Joe Lombardo
Governor

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MDS 3.0 Updates and Long-Term Care Changes

Division of Public and Behavioral Health
Bureau of Health Care Quality and Compliance

Presented by Carol Eastburg

May 17, 2023

Department of Health and Human Services

Helping people. It's who we are and what we do.

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Good Morning and Welcome, Everyone!

Grace
Attention
Patience
Cooperation

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Agenda*

09:00 – 10:10	Carol Eastburg
10:20 – 11:30	Chris Christiano
11:30 – 12:00	Post-Test/Eval

*Times are approximate

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Objectives

Attendees will:

- Be aware of recent and future changes to the RAI Item Sets
- Understand how to properly code recently changed Items
- Understand which interdisciplinary team members are most appropriate to complete specific sections of an assessment

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Disclaimer

CMS has not provided state RAI Coordinators with any formal training regarding the changes coming to MDS 3.0 October 1, 2023.

The RAI User Manual was still in draft form when this presentation was prepared. As CMS frequently makes changes, this information may also change.

Participants are encouraged to review the specific statutes, regulations, and other interpretive materials on a regular basis to ensure a full and accurate, up-to-date understanding of the contents.

Information being presented was gathered from various websites (AAPACN, CMS, MLN, Montero Therapy, etc.).

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Pre-Presentation Poll Query

1. On a scale of 1 – 10, with 1 being not at all and 10 being totally, what is your comfort level with the current MDS Item Sets?
2. Please list the three sections of the RAI (MDS 3.0) that make you want to scream, with the most frustrating one first.
3. Which three topics related to the MDS/RAI do you wish to better understand?

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Resident Assessment Instrument

The RAI consists of three basic components:

1) Minimum Data Set (MDS) Version 3.0
2) Care Area Assessment (CAA) process
3) RAI Utilization Guidelines* (User Manual)

*Primary source of information for completing an MDS assessment

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Minimum Data Set (MDS 3.0)

A core set of screening, clinical, and functional status data elements, including common definitions and coding categories, which form the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid.

The data elements (also referred to as "items") standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies.

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Care Area Assessment (CAA) Process

Assists the assessor to systematically interpret the information recorded in the MDS Item Set.

The CAA process helps the clinician to focus on key issues identified during the assessment so that decisions as to whether and how to intervene can be explored with the resident (and/or their family member or representative).

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Utilization Guidelines

Also known as the:

- Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (a mouthful!)
- RAI Manual
- RAI 3.0 Manual
- User Manual
- The Manual (most common)

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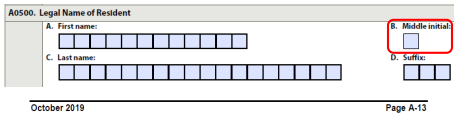
Section A - Identification

Comprehensive (NC) assessment:

- A0100 Provider ID
- A0200 Type of Provider (SNF/NF) or Swing Bed
- A0300 Type of Assessment (Six OBRA options; seven "sub" types)
- A0410 Medicare/Medicaid Certification Status of Provider
- **A0500 Legal Name of Resident**



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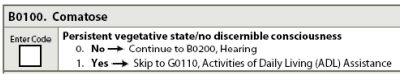
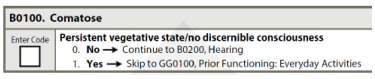
Section B – Hearing, Speech, Vision

Look back period for all items is 7 days unless another time frame is indicated

Current Version





Effective 10-01-2023

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Section C – Cognitive Patterns

- Read and understand the explicit instructions provided
- Follow instructions exactly for accurate assessments
- Get comfortable with the exact responses to use

NOTE:

- If a resident is unable or refuses to participate in the BIMS, complete C0700 – C1000, the Staff Assessment of Mental Status Items.

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Section D - Mood

Effective 10-01-2023:

D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
1. **Yes** → Continue to D0150, Resident Mood Interview (PHQ-2 to 9©)

D0150. Resident Mood Interview (PHQ-2 to 9©)

Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: *"About **how often** have you been bothered by this?"*
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
   9. **No response** (leave column 2 blank)
2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*	☐	☐
B. *Feeling down, depressed, or hopeless*	☐	☐

If either D0150A2 or D0150B2 is coded 2 or 3, CONTINUE asking the questions below. If not, END the PHQ interview.

