MDS 3.0 Questions

Following are questions raised during OHCA’s MDS 3.0 training programs. The reference information provided is based on the CMS Long-Term Care Resident Assessment Instrument (RAI Manual) User's Manual, Version 3.0, September 2010. Please note that page numbers may not correspond to earlier or later versions of the manual.

Section A

New Admissions - is entry tracking required or just admission assessment?
Yes, entry tracking is required see pages 2-45.

Would a skilled resident who improved but will discharge within a week need a significant change in status assessment?
If the resident is skilled it is expected that they will improve and a SCSA assessment is not necessary. Page 2-24. You also have 14 days to determine if there was a significant change for any resident. Page 2-15.

Will all PPS MDSs end up being a significant change because they are improving (hoping to return home) if only 2 areas of ADLs improve?
Read Chapter 2 - expected improvements in rehab patients do not have to be a significant change.

A0310A - Significant Change Assessment - Under significant change - Any decline in an ADL physical functioning area where a resident is newly coded as extensive assistance, total dependence, or activity did not occur since last assessment. Is the understanding then, that if the resident fluctuates from independent to a limited assist than this is okay, and a significant change would not need to be done if a resident went from independent in eating and turning to a limited assist in both of these areas?
Correct. Page 2-23.

Is the ADL section considered one whole area in change, or is each area (turning, eating, etc.) considered an area by itself? Example: If the resident was independent and walking and now are extensive assist then this would be a significant change?
See discussion on page 2-23. "An SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL decline or improvement)."

Significant change criteria - Resident's incontinence pattern changes - Does this include both bowel and bladder?
Yes. Page 2-23

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Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-9); Increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (behavior) - Would a few changes, example going from a 0 to a 1 in the symptom frequency, automatically make this a change in one area because couldn't this area fluctuate in a 14 day span for anyone? Also, would this whole area be considered one change or each question A, B, C, D, etc be each it's own area? See discussion on page 2-23 regarding consistent pattern of changes within one domain as example of significant change.

**Significant Change - Decline in two or more of the following:**
- Resident's decision-making changes;
- Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-9©); Increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (behavior);
- Any decline in an ADL physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment;
- Resident's incontinence pattern changes or there was placement of an indwelling catheter;
- Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days);
- Emergence of a new pressure ulcer at Stage II or higher or worsening in pressure ulcer status;
- Resident begins to use trunk restraint or a chair that prevents rising when it was not used before; and/or
- Overall deterioration of resident’s condition.

**A0310A/C.** When a resident is admitted with therapy orders and is skilled, do we code it as Admission 5 day or Admission 5 day Start of Therapy Assessment? You will have to think about whether coding it as a SOT OMRA would be helpful or not. Usually this is not necessary. SOT OMRA is optional. Page 2-47.

**A0310C.** Can we only mark “3” if therapy lasts no more than 6 days? Page A-4. **Code 3, both the start and end of therapy assessment:** with an ARD that is both 5 to 7 days after the first day therapy services were provided and that is 1 to 3 days after the last day therapy services were provided (except when the assessment is used as a short stay assessment, see Chapter 6).

If you do a Start of Therapy OMRA and the resident goes to the hospital - D/C Return Anticipated, do you need to do another Start of Therapy OMRA on readmit? If therapy continues? Start of Therapy OMRA is always optional - you need to ask yourself if coding a SOT OMRA is helpful. Page 2-47.

What if you complete a discharge with return anticipated and ends up turning for the worse and dies in the hospital after the discharge with return anticipated has been submitted? Do you just do another discharge with return not anticipated or modify it? **No.** Page 2-37, 2-38.

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If a resident is receiving therapy and is discharged to the hospital, is the assessment always/ever coded End of Therapy - Discharge?
This would be a discharge, but usually not an EOT OMRA. Page 2-48.

Do you have to do an End of Therapy OMRA if resident is not going to continue to be skilled?

