Q0300. Resident’s Overall Expectation
Complete only if A0310E = 1

A. Select one for resident’s overall goal established during initial MDS assessment:
1. Expects to be discharged to the community
2. Expects to remain in this facility
3. Expects to be discharged to another facility/institution
4. Unknown or uncertain

B. Indicate information source for Q0300A
1. Resident
2. If not resident, then family or significant other
3. If not resident, family, or significant other, then guardian
4. Unknown or uncertain
Long-Term Care MDS Coordinator’s Field Guide

Carol Maher, RN-BC, RAC-CT, RAC-MT, CPC
Contents

About the Author .................................................................................................................. vii

The Clinical Role of the MDS ............................................................................................... 1
  Getting Started .................................................................................................................. 3

OBRA MDS Scheduling ...................................................................................................... 7
  Types of Assessment (A0310) .......................................................................................... 8

MDS 3.0 A to Z ..................................................................................................................... 19
  Section A .......................................................................................................................... 19
  A0100: Facility Provider Numbers .................................................................................... 24
  Section B .......................................................................................................................... 38
  Section C .......................................................................................................................... 41
  Section D .......................................................................................................................... 48
  Section E .......................................................................................................................... 52
  Section F .......................................................................................................................... 66
  Section G .......................................................................................................................... 72
  Section GG ....................................................................................................................... 90
  Section H .......................................................................................................................... 110
  Section I .......................................................................................................................... 120
  Section J .......................................................................................................................... 124
  Section K .......................................................................................................................... 145
  Section L .......................................................................................................................... 160
  Section M .......................................................................................................................... 163
  Section N .......................................................................................................................... 193
  Section O .......................................................................................................................... 198
  Section P .......................................................................................................................... 222
  Section Q .......................................................................................................................... 227

MDS as the Basis of Reimbursement (SNF PPS and Medicaid Case-Mix) ......................... 239
  Reimbursement Role of the MDS 3.0 ............................................................................. 239
  Scheduling PPS Assessments .......................................................................................... 240
Mood State CAA .................................................................................................................................293
Behavior CAA ........................................................................................................................................294
Activities CAA ..........................................................................................................................................294
Falls CAA ................................................................................................................................................295
Nutritional Status CAA ............................................................................................................................296
Feeding Tube CAA .....................................................................................................................................297
Dehydration/Fluid Maintenance CAA ........................................................................................................297
Dental Care CAA .......................................................................................................................................298
Pressure Ulcer CAA ....................................................................................................................................299
Psychotropic Medication Use CAA ...........................................................................................................300
Physical Restraints CAA ..........................................................................................................................301
Pain CAA ..................................................................................................................................................302
Return to the Community/Referral CAA ......................................................................................................303
MDS/RAI Process ....................................................................................................................................304

The MDS Correction Process: Modifications vs. Inactivations ...............................................................307

Errors and Corrections ............................................................................................................................307
Modification or Inactivation ......................................................................................................................310
RN Attestation of Completion: X1000 Instructions ..................................................................................312
Inactivation ..............................................................................................................................................316

MDS 3.0 Quality Measures ..........................................................................................................................317

Proposed Quality Measures: Improving Medicare Post-Acute Care
Transformation (IMPACT) Act of 2014 ....................................................................................................317
Episode vs. Stay ........................................................................................................................................318
Five-Star Quality Measures .......................................................................................................................320
New Short-Stay QM ..................................................................................................................................330
Surveyor Use Following QMs ...................................................................................................................349
Payroll-Based Journal (PBJ) ....................................................................................................................350
New Quality Measures Affecting Nursing Home Compare
and the Five-Star Quality Rating System ................................................................................................352
SNF Quality Process Reporting Measures ............................................................................................372
Carol Maher, RN-BC, RAC-CT, RAC-MT, CPC, is a board-certified gerontological registered nurse and a certified professional coder with over 30 years long-term care experience. She has worked in long-term care in many roles. Beginning as a nursing assistant, she later became a charge nurse, a nurse manager, and then an RNAC/MDS coordinator. Maher has worked as an MDS coordinator since the early 1990s in a case-mix state. Managing the case-mix and Medicare PPS processes was her specialty, along with ensuring the residents were correctly assessed and resident-centered care was planned and provided.

Recently, Maher was the senior VP of utilization services and director of reimbursement for large multi-facility organizations. In those roles, she taught MDS intensive classes, Medicare PPS assessment scheduling, and compliance with Medicare regulations. She assisted the California QIO, Lumetra, as their MDS expert for two years.

Maher has worked as one of the gold standard nurses for MDS 3.0. She also served on the CMS RAP work group as the chair for the New RAPS and Format committees. The CMS RAP work group provided input to CMS to assist them to prepare the way for the CAAs for MDS 3.0. Maher also participated on a number of technical expert panels related to MDS, including the RTI technical expert panel to develop quality measures for MDS 3.0 and the CMS TEP to improve care planning. A sought-after speaker, she has given presentations at AANAC, AHCA, and LeadingAge national conferences as well as many state organization presentations. She is also a frequent author of articles related to the RAI process and PPS.

