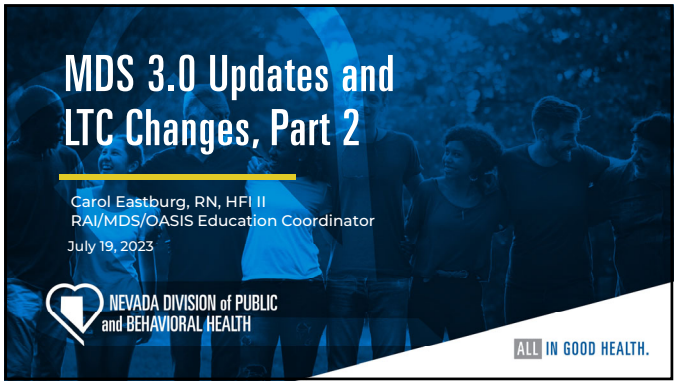
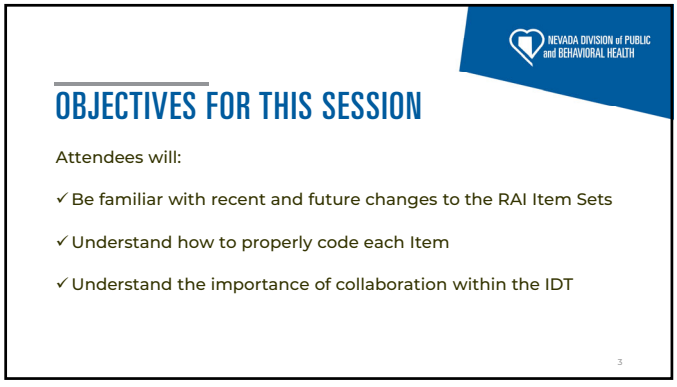

MDS 3.0 Updates and LTC Changes, Part 2
Carol Eastburg, RN, HFI II
RAI/MDS/OASIS Education Coordinator
July 19, 2023
NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH
ALL IN GOOD HEALTH.

1


NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH
AGENDA
09:00 – 10:10 Carol Eastburg presents
10:20 – 11:30 Chris Christiano presents
11:30 – 12:00 Post-test/Eval
2

2


NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH
OBJECTIVES FOR THIS SESSION
Attendees will:
✓ Be familiar with recent and future changes to the RAI Item Sets
✓ Understand how to properly code each Item
✓ Understand the importance of collaboration within the IDT
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DISCLAIMER

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

CMS has not provided state RAI Coordinators with any formal training regarding the changes coming to MDS 3.0 October 1, 2023, except for the recent CMS two-part training (to which you all were also invited).

The information in this presentation was current when assembled. As CMS frequently makes changes, the information presented here may also change.

You 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 requirements for CMS certified facilities.

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SECTION I: ACTIVE DIAGNOSES

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Intent:

The items in this section are intended to code diseases that have a **direct relationship** to the resident's **current** functional, cognitive, and mood or behavior status, medical treatments, nursing monitoring, or risk of death … to generate an updated, **accurate** view of the resident's *current overall* health status.

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SECTION I: ACTIVE DIAGNOSES

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Definition of Active Diagnoses:

Physician* documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day** look-back period.

*includes allowed non-physician practitioner

**30-day look-back for UTI

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SECTION I: ACTIVE DIAGNOSES

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Definition of Functional Status and Limitations:

Decreased range of motion, contractures, muscle weakness, fatigue, paresis, paralysis or decreased ability to perform ADLs.

Definition of Nursing Monitoring:

Clinical monitoring by a licensed nurse required for (serial blood pressure evaluations, observation related to medication dose adjustments, etc.).

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SECTION I: ACTIVE DIAGNOSES

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

I0020. Indicate the resident's primary medical condition category
Complete only if A0310B = 01 or if state requires completion with an OBRA assessment

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

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Primary Medical Condition Example 1:

Resident A (67) has a documented 10-year history of Alzheimer's dementia and a five-year history of insulin dependent diabetes; was admitted to acute care 10 days ago with hemiplegia secondary to a non-traumatic subarachnoid hemorrhage and transferred to your facility yesterday.

