MDS 3.0 – v1.15.1
Be Ready for the New Items!

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What We’ll Cover

- New items added to Section N
- Expansion of Section P
- RAI Manual – October 1, 2017
Overview of v1.15

- 1,393 pages
- 90 pages of change tables (21)
  - New and deleted verbiage; instruction changes
  - 5 change tables to update internal and external references
    - Title Page
    - Chapter 1
    - Chapter 6
    - Appendix C
  - 16 change tables with significant changes affecting the IDT and MDS Coordinators
- Chapter 2
- Chapter 3
  - Section A
  - Section B
  - Section G
  - Section H
  - Section I
  - Section J
  - Section L
  - Section M
  - Section N
  - Section O
  - Section P
  - Section Q
- Chapter 4
- Appendix A
RAI User’s Manual
(Are you archiving your manuals?)

Why New Items?

- Person-Centered Care
- Alignment with Requirements of Participation (RoPs)
Section N – N0410H

<table>
<thead>
<tr>
<th>Medication Type</th>
<th>Indicate the number of days the resident received the medication, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days. Enter “0” if medication was not received by the resident during the last 7 days.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Antipsychotic</td>
<td></td>
</tr>
<tr>
<td>B. Antianxiety</td>
<td></td>
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<tr>
<td>C. Antidepressant</td>
<td></td>
</tr>
<tr>
<td>D. Antiparkinson</td>
<td></td>
</tr>
<tr>
<td>E. Antiepileptic (e.g., neuroleptics, antidepressants)</td>
<td></td>
</tr>
<tr>
<td>F. Antibiotic</td>
<td></td>
</tr>
<tr>
<td>G. Diuretic</td>
<td></td>
</tr>
<tr>
<td>H. Opioid</td>
<td>NEW</td>
</tr>
</tbody>
</table>

Coding Instructions

N0410H, Opioid: Record the number of days an opioid medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
Coding Tips/Special Populations

Opioid medications can be an effective intervention in a resident’s pain management plan, but also carry risks such as overuse and constipation. A thorough assessment and root-cause analysis of the resident’s pain should be conducted prior to initiation of an opioid medication and re-evaluation of the resident’s pain, side effects, and medication use and plan should be ongoing.

Opioids

- Fentanyl – Duragesic, Fentora, Actiq
- Hydrocodone – Zohydro ER, Hysingla ER
- Hydrocodone/Acetaminophen – Lortab, Vicodin, Norco
- Codeine
- Meperidine - Demerol
- Oxycodone – OxyContin – Roxicodone
- Oxycodone/Acetaminophen – Percocet, Roxicet
- Hydromorphone – Dilaudid, Exalgo
- Morphine – MS Contin, Avinza, Ora-Morph SR
Section N – N0450

Item Rationale

- The use of unnecessary medications in long term care settings can have a profound effect on the resident’s quality of life.
- Antipsychotic medications are associated with increased risks for adverse outcomes that can affect health, safety, and quality of life.
- In addition to assuring that antipsychotic medications are being utilized to treat the resident’s condition, it is also important to assess the need to reduce these medications whenever possible.
Planning for Care

- Identify residents receiving antipsychotic medications to ensure that each resident is receiving the lowest possible dose to achieve the desired therapeutic effects.
- Monitor for appropriate clinical indications for continued use.
- Implement a system to ensure gradual dose reductions (GDR) are attempted at recommended intervals unless clinically contraindicated.

Let’s Look Closer

[Image of let's look closer section]
Coding Tips

- Any medication that has a pharmacological classification or therapeutic category as an antipsychotic medication must be recorded in this section, regardless of why the medication is being used.
- In this section, the term physician also includes physician assistant, nurse practitioner, or clinical nurse specialist.
- Do not include Gradual Dose Reductions that occurred prior to admission to the facility (e.g., GDRs attempted during the resident's acute care stay prior to admission to the facility).
- Physician documentation indicating dose reduction attempts are clinically contraindicated must include the clinical rationale for why an attempted dose reduction is inadvisable. This decision should be based on the fact that tapering of the medication would not achieve the desired therapeutic effects and the current dose is necessary to maintain or improve the resident's function, well-being, safety, and quality of life.