Maher served as a member of the AANAC (American Association of Nurse Assessment Coordination) board of directors for nine years. She is presently serving on the AANAC expert advisory panel and as an AANAC master teacher. Maher is the director of education for Hansen Hunter & Co., providing MDS and Medicare classes to the HHC clients. She also presents monthly educational webinars and completes compliance audits.

She enjoys traveling and spending time with her family when not working. She is the proud mother of three amazing daughters who have all been professional ballet dancers and are now preparing for second careers in the healthcare industry. She is also the grandmother of four adorable grandchildren.
Chapter 1

The Clinical Role of the MDS

The Resident Assessment Instrument (RAI) was developed to help skilled nursing facility (SNF) staff members correctly assess residents and guide their clinical care. Providing care to postacute residents with complex comorbidities is challenging work. The RAI helps SNF staff members gather definitive information on a resident’s strengths and needs, which must be addressed in an individualized care plan. The RAI is composed of three distinct parts:

- Minimum Data Set (MDS)
- Care Area Assessments (CAA)
- RAI Utilization Guidelines

It is important to remember that the primary purpose of the MDS is to help the facility staff develop accurate, individualized care plans so that appropriate care will be provided. This means that the MDS coordinator and interdisciplinary team (IDT) members who complete the MDS assessments are care managers for the residents in long-term care. Accurate assessment is crucial for correct care of the residents. After an accurate MDS has been completed, the clinical team must use their critical-thinking skills to determine the root cause of the residents’ problem areas, using the CAAs to guide their future care plans.

The MDS uses a snapshot view of the residents’ functional, cognitive, psychosocial, and clinical status. By using the same instructions for capturing the residents’ status on each MDS, the facility clinical team can look at each consecutive (required to be reassessed by regulatory timed intervals) MDS response to determine whether the residents have improved or declined.

The MDS coordinator functions as the leader/coordinator of the RAI process. The RAI process requires the review of a resident’s entire medical record with a specific focus on the MDS snapshot (look-back window),
Chapter 1

scripted and unscripted interviews of the residents, interviews of the direct care staff members who care for the resident, and cooperation with the entire IDT to develop an individualized care plan.

Quality Measures (QM) are calculated from the MDS data that have been collected and transmitted to the federal database. These QMs show how the facility compares to other SNFs in the United States. Facilities should use this information to refocus their quality improvement efforts, as necessary.

The Care Area Assessment (CAA) process is the link between the MDS data collection and the individualized resident care plan. The MDS team must use their critical-thinking skills to get to the root cause of the issue and to determine whether a care plan is required.

This CAA decision-making process is designed to assist the assessor to systematically interpret the information recorded on the MDS. Once a care area has been triggered, nursing home providers use current, evidence-based clinical resources to conduct an assessment of the potential problem and determine whether a care plan is required. The CAA process helps the clinician focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the resident. The MDS data collection reports whether the issue happened, and the CAAs help the MDS team determine the cause of the issue and whether it is problematic to the resident.

The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that:

1. The assessment accurately reflects the resident’s status
2. A registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals
3. The assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts

Nursing homes are left to determine:

4. Who should participate in the assessment process
5. How the assessment process is completed
6. How the assessment information is documented while remaining in compliance with the requirements of the federal regulations and the instructions contained within the manual

Successfully utilizing the RAI will lead to an effective, individualized care plan and optimal care for the resident. Optimal care for the residents should result in good QMs and lead the way to good survey outcomes and accurate reimbursement for the services that have been provided. The RAI leads the assessors to get to know the resident as a whole person with unique strengths and needs. Understanding the residents’ needs and choices should lead to a higher quality of care and, therefore, a better quality of life.
Getting Started

Whether you are just beginning your career or are a veteran MDS coordinator, you play a pivotal role in managing the long-term care residents’ care. The MDS coordinator role is vital to:

- Accurate care planning
- QMs
- Accurate reimbursement from state and federal funds

The resource utilization group (RUG) from the prospective payment system (PPS) MDS assessments also provides the basis for Medicare payment. MDS coordinators play a crucial role as a member of the facility’s Medicare team. By understanding the Medicare regulations and Medicare coverage rules, the MDS coordinator can assist the clinical team to make decisions that will provide the resident with appropriate Medicare coverage and ensure that the SNF is working within the regulatory guidelines.

The following tools will aid you during your MDS coordinator journey, including:

- The RAI MDS 3.0 User’s Manual: This manual is an absolute must-have for MDS coordinators. The RAI MDS 3.0 User’s Manual contains the Centers for Medicare & Medicaid Services (CMS) instructions for coding the MDS. It is crucial that you have the most updated version. CMS updates the manual at least annually, typically in October. Having a hard copy of the manual is nice, because you can then highlight important text and write notes in the margins. You can download a copy for free from the CMS website: www.cms.gov. Enter “MDS 3.0” in the search box and hit enter. You should be guided to the MDS portion of the CMS website. Scroll down and find the most updated version. Most MDS software also includes links to the RAI manual.

