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.

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

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.

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.

		• 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 hygience	