**MDS 3.0: The Differences in October**

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**MDS 3.0 Manual**

- Goes into effect 10/1/16
- Can be found: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursinghomeQualityInits/MDS30RAIManual.html

**Chapter 1 Changes**

- We now have version 1.14
- The contributing experts has been updated
- The discharge is now referred to as an OBRA discharge
- Updated links to CMS
- References to Section GG

**Chapter 2 Changes**

- References to the requirement for MDS purposes include now also for the IMPACT Act
- In the discussion of Short Term or respite residents it refers to OBRA admission and discharge
- For swing beds it reminds providers they are to do Entry records, PPS assessments, Discharges & Death in facility

**Chapter 2 Changes**

- Section GG discussion in regards to the reason we are doing it and the importance of submission.
- Failure to report the data results in a 2 percent payment reduction
- Reminder that the data collection for Section GG does not substitute for the data collected in Section G. We are required to collect both

**Chapter 2 Changes**

- Discharges from the building are now referred to as an OBRA Discharge
- Reminder that if we do a Death in Facility record NO Discharge Assessment is required
Chapter 2

- Discussion on THREE types of discharge
  - OBRA Required: return anticipated and return not anticipated
    - Part A PPS Discharge

  The facility policies regarding opening and closing clinical records and bed holds are not part of the MDS requirements

Chapter 2

- Entry and Discharge Reporting MDS
  - Entry tracking record
  - OBRA Discharge
  - PPS discharge
  - Death in Facility

Chapter 2

- We now have 11 different item subsets for nursing homes and 8 for swing bed providers

Chapter 2

- Clarification:
  - OBRA Discharge assessment either return anticipated or not anticipated. Resident physically discharged from the facility
  - PPS Discharge: resident’s Medicare Part A stay ends but the resident remains in the building

Chapter 2

- Item Set Codes: discussion reminds us there is the new item set because of A0310H which asks the question "Is this a PPS Discharge"

Chapter 2

- Medicare Required PPS Assessments now includes the PPS Discharge Assessment
- Respite residents need an entry racking and an OBRA discharge as long as they stay 14 days or less
- The tables for combining assessments include OBRA and PPS Assessments
Chapter 2

- Throughout Discharge assessment discussion if refers to OBRA discharge assessment on page 2-23 - 40

- Part A PPS Discharge (pg 2-44-45)
  - Part of the IMPACT Act
  - Part A PPS Discharge is completed when a resident’s Medicare Part A stay ends, but the resident remains in the facility (Item A0310H)
  - PPS Discharge can be combined as long as the OBRA discharge occurs on the day of or one day after the end date of Medicare

Chapter 2

- Page 2-45 is the discussion of Part A PPS Discharge Assessment
  - ARD is not set prospectively
  - ARD equals the end date of the most recent Medicare Stay (A2400C)
  - Must be completed within 14 calendar days
  - If the resident is discharged out of the building the next day combine the PPS Discharge with the OBRA discharge

- Must be submitted with 14 days of the completion date
  - If resident subsequently returns to a skilled of care and new Medicare 5 day PPS assessment is done.

Chapter 2

- Tables of page 2-46 - 48 reflect the addition of the OBRA Discharge and the PPS Discharge
  - In the SOT discussion on pages 2-50 – 51 there is emphasis on ONLY done to classify resident into a Rehab RUG

- Page 2-55 Clarification: If the date listed in A2400 C (Medicare end date) is on Day 7 of the COT observation period then the SNF must complete both the COT OMRA and the Part A PPS Discharge Assessment. These assessments must be completed separately.
Chapter 2

- BUT
- If it is a discharge from Medicare Part A and discharge from the facility, and day 7 of the COT the facility may choose to combine the COT OMRA with the

Chapter 2

- Updated tables on page 2-65 and 2-66 reflecting the PPS Discharge and OBRA Discharge

Chapter 2

- Page 2-78 – 81 Discharge Discussion regarding the OBRA Discharge and the PPS Discharge
- Reminder if we do a PPS discharge and the resident resumes Medicare we need to do a new 5 day
- Tables on 2-85 now includes the Part A discharge

Chapter 2

- Page 2-86-87 lengthy discussion on how to determine what item set is to be used:
  - Carol pearls: tell the computer the MDS needs that the resident has and trust the computer to give you the right set of questions.

Chapter 3

- Page 3-3: Reminder that with the exception of certain items in Section K and O the look back does not include the hospital stay.
- NEW: If we did assessments for private insurance and Medicare Advantage that are not submitted we can't count them as prior assessments that are submitted.