A0310F - For a resident who is discharged return anticipated who did not return in 30 days, it says you must modify the d/c assessment. Do you actually modify the original d/c and if so how, or do you do a new one?
"In some situations, a resident may be discharged return anticipated and the facility learns later that the resident will not be returning to the facility. Another Discharge assessment is not necessary although the state may require a modification from "return anticipated" to "return not anticipated"." Page 2-35, 2-36. The only time this is done in OH is when the resident is discharged Return Anticipated and then the facility finds out later that they are not returning for whatever reason. This is a Medicaid edit for Ohio and only occurs if the resident is not going to be returning at all. The way the modification is completed is covered in Chapter 5 and Section X. The provider will complete Section X and then pull up the previous record and modify the previous discharge and then send them both electronically to the QIES ASAP. However, if the resident is still anticipated to return, but doesn't do so within 30 days following a Discharge Return Anticipated, he/she will then have an Admission assessment completed when they do return. If the resident returns within 30 days when the provider has issued a Discharge Return Anticipated, he/she will complete a Reentry. (A1700)

What is A0310F-99- Not entry/discharge?
99. Page A-5. If it is not an Entry record (tracking record), a Discharge assessment- Return not anticipated, a Discharge assessment- Return anticipated, or a death in the facility record (tracking record), it would be coded 99 - Not entry/discharge.

Legal name (A0500). Some residents have an initial first name and full middle name legally (i.e. M. Patricia). How do I code this?
Enter M in first name as appears on Medicare card and enter P in middle name. Page A-6. "Legal Name - Resident's name as it appears on the Medicare card. If the resident is not enrolled in the Medicare program, use the resident's name as it appears on a Medicaid card or other government-issued document."

If they are discharged return anticipated and they die 4 days later in the hospital, do you do "death in facility" and do you have to modify to "discharge return anticipated"?
No. Page 2-37, 2-38.

Scheduling assessments, which is correct, must be set or must be completed and by when?
ARD must be within 92/366 (quarterly/comprehensive) days of previous ARD. Completion date must be within 14 days of ARD. Except for initial, 14th calendar day of the resident's admission (admission date + 13 calendar days). See Chapter 2.

With a significant change assessment for a patient who goes hospice, we currently do not complete anymore significant changes on this patient if they continue to decline because the RAI says it is an expected decline. Will this be the same with 3.0?
As long as it continues to be an expected decline, no further significant change would be necessary.

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If a resident goes onto Hospice and then within 14 days we do a MDS on that resident but on this resident at this point does not show a change in condition except that she is now on Hospice, then does actually decline in several areas in around four weeks and now is stabilized for awhile, does another significant change have to be done or is it enough to just change the care plan since a decline was expect? Read the discussion on Page 2-25.

Guidelines for Determining the Need for a SCSA for Residents with Terminal Conditions:  Note: this is not an exhaustive list.
The key in determining if a SCSA is required for individuals with a terminal condition is whether or not the change in condition is an expected, well-defined part of the disease course and is consequently being addressed as part of the overall plan of care for the individual.

- If a terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration and the criteria are met for a SCSA, a SCSA assessment is required.
- If a resident elects the Medicare Hospice program, it is important that the two separate entities (nursing home and hospice program staff) coordinate their responsibilities and develop a care plan reflecting the interventions required by both entities. The nursing home and hospice plans of care should be reflective of the current status of the resident.

A1000 What if the resident is not able to answer what race they are, how do you code?
Ask a family member or significant other. Page A-10. Only if the resident is unable to respond and no family member or significant other is available, observer identification or medical record documentation may be used. Page A-11.

Resident discharged to hospital and returns two days later not skilled. Do you count the D/C assessment as last MDS and next assess done in 92 days?
Follow the Entry, Discharge, and Reentry Algorithms Page 2-37. Depends on how they were coded at discharge.

If a resident goes to the hospital and dies before being out of the facility > 24 hours which do you do, discharge tracking, discharge assessment, or death in facility record?
If resident dies during an observation stay less than 24 hours, they are on a LOA and should do a death record. Page 2-36.

