# MDS Alert

## MDS 3.0: Check Out These 3 Highlights of MDS 3.0 Instructions

ADL examples clear up what a code of '7' entails.

With chapter 3 of the MDS 3.0 RAI User's Manual in hand, nursing facilities now have more of the "rest of the story" for how the assessment works, although CMS training may provide additional illumination.

Meantime, however, the manual includes some key clarifications and changes that give your facility a heads up on what to expect.

Examples Clarify How to Code a '7' in Section G

Simply reading on the MDS 3.0 form that a "7" for ADL self-performance means the "activity occurred only once or twice" can be confusing. But the manual's examples indicate the key to how a "7" differs from an "8" (activity did not occur) is that you use "7" if the resident does the activity one or two times, notes **Marilyn Mines, RN, RAC-CT, BC,** manager of clinical services for FR&R Healthcare Consulting in Deerfield, Ill.

Examples: Code "walk in corridor" as a "7" "if the resident came out of the room and ambulated in the hallway for a weekly tub bath but otherwise stayed in the room during the seven-day look-back period," states the manual. Code "locomotion off unit" as a "7" "if the resident left the vicinity of his or her room only one or two times to attend an activity in another part of the building."

Pressure Ulcers Present at Admission Timeframe Is Now Undefined

"The previous MDS 3.0 version (No. 26) had a definition of a pressure ulcer present on admission as one that was present within 48 hours of admission," observes **Rena  Shephard, MHA, RN, RAC-MT, C-NE**, president of RRS Healthcare Consulting Services in San Diego. The MDS 3.0 final item set and chapter 3 of the manual, however, simply direct the assessor to code pressure ulcers present on admission.

Tip: "Facilities should have a policy where nurses do the wound assessment right away after admission," says **Elisa Bovee, OTR/L,** director of education and training for Harmony Healthcare International in Topsfield, Mass. You want to "document pressure ulcer risk and any skin alterations as soon as possible." **Section I Involves 2-Step Process, Physician Extenders**

The MDS 3.0 RAI User's Manual notes that "physician extenders [nurse practitioners, physician assistants, and clinical nurse specialists] can document a diagnosis for purposes of coding Section I -- as long as the state practice act allows that," says Mines.

Section I coding involves a two-step process. As a first step, the instructions direct the coder to identify diagnoses documented by the physician or physician extender in the last 30 days.

Then in the second step, you look at whether the diagnosis is active or inactive during the sevenday lookback period.

You only code active diagnoses. These "have a direct relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the look-back period," states the RAI User's Manual for the MDS 3.0.

Urinary tract infection has a 30-day lookback in Section I. For more information on coding UTI, see the RAI User's Manual for the MDS 3.0, chapter 3, Section I, page 8. (Each MDS section of chapter 3 is in a separate pdf file at www.cms.hhs.gov/Nursinghomequalityinits/25_NHQIMDS30.asp.)