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Section E – Behavior, 1 of 4

Section E	**Behavior**
E0100. Potential Indicators of Psychosis	
↓ **Check all that apply**	
☐	**A. Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
☐	**B. Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
☐	**Z. None of the above**
Behavioral Symptoms	
E0200. Behavioral Symptom - Presence & Frequency	
Note presence of symptoms and their frequency	
Coding: 0. **Behavior not exhibited** 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**	↓ **Enter Codes in Boxes**
☐	**A. Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
☐	**B. Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)
☐	**C. Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

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Section E – Behavior, 2 of 4

E0300. Overall Presence of Behavioral Symptoms	
Enter Code ☐	**Were any behavioral symptoms in questions E0200 coded 1, 2, or 3?** 0. **No** → Skip to E0800, Rejection of Care 1. **Yes** → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below

E0500. Impact on Resident	
	Did any of the identified symptom(s):
Enter Code ☐	**A. Put the resident at significant risk for physical illness or injury?** 0. **No** 1. **Yes**
Enter Code ☐	**B. Significantly interfere with the resident's care?** 0. **No** 1. **Yes**
Enter Code ☐	**C. Significantly interfere with the resident's participation in activities or social interactions?** 0. **No** 1. **Yes**

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Section E – Behavior Example

Example:

A resident frequently grabs and scratches staff when they attempt to change her soiled brief, digging her nails into their skin and making it very difficult to provide much needed incontinent care.

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Section E – Behavior, 3 of 4

E0600. Impact on Others	
	Did any of the identified symptom(s):
Enter Code ☐	**A. Put others at significant risk for physical injury?** 0. **No** 1. **Yes**
Enter Code ☐	**B. Significantly intrude on the privacy or activity of others?** 0. **No** 1. **Yes**
Enter Code ☐	**C. Significantly disrupt care or living environment?** 0. **No** 1. **Yes**

E0800. Rejection of Care - Presence & Frequency	
Enter Code ☐	**Did the resident reject evaluation or care** (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals. 0. **Behavior not exhibited** 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**

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Section E – Behavior, 4 of 4

E0900. Wandering - Presence & Frequency

Enter Code ☐

Has the resident wandered?
0. **Behavior not exhibited** → Skip to E1100, Change in Behavior 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

Enter Code ☐

A. Does the wandering place the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility)?
0. **No**
1. **Yes**

Enter Code ☐

B. Does the wandering significantly intrude on the privacy or activities of others?
0. **No**
1. **Yes**

E1100. Change in Behavior or Other Symptoms

Consider all of the symptoms assessed in items E0100 through E1000

Enter Code ☐

How does resident's current behavior status, care rejection, or wandering **compare to prior assessment (OBRA or Scheduled PPS)?**
0. **Same**
1. **Improved**
2. **Worse**
3. **N/A** because no prior MDS assessment

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Section F – Routine/Activities, 1 of 5

F0300. Should Interview for Daily and Activity Preferences be Conducted? - Attempt to interview all residents able to communicate. If resident is unable to complete, attempt to complete interview with family member or significant other

Enter Code ☐

0. **No** (resident is rarely/never understood and family/significant other not available) → Skip to and complete F0800, Staff Assessment of Daily and Activity Preferences
1. **Yes** → Continue to F0400, Interview for Daily Preferences

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Section F – Routine/Activities, 2 of 5

F0400. Interview for Daily Preferences

Show resident the response options and say: ***"While you are in this facility..."***

Coding:
1. **Very important**
2. **Somewhat important**
3. **Not very important**
4. **Not important at all**
5. **Important, but can't do or no choice**
9. **No response or non-responsive**

↓ **Enter Codes in Boxes**

☐ ***A.*** *how important is it to you to* ***choose what clothes to wear?***

☐ ***B.*** *how important is it to you to* ***take care of your personal belongings or things?***

☐ ***C.*** *how important is it to you to* ***choose between a tub bath, shower, bed bath, or sponge bath?***

☐ ***D.*** *how important is it to you to* ***have snacks available between meals?***

☐ ***E.*** *how important is it to you to* ***choose your own bedtime?***

☐ ***F.*** *how important is it to you to* ***have your family or a close friend involved in discussions about your care?***

☐ ***G.*** *how important is it to you to* ***be able to use the phone in private?***

☐ ***H.*** *how important is it to you to* ***have a place to lock your things to keep them safe?***

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Section F – Routine/Activities, 3 of 5

F0500. Interview for Activity Preferences

Show resident the response options and say: ***"While you are in this facility..."***

