CHAPTER 3: OVERVIEW TO THE ITEM-BY-ITEM GUIDE TO THE MDS 3.0

This chapter provides item-by-item coding instructions for all required sections and items in the MDS Version 3.0 item sets. The goal of this chapter is to facilitate the accurate coding of the MDS resident assessment and to provide assessors with the rationale and resources to optimize resident care and outcomes.

3.1   Using this Chapter

Throughout this chapter, MDS assessment sections are presented using a standard format for ease of review and instruction. In addition, screenshots of each section are available for illustration purposes. Note: There are images imbedded in this manual and if you are using a screen reader to access the content contained in the manual you should refer to the MDS 3.0 item set to review the referenced information. The order of the sections is as follows:

- **Intent.** The reason(s) for including this set of assessment items in the MDS.

- **Item Display.** To facilitate accurate resident assessment using the MDS, each assessment section is accompanied by screenshots, which display the item from the MDS 3.0 item set.

- **Item Rationale.** The purpose of assessing this aspect of a resident's clinical or functional status.

- **Health-related Quality of Life.** How the condition, impairment, improvement, or decline being assessed can affect a resident's quality of life, along with the importance of staff understanding the relationship of the clinical or functional issue related to quality of life.

- **Planning for Care.** How assessment of the condition, impairment, improvement, or decline being assessed can contribute to appropriate care planning.

- **Steps for Assessment.** Sources of information and methods for determining the correct response for coding each MDS item.

- **Coding Instructions.** The proper method of recording each response, with explanations of individual response categories.

- **Coding Tips and Special Populations.** Clarifications, issues of note, and conditions to be considered when coding individual MDS items.

- **Examples.** Case examples of appropriate coding for most, if not all, MDS sections/items.

Additional layout issues to note include: (1) the ⏻ symbol is displayed in all MDS 3.0 sections/items that require a resident interview, and (2) important definitions are highlighted in text boxes, and may be found, along with other definitions of interest, in Appendix A: Glossary and Common Acronyms.

3.2 Becoming Familiar with the MDS-recommended Approach

1. **First, reading the Manual is essential.**

   - The CMS Long-Term Care Facility Resident Assessment Instrument User's Manual is the <u>primary</u> source of information for completing an MDS assessment.

   - Notice how the manual is organized.

   - Using it correctly will increase the accuracy of your assessments.

   - While it is important to understand and apply the information in Chapter 3, facilities should also become familiar with Chapters 1, 2, 4, 5 and 6. These Chapters provide the framework and supporting information for data collected on the item set as well as the process for further assessment and care planning, submitting and modifying assessments, and information on the SNF PPS payment system.

   - It is important to understand the entire process of the RAI in conjunction with the intent and rationale for coding items on the MDS 3.0 item set.

   - Check the MDS 3.0 Web site regularly for updates at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.

   - If you <u>require</u> further assistance, submit your question to your State RAI Coordinator listed in Appendix B: State Agency and CMS Locations RAI/MDS Contacts available in the Downloads section on CMS' website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.

2. **Second, review the MDS item sets.**

   - Notice how sections are organized and where information should be recorded.

   - Work through one section at a time.

   - Examine item definitions and response categories as <u>provided</u> on the item sets, realizing that more detailed definitions and coding information is found in each Section of Chapter 3.

   - There are <u>several</u> item sets, and depending on which item set you are completing, the skip patterns and items active for each item set may be different.

3. **Complete a thorough review of Chapter 3.**

   - Review procedural instructions, time frames, and general coding conventions.

   - Become familiar with the intent of each item, rationale and steps for assessment.

   - Become familiar with the item itself with its coding choices and response options, keeping in mind the clarifications, issues of note, and other pertinent information needed to understand how to code the item.

   - Do the definitions and instructions differ from current practice at your facility?

   - Do your facility processes require updating to comply with MDS requirements?

- Complete a test MDS assessment for a resident at your facility. Enter the appropriate codes on the MDS.

- Make a note where your review could benefit from additional information, training, and using the varying skill sets of the interdisciplinary team. Be certain to explore resources available to you.

- As you are completing this test case, read through the instructions that apply to each section as you are completing the MDS. Work through the Manual and item set one section at a time until you are comfortable coding items. Make sure you understand this information before going on to another section.

- Review the test case you completed. Would you still code it the same way? Are you surprised by any definitions, instructions, or case examples? For example, do you understand how to code Functional Abilities?

- As you review the coding choices in your test case against the manual, make notations corresponding to the section(s) of this Manual where you need further clarification, or where questions arose. Note sections of the manual that help to clarify these coding and procedural questions.

- Would you now complete your initial case differently?