I0020 Code = _____

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SECTION I: ACTIVE DIAGNOSES

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Primary Medical Condition Example 2:

Resident B, who is 82 years young was hospitalized with a hip fracture, had a total hip replacement and is admitted to your building for rehab. The admitting physician documented Resident B's primary medical condition as a total left hip replacement in the medical record; the hospital discharge summary documented a left hip fracture occurred the day of the resident's admission there five days ago.

I0020 Code = _____

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SECTION I: ACTIVE DIAGNOSES

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Primary Medical Condition Example 3:

Resident C, (78) w/ long hx of HTN; THR two years ago; just discharged after an extended acute care stay for idiopathic pancreatitis; has central line, receiving TPN, regular blood glucose monitoring with insulin coverage; goal to transition from NPO to full oral intake. Hospital DC diagnoses including idiopathic pancreatitis, HTN and malnutrition have been incorporated into the SNF record.

I0020 Code = _____

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SECTION I: ACTIVE DIAGNOSES

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

	Infections
☐	I1700. **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)

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STEPS FOR ASSESSMENT

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There are two look-back periods for this section:

- Diagnosis identification (Step 1) is a 60-day look-back period.
- Diagnosis status: Active or Inactive (Step 2) is a seven-day look-back period (except for Item I2300 UTI).

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URINARY TRACT INFECTION

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Item I2300 Urinary tract infection (UTI):

- The UTI has a look-back period of **30 days** for active disease.
- Code **only if both of the following** are met in the last 30 days:
  1. It was determined the resident had a UTI using evidence-based criteria such as McGeer, NHSN, or Loeb in the last 30 days, **AND**
  2. A physician (or allowed non-physician provider) documented a diagnosis of UTI in the last 30 days.

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INFORMATION SOURCES

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Include, but are not limited to:

Transfer documents, physician progress notes, recent history and physical, recent discharge summaries, recent nursing assessments/care plans, medication administration records, a diagnosis/problem list, physician orders, specialist consults, official diagnostic (lab, radiological, nerve conduction test reports) etc.

History obtained from patient/family members **only** when also documented in the medical record by the physician within the specified timeframe.

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CODING TIPS

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

In the absence of specific documentation that a disease is active, the following indicators may be used to confirm active disease:

Documentation of a recent onset or acute exacerbation of a disease or condition indicated by a positive study, test or procedure, hospitalization for acute symptoms and/or recent change in therapy in the last 7 days.

Examples of a recent onset or acute exacerbation include the following: new diagnosis of pneumonia indicated by chest X-ray; hospitalization for fractured hip; or a blood transfusion for a hematocrit of 24. Sources may include radiological reports, hospital discharge summaries, doctor's orders, etc.

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ACTIVE DIAGNOSIS

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Example A:

A resident is prescribed hydrochlorothiazide for hypertension and requires regular blood pressure monitoring to determine if blood pressure parameter goals are achieved with the current regimen. Physician progress note documents hypertension.

Item **I0700, Hypertension**, would be indicated as active due to the need for skilled nursing to regularly monitor the resident's blood pressure to determine if the medication is effective or requires any adjustment.

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ACTIVE DIAGNOSIS

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Example B:

A resident with atrial fibrillation is prescribed Warfarin to decrease the risk of embolic stroke. The resident must be monitored for changes in heart rhythm, abnormal bleeding and coagulation tests.

Item **I0300, Atrial fibrillation**, would be coded as active due to the need for skilled nursing to regularly monitor the resident's heart rate and rhythm, along with side effects related to the medication and labs to check coagulation times.

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INACTIVE DIAGNOSIS

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Example C:

According to the admission history, the resident had pneumonia two months prior to this admission. The resident recovered completely and has had no residual effects or continued treatment during the 7-day look back period.

I2000, Pneumonia, would not be coded because the resident had no symptoms of active disease, nor did they receive any treatment for pneumonia during the look back period.