↓ Enter Codes in Boxes

Coding:
1. **Very important**
2. **Somewhat important**
3. **Not very important**
4. **Not important at all**
5. **Important, but can't do or no choice**
9. **No response or non-responsive**

☐	**A.** *how important is it to you to* ***have books, newspapers, and magazines to read?***
☐	**B.** *how important is it to you to* ***listen to music you like?***
☐	**C.** *how important is it to you to* ***be around animals such as pets?***
☐	**D.** *how important is it to you to* ***keep up with the news?***
☐	**E.** *how important is it to you to* ***do things with groups of people?***
☐	**F.** *how important is it to you to* ***do your favorite activities?***
☐	**G.** *how important is it to you to* ***go outside to get fresh air when the weather is good?***
☐	**H.** *how important is it to you to* ***participate in religious services or practices?***

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Section F – Routine/Activities, 4 of 5

F0600. Daily and Activity Preferences Primary Respondent

Enter Code ☐

Indicate primary respondent for Daily and Activity Preferences (F0400 and F0500)
1. **Resident**
2. **Family or significant other** (close friend or other representative)
9. **Interview could not be completed** by resident or family/significant other ("No response" to 3 or more items")

F0700. Should the Staff Assessment of Daily and Activity Preferences be Conducted?

Enter Code ☐

0. **No** (because Interview for Daily and Activity Preferences (F0400 and F0500) was completed by resident or family/significant other) → Skip to and complete G0110, Activities of Daily Living (ADL) Assistance
1. **Yes** (because 3 or more items in Interview for Daily and Activity Preferences (F0400 and F0500) were not completed by resident or family/significant other) → Continue to F0800, Staff Assessment of Daily and Activity Preferences

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Section F – Routine/Activities, 5 of 5

F0800. Staff Assessment of Daily and Activity Preferences

Do not conduct if Interview for Daily and Activity Preferences (F0400-F0500) was completed

Resident Prefers:

↓ Check all that apply

☐	A. Choosing clothes to wear
☐	B. Caring for personal belongings
☐	C. Receiving tub bath
☐	D. Receiving shower
☐	E. Receiving bed bath
☐	F. Receiving sponge bath
☐	G. Snacks between meals
☐	H. Staying up past 8:00 p.m.
☐	I. Family or significant other involvement in care discussions
☐	J. Use of phone in private
☐	K. Place to lock personal belongings
☐	L. Reading books, newspapers, or magazines
☐	M. Listening to music
☐	N. Being around animals such as pets
☐	O. Keeping up with the news
☐	P. Doing things with groups of people
☐	Q. Participating in favorite activities
☐	R. Spending time away from the nursing home
☐	S. Spending time outdoors
☐	T. Participating in religious activities or practices
☐	Z. None of the above

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Section G – Functional Status

Section G — Functional Status

G0110. Activities of Daily Living (ADL) Assistance
Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

Instructions for Rule of 3
- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.

1. ADL Self-Performance
Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times
0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or coaxing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times
7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

2. ADL Support Provided
Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:
0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

1. Self-Performance	2. Support
↓ Enter Codes in Boxes ↓	

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Section I – Active Diagnoses, 1 of 4

Section I — Active Diagnoses

I0020. Indicate the resident's primary medical condition category
Complete only if A0310B = 01 or 08

Enter Code: ☐☐

Indicate the resident's primary medical condition category that best describes the primary reason for admission

01. **Stroke**
02. **Non-Traumatic Brain Dysfunction**
03. **Traumatic Brain Dysfunction**
04. **Non-Traumatic Spinal Cord Dysfunction**
05. **Traumatic Spinal Cord Dysfunction**
06. **Progressive Neurological Conditions**
07. **Other Neurological Conditions**
08. **Amputation**
09. **Hip and Knee Replacement**
10. **Fractures and Other Multiple Trauma**
11. **Other Orthopedic Conditions**
12. **Debility, Cardiorespiratory Conditions**
13. **Medically Complex Conditions**

I0020B. ICD Code
☐☐☐☐☐☐☐☐

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Section I – Active Diagnoses, 2 of 4

Section I — Active Diagnoses

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Cancer
☐ **I8100. Cancer** (with or without metastasis)

Circulation
☐ **I5200. Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
☐ **I5300. Atrial Fibrillation or Other Dysrhythmias** (e.g., bradycardias and tachycardias)
☐ **I6400. Coronary Artery Disease (CAD)** (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
☐ **I6500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)**
☐ **I6600. Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
☐ **I6700. Hypertension**
☐ **I6800. Orthostatic Hypotension**
☐ **I6900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**