Chapter 3

- A0310E (First Assessment)
  - Answer No if
    - Tracking record
    - Stand alone Part A PPS Discharge Assessment
    - A standalone unscheduled PPS assessment
<table>
<thead>
<tr>
<th>Chapter 3</th>
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</table>
| **Definition of Part A PPS Discharge**
| Assessment on page A-7 |
| Can do a Part A discharge and combine with an OBRA discharge as long as no more than one day difference between the end of Medicare and discharged from the building page A-28 |

<table>
<thead>
<tr>
<th>Chapter 3</th>
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<tbody>
<tr>
<td><strong>OBRA Discharge Status</strong> pg. A-33</td>
</tr>
<tr>
<td>- End date of most recent Medicare stay is earlier than the actual discharge date a PPS discharge is required and then later the actual discharge date then an OBRA discharge</td>
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<tr>
<td>- If Med A discharge then actual discharge the next day you may combine and the ARD must be the ARD</td>
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<tr>
<td><strong>OBRA Discharge Status</strong> pg. A-33</td>
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<tr>
<td>- If the end date of the Most Recent Medicare Stay occurs on the same day as a resident dies a Death in Facility discharge is done. PPS Discharge is NOT required</td>
</tr>
<tr>
<td>- Standalone PPS Discharge assessment the end date of most recent Medicare stay must be equal to the ARD</td>
</tr>
<tr>
<td>Excellent examples on page A34-36</td>
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<tr>
<td><strong>C-27-28:</strong> Discussion on identifying Acute Mental Status Change and accompanying examples</td>
</tr>
<tr>
<td>In coding the CAM multiple changes related to the numbering changes C1300 to C1310 and the removal of Psychomotor Retardation</td>
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<tr>
<td><strong>C1600 Acute onset of mental status change has been deleted.</strong> It is now at the beginning of the CAM</td>
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<tr>
<td><strong>Section D Updated web sites for depression resources</strong></td>
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<td><strong>Section E: no changes</strong></td>
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### Chapter 3

- Section F Customary routines: added. That the interview is to be conducted during the observation period.

### Section GG?

- Section GG: Functional Abilities and Goals assesses the need for assistance with self-care and mobility activities; it is collected at the start of a Medicare Part A stay on the 5-Day PPS assessment and is also collected at the end of the stay on the Part A PPS Discharge assessment.
- It is important to note that data collection for Section GG does not substitute for the data collected in Section G because of the difference in rating scales, item definitions, and type of data collected. Therefore, providers are required to collect data for both Section GG and Section G.

### Section GG-PLAN AHEAD: coming Oct 2016

- Where will the information to fill out Section GG come from?
- Staff Education to the specific requirements for the data collection: Difference between Section G and GG
- Who will sign MDS Section GG?
- How to develop GG care plan? What is in the care plan?
- Care plan for G and GG: one or more ADL care plan?
- What documentation needed to support section GG coding?

### Who completes “change”

- Completion of this section should be a “group effort”
- Physical therapists, occupational therapists, speech language pathologists, and nursing staff should be doing the completion jointly
- NOT CNA’S. Too confusing with the different scales

### Steps for Assessment

- Assess the resident’s self-care status based on direct observation, the resident’s self-report, family reports, and direct care staff reports documented in the resident’s medical record during the 3-day assessment period, which is days 1 through 3, starting with the date in A2400B, Start of most recent Medicare stay.
- Residents should be allowed to perform activities as independently as possible, as long as they are safe.

### Steps for the Assessment

- If helper assistance is required because of resident’s performance is unsafe or of poor quality, only consider staff assistance when scoring according to amount of assistance provided.
- Activities may be completed with or without assistive devices. Use of assistive devices to complete an activity should not affect coding of the activity.
Steps for Assessment

- Should be coded based on the resident’s “usual performance” or baseline performance, which is identified as the resident’s usual activity/performance for any of the self care or mobility activities, not the most independent performance and not the most dependent performance over the assessment period.

Steps for the Assessment

- Refer to facility, Federal, and State policies and procedures to determine which staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal and State requirements.

Section GG! When?

- Complete section GG with EACH five day assessment
- Three days look back (ARD) period:
  - from day 1 through 3 of the PPS stay, starting the day of most recent Medicare stay (A2400b)
  - Last 3 days of SNF PPS stay ending with day recorded in A2400c
- Complete on end of stay for ALL part A discharge whether the resident stays in the facility or not

Section GG! When?

- The 5-Day PPS assessment is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay
- On the Part A PPS Discharge assessment (A0310H = 1), the Self-Care items in GG0130 are completed only if the Type of Discharge is Planned (A0310G = 1).

