



WISCONSIN DEPARTMENT  
*of* HEALTH SERVICES

# Quarterly MDS Forum

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May 2026



# Discharge

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- Discharge planning and requirements
- Section Q of the MDS
- Non-Q referral
- State Operations Manual (SOM) Appendix PP – F627
- Critical element pathway – Discharge CMS-20132



# Discharge

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## Referral process

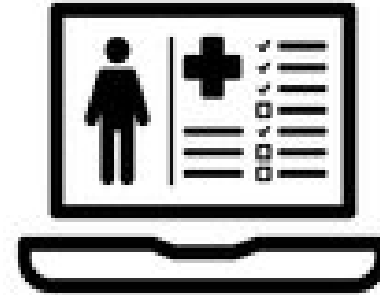
- Complete form F-00311
- Send completed form to the ADRC or if enrolled in a LTC program, send the form to the care manager, nurse, or independent consultant agency
- Notify the resident and/or rep that a referral was made



# Discharge

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- Resident's health record
- Resident's care plan



# IV Fluids Section K0520

## K0520. Nutritional Approaches

Check all of the following nutritional approaches that apply

1. On Admission	2. While Not a Resident	3. While a Resident	4. At Discharge
Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B	Performed <b>while NOT a resident</b> of this facility and within the <b>last 7 days</b>  Only check column 2 if resident entered (admission or reentry) <b>IN THE LAST 7 DAYS</b> . If resident last entered 7 or more days ago, leave column 2 blank.	Performed <b>while a resident</b> of this facility and within the <b>last 7 days</b>	Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C
<b>Check all that apply</b>			
<b>A. Parenteral/IV feeding</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



# IV Fluids Section K0710

<b>Check all that apply</b>				
	1. On Admission	2. While Not a Resident	3. While a Resident	4. At Discharge
A. Parenteral/IV feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**K0710. Percent Intake by Artificial Route**  
 Complete K0710 only if Column 2 and/or Column 3 are checked for K0520A and/or K0520B

<b>2. While a Resident</b>	<b>3. During Entire 7 Days</b>
Performed <i>while a resident</i> of this facility and within the <i>last 7 days</i>	Performed during the entire <i>last 7 days</i>

	Enter Codes	2. While a Resident	3. During Entire 7 Days
A. Proportion of total calories the resident received through parenteral or tube feeding		<input type="checkbox"/>	<input type="checkbox"/>
1. 25% or less			
2. 26–50%			
3. 51% or more			
B. Average fluid intake per day by IV or tube feeding		<input type="checkbox"/>	<input type="checkbox"/>
1. 500 cc/day or less			
2. 501 cc/day or more			



# IV Fluid Scenarios

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1. IV fluids and IV antibiotics administered in the hospital **prior to admission** and within the 7-day look-back.
2. IV antibiotics reconstituted with 250cc vs 100cc for inadequate oral intake given in the hospital **prior to admission** and within the 7-day look-back.
3. Resident sent to the hospital, not admitted, but received IV fluids for hydration.



# Falls with Head Injury

Classified as “major injury”

## Injury to the Head

### *Intracranial (without Loss of Consciousness)*

S060	Concussion
S061	Traumatic cerebral edema
S062	Diffuse traumatic brain injury
S063	Focal traumatic brain injury
S064	Epidural hemorrhage
S065	Traumatic subdural hemorrhage
S066	Traumatic subarachnoid hemorrhage
S068	Other specified intracranial injuries
S069	Unspecified intracranial injury
S080	Avulsion of scalp

## Injury to the Head

### *Intracranial (with Loss of Consciousness)*

S060	Concussion
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S062	Diffuse traumatic brain injury
S063	Focal traumatic brain injury
S064	Epidural hemorrhage
S065	Traumatic subdural hemorrhage
S066	Traumatic subarachnoid hemorrhage
S068	Other specified intracranial injuries
S069	Unspecified intracranial injury
S06A	Traumatic brain compression and herniation



# “Active” Diagnoses

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## Key terms/items

- Intended to code diseases that have a **direct relationship** to the resident’s current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death.
- Active diseases and infections that drive the current plan of care.
- Physician-documented in the last 60 days and active in the last 7-day look-back period (except UTI’s which is 30-day look-back)



# “Active” Diagnoses

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- Functional limitations – loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis, or paralysis.
- Nurse monitoring – clinical monitoring by a licensed nurse (BP eval, med management).