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INACTIVE DIAGNOSIS

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Example D:

A resident's problem list includes a diagnosis of coronary artery disease with angioplasty three years ago. The resident is asymptomatic and not taking any medication related to CAD.

I0400, Coronary Artery Disease, would not be coded because the resident had no symptoms or treatment for this problem during the 7-day look back period.

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INACTIVE DIAGNOSIS

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Example E:

A resident fell and fractured a hip two years ago. Following surgical repair, the resident had several weeks of physical therapy with the goal to regain their pre-fall ambulation status of independent without any assistive devices. The resident now uses a walker and requires assistance with sit to stand and lower body dressing.

I3900, Hip Fracture, would not be coded because the resident received no skilled therapy services for this problem during the 7-day look back period.

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INACTIVE DIAGNOSIS

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Example F:

A resident was admitted with no documented psychiatric diagnoses. After admission, the primary provider ordered an antipsychotic medication secondary to the resident resisting personal care. The medical record lacked a detailed evaluation by an appropriate practitioner of the resident's mental, physical, psychosocial, and functional status and persistent behaviors for six months prior to the start of the antipsychotic medication, in accordance with professional standards. (PASRR?)

I6000, Schizophrenia, should not be coded due to a lack of documentation of a detailed evaluation of the resident's mental, physical, psychosocial, functional status and persistent behaviors for the time period required.

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SECTION J: HEALTH CONDITIONS

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J2000. Prior Surgery - Complete only if A0310B = 01	
Enter Code ☐	Did the resident have major surgery during the **100 days prior to admission**? 0. **No** 1. **Yes** 8. **Unknown**
J2100. Recent Surgery Requiring Active SNF Care - Complete only if A0310B = 01 or if state requires completion with an OBRA assessment	
Enter Code ☐	Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay? 0. **No** 1. **Yes** 8. **Unknown**

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MAJOR SURGERY

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Refers to a procedure that meets the following criteria:

1. The resident was an inpatient in an acute care hospital for at least one day in the 100 days prior to admission to the skilled nursing facility (SNF), **and**

2. The surgery carried some degree of risk to the resident's life or the potential for severe disability.

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REQUIRE ACTIVE SNF CARE?

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Identify recent surgeries:

The surgeries in this section must have been documented by a physician (or NPP) In the last 30 days and must have occurred during the inpatient stay that immediately preceded the resident's Part A admission to the SNF.

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REQUIRE ACTIVE SNF CARE?

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Determine whether the surgeries require active care during the SNF stay:

Once a recent surgery is identified, it must be determined if the surgery requires active care during the SNF stay. Surgeries requiring active care during the SNF stay are surgeries that have a direct relationship to the resident's primary SNF diagnosis, as coded in I0020B.

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REQUIRE ACTIVE SNF CARE?

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

In the rare case of missing documentation indicating a surgery requires active SNF care, the following indicators may be used to confirm the status:

For example:

- Skilled surgical wound care/management (dressing changes, observation for s/s infection);

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REQUIRE ACTIVE SNF CARE?

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Missing documentation indicators may be used to confirm the status examples continued:

- Daily skilled therapy to restore functional loss after surgical procedures;
- Administration of medications and monitoring that requires skilled nursing.

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RECAP/SUMMARY

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Defined/discussed how to determine the following:

- Active and inactive diagnoses
- Functional status and limitations
- Nursing monitoring
- Different look-back periods (UTI = 30 days)/criteria x2
- Documentation required and where to find it
- Major surgery and required skilled care in a SNF

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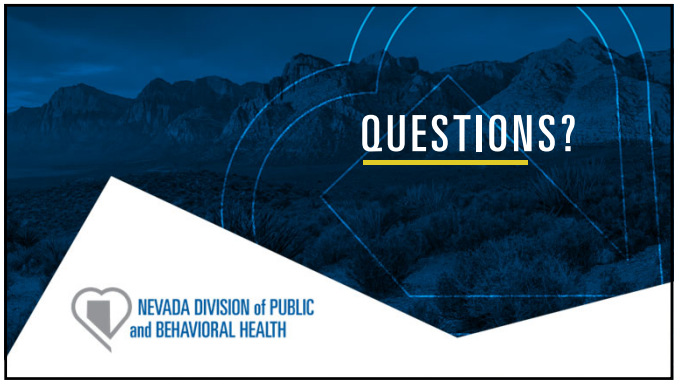