- Hard copies of the MDS forms (item sets): These copies can be used in case of internet or software issues. They are also helpful to review when learning the process. It is easier to see the skip patterns when looking at the item sets. You can purchase MDS forms; some of the purchased forms have payment items highlighted and CAA triggers listed. You can also download the most updated MDS item sets from the CMS website for free.

- MDS interview cue cards: It is important to have cue cards available for the residents during the MDS resident interviews. It is helpful to have a set that is laminated so that it can be wiped off after the resident points to the answer on the cue card during the interview. It can also be helpful to print each different set of cue cards in a pastel color. I think it is easier for older eyes to see the black print on light-colored paper than on stark black and white. Each one of your IDT members will need their own set of cue cards.

- Portable hearing amplifier (pocket talker): In order to ensure that your residents can hear the interview questions, it is helpful to have a portable hearing amplifier available for them to use. Hearing
amplifiers are available in larger discount and electronic stores or on the internet. Consider infection control guidelines when choosing a model.

- MDS software: Your facility should have MDS software where you will enter data from the MDS assessments and transmit them to the federal database. You will need time to learn how to use the software system. Specific areas to focus on include how to:
  - Create new assessments
  - Set assessment reference dates (ARD)
  - Modify an MDS when an error occurs
  - Find the MDS scheduler
  - Print the forms
  - Sign the forms for accuracy and for completion
  - Batch the forms to prepare for transmission
  - Transmit
  - Mark the assessments as accepted or rejected
  - Complete the CAAs
  - Complete the care plans

- MDS scheduler: Your software should include an effective scheduling tool for determining when the next MDS ARD is due. Some MDS software systems do not include a scheduler or have an ineffective scheduler. Setting the schedules is one of the most important parts of the job and one of the most difficult to master. CMS releases an MDS scheduling tool each year, which you can find on the CMS website. For Medicare residents, you will also need a PPS scheduling tool. Many MDS coordinators use spreadsheets (100-day tools) to help them keep track of their Medicare residents’ PPS assessments. Other MDS nurses use a tool like a spinner/wheel that is available for purchase.

- *ICD-10 Coding Manual*: You will want to be sure that the correct diagnosis codes are entered onto the MDS and onto the Medicare claims (UB-04s). You will need a new *ICD-10 Coding Manual* every October, when the codes are updated.

- Care planning books: Part of the RAI process is to develop the resident care plans. You will need to learn what style of care plans your facility prefers. Care plans range from formal care plans to “I” care plans. HCPro published *MDS Care Plans: A Person-Centered Interdisciplinary Approach to Care* by Debbie Ohl, that comes with over 100 customizable (print and digital) care plans. See [https://hcmarketplace.com/mds-care-plans-person-centered-interdisciplinary-approach-to-care](https://hcmarketplace.com/mds-care-plans-person-centered-interdisciplinary-approach-to-care).
• Medicare binder: If your facility contains Medicare certified beds, you will need a binder to keep your Medicare information together. The Medicare binder should contain, at a minimum:
  - *Medicare Benefit Policy Manual*, Chapter 8
  - *RUG IV Guide*
  - 100-day tools for each of the residents who are presently covered under Medicare A or Medicare Advantage programs that require the PPS MDS schedule to be followed
  - 100-day tools for those Medicare A residents who have discharged during the present month (need information for triple-check meeting)
  - Change of therapy observation tools (if used by your facility)

• *RUG IV Guide*: It is helpful to keep a copy of the qualifiers for the Medicare RUG payment groups in the front of your Medicare binder. Many states are case-mix states, meaning that the RUG from the MDS affects the Medicaid payment to the facility. You will eventually want to memorize the RUG qualifiers, but in the beginning it helps to keep a copy close by.

• *Medicare Benefit Policy Manual*, Chapter 8: You are expected to know about Medicare benefits in your MDS role. There are many Medicare manuals that are pertinent to Medicare coverage in SNFs, but the *Medicare Benefit Policy Manual*, Chapter 8, is convenient, because it contains lists of Medicare nursing and therapy skilled services along with lists of noncovered services. It can be downloaded from the CMS website. To find it, enter the complete name of the manual, including the chapter, in the search box on [www.cms.gov](http://www.cms.gov).
Long-Term Care
MDS Coordinator’s Field Guide
Carol Maher, RN-BC, RAC-CT

The MDS impacts virtually every aspect of a SNF’s operations, so MDS coordinators and other nursing home staff need to fully understand it for accurate form completion. The Long-Term Care MDS Coordinator’s Field Guide gives coordinators step-by-step guidance on the various parts of the MDS form, helping them break down and look at trouble areas in an easy-to-use format. With quick access to needed information, coordinators can accurately fill out the MDS while ensuring they are addressing optimal care, resulting in good quality measures and, in turn, accurate reimbursement.

This book will help you:

• Accurately complete the MDS 3.0 with section-by-section guidance
• Learn how to systematically interpret the MDS sections through care area assessments to develop individualized resident care plans
• Understand that optimal resident care should result in good quality measures and lead the way to positive survey outcomes as well as accurate reimbursement
• Identify and resolve MDS discrepancies prior to submission