



A SPECIAL EDITION Bulletin Brought To You By Polaris Group

SPECIAL EDITION

MDS Corner



As of July 15 2010, CMS has released all updated sections of the *RAI User's Manual* for the MDS 3.0, except for Appendix F. A list of the major changes to each section included in Chapter 3 of the manual is as follows:

Section A: Identification Information

- A1700: Type of Entry – Clarification on coding instructions. (pg. A-18)
- A2000: Discharge Date – Clarification of Discharge Date: For Discharge Assessments, the Assessment Reference Date (ARD) must be Discharge Date, which is the date the resident leaves the building. (pg. A-21)
- A2400C: Coding Instructions for End Date of Most Recent Medicare Stay (pg. A-25)

Section B: Hearing, Speech, and Vision

- Visual Aids do not include surgical lens implants. (pg. B-11)

Section C: Cognitive Patterns

- C0200-C0500: Brief Interview for Mental Status (BIMS) – Changes related to circumstances that BIMS questions are given in writing and resident answers in writing. Details in Appendix E. (pg. C-5)
- C0500 Summary Score – Example of coding the summary score on the BIMS. (pg. C-15)

Section D: Mood

- D0200: Resident Mood Interview (PHQ-9) – Conduct the interview preferably the day before or the day of the Assessment Reference Date (ARD). (pg. D-4)

Section E: Behavior

- E0800: Rejection of Care (addition) (pg.E-13)
- New Definitions of Rejection of Care and Interference with Care (pg.E-14)
- New example for Psychosis (pg. E-3)

Section F: Preferences for Customary Routine and Activities

- Minor changes to wording.

Section G: Functional Status

- New Balance During Transitions and Walking Algorithm. (pg. G-21)
- G0110: Toilet Use – Do Not include the emptying of bedpans, urinals, bedside commodes, catheter bags, or ostomy bags in this section. (pg G-7)
- G0120B: Revised coding tips for bathing. (pg. G-18)
- G0400: Functional Limitation in Range of Motion – added steps to the assessment process for ROM. (pg. G-30)

Section H: Bladder and Bowel

- Added coding tips for intermittent catheterization – Do not include one time catheterization for urine specimen during look back period as intermittent catheterization. (pg. H-2)

Section I: Active Diagnoses

- Diagnosis Identification period is 60 days (previous 30 days). (pg. I-3)
- I2300: Urinary Tract Infection-The UTI has a look-back period of 30 days for active or in-active disease status instead of 7. Clarification regarding Urinary Tract Infections based on guidelines from the Center for Disease Control (CDC). (pg. I-8)



Section J: Health Conditions

- J0300-J0600: Pain Assessment Interview – The pain interview should be conducted close to the end of the 5-day look-back period, preferably the day before or the day of the ARD. (pg. J-7)
- J1550: Problem Conditions – Changes to intent and coding tips on fever clarification. (pg. J-25)

Section K: Swallowing/Nutritional Status

- K0200: Height and Weight- Steps for Assessment for K0200A, Height (pg. K-3)
- K0500: Nutritional Approaches - Clarification regarding what IV fluids and feedings can be coded. (pg. K-9)

Parenteral/IV feeding may only be included “when there is supporting documentation that reflects the need for additional fluid intake specifically addressing nutrition or hydration need. This supporting documentation should be noted in the resident’s medical record according to state and/or internal facility policy.”

IV fluids administered solely for the purpose of prevention of dehydration should not be coded in Item K0500A unless there is an active diagnosis of dehydration.

Section L: Dietary/Oral Status

- Minor changes in wording.

Section M: Skin Conditions

- Addition to intent: “Be certain to include in the assessment process, a holistic approach. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.” (pg. M-1)
 - Additions to Planning for Care: (pg.M-1)
- ⇒ “Throughout this section, terminology referring to ‘healed’ vs. ‘unhealed’ ulcers refers to whether or not the ulcer is ‘closed’ vs. ‘open.’ When considering this, recognize that Stage 1, DTI, and unstageable pressure

ulcers although ‘closed,’ (i.e. may be covered with tissue, eschar, slough, etc.) would not be considered ‘healed.’”