When a resident is discharged from hospice care, is a significant change mandatory?
Yes.
A SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD must be within 14 days from one of the following: 1) the effective date of the hospice election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician’s or medical director’s order stating the resident is no longer terminally ill. Page 2-21.

Resident is discharged to hospital and comes back less than 24 hours later. Do you do discharge MDS or just D/C tracking?
If not admitted to the hospital and return within 24 hours you do not do ANYTHING.
A1700 - If a resident was skilled prior to going to the hospital and later returns and is skilled again, what would be the first MDS 3.0 type using option 1 be called? A 5 day or a 5 day readmission?  
Depends on if it was a discharge return anticipated or a discharge return not anticipated. Page 2-37.

A1800 - Psychiatric hospital - Can this be marked if a resident is sent to a psych unit in an acute care hospital or should this still be coded as an acute care hospital?  

Is the ARD for discharge assessment the day of discharge with 7 day look back?  
Yes, page 2-34. Discharge date (Item A2000) must be the ARD (Item A2300) of the discharge assessment.

A2400 - If patient changes from traditional part A to a managed care that follows PPS guidelines, do we fill out the end date? What if the managed care company doesn't require following PPS guidelines?  
Managed Care is not considered to be part of Part A - so you would complete the end of the stay date regardless of whether or not the managed care follows PPS guidelines. Page A-24. "Identifies when a resident's Medicare Part A stay begins and ends."

When starting part B therapy do you do a start of therapy OMRA and when they are discharged do you do an end of therapy OMRA? What if they are receiving multiple therapies and one is discharging do you do a end of therapy OMRA?  
Start of Therapy OMRA and End of Therapy OMRA are only for Part A. Do not do End of Therapy OMRA when only one discipline discharges, only when the final discipline discharges. Page 2-47, 2-48.

**Section B**

B0700 - Rarely/Never understood - when to assess?  
During the observation period, observe the resident in different settings and circumstances and consult with the primary nurse assistant over all shifts as well as (if available) resident's family and speech-language pathologist. Page B-7, B-8.

**Section C**

Why does the LSW do or not do the delirium section along with the cognitive sections?  
It is up to the facility to determine who is the most appropriate staff member to complete each section and this may vary by resident.

Does BIMS replace the need for MMSE?  
Yes

Can cognitive interview take the place of MMSE?  
Yes

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Do you have to complete the BIMS for every PPS assessment?
Depends on the assessment type. As far as 5 day and 14 day that was the intention.

C0400 - Do you let them know they have 5 seconds, because some people hesitate and come up with the right answer after 10-20 seconds? Is it a pass/fail if not answered in 5 seconds?
No, just allow up to 5 seconds, don't tell them 5 seconds. Also it is 0 if can't recall even with category clue, 1 if can with category clue which gives an additional 5 seconds, and 2 if correct without category clue. Page C-12.

How can you do a BIMS on a discharged resident who discharges suddenly to the hospital?
You can't. Do the staff interview C-16, C0600 resident unable to complete.

C1300. My staff documents, "No unusual behaviors" for residents that have care planned behaviors, will this affect the supporting documentation for continuously present? Or do I need to change the way they document?
This would not support C1300 - will need to change the documentation. Page C-26 to C-31.

Section D

Can mood interview take the place of a depression screen?
Yes

Can the mood section count for geriatric depression scale?
Page D-3. Different assessment, same outcomes, can REPLACE Geriatric Depression Scale.

Why do we interview staff for mood even though we don't/can't do resident?
If resident is rarely/never understood, you need to interview staff to assess patient fully. Page D-1.

Should a resident interview be conducted for Section D 0200 if staff interview is indicated in Section C, or should interviews be attempted for both sections?
Attempt individually. Follow MDS skip patterns and it will show you where to go next.

If the resident can not complete the interviews in Section C, but does in Section D, can the results in Section D be considered valid?
Yes it is a resident interview based on resident responses.