More Coding Tips

- Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless physician documentation is present in the medical record indicating a GDR is clinically contraindicated. After the first year, a GDR must be attempted at least annually, unless clinically contraindicated.

- Do not count an antipsychotic medication taper performed for the purpose of switching the resident from one antipsychotic medication to another as a GDR in this section.
And...

- In cases where a resident is or was receiving **multiple antipsychotic medications on a routine basis**, and one medication was reduced or discontinued, record the date of the reduction attempt or discontinuation in N0450C, Date of last attempted GDR.

- If **multiple dose reductions** have been attempted since admission/entry or reentry or the prior OBRA assessment, **record the date of the most recent reduction attempt** in N0450C, Date of last attempted GDR.

Regulatory References

F757 – Unnecessary Drugs
F758 – Psychotropic Drugs

- Each resident’s entire drug/medication regimen is managed and monitored to promote or maintain the resident’s highest practicable mental, physical, and psychosocial well-being.

- Each resident’s drug regimen must be free from unnecessary drugs.

- The facility implements gradual dose reductions (GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication.
Item Rationale

- An alarm is any physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected, and may include bed, chair and floor sensor pads, cords that clip to the resident’s clothing, motion sensors, door alarms, or elopement/wandering devices.
- While often used as an intervention in a resident’s fall prevention strategy, the efficacy of alarms to prevent falls has not been proven; therefore, alarm use must not be the primary or sole intervention in the plan.
- The use of an alarm as part of the resident’s plan of care does not eliminate the need for adequate supervision, nor does the alarm replace individualized, person-centered care planning.
- Adverse consequences of alarm use include, but are not limited to, fear, anxiety, or agitation related to the alarm sound; decreased mobility; sleep disturbances; and infringement on freedom of movement, dignity, and privacy.

Coding Tips

- Bed alarm includes devices such as a sensor pad placed on the bed or a device that clips to the resident’s clothing.
- Chair alarm includes devices such as a sensor pad placed on the chair or wheelchair or a device that clips to the resident’s clothing.
- Floor mat alarm includes devices such as a sensor pad placed on the floor beside the bed.
- Motion sensor alarm includes infrared beam motion detectors.
- Wander/elopement alarm includes devices such as bracelets, pins/buttons worn on the resident’s clothing, sensors in shoes, or building/unit exit sensors worn/attached to the resident that alert the staff when the resident nears or exits an area or building. This includes devices that are attached to the resident’s assistive device (e.g., walker, wheelchair, cane) or other belongings.
- Other alarm includes devices such as alarms on the resident’s bathroom and/or bedroom door, toilet seat alarms, or seatbelt alarms.
More Coding Tips

- Identify all alarms that were used at any time (day or night) during the 7-day look-back period.
- If an alarm meets the criteria as a restraint, code the alarm use in both P0100, Physical Restraints, and P0200, Alarms. Review F604 – Appendix PP.
- Bracelets or devices worn or attached to the resident and/or his or her belongings that signal a door to lock when the resident approaches should be coded in P0200F Other alarm, whether or not the device activates a sound.
- Do not code a universal building exit alarm applied to an exit door that is intended to alert staff when anyone (including visitors or staff members) exits the door.
- While wander, door, or building alarms can help monitor a resident’s activities, staff must be vigilant in order to respond to them in a timely manner. Alarms do not replace necessary supervision.

Planning for Care

- Individualized, person-centered care planning surrounding the resident’s use of an alarm is important to the resident’s overall well-being.
- When the use of an alarm is considered as an intervention in the resident’s safety strategy, use must be based on the assessment of the resident and monitored for efficacy on an ongoing basis, including the assessment of unintended consequences of the alarm use and alternative interventions.
- There are times when the use of an alarm may meet the definition of a restraint, as the alarm may restrict the resident’s freedom of movement and may not be easily removed by the resident.
  - Evaluate whether the alarm affects the resident’s freedom of movement when the alarm/device is in place. For example, does the resident avoid standing up or repositioning himself/herself due to fear of setting off the alarm?
Chapter 2

- Inclusion of nurse aide and member of food and nutrition services staff in preparation of comprehensive care plan.