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CONTACT INFORMATION

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Carol Eastburg, RN
Health Facilities Inspector II
RAI/MDS/OASIS Education Coordinator
ceastburg@health.nv.gov
(702) 622-9380 (Direct line)

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ACRONYMS

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

- 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
- MDS – Minimum Data Set
- NAC – Nurse Assessment Coordinator

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ACRONYMS

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

- NF – Nursing Facility
- NHSN – National Healthcare Safety Network
- NPP – Non-Physician Practitioner
- PHQ – Patient Health Questionnaire
- RAI – Resident Assessment Instrument
- SNF – Skilled Nursing Facility
- TPN – Total Parenteral Nutrition

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RESOURCES& LINKS

NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual

https://pro.psycom.net/assessment-diagnosis-adherence/schizophrenia

https://www.verywellhealth.com/how-schizophrenia-is-diagnosed-5114038

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Joe Lombardo
Governor

Richard Whitley
Director

Medicaid Review Process

Division of Healthcare Financing and Policy
Christopher Christiano RN RAC-CT HCC IV
State of Nevada Case Mix Coordinator
July 19th,2023

Department of Health and Human Services

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

1

Agenda

- Overview of Nevada Medicaid Case Mix Program
- Nevada Medicaid Facility review process
- PDPM transition
- Nevada Documentation Guidelines
- Questions

2

2

Introduction

- The Case Mix Review program determines free standing Nursing facilities registered with Nevada Medicaid reimbursement rates.
- Case Mix refers to the mixture of residents cared for in a Nursing facility.
- Case Mix Reimbursement considers the resident's clinical condition & the resources needed to provide appropriate care
- Nevada's case mix program is overseen by a State Case Mix coordinator and staffed with RNs who are RAC-CT certified
- We review around 60 nursing facilities in Nevada.

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Introduction Continued….

- Reviews are done annually based on a quarterly data for chosen review period.
- Follow-up reviews are done more frequently if facility scores less than 60 % for a specified quarter.
- We review a 20% sample size of occupied beds on the day of review.
- Units that work in conjunction with Case Mix program are Rates and Long-term support services units.

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Case Mix Verification Reviews

- Conducted by Medicaid district office registered Nurses
- Training is provided in reviews
- Lead nurse available to assist facility after reviews
- Tools used: CMS RAI manual, CMS updates and Nevada documentation guidelines

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Our Team Members

- Each team has 2 primary review staff
- Lead Review Nurse
- Support review nurse

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Purpose of Reviews

- Reviews ensure that Medicaid reimbursement is accurate and appropriate.
- Determine accuracy of MDS scores
- Provide training to facility staff to improve accuracy of coding and supportive documentation
- Identify individuals who may benefit from a FOCIS(Facility Outreach and Community Integration Services) referral.
- Identify potential fraud and abuse of the Medicaid program and make referrals for investigation

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Review process procedures

- Notification of review
- Entrance meeting
- Pre-chart review
- Review of RUG items
- Exit Meeting
- Post review process
- Follow up training

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What is Medicaid looking for?

- Verifying accuracy of MDS items coded
- Codes submitted match the MDS
- Medical record documentation supports the coding on the MDS (per RAI manual intent, process, definitions, coding, instructions, and clarifications) and any of Medicaid's Nevada supportive documentation guidelines
- Items coded occurred within specified look-back period
- Facilities should implement internal processes that strive for 100% accuracy

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Importance of Accuracy of MDS Assessments

- Reflects an accurate resident status as of the ARD
- Essential in developing appropriate Care Plan
- Appropriate reimbursement
- Avoid the appearance of fraud or abuse

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Accuracy Resources

- The RAI Manual is the resource for MDS coding instructions: always use current version. Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual | CMS
- In Nevada, the MDS is not a sole source document which means there must be supporting documentation in the resident's medical record to support MDS coding.
- Nevada has State specific documentation requirements: NV Supportive Documentation Guidelines

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Reimbursement

- Base rates are paid based on Case Mix Index (CMI) data reported by facilities.
- Additional reimbursement to facilities is available through Nevada's supplemental payment program.
- Supplemental payments are based on review scores and are in addition to base rates paid.