Gastrointestinal
☐ **I7100. Cirrhosis**
☐ **I7200. Gastroesophageal Reflex Disease (GERD) or Ulcer** (e.g., esophageal, gastric, and peptic ulcers)
☐ **I7300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease**

Genitourinary
☐ **I7400. Benign Prostatic Hyperplasia (BPH)**
☐ **I7500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)**
☐ **I7550. Neurogenic Bladder**
☐ **I7650. Obstructive Uropathy**

Infection
☐ **I7700. Multidrug-Resistant Organism (MDRO)**
☐ **I2000. Pneumonia**
☐ **I2100. Septicemia**
☐ **I2200. Tuberculosis**
☐ **I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)**
☐ **I2400. Viral Hepatitis** (e.g., Hepatitis A, B, C, D, and E)
☐ **I2500. Wound Infection** (other than foot)

Metabolic
☐ **I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
☐ **I3100. Hyponatremia**
☐ **I3200. Hyperkalemia**
☐ **I3300. Hyperlipidemia** (e.g., hypercholesterolemia)
☐ **I3400. Thyroid Disorder** (e.g., hyperthyroidism, hyperthyroidism, and Hashimoto's thyroiditis)

Musculoskeletal
☐ **I3700. Arthritis** (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))
☐ **I3800. Osteoporosis**
☐ **I3900. Hip Fracture** - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
☐ **I4000. Other Fracture**

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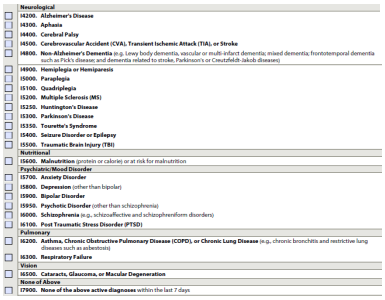
Section I – Active Diagnoses, 3 of 4



	Neurological
☐	**I4200. Alzheimer's Disease**
☐	**I4300. Aphasia**
☐	**I4400. Cerebral Palsy**
☐	**I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
☐	**I4800. Non-Alzheimer's Dementia** (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob disease)
☐	**I4900. Hemiplegia or Hemiparesis**
☐	**I5000. Paraplegia**
☐	**I5100. Quadriplegia**
☐	**I5200. Multiple Sclerosis (MS)**
☐	**I5250. Huntington's Disease**
☐	**I5300. Parkinson's Disease**
☐	**I5350. Tourette's Syndrome**
☐	**I5400. Seizure Disorder or Epilepsy**
☐	**I5500. Traumatic Brain Injury (TBI)**
	Nutritional
☐	**I5600. Malnutrition** (protein or calorie) or at risk for malnutrition
	Psychiatric/Mood Disorder
☐	**I5700. Anxiety Disorder**
☐	**I5800. Depression** (other than bipolar)
☐	**I5900. Bipolar Disorder**
☐	**I5950. Psychotic Disorder** (other than schizophrenia)
☐	**I6000. Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
☐	**I6100. Post Traumatic Stress Disorder (PTSD)**
	Pulmonary
☐	**I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
☐	**I6300. Respiratory Failure**
	Vision
☐	**I6500. Cataracts, Glaucoma, or Macular Degeneration**
	None of Above
☐	**I7900. None of the above active diagnoses** within the last 7 days

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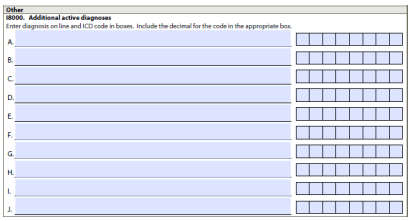
Section I – Active Diagnoses, 4 of 4



	Other
	I8000. Additional active diagnoses
	Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.
A.	
B.	
C.	
D.	
E.	
F.	
G.	
H.	
I.	
J.	

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Look Back Reminder

Look back period for all items is 7 days
unless another time frame is indicated

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Questions?