D0600 - If we interview staff from all three shifts and those answers differ, which response is coded? What if more than 3 staff members are interviewed? What if only one can answer?
The highest frequency, and if any staff rate symptom presence it is coded. Also should interview at least all shifts but if they can not answer that is okay. Can interview more than 3 though. Page D-14.
Section E

Section E resident interview - What about proof for reimbursement? What if clinical record contradicts?
No interview in Section E. But for other interviews you document "residents" response.

E0800 - Rejection of care - Resident who fails cookie swallow who chooses to eat, or is that their goal, does waiver play a role?
Do not include behaviors that have already been addressed and/or determined to be consistent with resident values, preferences, or goals. Page E-13.

E0800, how do you code residents that are cognitively impaired and have chronic rejection of care? These behaviors are care planned and continue to be present. Resident does not understand the consequences of rejecting care.
Once care planned it is not continued to be coded here. See answer above. Page E-13.

E0800 - If a resident is A&O x 3 and their choices are not consistent with their preference/goals do you need to chart rejection of care?
Yes, the first time.

E1000 - If on an Alzheimer's unit, does wandering count as impacting others?
Not automatically. Is the residents wandering on the unit significantly intruding on the privacy or activity of others? Page E-19.

Our facility has two secured units for Alzheimer's residents. Both units have behavior problems coded on the 2.0 and care planned. Will these be coded on 3.0 since they already exist?
Some behaviors continue to be coded even though they have been care planned, just not rejection of care. Need to read all of the sections and the instructions.

Section G

If 2 people transfer a resident to bed on admission and one is the transporter and the other a staff member, are we allowed to count this as a 2 person transfer since one is not our staff member?
No. Both have to be your staff. Page G-5.

G0110I - How do you code use of EZ stand and or Hoyer with balance for toileting?
You code the support levels that are provided by the staff and the number of staff providing the assistance. Most devices require a minimum of two people to safely execute the transfer and usually they require periods of maximum assistance.

Catheter care in ADL's- How do we code if emptying does not occur by resident? Managing catheter?
G0110I - do not include emptying of bed pan, urinal, bed side commode, catheter bag, or ostomy bag. Page G-7.

Do we need chart documentation to support ADL's?
Yes

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How do we code ADL's if they are multiple levels of performance - when is it "highest level of dependence"?

G0300 How do you code the balance test if walker is used? Or if transfers as extensive assistance with 2 staff?
The resident is able to use their walker and it is coded depending on how steady the resident is during the observation time. If steady at all times with use of walker it is coded as a 0. If the resident is able to perform the task with assistance it is coded as a 2. Pages G-19 to G-29.

G0900 - Functional Rehabilitation Potential - Only on admission(or on readmit)?
Only if A0310A=01. Page G-33.

Section H

H0100 - If a resident has an order to straight catheter PRN does that constitute intermittent catheterization and can it be marked on the MDS?
Read definition of intermittent catheter page H-2. "Intermittent Catheterization - Sterile insertion and removal of a catheter through the urethra for bladder drainage."

H0100 - Resident comes from hospital with Foley, facility policy is to remove Foley the following AM. Does the Foley get coded on admission MDS?
Yes. "Check next to each appliance that was used at any time in the past 7 days. Select none of the above if none of the appliances A-D were used in the past 7 days." Page H-2.

H0300 - If resident has an indwelling catheter but it leaks at times because of bladder spasms etc, is it still coded as a "9"?
Pg H-8 doesn't specifically discuss leaks, but states if during the 7 day look back period the resident had an indwelling bladder catheter for entire 7 days it is a 9.

Regarding bowel and bladder programs - for programs other than prompted voiding/scheduled voiding - are there programs that are generally initiated by therapy department and turned over to restorative nursing?
For purposes of the MDS it doesn't matter who initiates the program, but you can speak with your therapy department to see what programs they offer. There are also continuing education opportunities if they have no experience in this area.
Regarding a bowel program, how often should documentation be done? Is monthly enough?

No, see steps for assessment on page H-12.