- It will take time to go through all this material. Do it slowly and carefully without rushing. Discuss any clarifications, questions or issues with your State RAI Coordinator (see **Appendix B**: State Agency and CMS Locations RAI/MDS Contacts available in the Downloads section on CMS' website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html).

4. **Use of information in this chapter:**

   - Keep this chapter with you during the assessment process.

   - Where clarification is needed, review the intent, rationale and specific coding instructions for each item in question.

3.3 Coding Conventions

There are several standard conventions to be used when completing the MDS assessment, as follows.

- The standard look-back period for the MDS 3.0 is **7 days**, unless otherwise stated.

- **With the exception of certain items (e.g., some items in Sections J, K and O), the look-back period <u>does not</u> extend into the preadmission period unless the item instructions state otherwise.** In the case of reentry, the look-back period <u>does not</u> extend into time prior to the reentry, unless instructions state otherwise.

- When determining the response to items that have a look-back period relating back to the Admission/Entry, Reentry, or Prior OBRA or scheduled PPS assessment, whichever is most recent, staff must only consider those assessments that are required to be submitted to iQIES. PPS assessments that are completed for private insurance and Medicare Advantage Plans must **not** be submitted to iQIES and therefore should not be considered when determining the "prior assessment."

- There are a few instances in which scoring on one item will govern how scoring is completed for one or more additional items. This is called a skip pattern. The instructions direct the assessor to "skip" over the next item (or several items) and go on to another. When you encounter a skip pattern, leave the item blank and move on to the next item as directed (e.g., item B0100, **Comatose**, if B0100 is answered **code 1, yes**, the assessor is instructed to skip to item GG0100, *Prior Functioning: Everyday Activities*. The intervening items from B0200–F0800 would not be coded (i.e., left blank). If B0100 was answered **code 0, no,** then the assessor would continue to code the MDS at the next item, B0200, **Hearing**).

- Use a check mark for boxes where the instructions state to "check all that apply," if the specified condition is met; otherwise, these boxes should remain blank (e.g., F0800, **Staff Assessment of Daily and Activity Preferences**, boxes A-Z).

- Use a numeric response (a number or pre-assigned value) for blank boxes (e.g., M1030, **Number of Venous and Arterial Ulcers**).

- When completing hard copy forms to be used for data entry, capital letters may be easiest to read. Print legibly to ensure accurate encoding of data.

- When recording month, day, and year for dates, enter two digits for the month and the day and four digits for the year. For example, the third day of January in the year 2020 is recorded as:

0	1		0	3		2	0	2	0
Month			Day			Year			

- Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to iQIES.
  - A dash value indicates that an item was not assessed. This most often occurs when a resident is discharged before the item could be assessed.
  - Dash values allow a partial assessment to be submitted when an assessment is required for payment purposes.
  - There are four date items (A2400C, O0400A6, O0400B6, and O0400C6) that use a dash-filled value to indicate that the event has not yet occurred. For example, if there is an ongoing Medicare stay, then the end date for that Medicare stay (A2400C) has not occurred, therefore, this item would be dash-filled.
  - The few items that do not allow dash values include identification items in Section A [e.g., Legal Name of Resident (Item A0500), Assessment Reference Date (Item A2300), Type of Assessment (Item A0310), and Gender (Item A0800)] and ICD diagnosis codes (Item I8000). All items for which a dash is not an acceptable value can be found on the CMS MDS 3.0 Technical Information web page at the following link: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html.

- When the term "physician" is used in this manual, it should be interpreted as including nurse practitioners, physician assistants, or clinical nurse specialists, if allowable under state licensure laws and Medicare.

- Residents should be the primary source of information for resident assessment items. Should the resident not be able to participate in the assessment, the resident's family, significant other, and guardian or legally authorized representative should be consulted.

- Several times throughout the manual the word "significant" is used. The term may have different connotations depending on the circumstance in which it is used. For the MDS 3.0, the term "significant" when discussing clinical, medical, or laboratory findings refers to measures of supporting evidence that are considered when developing or assigning a diagnosis, and therefore reflects clinical judgment. When the term "significant" is used in discussing relationships between people, as in "significant other," it means a person, who may be a family member or a close friend that is important or influential in the life of the resident.

- When completing the MDS 3.0, there are some items that require a count or measurement, however, there are instances where the actual results of the count or measurement are greater than the number of available boxes. For example, number of pressure ulcers, or weight. When the result of a count or measurement is greater than the number of available boxes, facilities are instructed to maximize the count/measurement by placing a "9" in each box (e.g., for item K0200B, if the weight was 1010 lbs., you would enter 999 in the available boxes). Even though the number is not exact, the facility should document the correct number in the resident's medical record and ensure that an appropriate plan of care is completed that addresses the additional counts/measurements.