- Significant change definition now includes Emergence of a condition/disease in which a resident is judged to be unstable.

- Development of baseline Care Plan within 48 hours of admission.

- Inclusion of resident preferences and goals – changes, ongoing discussions w/resident and resident rep.; reflected in comprehensive care plan.
Section A

- All individuals admitted to a Medicaid certified facility, regardless of the individual’s payment source, must have a Level I PASRR screen.

- 2 scenario coding changes involving A0310H = 1 (SNF Part A Discharge)
  - Both involve the last covered day being on the day of or day before the date of discharge

A0600B

www.cms.gov/newcard

Begins April 2018

New Medicare Card Information
Section G – ADL Algorithm
Section G Clarifications

- Coding resident holding onto bar or strap while being transferred via mechanical lift – **NOT** resident participation
- Use of stand-up lift (requires resident to bear weight) to be coded as Extensive Assistance – resident participates/lift provided WB support
- Turning side to side during incontinence care is not coded in Toileting – coded in Bed Mobility
- Transferring in/out of bed or chair for incontinence care or to use bedpan urinal is coded in Transfers; how resident uses bedpan or urinal is coded in Toilet Use
- G0600C...**do not include** geri-chairs, reclining chairs, scooters or other types of specialty chairs

Section GG Clarifications

- Assessment period is first 3 days of Part A stay...conduct prior to treatment interventions when possible to determine true baseline functional status...Assessment can still be conducted if treatment has started...Don’t withhold treatment to conduct the functional assessment.
- Provider may need the entire 3-day assessment period to obtain resident’s usual performance
- Additions/clarifications to coding tips – worth the read!
- Use of the dash (-)...CMS expects dash use for SNF QRP items to be a rare occurrence. Use may cause reduction in annual payment update...**at least one** Self-Care (GG0130) or one Mobility (GG0170) discharge goal must be coded
- Completion of GG items not required if unplanned discharge to an acute-care hospital or if Part A Stay is less than 3 days.
Section H

Addition of self-catheterizations:

Self-catheterizations that are performed by the resident in the facility should be coded as intermittent catheterization (H0100D)

This includes self-catheterizations using clean technique.

Section I – I2300

Code only if both of the following are met in the last 30 days:

1. It was determined that the resident had a UTI using evidence-based criteria such as McGeer, NHSN or Loeb in the last 30 days AND
2. A physician documented UTI diagnosis (or by nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days.

Section J

FALL

CMS understands that challenging a resident’s balance and training him/her to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.

Section L

- Updated definition of edentulous – having no natural permanent teeth in the mouth. Complete tooth loss.

- Dental status – some but not all natural teeth that do not appear damaged (broken, loose, obvious or likely cavity) and does not have any other conditions in L0200A -> G…code as NOA in L0200Z

- Clinical language regarding care planning and working with residents whose dentures or partials fit well and work properly.
Section M Clarifications

- Nod to last year’s NPUAP staging changes:
  - Different terms used: ulcer, injury, sore, decubitus ulcer, bed sore
  - Acceptable to code pressure-related skin conditions if different terminology used in clinical record as long as primary cause of skin alteration is related to pressure
  - Oral mucosal ulcers not coded in M0210...code in L0200C, Abnormal mouth tissue.
  - Mucosal ulcers should not be coded in M0210 either – those related to NG tubes, nasal oxygen tubing, ET tubes, urinary catheters, etc. Not staged using PU staging system because no anatomical comparisons can be made.
  - PU unstageable on admission/entry or reentry but becomes numerically stageable later, code as present on admission at which it first becomes numerically stageable.
  - Review other verbiage changes throughout this section.

Section N Clarifications

- Don’t code OTC medications in N0410D – hypnotics.
  - Herbal/dietary supplements are not coded, i.e. melatonin, chamomile and valerian root.

- Xaralto, Eliquis and Pradaxa are to be coded in N0410E - Target Specific Oral Anticoagulants (TSOACs)
Section O – Respiratory Therapy

- Count only the minutes the respiratory therapist or respiratory nurse spends with the resident.