1. Review the medical record for evidence of a bowel toileting program being used to manage bowel incontinence during the 7-day look-back period.
2. Look for documentation in the medical record showing that the following three requirements have been met:
   - implementation of an individualized, resident-specific bowel toileting program based on an assessment of the resident’s unique bowel pattern;
   - evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, verbal and a written report; and
   - notations of the resident’s response to the toileting program and subsequent evaluations, as needed.

Section I

I1700 - If MRSA is colonized is it coded on MDS?

Yes

Is a signed diagnosis list enough documentation to identify it as active or does it have to be a narrative note by physician?

No, must be active within the last 7 days. UTI has a separate look back criteria. Page I-8.

If on maintenance ATB for UTI do you code that?

Must meet all 4 criteria to code not just #4. Page I-8.

Code only if all the following are met

1. Physician, nurse practitioner, physician assistant, or clinical nurse specialist or other authorized licensed staff as permitted by state law diagnosis of a UTI in last 30 days,
2. Sign or symptom attributed to UTI, which may or may not include but not be limited to: fever, urinary symptoms (e.g., peri-urethral site burning sensation, frequent urination of small amounts), pain or tenderness in flank, confusion or change in mental status, change in character of urine (e.g. pyuria),
3. “Significant laboratory findings” (The attending physician should determine the level of significant laboratory findings and whether or not a culture should be obtained), and
4. Current medication or treatment for a UTI in the last 30 days.

Should UTI be checked if resident had a UTI in the hospital but ABO was finished prior to admission to facility and UTI is resolved?

Need to reference all 4 items on page I-8, if all true then it is coded.

I2300 - Urinary tract infection - It reads code only if all the following are met. If no UA, C&S was done, but does have number 1, 3, & 4 met, it is my understanding then that UTI cannot be marked because it does not meet the definition of the UTI. Is this correct?

Will UTI's on QI's increase because we code UTI if they are getting an ATB for it? It will trigger potentially for CAA's. Specific criteria must be met within 30 days to code. QI changes have not been announced.

I2500 - Wound infection - Does a physician have to actually write the diagnosis of wound infection or can this one be marked if it has all of the symptoms of an infection? All diagnoses in Section I require a physician diagnosis. Page I-5.

I5600 Malnutrition - Who does this? How is this a diagnosis? What tool is used? This requires a physicians diagnosis.

If resident has a diagnosis of psychosis but no behaviors but is on QD behavior monitoring would you mark psychotic disorder? Monitoring makes the diagnosis active and could be coded.

Since psychosis, schizophrenia, and bi polar are all able to be checked in section I - Will this avoid a quality indicator not being triggered for antipsychotic medication marked? Quality Indicator changes have not been announced yet.

Are allergies recorded somewhere on the 3.0? As with any other diagnosis not specifically listed in I, you would enter it in "other" if it has been active in the last 7 days.

Section J

Since pain assessment has changed on MDS, is it still necessary to do the quarterly pain assessment on each resident separate from the MDS? No.

If J0300 pain presence is Yes, and the resident answers J0600A Pain Intensity as 00 (no pain), don't those contradict each other? Why is 00 an option? That would be a situation where the resident is best suited to use the Verbal Descriptor Scale (J0600B) as opposed to the Numeric Rating Scale (J0600A). Page J-13.

Can we count therapy non-medication interventions that they complete or have on their care plan for pain? Page J-2. "Non-medication pain (non-pharmacologic) interventions for pain can be important adjuncts to pain treatment regimens. Interventions must be included as part of a care plan that aims to prevent or relieve pain and includes monitoring for effectiveness and revision of care plan if stated goals are not met. There must be documentation that the intervention was received and its effectiveness was assessed. It does not have to have been successful to be counted." "Non-Medication Pain Intervention - Scheduled and implemented non-pharmacological interventions include, but are not limited to: bio-feedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electrical stimulation, radiotherapy, ultrasound and acupuncture. Herbal medications are not included in this category."

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Does the pain medication have to be classified as an analgesic or do anti-inflammatory or other medications used for pain (i.e. steroids) count as well?