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Contact Information

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Acronyms

- ADL – Activities of Daily Living
- ARD – Assessment Reference Date
- ASPEN – Automated Survey Processing Environment
- BIMS – Brief Interview for Mental Status
- CAA – Care Area Assessment
- CASPER – Certification and Survey Provider Enhanced Reports
- CCN – CMS Certification Number
- CMS – Centers for Medicare & Medicaid Services
- IDT – Interdisciplinary Team
- iQIES – internet Quality Improvement Evaluation System

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Acronyms

- MDS – Minimum Data Set
- MDSC – Minimum Data Set Coordinator
- NAC – Nurse Assessment Coordinator
- NF – Nursing Facility
- NPP – Non-Physician Practitioner
- PHQ – Patient Health Questionnaire
- RAI – Resident Assessment Instrument
- SNF – Skilled Nursing Facility

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Resources

- Check the MDS 3.0 Web site regularly for updates at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.
- ICD-10-CM coding guidance with links to appendices can be found here: https://www.cms.gov/Medicare/Coding/ICD10/index.html
- See Appendix G in the Manual for additional links to resources.

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3.2 Become Familiar with the MDS-recommended Approach

1. **First, reading the Manual is essential.**
• The CMS Long-Term Care Facility Resident Assessment Instrument User's Manual is the primary source of information for completing an MDS assessment.
• Notice how the manual is organized.
• Using it correctly will increase the accuracy of your assessments.
• While it is important to understand and apply the information in Chapter 3, facilities should also become familiar with Chapters 1, 2, 4, 5 and 6. These Chapters provide the framework and supporting information for data collected on the item set as well as the process for further assessment and care planning.
• It is important to understand the entire process of the RAI in conjunction with the intent and rationale for coding items on the MDS 3.0 item set.
• Check the MDS 3.0 Web site regularly for updates at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.
• If you require further assistance, submit your question to your State RAI Coordinator listed in Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts available on CMS' website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.

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3.2 Become Familiar with the MDS-recommended Approach

2. Second, review the MDS item sets.

- Notice how sections are organized and where information should be recorded.
- Work through one section at a time.
- Examine item definitions and response categories as provided on the item sets, realizing that more detailed definitions and coding information is found in each Section of Chapter 3.
- There are several item sets, and depending on which item set you are completing, the skip patterns and items active for each item set may be different.

3. Complete a thorough review of Chapter 3 ("Only" 599 pages)**.**

- Review procedural instructions, time frames, and general coding conventions.
- Become familiar with the intent of each item, rationale and steps for assessment.
- Become familiar with the item itself with its coding choices and responses, keeping in mind the clarifications, issues of note, and other pertinent information needed to understand how to code the item.
- Do the definitions and instructions differ from current practice at your facility?
- Do your facility processes require updating to comply with MDS requirements?
- Complete a test MDS assessment for a resident at your facility. Enter the appropriate codes on the MDS.

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3.2 Become Familiar with the MDS-recommended Approach

Make a note where your review could benefit from additional information, training, and using the varying skill sets of the interdisciplinary team. Be certain to explore resources available to you.

- As you are completing this test case, read through the instructions that apply to each section as you are completing the MDS. Work through the Manual and item set one section at a time until you are comfortable coding items. Make sure you understand this information before going on to another section.
- Review the test case you completed. Would you still code it the same way? Are you surprised by any definitions, instructions, or case examples? For example, do you understand how to code ADLs?
- As you review the coding choices in your test case against the manual, make notations corresponding to the section(s) of this Manual where you need further clarification, or where questions arose. Note sections of the manual that help to clarify these coding and procedural questions.
- Would you now complete your initial case differently?
- It will take time to go through all this material. Do it slowly and carefully without rushing. Discuss any clarifications, questions or issues with your State RAI Coordinator (see Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts available on CMS' website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html).

4. Use of information in this chapter:

- Keep this chapter with you during the assessment process.
- Where clarification is needed, review the intent, rationale and specific coding instructions for each item in question.

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Joe Lombardo
Governor

Richard Whitley
Director

Medicaid Review Process Changes

Division of Healthcare Financing and policy

Christopher Christiano RN RAC-CT HCC IV
State of Nevada Case Mix Coordinator

May 17th,2023

Department of Health and Human Services

Helping people. It's who we are and what we do.

1

Agenda

- Transition to patient driven payment model (PDPM) model
- RUG III vs. PDPM
- Section GG Review
- Nevada Documentation Guidelines Changes
- Questions

2

2

PDPM transition

- Nevada Medicaid will transition from RUG III payment model to PDPM on July 1st, 2024
- Stakeholder meetings are currently being held to discuss, determine and finalize components of transition to PDPM.
- Section G will not be reviewed.
- Section GG will be focus of review.
- Items reviewed will be GG sections used to obtain Nursing Function Score
- It is still being discussed with stakeholders to determine if PDPM components NTA, PT, OT, SLP will contribute to CMI data collected and reviewed.

