

MDS Alert

MDS 3.0: Back To Basics: Honor 6 Essential MDS Coding Conventions

Follow these instructions when entering dash values for items

Whether you're new to MDS coding, or just need a refresher, here are a handful of fundamental coding rules from the RAI Manual (pages 3-3 through 3-5) that you should always keep in mind:

1. Expect a 7-Day Look-Back Period

Rule of thumb: You can count on the standard look-back period to be seven days, unless otherwise indicated. There are, however, a handful of items where the look-back period is another amount. For instance, item D0200 Resident Mood Interview (PHQ-9©) has a look-back period of the last two weeks.

Also, the look-back period typically does not include a hospital stay, except for certain items in Section K Swallowing/Nutritional Status and Section O Special Treatments, Procedures, and Programs.

And some other items have a look-back period that reaches back to the Admission/Entry, Reentry, or Prior Omnibus Reconciliation Act of 1987 (OBRA) or scheduled Prospective Payment System (PPS) assessment, whichever is most recent. In these cases, you must only consider the assessments required for submission to the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system.

Mistake: When determining which is the "prior assessment," don't consider PPS assessments that you've completed for private insurance and/or Medicare Advantage Plans, because you aren't supposed to submit these to QIES ASAP.

2. How to Follow 'Skip Patterns'

Many parts of the MDS 3.0 follow so-called "skip patterns," in which your scoring of an item will dictate how you complete the scoring for one or more subsequent items. Follow the instructions to skip over the next item (or in some cases several items). If the instructions tell you to skip over items, simply leave those items blank and move onto the next item as directed.

Example: If you code item B0100 Comatose as 1 Yes, the skip pattern instructs you to skip to item G0110 Activities of Daily Living (ADL) Assistance. You would leave blank items B0200 Hearing through F0800 Staff Assessment of Daily and Activity Preferences, and then begin coding again at item G0110.

3. Fill in the Boxes the Right Way

The MDS 3.0 requires a variety of different responses throughout the item sets. In some cases, you need to simply check a box, while in other cases you may need to provide a numeric response. Use a check mark for boxes where the instructions tell you to "check all that apply." If no condition is met, simply leave the boxes blank.

Some items require you to enter a number or pre-assigned value. For instance, item B0700 Makes Self Understood asks you to choose a numeric code based on the response:

- 0 Understood;
- 1 Usually understood;
- 2 Sometimes understood; or
- 3 Rarely/never understood.

And still other items ask you to record a date, such as item A0900 Birth Date. For dates, make sure you enter two digits

for the month, two digits for the day, and four digits for the year.

Yet another tricky situation that you might encounter is when you must fill in a count or measurement, but the number of boxes available to enter that number is insufficient to record the actual count or measurement. When the result of a count or measurement is greater than the number of available boxes, the RAI Manual instructs you to "maximize the count/measurement by placing a "9" in each box.

Example: The resident weighs 1,010 lbs., but there are only three available boxes for item K0200B □ Weight. In this case, you would enter the resident's weight as "999" in the available boxes. You should still document the resident's correct weight in the medical record and ensure that you complete the appropriate care plan to address the additional counts/measurements.

4. Tread Carefully When Using Dashes

The use of dashes is a tricky issue for MDS coding, because the **Centers for Medicare & Medicaid Services (CMS)** discourages this practice. But still, nearly all the items in the MDS 3.0 allow you to enter a dash [-] value into the box and submit this to the QIES ASAP system.

Important: Always keep in mind that entering a dash value indicates that you didn't assess that item. Dashes are acceptable in situations like when a resident is discharged before you could assess that given item, or when you need to submit a partial assessment when it's required for payment purposes.

There are also four specific items requiring dates that use dash values to indicate that the event hasn't yet occurred. These include item A2400C □ End date of most recent Medicare stay, and the therapy end dates for items O0400A6, O0400B6 and O0400C6. »»»»

Pitfall: But whatever you do, don't try to enter dashes for certain items that don't allow dash values. These include item I8000 and certain items in Section A □ Identification Information like:

- A0310 □ Type of Assessment;
- A0500 □ Legal Name of Resident;
- A0800 □ Gender; and
- A2300 □ Assessment Reference Date.

5. Tap Into These Information Sources

Because the MDS 3.0 is fundamentally the "voice of the resident," you should use the resident as the primary source of information for the resident assessment items. Of course, this isn't always possible, especially when a resident is unable or unwilling to communicate.

You should always attempt the resident interviews:

- C0200-C0500 □ Brief Interview for Mental Status (BIMS);
- D0200 □ Resident Mood Interview (PHQ-9©);
- F0400 □ Interview for Daily Preferences and F0500 □ Interview for Activity Preferences; and
- J0300-J0600 □ Pain Assessment Interview.

But when the resident is unable to participate in Section F, seek out the resident's family, significant other, and guardian or legally authorized representative.

6. Understand What 'Significant' & 'Physician' Really Mean

Certain recurrent terms used in the MDS 3.0 can be confusing at first. For instance, you'll see the term "physician" used frequently throughout the MDS. When CMS uses the term "physician" in the RAI Manual, this includes nurse practitioners, physician assistants and/or clinical nurse specialists, as allowable under your state licensure laws and Medicare.

Likewise, you'll see the term "significant" quite a bit throughout the MDS. According to the RAI Manual, the term "significant" can have different connotations depending on the circumstances in which it's used. When discussing clinical, medical or laboratory findings, significant "refers to measures of supporting evidence that are considered when developing or assigning a diagnosis, and therefore reflects clinical judgment," the RAI Manual states.

Bottom line: The MDS 3.0 can seem a bit overwhelming for new coders, but don't despair. Understanding these common MDS coding conventions will go a long way toward helping you master MDS completion.