day – Year

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Correction Request Form: **Correction Section**

CORRECTION SECTION:
COMPLETE THIS SECTION TO EXPLAIN THE CORRECT REQUEST

AT1.	CORRECTION SEQUENCE NUMBER	(Enter total number of corrections for this record, including the present one.)	
AT2.	ACTION REQUESTED	1. MODIFY record in error (Attach and submit a COMPLETE assessment or tracking form. Do NOT submit the corrected items ONLY. Proceed to item AT3 below). 2. INACTIVATE record in error. (DO NOT submit an assessment or tracking form. Submit the correction request only. Skip to item AT4).	
AT3.	REASONS FOR MODIFICATION	(If AT2=1, check at least one of the following reasons; check all that apply, then skip to AT5) a. Transcription error b. Data entry error c. Software product error d. Item coding error e. Other error If "Other" checked, please specify:	a. b. c. d. e.
AT4.	REASONS FOR INACTIVATION	(If AT2=2, check at least one of the following reasons; check all that apply.) a. Test record submitted as production record b. Event did not occur c. Inadvertent submission of non-required record d. Other reason requiring inactivation If "Other" checked, please specify:	a. b. c. d.

MDS-RCA COORDINATOR SIGNATURE AND DATE COMPLETION

AT5.	INDIVIDUAL NAME	a.(First) b.(Last) c.(Title)
	SIGNATURE	
AT6.	CORRECTION DATE	Month – Day – Year

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MDS-RCA CASE MIX DOCUMENTATION REQUIREMENTS

For MDS-RCA form version 12/03

One of the important functions of the MDS-RCA assessment is to generate an updated, accurate picture of the resident's health status.

This document is to help with the understanding of the what case mix team will be looking for to verify the MDS coding. this document is not to minimize the need to refer to the manual for all coding instructions. When you find conflicting reports about a resident's functioning in a particular area, seek additional information to clarify the issue and, when possible, resolve the apparent conflict. When a conflict remains, use your best judgment in reaching a decision.

The S2b date must be signed as being complete within 7 days of the Assessment date (item A5). When calculating the due date for subsequent assessments, the S2b date is day 1. Clarification notes written after the S2b (completion) date will not be accepted as supporting documentation for case mix review purposes.

MaineCare Benefits Manual, Chapter III, Section97c:

7020 **Schedule of Resident Assessments:** The provider must complete the MDS-RCA within 30 days of admission and will complete subsequent assessments at least every 180 days during the residents stay. The provider will sequence the assessments from the date in Section S.2.B of the MDS-RCA Providers must complete a significant change MDS-RCA assessment, as defined in the Training Manual for the MDS-RCA Tool within 14 calendar days, that will reset the S2b date for scheduling purposes. Providers must complete a Resident Tracking Form within 7 days of the discharge, transfer, or death of a resident.

Providers must maintain all resident assessments completed within the previous 12 months in the resident's active record.

7030.3 Documentation: Documentation is required to support the time periods and information coded on the MDS-RCA.

MDS RCA item and reference	Field	Documentation Requirement
		Clinically Complex
I1a and O4Ag	Diabetes receiving daily insulin injections	• Physician's diagnosis of diabetes, order for insulin, **and** • Documentation the resident received daily insulin injections during the look back period.

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I1r	Aphasia	Definition: A speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts (i.e. speaking, writing) or understanding spoken or written language. Documentation requirements: • Difficulty with communication must be noted in the resident's record • Physician's diagnosis in the resident's record • Current and active treatment identified and provided as on the service plan
I1s I1v I1w	Cerebral Palsy Hemiplegia/Hemiparesis Multiple Sclerosis	• All diseases, conditions (not limited to those below) must have physician documented diagnosis at the time of the visit closest to the scheduled MDS-RCA assessment in the clinical record. • Current and active treatment identified and provided as on the service plan "Current" means the diagnosis has been confirmed by the physician as being active (not a "history of") based on the most recent physician progress notes and the resident is receiving active treatment for, or because of, this diagnosis.
I1ww	Explicit Terminal	• Primary care physician must document in the clinical record that the resident is terminally ill and, based on his/her experience, has no more than 6 months to live. • This judgment must be substantiated with documentation of a diagnosis and deteriorating clinical condition.
I1z	Quadriplegia	A physician diagnosis of paralysis of all four limbs due to spinal cord injury Current diagnosis and active treatment that have a relationship to the resident's clinical status. In general, these are conditions that drive the current service plan
M1b	Burns – 2nd or 3rd degree	• Confirmation of the degree of the burn by RN or physician • Current status of the burn during the 7-day look back period, by RN or physician. • Documentation of treatment received during the 7-day look back period

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M2	Ulcers	• Ulcers must be staged, in accordance with the Training Manual, by a RN or physician based on the appearance of the wound at the time of the assessment. • Documentation of treatment received during the 7-day look back period
P1aa	Chemotherapy	• Physician's order for any type of anticancer drug given by any route. • Documentation of administration within the 14-day look back period. • Chemotherapy can only be code for a diagnosis of cancer.
P1aa	Radiation	• Physician's order for radiation therapy or implant • Documentation of administration within the 14-day look back period • Radiation therapy can be coded only for a diagnosis of cancer.
P1ab	Oxygen	• Physician's order for oxygen, including flow rate (dosage) and frequency • Documentation of administration within the 14-day look back period.
P1bdA	Respiratory Therapy 5 or more days per week	• Physician's order for respiratory therapy, including frequency and duration, for onset of a new respiratory condition or exacerbation of a chronic respiratory condition • Performed by a "qualified professional" (RN or RT) • Services are directly and specifically related to an active written service plan • Documentation of administration frequency and duration, and • Documentation of the minutes the RN/RT spent with the resident for each respiratory assessment and treatment received during the 7-day look back period
P3a	Need for ongoing monitoring	• The need for monitoring of an acute condition or exacerbation of a chronic condition into an acute episode must be determined, directed, and documented by RN or physician. • Documentation by staff coded as being responsible for monitoring to show that monitoring occurred during 7-day look back period.