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PDPM transition

- Reviews may start as early as October 1st, 2023
- Nevada Medicaid is investigating/working towards a mostly remote review process.
- Reviews will still be annually.
- Point of time vs. time weighted CMI average system.
- Review notification process will be most likely be unchanged.
- All updates will be provided through MDS-PDPM emails.

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RUG III model vs. PDPM

- RUG III System was replaced by RUG IV.
- Nevada previously used RUG III.
- 34 group classification.
- Volume based services.

- PDPM is a case-mix group (CMG) reimbursement method that focuses on clinically relevant factors rather than volume-based services
- It improves payment accuracy and appropriateness.
- PDPM focuses on the unique, individualized, and characteristic needs, and goals of each patient,.

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RUG III model vs. PDPM

- Reverse scoring methodology:
- Under Section G, increasing score means increasing dependence
- Under Section GG, increasing score means increasing independence
- Non-linear relationship to payment:
- Under RUG-IV, increasing dependence, within a given RUG category, translates to higher payment
- Under PDPM, there is not a direct relationship between increasing dependence and increasing payment

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Section GG:
Nursing Function Score Items

- GG0130A1- Eating.
- GG0130C1- Toileting Hygiene.
- GG0170B1- Sit to lying.
- GG0170C1- Lying to sitting on side of bed
- GG0170D1- Sit to stand
- GG0170E1- Chair/bed-to chair transfer
- GG017F1- Toilet transfer

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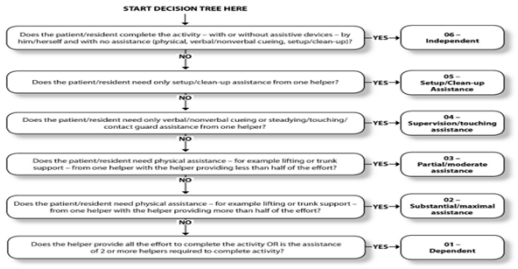
Decision Tree

Use this decision tree to code the resident's performance on the assessment instrument. If helper assistance is required because the resident's performance is unsafe or of poor quality, score according to the amount of assistance provided. Only use the "activity not attempted codes" if the activity did not occur; that is, the resident did not perform the activity and a helper did not perform that activity for the resident.



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Activity Not Attempted Codes

• Code 07, Resident refused: if the resident refused to complete the activity.

• Code 09, Not applicable: if the activity was not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.

• Code 10, Not attempted due to environmental limitations: if the resident did not attempt this activity due to environmental limitations.

• Code 88, Not attempted due to medical condition or safety concerns:

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Usual performance in section GG

- **Tips for Coding the Resident's Usual Performance**
- When coding the resident's usual performance, "effort" refers to the type and amount of assistance a helper provides in order for the activity to be completed.
- Do not record the resident's best performance, and do not record the resident's worst performance,
- Do not record the staff's assessment of the resident's potential capability to perform the activity.
- If the resident performs the activity more than once during the assessment period and the resident's performance varies, coding in Section GG should be based on the resident's "usual performance,".
- If the resident's Self-Care performance varies during the assessment period, report the resident's usual performance.

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Section GG: Steps for Assessment

Steps for Assessment

1. Assess performance based on:

a) Direct observation

b) Resident's self-report

c) Reports from qualified clinicians, care staff, or family

documented in the resident's medical record during the three-day assessment period

2. Residents should be allowed to perform activities as independently as possible.

3. When helper assistance is required, consider only facility staff when scoring.

4. Activities may be completed with or without assistive device(s).

5. Admission functional assessment should be completed prior to the person benefitting from treatment interventions (when possible).

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GG0130A1- Eating

The MDS manual defines eating as follows:

GG0130A, Eating involves bringing food and liquids to the mouth and swallowing food.

The administration of tube feedings and parenteral nutrition is not considered when coding this activity.

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GG0130A1- Eating

- If the resident ***does not eat or drink by mouth*** and relies solely on nutrition and liquids through tube feedings or *total parenteral nutrition (TPN)* because of a new (recent onset) medical condition, code GG0130A as 88, Not attempted due to medical condition or safety concerns.
- If the resident ***does not eat or drink by mouth*** at the time of the assessment, and the resident did not eat or drink by mouth prior to the current illness, injury, or exacerbation, code GG0130A as 09, Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- If the resident ***eats and drinks by mouth***, and relies partially on obtaining nutrition and liquids via tube feedings or parenteral nutrition, code Eating based on the amount of assistance the resident requires to eat and drink by mouth.