- Do not include the administration of metered-dose and/or dry powder inhalers in respiratory minutes.

Section O – Physician Exam/Orders

- O0600 & O0700 no longer required by CMS
  - Check with your state RAI Coordinator for completion requirements
  - These are both qualifiers for Clinically Complex RUG in the RUG-III system

- Includes orders written by medical doctors, doctors of osteopathy, podiatrists, dentists, and physician assistants, nurse practitioners, or clinical nurse specialists, qualified dietitians, clinically qualified nutrition professionals or qualified therapists, working in collaboration with the physician as allowable by state law.
  - Review F715 & F808 for definitions of qualified dietitian and clinically qualified nutrition professionals
Section Q

- Participation in assessment, care planning and discharge planning is a civil right for all residents
- Intent of this section is person-centered
- Ensures all individuals have the opportunity to learn about home and community-based services; receive LTC in the least restrictive setting possible
- Q0300...this is the resident’s expectation and should be coded with the resident’s response, even if the opinion of family member/significant other or guardian/legally authorized representative differs. Coding other than the resident’s stated expectation is a violation of the resident’s civil rights.

Section Q (cont’d)

- Civil rights upheld in the 1999 U.S. Supreme Court decision: Olmstead v. L.C. – civil right to receive services in the least restrictive and most integrated setting appropriate to their needs
- LCA responsible for providing information to residents re: community-based services
- LCA and IDT should work closely together
- Each state has a process for referral to LCA – vital to know the process in your state and for your facility.
- Referrals should not be avoided based on facility staff judgment of potential discharge success or failure; resident’s right to be provided information if requested and to receive care in the most integrated setting.
- Q0500B is mandatory on all comprehensive assessments
Chapter 4

Overall care plan oriented towards:

- Assisting the resident in achieving his/her goals.
- Individualized interventions that honor the resident’s preferences.
- Addressing ways to try to preserve and build upon resident strengths.

Added key components of care plan include, but not limited to:

- Resident goals & preferences
- Measurable objective with established timeframes
- Resident’s preference & potential for future discharge and discharge plan

Appendix A

Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function. Respiratory therapy services include coughing, deep breathing, humidified treatments, aerosol treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse. A respiratory nurse must be proficient in the modalities listed above either through formal training or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws.
Tips to Manage MDS Changes

- Obtain copies of the RAI Manual to be used October 1, 2017 through September 30, 2018.
- Ensure all members of IDT have access to the current manual and USE IT!
- Chunk it down – lead your team through the review of changes by section.
- Audit to make sure coding is accurate.
- Address specific questions not covered in the RAI manual – in writing – with your state RAI Coordinator

Don’t Forget!

The MDS is a critical tool in every LTC facility!
MDS data is used to/for:

- Identify potential & actual care issues for each resident
- Individualized person-centered care plan development
  - Reimbursement
- Recertification surveys and complaint investigation
  - Quality Measures
  - Public reporting
Your Attestation Matters

Section Z
Assessment Administration

2460. Signature of Persons Completing the Assessment or Event or Death Reporting

2500A. Signature of RN Assessment Coordinator Verifying Assessment Completion

A. Signature
B. Date RN Assessment Coordinator signed

Resources

- https://www.simpleltc.com/blog/
- https://system.na1.netsuite.com/core/media/media.nl?id=4631915&c=3588261&h=cedb17aa84f572997aa&_xt=.pdf
Questions

TIP: For specific scenarios/questions regarding MDS coding, contact your state RAI Coordinator for direction. DOCUMENT that question & answer.


Our Speaker

Mary Madison is a registered nurse with over 44 years of experience in the healthcare field, with 40 years in the long-term care industry. Mary has held positions of Director of Nursing in a 330-bed SNF, DON in two 60-bed SNFs, Reviewer with Telligen (Iowa QIO), Director of Continuing Education, Manager of Clinical Software Support, Clinical Software Implementer and Clinical Educator. Mary has conducted numerous MDS training and other LTC educational sessions across the country in the past 2+ decades. She joined Briggs Healthcare® as their LTC/Senior Care Clinical Consultant in July 2014.

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