⇒ “Facilities should be aware that the resident is at higher risk of having the area of a closed pressure ulcer open up due to damage, injury, or pressure, because of the loss of tensile strength of the overlying tissue. Tensile strength of the skin overlying a closed pressure ulcer is 80% of normal skin tensile strength. Facilities should put preventative measures in place that will mitigate the opening of a closed ulcer due to the fragility of the overlying tissue.”

- Tools other than Norton and Braden can be used for determination of risk.
- Revised definitions.
- Revised/new steps for assessment and coding tips.
- Added 16 pages of Scenarios for Pressure Ulcer Coding (pg. M-36)

Section N: Medications

- New coding tips for herbal and alternative medicine products. (N-8)

Section O: Special Treatments, Procedures, and Programs

- O0100H: IV Medications - Dextrose 50% and/or Lactated Ringers given intravenously are not considered medications, and should not be coded in Item Set. (pg. O-3)
- O0400: Therapies

Addition to Therapy Start Date: “This is the date the initial therapy evaluation is conducted regardless if treatment was rendered or not.” (pg. O-15)

Addition to Therapy End Date: “This is the last date the resident received skilled therapy treatment.” Therapy regimen may through day of discharge when a resident is unexpectedly discharged to the hospital for example; which would be indicated by “dashes” since therapy was ongoing at time of discharge. (pg. O-15)



- Additions to coding tips for minutes of therapy: (pg. O-16)
- ⇒ “The time for the interruption is not considered treatment time and shall not be coded as therapy minutes.”
- ⇒ “Minutes reported on the MDS may not match the time reported on a claim. For example, therapy aide set-up time is recorded on the MDS when it precedes skilled individual therapy; however, the therapy aide time is not included for billing purposes on a therapy Part B claim.” (pg. O-17)
- ⇒ Addition to Non-Skilled Services: “When a resident refuses to participate in therapy, it is important for care planning purposes to identify why the resident is refusing therapy. However, the time spent investigating the refusal or trying to persuade the resident to participate in treatment is not a skilled service and shall not be included in the therapy minutes.” (pg. O-18)
- ⇒ Clarification regarding coding when a therapy student is involved in treatment. (pg. O-19)
- ⇒ New information regarding Therapy Modalities and Dates of Therapy. (pg. O-21)

Section P: Restraints

- Minor changes to wording.

Section Q: Participation in Assessment and Goal Setting

- Addition to Participation – Planning for Care: “During care planning meetings, if the resident is present, he or she should be made comfortable and verbal communication should be directly with him or her.” (pg. Q-1)
- Q0400: Addition to Discharge Plan – Health-Related Quality of Life: “For residents that have been in the facility for a long time, it is important to discuss with them their interest in talking with local contact agency (LCA) experts about returning to the community. There are improved community resources and supports that may benefit these residents and allow

them to return to a community setting.” (Q-8)

- Addition to Discharge Plan – Planning for Care: “Important progress has been made so that individuals have more choices, care options, and available supports to meet care preferences and needs in the least restrictive setting possible. This progress resulted from the U. S. Supreme Court Olmstead ruling, which states that residents needing long-term care services have a right to receive services in the least restrictive and most integrated setting.” (Q-8)
- Additions to Discharge Plan – Planning for Care: Minimum discharge instructions.
- Additions to Discharge Plan – Coding Tips.
- Additional examples provided.

Section V: Care Area Assessment (CAA) Summary

- Minor changes to wording.

Section Z: Assessment Administration

- With MDS 3.0 implementation on October 1, 2010, the initial Medicare RUG-IV Version Code is “1.0066.” (pg. Z-3)
- Other minor changes.

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