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GG0130C1- Toileting Hygiene

Coding Tips for GG0130C, Toileting hygiene

- Toileting hygiene includes managing undergarments, clothing, and incontinence products and performing perineal cleansing before and after voiding or having a bowel movement.
- If the resident does not usually use undergarments, then assess the resident's need for assistance to manage lower body clothing and perineal hygiene.
- Toileting hygiene takes place before and after use of the toilet, commode, bedpan, or urinal. If the resident completes a bowel toileting program in bed.
- If the resident has an indwelling urinary catheter and has bowel movements, code the Toilet hygiene item based on the amount of assistance needed by the resident

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GG0170B1- Sit to lying

Steps for Assessment

1. Assess the resident's mobility performance. Residents should be allowed to perform activities as independently as possible, as long as they are safe.
2. For the purposes of completing Section GG, a "helper" is defined as facility staff who are direct employees and facility contracted employees (e.g., rehabilitation staff, nursing agency staff).
3. Activities may be completed with or without assistive device(s).
4. The admission functional assessment, when possible, should be conducted prior to the resident benefitting from treatment interventions in order to reflect the resident's true admission baseline functional status..
5. Refer to facility, Federal, and State policies and procedures to determine which SNF staff members may complete an assessment

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GG0170B1- Sit to lying

DEFINITION

USUAL PERFORMANCE A resident's functional status can be impacted by the environment or situations encountered at the facility.

Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status.

If the resident's functional status varies, record the resident's usual ability to perform each activity.

Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance.

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GG0170B1- Sit to lying

- Code based on the resident's performance.
- Do not record the staff's assessment of the resident's potential capability to perform the activity
- When coding the resident's usual performance, "effort" refers to the type and amount of assistance a helper provides in order for the activity to be completed.
- The six-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance

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GG0170C1- Lying to sitting on side of bed

- The activity includes resident transitions from lying on his or her back to sitting on the side of the bed with his or her feet flat on the floor and sitting upright on the bed without back support.
- For item GG0170C, Lying to sitting on side of bed, clinical judgment should be used to determine what is considered a "lying" position for a particular resident.
- If the resident's feet do not reach the floor upon lying to sitting, the qualified clinician will determine if a bed height adjustment is required to accommodate foot placement on the floor.
- Back support refers to an object or person providing support for the resident's back.
- If bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, then code the activities as 88, Not attempted due to medical condition or safety concern.

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GG0170D1- Sit to stand

Coding Tip for GG0170D,

If a sit-to-stand (stand assist) lift is used and two helpers are needed to assist with the sit-to stand lift, then code as 01, Dependent.

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GG0170E1- Chair/bed-to chair transfer

- GG0170E, Chair/bed-to-chair transfer, begins with the resident sitting in a chair or wheelchair or sitting upright at the edge of the bed and returning to sitting in a chair or wheelchair or sitting upright at the edge of the bed.
- If a mechanical lift is used to assist in transferring a resident for a chair/bed-to-chair transfer and two helpers are needed to assist with the mechanical lift transfer, then code as 01, Dependent, even if the resident assists with any part of the chair/bed-to-chair transfer.

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GG017F1- Toilet transfer

- Follow decision tree as in previous examples
- Remember to code usual performance

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Tips for Success

- Understand importance of functional improvement and how to best facilitate resident progress
- Review and adapt current GG coding practices to ensure a collaborative approach to coding determination
- Review 6-point rating scale and activity not attempted codes
- Establish documentation protocols to support GG coding decisions
- Practice coding a variety of scenarios
- Review (audit) GG items for accuracy on an ongoing basis

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Nevada Supportive Documentation Guidelines

- The Nevada Supportive Documentation Guidelines form (referred to as NMO-6180) is being incorporated into the Medicaid Services Manual. This form includes federal MDS descriptions and categories. It also presents Nevada-specific requirements in addition to federal requirements. These more stringent standards and documentation requirements are described in the column named "Nevada Specific Requirements."
- Nevada Supportive Documentation Guidelines will be updated to reflect PDPM Changes
- Document can be found at LTSSNursing (nv.gov)
- When new version is completed, it will also be sent to providers through PDPM-MDS email.