"Pain medication regimen" - Pharmacological Agent(s) prescribed to relieve or prevent the recurrence of pain. Include all medications used for pain management by any route and any frequency during the look-back period. Include oral, transcutaneous, subcutaneous, intramuscular, rectal, intravenous injections or intraspinal delivery. This item does not include medications that primarily target treatment of the underlying condition, such as chemotherapy or steroids, although such treatments may lead to pain reduction." Page J-1.

We use PRN pain medication prior to therapy but not for complaints of pain. Will this trigger anything because PRN pain medication will be marked J0100B but under J0300 the answer will be no?
There are many circumstances where J0100 and J0300 will appear to conflict. This is okay.

Why is pain look back 5 days instead of 7?
Research shows that recollection of pain is only accurate within about 5 days.

If they have both routine pain and PRN pain medications do you code both?
Yes

With these new assessments such as pain - will this eliminate the need for quarterly assessments done separately at this time?
There is no requirement to do two different forms to assess the same thing.

If pain section is done by interview does documentation of pain during ARD count?
No - you must record what the resident reports during the interview.

If a resident goes OOF to hospital and they are diagnosed with dehydration, they hydrate them and send them back do we code dehydration on the MDS?
Dehydrated: Check this item if the resident presents with two or more of the following potential indicators for dehydration:
1. Resident takes in less than the recommended 1,500 ml of fluids daily (water or liquids in beverages and water in foods with high fluid content, such as gelatin and soups). Note: The recommended intake level has been changed from 2,500 ml to 1,500 ml to reflect current practice standards.
2. Resident has one or more potential clinical signs (indicators) of dehydration, including but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, or abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium, albumin, blood urea nitrogen, or urine specific gravity).
3. Resident’s fluid loss exceeds the amount of fluids he or she takes in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement).
Does menstrual bleeding count as internal bleeding?
No, Page J-26. *Internal Bleeding: Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools). Clinical indicators include black, tarry stools, vomiting "coffee grounds," hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed) that requires packing. However, nose bleeds that are easily controlled, menses, or a urinalysis that shows a small amount of red blood cells should not be coded as internal bleeding."

J1550 - Internal bleeding - it reads a urinalysis that shows a small amount of red blood cells should not be coded as internal bleeding. Is there an amount that can be coded? At one time, I thought it was > 3 red blood cells. Is this correct?
Must be hematuria documented not just a urinalysis that shows a small amount of red blood cells. No specific guidelines on red blood cell count may be good to check with your lab. Page J-26.

As therapists, we get patients walking and during that process we keep patients from falling all the time, is this considered a fall on the MDS?
Yes. "An intercepted fall occurs when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person – this is still considered a fall." Page J-27. "Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident)."
During balance activities, if the therapist is administering an overwhelming external force and the resident can not self right, this may not be deemed a fall.

Why if a resident self corrects before a fall is it counted as a fall?
Because this puts them at greater risk for a fall in the future.

If you state that an intercepted fall is any time that they catch themselves or someone stops them, then wouldn't anyone who uses a walker to ambulate be coded as a fall, as they would fall without the walker?
No

Is every person that ambulates with 1-2 person extensive assistance a "fall" every time they are walked?
No. If they become unsteady and are "righted" it would be a fall.

Re: Fall - if definition is "unintentional" what about residents that 1. role themselves out of bed onto a mat, 2. release seatbelts on W/C?
Remember that falls are assessed due to risk for future falls. Be very careful about "intentional".

If a resident has a fracture not related to a fall is it coded in J1900?
No. "major injurious fall" Page J-32.

If fall with skin tear and fracture do you mark both?
No - you code the highest level of injury that occurred.

How would you code a fall in J1900 that was a laceration with sutures?
Injury (except major) B

J1700A - Did the resident have a fall any time in the last month prior to admission? If during the transition period is it during the ARD period or prior to their admission to the facility (may be several years old)? Is dehydration still a sentinel event?
The changes to the QI/QM have not been announced yet.

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