# “Active” Diagnoses

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- Diseases to be coded in each category are not limited to only those listed in the examples.
- If the disease or condition is not specifically listed, enter ICD-10 code in I8000.
- Do not stretch diagnoses or lead the physician into a diagnosis.
- If the diagnosis is not clear or unsure if it is active – QUERY the physician!



# “Active” Diagnoses

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1. Physician documents that the resident has inadequately controlled hypertension and will modify medications.
2. Recent onset or acute exacerbation include the following:  
new diagnosis of pneumonia indicated by chest X-ray
3. Hospitalization for fractured hip
4. A blood transfusion for a hematocrit of 24
5. Intermittent claudication (lower extremity pain on exertion) in conjunction with a diagnosis of peripheral vascular disease.



# “Inactive” Diagnoses

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1. Pneumonia two months prior to admission, no residual effects and no current treatment
2. Diagnoses of coronary artery disease, angioplasty three years ago, not symptomatic, no medications
3. On an antipsychotic, no diagnosis of schizophrenia, no documentation of a detailed evaluation by an appropriate practitioner
4. Diagnoses of arthritis, no medications, no documentation of PT or other therapy for functional limitations



# “Active” Diagnosis?

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New resident in the facility. Diagnoses which include morbid obesity and a stage 3 pressure injury. Resident is receiving protein supplements which were ordered by the physician after consultation with the facility dietitian to aid in healing the pressure injury. Resident is also receiving a weight reduction diet per their request. Most recent (30 days old) albumin level, the physician noted a protein malnutrition and requested the dietitian reevaluate the nutrition plan. Adjustments to the dietary approaches on resident's plan were made and continued.



# Diagnoses

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- Lack of appropriate diagnostic information (F605)
- Mental disorders – evidence-based criteria and professional standards
- Supporting documentation (F641)
- Insufficient documentation (F658)



# Sufficient Documentation

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1. Nurse's notes indicating the resident has had symptoms, disturbances, or behaviors consistent with those listed in the DSM criteria, and for the period of time in accordance with the DSM criteria.
2. Practitioner indicating that the diagnosis was given based on a comprehensive assessment, such as notes from a practitioner's visit.



# Sufficient Documentation

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3. Practitioner indicating that the symptoms, disturbances, or behaviors are not attributable to the effects of a substance or another medical condition.
4. Effect the disturbance is having on the resident's function, such as interpersonal relationships, or self-care, in comparison to their level of function prior to the onset of disturbance.



# F658 Comprehensive Care Plan

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## SCHIZOPHRENIA

### Diagnostic Criteria

A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):

1. Delusions.

2. Hallucinations.

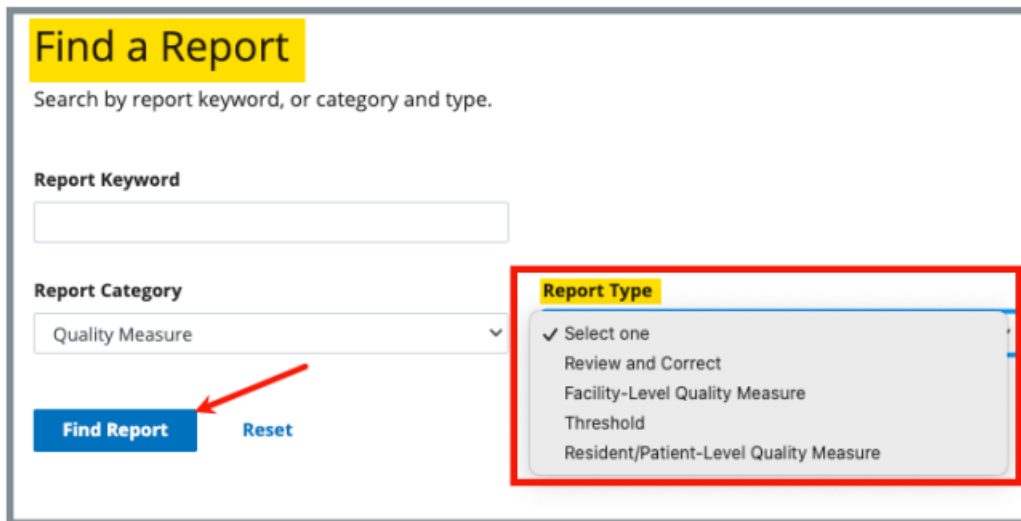
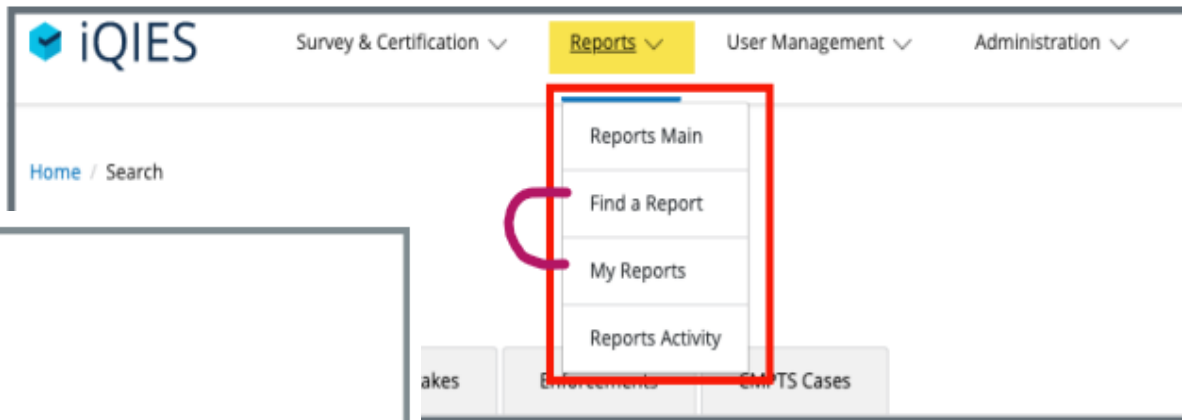
1. Disorganized speech (e.g., frequent derailment or incoherence).