Section GG! When?

- Admission or Discharge Performance Coding Instructions: Complete only if
  - A0310B = 01 PPS 5-Day assessment or
  - A0310G = 1, Planned, and
  - A0310H = 1 Part A PPS Discharge

Section GG! When?

- Section GG will be completed when all of the following occurs:
  - Planned discharges (if A0310G Type of Discharge is not coded as “unplanned”)
  - The resident is not discharged to the acute care hospital (A2100 discharge status is not is not “acute hospital”)
  - When the discharge occurs on or after the fourth day of their Medicare Stay (A2400C End date of most recent Medicare stay minus A2400B Start date of most recent Medicare stay is greater than two)
Coding-How?

- On the Part A PPS 5-day and Discharge assessment, code the resident's usual performance using the 6-point scale or code the reason an activity was not attempted.

Coding-How?

- Code 07, Resident refused: if the resident refused to complete the activity
- Code 09, Not applicable: if the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- Code 88, Not attempted due to medical condition or safety concerns

So, just start ASKING the question ....Does the resident need assistance to complete the activities?

Coding-What?

- 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.
- Do not record the staff's assessment of the resident's potential capability to perform the activity.

Coding-What?

- Coding a dash ("-"), in these items indicates "No information." CMS expects dash use for SNF QRP items to be a rare occurrence. Use of dashes for these items may result in a 2% reduction in the annual payment update.
**Coding-Where?**

13 ADL areas

- Eating
- Oral hygiene
- Toileting hygiene
- Sit to lying
- Lying to sitting on side of bed
- Chair/bed-to-chair transfer
- Toilet transfer
- Does the resident walk?
- Walk 50 feet with two turns
- Walk 150 feet
- Does the resident use a wheelchair/scooter?
- The type of wheelchair/scooter used (Manual or Motorized if the resident uses a wheelchair/scooter) to Wheel 50 feet with two turns
- The type of wheelchair/scooter used (Manual or Motorized if the resident uses a wheelchair/scooter) to Wheel 150 feet

**CODING TIPS**

- Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
- Residents should be coded performing activities based on their "usual performance," or baseline performance, which is identified as the resident’s usual activity/performance for any of the self-care or mobility activities. Not the most independent or dependent performance over the assessment period.
- Review documentation in the medical record for the 3-day assessment period.
- Talk with direct care staff.
- Use probing questions.
- Observe the resident as he/she performs each self-care activity.
- Be specific in evaluating each component.
- Record the resident’s actual ability to perform each activity.
- Score will be based on the amount of assistance/effort provided.
- Activities may be completed with or without assistive devices.

**How is “usual” defined for Section GG?**

Per CMS:

Usual is defined as how the patient typically performs the activity during an assessment. The performance score is to be based on an assessment of the patient in which the patient is allowed to perform the activity as independently as possible, as long as he/she is safe. If the patient’s self-care or mobility performance varies during the assessment period, report the patient’s usual status, not the patient’s most independent performance and not the patient’s most dependent episode. (CMS Q&A April 2016)
Who- “helper”?  

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). Thus, does not include individuals hired, compensated or not, by individuals outside of the facility’s management and administration such as hospice staff, nursing/certified nursing assistant students, etc. Therefore, when helper assistance is required because a resident’s performance is unsafe or of poor quality, only consider facility staff when scoring according to amount of assistance provided.
Use the 6-point scale to code the resident's discharge goal(s). Do not use codes 07, 09, or 88 to code discharge goal(s).

Establish a resident's discharge goal(s) at the time of admission based on the 5-Day PPS assessment. Goals should be established as part of the resident's care plan.

May code one goal for each self-care and mobility item included in Section GG at the time of the 5-Day PPS assessment.

For the cross-setting quality measure, a minimum of one self-care or mobility goal must be coded per resident stay on the 5-Day PPS assessment.

### GG0130. Self-Care

**Assessment period** is days 1 through 3 of the SNF PPS Stay starting with A2400B. Complete only if A0310B = 01.

- **Eating:** The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. Includes modified food consistency.
- **Oral hygiene:** The ability to use suitable items to clean teeth. [Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.]
- **Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after using the toilet, commode, bedpan, or urinal. If managing an ostomy, include wiping the opening but not managing equipment.

### Section GG: GG0130A - EATING

**Case 1:** Ms. S has multiple sclerosis, affecting her endurance and strength. Ms. S prefers to feed herself as much as she is capable. During all meals, after eating three-quarters of the meal by herself, Ms. S usually becomes extremely fatigued and requests assistance from the certified nursing assistant to feed her the remainder of the meal.