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P3b	Need for ongoing monitoring	• The need for monitoring of a new medication or treatment, in accordance with the Training Manual, must be determined, directed and documented by an RN or physician. • Documentation by staff coded as being responsible for monitoring to show that monitoring occurred during 7-day look back period.
P10	4 or more order *change days*	• Code the **number of days** there were changes in the physician's orders. • Written, telephone, fax or consultation orders for new or altered treatment. • Does NOT include admission orders, re-entry orders, clarifying, or renewal orders without changes. • Do NOT count orders received prior to the date of admission or re-entry.
Impaired Cognition		
B3	Cognitive Skills for Daily Decision Making	• Clinical record must include documentation of the resident's actual performance in making everyday decisions about task or activities of daily living within the look back period. The documentation must include specific examples of resident behaviors and ability to make decision, to support the coding selected. • When you find conflicting reports about a resident's functioning in a particular area, seek additional information to clarify the issue and, when possible, resolve the apparent conflict. When a conflict remains, use your best judgment in reaching a decision. • There must be documentation in the clinical record of the decision-making process when there is a conflict
Problem Behaviors and Conditions		
E1a-E1r	Indicators of Depression	• Review daily staff documentation, consult with or interview staff across all shifts for the time frame of the observation. Daily staff documentation for all shifts is the preferred method to support the coding of these conditions. When daily documentation is not utilized, the results of the consultations and/or interviews must be documented in the resident's clinical record to support the entire time frame.

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		• The look back period is the last 28 days, or since admission if less than 28 days. Behavior must have occurred at least one day every week to be coded. • Refer to the manual for the coding of change items E1o and E1p for specific coding requirements. • For E1o and E1p, there must be documentation in the clinical record to support the coder's rationale for coding a change in these areas.
J1e	Delusions	Documentation in the resident's clinical record must describe the *fixed, false beliefs, not shared by others even when there is obvious proof or evidence to the contrary*, that occurred within the look back period and evidence that the resident's delusion was false. A resident's repetitive delusions should be reference on the service plan. Refer to the MDS-RCA manual for examples.
J1f	Hallucinations	Documentation in the resident's record must describe the *tactile, auditory, visual, gustatory, or olfactory false perceptions in the absence of any real stimuli* that occurred within the look back period and evidence that the hallucination did not exist. A resident's repetitive hallucinations should be reference on the service plan.
P2a-P2j	Interventions and Programs for Mood, Behavior, and Cognitive Loss	Programs coded must contain the following documentation: • Interventions and strategies on the service plan • Evidence of utilization of the program within the 7-day look back • Evaluation describing the outcomes of treatment provided and any necessary revisions to the program.
Physical		
G1aA	Bed mobility	Documentation to support the total picture of the resident's ADL self-performance over the 7-day look back period, 24 hours per day, with all shifts present. Only self-performance counts toward the ADL score. Refer to the MDS-RCA manual for coding of G1eA, Eating-Supervision.
G1bA	Transfer	
G1cA	Locomotion	
G1dA	Dressing	
G1eA	Eating	
G1fA	Toilet Use	
G1gA	Personal hygiene	

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MDS-RCA Training

Questions?

This completes session #3 of the MDS-RCA Mini-Series.

Email the help desk to register for other training sessions or to send questions for the forum call.

MDS3.0.dhhs@maine.gov

State of Maine website for handouts:

https://www.maine.gov/dhhs/oms/providers/case-mix-private-duty-nursing-and-home-health

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MDS-RCA Training

Forum Calls are held the first Thursday of **March**, **June**, **September**, and **December**

Email the help desk to register for the call or to send questions or suggestions for Snippet topics.

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MDS-RCA Training

Reminders:

Call the MDS help desk to inquire or register for training.

ASK questions!

ASK more questions!

Attend training as needed

Evaluations would be appreciated so we can continually improve our training.

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Case Mix Team Contact Information

- **MDS Help Desk**: 624-4095 or toll-free: 1-844-288-1612
  MDS3.0.DHHS@maine.gov

- **Lois Bourque, RN**: 592-5909
  Lois.Bourque@maine.gov
- **Debra Poland RN**: 215-9675
  Debra.Poland@maine.gov
- **Emma Boucher RN:** 446-2701
  Emma.Boucher@maine.gov
- **Christina Stadig RN**: 446-3748
  Christina.Stadig@maine.gov
- **Sue Pinette, RN**: 287-3933 or 215-4504 (cell)
  Suzanne.Pinette@maine.gov

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Questions?

Sue Pinette RN, RAC-CT,
Case Mix Manager
207-287-3933

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