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Nevada Supportive Documentation Guidelines

Review Procedures

Supporting Documentation Related to the MDS/Case Mix Documentation Review:

a) Any corrections made including but not limited to, the Activities of Daily Living (ADL) grid must have an associated note of

explanation per correction within the observation period.

b) A quarterly, annual, or summary note will not substitute for Documentation which is date specific to the observation period.

c) Improper or illegible corrections will not be accepted for the MDS case mix documentation review.

d) All documentation, including corrections, must be part of the original legal medical record.

e) Any and all MDS coding and interpretation questions shall be referred to the local State RAI Coordinator.

f) Late entry documentation more than 72 hours from the ARD will not be accepted

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Nevada Supportive Documentation Guidelines

Signature Date at Z0400:

a) Interview items (BIMS and PHQ-9) must be conducted during the observation periods stated in the RAI Manual and the signature date entered at Z0400 must be prior to or on the ARD.

b) The signature date for these interview items entered at Z0400 must match the date the interview was actually conducted in the medical records. If these dates do not match, facility will not receive credits for these interview items due to conflicting documentation.

c) In the rare situation that interview items were collected (completed) by two people or by the same person but on different dates, (e.g. half of the interview questions were conducted on the next day), each person must enter the signature date at Z0400 and indicate specific interview questions conducted (e.g. D0200 2.A through D; D0200 2.E through I and D0300) in "Sections."

d) The definition of "date collected" and "date completed": date information was collected and coding decision were made. They are one, the same date. This is not the same as the data entry date.

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Nevada Supportive Documentation Guidelines

Available online at: http://dhcfp.nv.gov/pgms/LTSS/LTSSnursing (Resources/MDS Guidelines)

Resource Utilization Group, Version III, Revised

For MDS 3.0 Assessments with an ARD on or after 10/01/2016 based on MDS 3.0 RAI Manual

MDS 3.0 Location, Field Description, Observation Period	RUG-III Categories Impacted	Minimum Documentation and Review Standards Required during the Specific Observation Period Denoted in Column One	Nevada Specific Requirements
E0100B Delusions **(7-day look back)**	-Behavior Problems	**Delusions defined:** • Example of a fixed, false belief not shared by others that a resident holds even in the face of evidence to the contrary. **Does NOT include:** • A resident's expression of a false belief when easily accepts a reasonable alternative explanation.	Document As Evidenced By (AEB) example within the observation period.
E0200A Physical behavioral symptoms *directed toward others* **(7-day look back)**	-Behavior Problems	• Example and frequency of physical behavior symptoms direct toward others. • Hitting, kicking, pushing, scratching, abusing others sexually.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
E0200B Verbal behavioral symptoms *directed toward others* **(7-day look back)**	-Behavior Problems	• Example and frequency of verbal behavior symptoms directed toward others. • Threatening others, screaming at others, cursing at others.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
E0200C Other behavioral symptoms *not directed toward others* **(7-day look back)**	-Behavior Problems	• Example and frequency of other behavior symptoms NOT directed toward others. • Hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste, or verbal/vocal symptoms like screaming, disruptive sounds.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
E0800 Rejection of Care Presence and frequency **(7-day look back)**	-Behavior Problems	Example of the resident's rejection of care (e.g. blood work, taking medications, ADL assistance) that is necessary to achieve the resident's goal for health and well-being. When rejection/decline of care is first identified, it is investigated to determine if the rejection/decline of care is a matter of the resident's choice. Education is provided (risks and benefits) and the resident's choice becomes part of the plan of care. On future assessments, this behavior would not be coded again in this item.	Document As Evidenced By (AEB) example within the observation period – must include frequency.
E0900 Wandering - Presence and Frequency **(7-day look back)**	-Behavior Problems	Example and frequency of wandering from place to place without a specified course or known direction. **Does NOT include:** • Pacing, walking for exercise or out of boredom. • Traveling via a planned course to another specific place (dining room or activity).	Document As Evidenced By (AEB) example within the observation period – must include frequency.

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Nevada Supportive Documentation Guidelines

Signature Date at Z0400:

a) Interview items (BIMS and PHQ-9) must be conducted during the observation periods stated in the RAI Manual and the signature date entered at Z0400 must be prior to or on the ARD.

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d) The definition of "date collected" and "date completed": date information was collected and coding decision were made. They are one, the same date. This is not the same as the data entry date.

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Additional Resource Contacts

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Questions?

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