- **Coding:** GG0130A. Eating would be coded 03, Partial/moderate assistance.
- **Rationale:** The certified nursing assistant provides less than half the effort for the resident to complete the activity of eating for all meals.

**Case 2:** Mr. M has upper extremity weakness and fine motor impairments. The occupational therapist places an adaptive device onto Mr. M’s hand that supports the eating utensil within his hand. At the start of each meal Mr. M can bring food to his mouth. Mr. M then tires and the certified nursing assistant feeds him more than half of each meal.

- **Coding:** GG0130A. Eating would be coded 02, Substantial/maximal assistance.
- **Rationale:** The helper provides more than half the effort for the resident to complete the activity of eating at each meal.

**Case 3:** The dietary aide opens all of Mr. S’s cartons and containers on his food tray before leaving the room. There are no safety concerns regarding Mr. S’s ability to eat. Mr. S eats the food himself, bringing the food to his mouth using appropriate utensils and swallowing the food safely.

- **Coding:** GG0130A. Eating would be coded 05, Setup or clean-up assistance.
- **Rationale:** The helper provided setup assistance prior to the eating activity.
### Section GG: GG0130A - EATING

**Case 4:** Mrs. V has had difficulty seeing on her left side since her stroke. During meals, the certified nursing assistant has to remind her to scan her entire meal tray to ensure she has seen all the food.

- **Coding:** GG0130A. Eating would be coded 04, Supervision or touching assistance.
- **Rationale:** The helper provides verbal cueing assistance during meals as Mrs. V completes the activity of eating. Supervision, such as reminders, may be provided throughout the activity or intermittently.

**Case 5:** Mr. A. eats all meals without any physical assistance or supervision from a helper. He has a gastrostomy tube (G-tube), but it is no longer used, and it will be removed later today.

- **Coding:** GG0130A. Eating would be coded 06, Independent.
- **Rationale:** The resident can independently complete the activity without any assistance from a helper for this activity. The presence of a G-tube does not affect the eating score.

**Case 6:** Mr. R is unable to eat by mouth due to his medical condition. He receives nutrition through a gastrostomy tube (G-tube), which is administered by nurses.

- **Coding:** GG0130A. Eating would be coded 88, Not attempted due to medical condition or safety concerns.
- **Rationale:** The resident does not eat by mouth at this time. Assistance with G-tube feedings is not considered when coding the item Eating.

**Case 7:** Mr. F is fed all meals by the certified nursing assistant, because Mr. F has severe arm weakness and he is unable to assist.

- **Coding:** GG0130A. Eating would be coded 01, Dependent.
- **Rationale:** The helper does all of the effort for each meal. The resident does not contribute any effort to complete the eating activity.

### Section GG: GG0130B, Oral hygiene

- Case studies (RAI Manual p. GG 7-GG9)

### Section GG: GG0130C, Toileting hygiene

- Case studies (RAI Manual p. GG 9-GG10)
GG0170: Mobility (3-day assessment period)

- On the Part A PPS Discharge assessment (A0310H = 1), the Mobility items in GG0170 are completed only if the Type of Discharge is Planned (A0310G = 1).

GG0170B, Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed (case studies RAI manual p GG17-GG19).

GG0170C, Lying to sitting on side of bed: The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support (case studies RAI manual p GG 19-20).

GG0170D, Sit to stand: The ability to safely come to a standing position from sitting in a chair or on the side of the bed (case studies RAI manual p. GG 20-21).

GG0170E, Chair/bed-to-chair transfer: The ability to safely transfer to and from a bed to a chair (or wheelchair). (case studies RAI manual p GG21-GG22)

GG0170F, Toilet transfer: The ability to safely get on and off a toilet or commode (case studies RAI manual p GG22-GG24)

GG0170H1, Does the resident walk? (RAI-P. GG 22)

No, and walking goal is not clinically indicated. Skip to GG0170Q1, Does the resident use a wheelchair/scooter?—No, and walking goal is clinically indicated. Code the resident’s discharge goal(s) for items GG0170J and GG0170K.

Yes Continue to GG0170J, Walk 50 feet with two turns (RAI-P. GG 22-25).

GG0170J, Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns (RAI-P. GG 2-25).

GG0170K, Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space. (RAI-P. GG 25-26)

GG0170RR, Indicate the type of wheelchair/scooter used:

- 0. No Skip to GG0130, Self Care.
- 1. Yes. Continue to GG0170R, Wheel 50 feet with two turns.

