

# Getting Ready for MDS 3.0 Implementation

Wyoming Department of Health  
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## Goals for Today

- Review sections
  - K Nutrition
  - L Dental
  - M Skin
  - N Medications
  - O Treatments, Conditions, Therapy

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## Section K: Swallowing and Nutritional Status

- Intent is to assess many conditions that could affect the resident's ability to maintain adequate nutrition and hydration
  - Section covers swallowing disorders, height and weight, weight loss and nutritional approaches
  - Improved definitions and clarifications for coding
  - Expands instructions and definitions about weight loss and comparisons for 30 and 180 days
  - Encourages collaboration between nurse assessors and dietary professionals

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## Section K: Swallowing and Nutritional Status

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- K0100 Swallowing Disorders
- K0200 Height and Weight (continue to round upward if  $\geq .5$  and down if  $< .5$ 
  - Requires admission and annual Height
- K0300 Weight Loss (Wt. should be no more than 1 month old)
- K0500 Nutritional Approaches
  - IV fluid past 7 days (must be reflected in chart that it reflects nutrition or hydration need.) May include IV fluids if received in facility or at a hospital provided it was received for nutrition or hydration.
  - May not include IV fluid used to reconstitute and or dilute meds for IV administration
- K0700 Average Percent of Intake via Artificial Route

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## Section L: Oral Dental

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- Intent is to record dental problems in the past 7 days
- Check all that apply

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## Section M: Skin Conditions

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- Intent is to document the risk, presence, appearance and change of pressure ulcers.
  - Includes other skin conditions and problems including ulcers, wounds and lesions
  - Includes documentation of skin treatments and treatment categories related to skin injury and avoiding injury
  - Includes assessment of unstageable ulcers
  - Requires information about ulcers present on admission
  - Requires identification on largest and deepest site
- Identification of venous and arterial ulcers, healed ulcers
- Eliminates reverse staging of ulcers,
- Utilizes PUSH scale and NPUAP guidelines except blister caused from pressure
- Manual instructions and guidance greatly enhanced

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## Section M: Skin Conditions

- Requires detailed facility assessment, tracking and documentation systems
- Requires training and knowledge of many clinical staff members
  - Coding of unstageable ulcers change once they are debrided or opened
  - Significant care plan issues
- Requires MD involvement

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## Section M: Skin Conditions

- M0100 thru M0210 Determination of Pressure Ulcer Risk and Unhealed ulcers
- M0300 Current Number of Unhealed Ulcers
  - How many at each Stage/Type
  - Number present on Admission
  - Date of oldest Stage 2 pressure ulcer
  - All Blisters coded as Stage 2
  - Non-removable dressing
  - Slough and/or eschar
  - Deep tissue (coded as unstageable until opened)
- M0610 Dimensions of Unhealed Stage 3 or 4
- M0700 Most Severe by Tissue Type
- M0800 Worsening of Ulcer from Prior Assessment

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## Section M: Skin Conditions

- PU with flap graft coded as surgical wound.
- **If caused by pressure** even if venous, arterial or diabetic, it is considered a PU.
- Measure all PU in cm. to one decimal point
- Code the deepest PU in length by width
- If unstageable on admission it is captured as “had on admission” unless stage worsened while in facility.
- Worsening ulcers since admission becomes facility acquired
- If PU was in-house acquired and worsens while in hospital, consider it as present on admission.
- Considered as unstageable if there is a non-removable dressing or device.

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## Section M: Skin Conditions

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- Code unstageable due to slough and/or eschar PU diagnosed.
- If PU debrided and any part of the wound bed can be seen and depth determined, the wound should be appropriately staged. May still have slough and/or eschar
- **Deep Tissue Injury** usually “purple or maroon area of intact skin or blood filled blister due to damage of underlying soft tissue. May be mushy, boggy, warm or cool.”
- PU are referred to highest stage even if healed, but not coded if healed e.g. healed stage III

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## Section M: Skin Conditions

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- **Venous ulcers** occur on lower portion of the leg. Usually superficial w/ a moist red to pink bed and irregular edges
- **Arterial ulcers** usually from PAD (peripheral arterial disease). Usually located on the distal area of lower extremity including toes, top of the foot and outside edges of the foot.
- **Diabetic ulcers** occur in areas of constant pressure such as the ball of the foot and often below the great toe on the ball of the foot,

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## Section M: Skin Conditions

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- M0900 Healed Pressure Ulcers from Prior Assessment
- M1030 Venous and Arterial Ulcers
- M1040 Other Ulcers, Wounds, Skin Problems
  - Foot Problems
  - Other Problems
- M1200 Skin and Ulcer Treatments