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Reimbursement continued

- All MDS RUG scores transmitted into the state database are averaged each quarter & the facility-specific rate is adjusted accordingly
- Facility submits a Payor Source Document to Myers & Stauffer (NV Medicaid Case Mix Consultants) quarterly to identify all individuals' current payment source (regardless of payment source identified when the MDS was transmitted).

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Data collection & coding decisions

- Collect information from all sources permitted by the instructions
- Collect information for the time frame on the look-back period on. Always refer to the look back period for each section being reviewed, unless specified otherwise and apply the item specific rules from the RAI Manual.
- *Anything that happened before or after the look-back period does not go on the MDS*

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Types of Errors

- **No Documentation** – there was no documentation found to support the RUG item code
- **Out of ARD** – documentation existed, but was not within the CMS-defined ARD range
- **Conflicting Documentation–** within the ARD there was conflicting documentation in the medical record
- **Wrong Code**–code on the MDS is different from that transmitted to the state repository, OR the MDS coordinator states that they coded the item incorrectly

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Errors cont'd …

- **Conflicting Documentation** – there were two or more statements documented within the ARD range that conflicted. EX. C0700 Short term memory was coded "05" & the Soc. Services Notes indicated "able to speak clearly & recognizable". *Note: Available codes for C0700 are "0" and "1".*
- **Wrong Code** – the code on the MDS is different from that transmitted to the repository **OR** the MDS coordinator states that they coded the item incorrectly. This may have a significant impact on the facility's reimbursement, could be considered fraudulent reporting, and could indicate that the QI (quality indicators) were incorrectly reported to CMS

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Documentation Basics

- Must be signed by the appropriate staff
- Must be dated (Month, Day, and Year)
- Must have residents name on it
- Must be legible
- Must have been documented within the ARD look-back period
- ***NOTE:*** *We often identify appropriate documentation that is not acceptable because of one or more of the above*

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Let's Compare HCQC vs. Medicaid

- HCQC
- Surveyors or inspectors
- Ensures federal and state regulatory requirements are met
- Looks from most current MDS assessment date and compare to previous forward (care planning; care plans implemented; timing)
- Looks at quality of care and quality of life issues. If problems are identified, "cites facility with a deficiency"

- Medicaid
- Are called "reviewers"
- Ensures Medicaid payment is accurate
- Looks from ARD back in time
- Documentation supports coding
- If documentation is different than the code on the MDS, tells the facility they have an error and how to correct it.

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Current Case Mix program

- Nevada previously used the RUG III review process for reviews.
- CMS implemented that states transition to a new system Patient Driven Payment Model (PDPM)
- Nevada will fully transition to PDPM by July 1st, 2024.

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Current Case Mix program continued…

- PDPM differs from RUG III model in that RUG III focused on volume of services
- PDPM is driven by residents' condition and resulting care needs and improvement.
- Designed to provide incentives to treat whole needs of residents not just conditions.

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Current Case Mix program continued…

- Review process was historically an on-site facility review.
- Review process will transition to mostly remote reviews in the future.
- Ongoing changes may occur as we transition to PDPM and remote reviews

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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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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
E1100B 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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Additional Resource Contacts

Carol Eastburg, RN
Health Facilities Inspector II
RAI/MDS/OASIS Education Coordinator
(702) 622-9380 (Office)
DPBHCMS-MDS@health.nv.gov

Christopher Christiano, RN, RAC-CT
Statewide MDS Coordinator
(775) 687-1925 (Office)
MDS-PDPM@dhcfp.nv.gov

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References

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Questions?

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