2. Grossly disorganized or catatonic behavior.

5. Negative symptoms (i.e., diminished emotional expression or avolition).



# Reports in iQIES



# Reports in IQIES

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<b>MDS 3.0 Facility-Level Quality Measure (QM) Report</b>	Quality Measure	Facility-Level Quality Measure	Displays the facility percentage and how the facility compares with other facilities in their state and in the nation for each quality measure. This report helps facilities identify possible areas for further emphasis in facility quality improvement activities or investigation during the survey process.
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# Reports in IQIES

**My Reports**  
Access and manage your available reports.




Search My Reports

11 - 11 of 11 Reports

Sort reports/folders by name

Sort reports/folder by created date

Organize reports in a folder

Name	Created Date	Actions
 Amazing Home Health Care Outcome Report	06/02/2022 4:33 PM	<input type="button" value="More -"/>
 LTCH Provider Final Validation Reports	02/14/2019 1:17 PM	
 June Outcome Reports	06/02/2022 5:02 PM	

**New Folder**

- View
- Download PDF
- Download CSV
- Run Again
- Rename
- Delete
- Move



# Reports in IQIES

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- QM reports - monthly
- QRP provider threshold report – monthly to quarterly
- Review and correct reports – monthly to quarterly
- Error detail report (3897, 3908) (1038, 1040, 3749A-E, 3810A-E) - monthly
- Final validation report – after each submission
- Missing OBRA assessment report - weekly
- Five-star provider rating report - quarterly



# Submit to iQIES?

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## OBRA

- Entry
- Discharge
- Comprehensive
- Non-comprehensive

## SNF PPS Medicare Part A

- 5-day
- Discharge
- IPA

## Other

- Test data
- Private insurance
- Medicare advantage (Part C)
- Veteran's benefits





# Questions and Answers



# Contact Us

## Heather Newton – Education Coordinator



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<https://www.dhs.wisconsin.gov/regulations/nh/rai-mds.htm>



# Contact Us

## Emily Virnig – Automation Coordinator



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<https://www.dhs.wisconsin.gov/regulations/nh/rai-mds.htm>





# Thank you!

Protecting and promoting the  
health and safety of the people  
of Wisconsin



WISCONSIN DEPARTMENT  
*of* HEALTH SERVICES

# Resources

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- [ADRC Required Statewide Policies, P-02923](#)
- [Resident Relocation Manual, P-01440](#)
- [The National Long-Term Care Ombudsman Resource Center](#)
- [MDS-Q Training - Resident Referrals to Community\(opens external video\) and presentation slides](#)
- [SNF – Falls with Major Injury Respecification Technical Specification Report](#)
- [MDS 3.0 Provider Updates: Section I](#)
- [Reports User Manual](#)
- [CMS iQIES Assessment Management for Assessment Submitter v2.2](#)