(RAI-P. GG 27-28)

GG0170R:  Wheel 50 feet with two turns: Once seated in wheelchair/scooter, can wheel at least 50 feet and make two turns.

GG0170RR1, Indicate the type of wheelchair/scooter used:


GG0170R:  Wheel 150 feet: Once seated in wheelchair/scooter, can wheel at least 150 feet in a corridor or similar space.

GG0170SS1, Indicate the type of wheelchair/scooter used:


CAA

- No trigger for extra CAA
- Should address if the PPS admission combined with OBRA assessment
- Documentation should support the assessment
Absolutely! And... Don’t forget your PT, PTA, OT, COTA!

What your care plan should include
- The incorporation of ADL coding between section G and GG
- Discharge Goal should be addressed in the care plan
- The relationship of care planning and actual execution
- The goal should reflect the functional status for IMPROVING, MAINTAINING, and PREVENTING
- Has a quantifiable, measurable objective with timeframes to be able to assess whether the objectives have been met
- Based upon resident’s goals, needs, preferences and strengths
- Reflects comprehensive assessment (MDS & CAA)
- Consistent with current standards of practice

Promotes resident dignity
- Identifies interventions with sufficient specificity to guide provision of ADL services and treatment
- Identifies restorative nursing approaches specific enough to identify steps that both resident and staff will take to improve/or maintain ADL functioning
- Identifies interventions staff will provide for resident who requires assistance with ADLs
- Defines environmental approaches to promote resident’s independence in ADLs

Identifies needed adaptive devices, appliances, and equipment for ADL performance
- When refers to nursing home protocol for ADL assistance, deviations from or revisions to protocol for resident are clarified
- Protocol referenced in care plan available to caregivers and staff familiar with protocol requirements

Chapter 3
- Section I: New discussion about the use of Z codes and a reminder that if we have a Z code we also need another diagnosis for the related primary medical condition. Also gave a web site for further assistance
- Updated the CDC web site

Chapter 3
- Section J1900: Planning for care: It is important to ensure the accuracy of the level of injury resulting from a fall. The assessor may need to look beyond the ARD to obtain the accurate information for the complete picture of the fall that occurs in the look back of the MDS
- Coding tip for J1900: We must do a modification to update the level of injury that occurred with the fall, if we find out after submission that we had not coded it correctly.
  - Examples of coding is on page J-34
Chapter 3

Section M Page M-7  Further clarification on Present on admission

Chapter 3

4. If the pressure ulcer was unstable on admission/entry or reentry, but becomes essentially stageable later, it should be considered as “present on admission” in the stage at which it first becomes essentially stageable. If subsequently increases in numerical stage, that higher stage should not be considered “present on admission.”

5. A resident who has a pressure ulcer that was originally acquired in the facility is hospitalized and returns with that pressure ulcer to the same numerical stage, the pressure ulcer should not be coded as “present on admission” because it was present and acquired at the facility prior to the hospitalization.

6. If a resident who has a pressure ulcer that was “present on admission” (not acquired in the facility) is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer is still coded as “present on admission” because it was originally acquired outside the facility and has not changed in stage.

7. If a resident who has a pressure ulcer is hospitalized and the ulcer increases in numerical stage during the hospitalization, it should be coded as “present on admission” at that higher stage upon reentry.

Chapter 3

M0300G: Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury

Chapter 3

Section M

- M 1040H MASD now includes IAD

Chapter 3

- NO410 A-G Code medications according to the pharmacological classification, not how they are being used.
- Updated web sites in Section N including where to find appropriate classifications, warnings, dosing, etc.
Chapter 3

- Section O: updated web sites for vaccine information

The licensed psychological therapy by a Psychologist (PhD) should be recorded in O040E. Psychological Therapy: Psychological therapy visits by a licensed psychologist (PhD) should be recorded in O040E. Psychological Therapy, and should not be included as a physician visit in this section.

Chapter 3

- Section Q: Updated the web site for Planning for your discharge, which is a checklist for residents and caregivers

Chapter 3

OLD

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<th>Q596: Resident Preference about being located (Section O1546)</th>
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<tbody>
<tr>
<td>Community (O1546) [O1546.01, O1546.02, O1546.03]</td>
</tr>
<tr>
<td>1. Yes</td>
</tr>
<tr>
<td>2. No</td>
</tr>
<tr>
<td>3. Interactions not available</td>
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NEW

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- Section Q: CMS has removed the None of the above option for Question Q0550

References

- RAI Manual 2016
- Skilled Nursing Facility Quality Reporting Program Provider Training August 24, 2016