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## Section N: Medications

- Intent is to record the number of days during the last 7 days (or since admission) that any types of injections, insulin, and/or select oral medications were received
  - Simplified
  - Injections to include antigens and vaccines
  - Combination meds are now coded in each med category
  - Anticoagulant drugs are not antiplatelet i.e. plavix, agrenox or ASA
  - For subq pumps code only the number of days it was restarted as an injection
  - Insulin injections
    - now a payment driver for Diabetics with order change
    - Sliding scale is not considered an insulin order change

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## Section O: Special Treatments and Procedures

- Intent is to identify any special treatments, programs and procedures that the resident received during specific time frame
  - Combines Sections P, W and part of T from 2.0
- O0100 During prior **14 days**
  - “Received while not a resident” or “While a resident”
  - “Leave blank if resident entered > 14 days ago
  - Instructions to not code items provided solely in conjunction with surgical procedures; and pre and post op
  - Contrast material included in diagnostic procedures now counted as IV med
  - May capture IV meds if out to ER and returns

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## Section O: Special Treatments and Procedures

- Cancer Treatments
- Respiratory Treatments (Includes payment and non payment drivers)
- May not code hyperbaric oxygen for wound care under oxygen
- Isolation (Must be in a separate room) Can be MRSA/VRSA, but must have drainage and not be colonized
- O0250 Influenza Vaccine (No longer specifies specific months- CDC will announce yearly)
- O0300 Pneumococcal Vaccine- if unknown whether received, suggested to give again

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## Section O: Special Treatments and Procedures

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- O0400 Respiratory, Psychology, Recreational Therapy programs (Total minutes and days)
- O0500 Restorative Nursing (No changes)
- O0600 Physician Examinations
  - changed from Visits; Since admission 14 day look back
- O0700 Physician Orders (Since admission 14 day look back)

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## Changes to Therapy

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- Now includes start and stop dates of therapy programs
- Includes breakdown of Treatment Modes delivered
  - **Individual** therapy
  - **Concurrent therapy** consisting of no more than 2 patients (regardless of payer source), both of whom must be in **line-of-sight** of the treating therapist (or assistant); or
  - **CT involving 3 or more residents will NOT be recognized as reimbursable treatment**
  - **Group therapy** consisting of 2 - 4 patients (regardless of payer source), performing similar activities, and supervised by a therapist (or assistant) who is not supervising any other individuals
- Expanded rules related to care and payment

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## Section O0400 Therapy

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- Captures total minutes administered in Individual, Concurrent and Group over prior 7 days (since admission)
- Includes start and stop dates
  - OMRA required after 3 days
- Weights changed under RUG-IV
  - Framework does not change
  - 5 levels of intensity with same thresholds

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## Restorative Nursing

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- Does not require a physician order.
- Must be within the 10 practice areas
- Must deliver a total of 15 min/day (minutes do not have to occurred at the same time)
- Measurable objectives and interventions and care planned and in clinical record
- Evidence of periodic evaluation by a licensed nurse and in chart
- Nurse assistants/aides must be skilled in the techniques that promote resident involvement in the activity.
- May not have more than 4 residents per supervising helper or caregiver.
- Therapist time for maintenance can be included

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## MD Examinations and Orders

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- **Visits:** Resident must be examined by physician
- May not include exams during ER visit of hospital observation stay
- Must have documentation in record
  
- **Orders:** code only number of days orders were changed –Do not code clarification orders to continue Tx, sliding scale orders after initial order written unless a new order is received that changes the schedule, or orders to change physicians

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## Section P: Restraints

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- P0100 Physical Restraint
  - Revisions include detailed definitions in manual and significant changes to evaluate device
  - Side rails of any type may be considered a restraint
  - \*\*MD order must include specific medical problem or condition that requires restraint
  - Team must document on-going review to reduce restraint

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## Care Area Assessments

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- Feeding tubes
- Dental care
- Psychotropic Medication
- Nutritional Status
- Dehydration/Fluid status
- Pressure Ulcer
- Physical Restraints

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## Start Thinking 2010 Strategy Today!

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- Clinical Assessments and facility Documentation
- Standards of Practice
  - Expert consultations
  - Cognition, Pain, Skin
- Coordination of Resources
  - AANAC education
- Stay calm
- OBRA '87: Highest Quality of Care, Meaning and Purposeful Lives

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## Web Sites

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<http://www.cms.hhs.gov/Nursing HomeQualityInsites/25NHQIMDS30.asp>

–RAI Manual

–Forms

–Data specifications

–Edit Report

<http://www.cms.hhs.gov/SNFPPS/09RUGRefinement.asp>

–RUG-IV

–MC PPS information

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