CODING THE MDS, A-GG

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OBJECTIVES

- Review how to code sections A-GG per the RAI manual
- Define what an interrupted stay and interruption window are
- List what items are not required to be completed in Wisconsin

OBJECTIVES

- Watch a video on interviewing techniques
- Explain what Preadmission Screen and Resident Review (PASRR) Level 1 and Level 2 are and when they are needed
- Review key elements to section GG

TERMS

- ARD: Assessment reference date; the last day of the observation or look back period
- CAA: Care area assessment
- DCRA: Discharge return anticipated
- IPA: Interim payment assessment
- PPS: Prospective payment system
- OBRA: Omnibus Budget Reconciliation Act

TERMS

- SCQA: Significant correction to prior quarterly
- Observation period: Time period over which the resident's condition or status is captured by the MDS
- SCSA: Significant change in status
- SCPA: Significant correction to prior comprehensive
- SNF: Skilled nursing facility

REVIEW

Last session

- What the Resident Assessment Instruction (RAI) is
- Where to locate the RAI
- The three components of the RAI
- Why the Minimum Data Set (MDS) is completed
- The different assessment types
- The definitions related to MDS
- Regulatory requirements related to timing and submission

STARTING WITH SECTION A

- Software vendor
- Free software “jRAVEN”
- Chapter 3 of RAI manual
- Required subset
- Who within your facility completes certain sections

SECTION A

- **A0050** Type of record
  - New, modification, inactivation
- **A0100** Facility provider numbers
  - NPI, CCN
- **A0200** Type of provider
  - Nursing home, swing bed

SECTION A

- ~~**A0300** Optional state assessment~~
- **A0310A** Federal OBRA reason for assessment
  - Admission, quarterly, annual, significant change, significant correction
- **A0310B** PPS assessment
  - Five day, IPA

SECTION A

- **A0310E** Is this…the first assessment since the most recent admission/entry or re-entry?
- **A0310E = 0** for:
  - Entry or death in facility tracking records (A0310F = 01 or 12);
  - A standalone part A PPS discharge (A0310A = 99, A0310B = 99, A0310F = 99, and A0310H = 1); or
  - An IPA (A0310A = 99, A0310B = 08, A0310F = 99, and A0310H = 0).
- **A0310E = 1** on the first OBRA, Scheduled PPS or OBRA discharge assessment

SECTION A

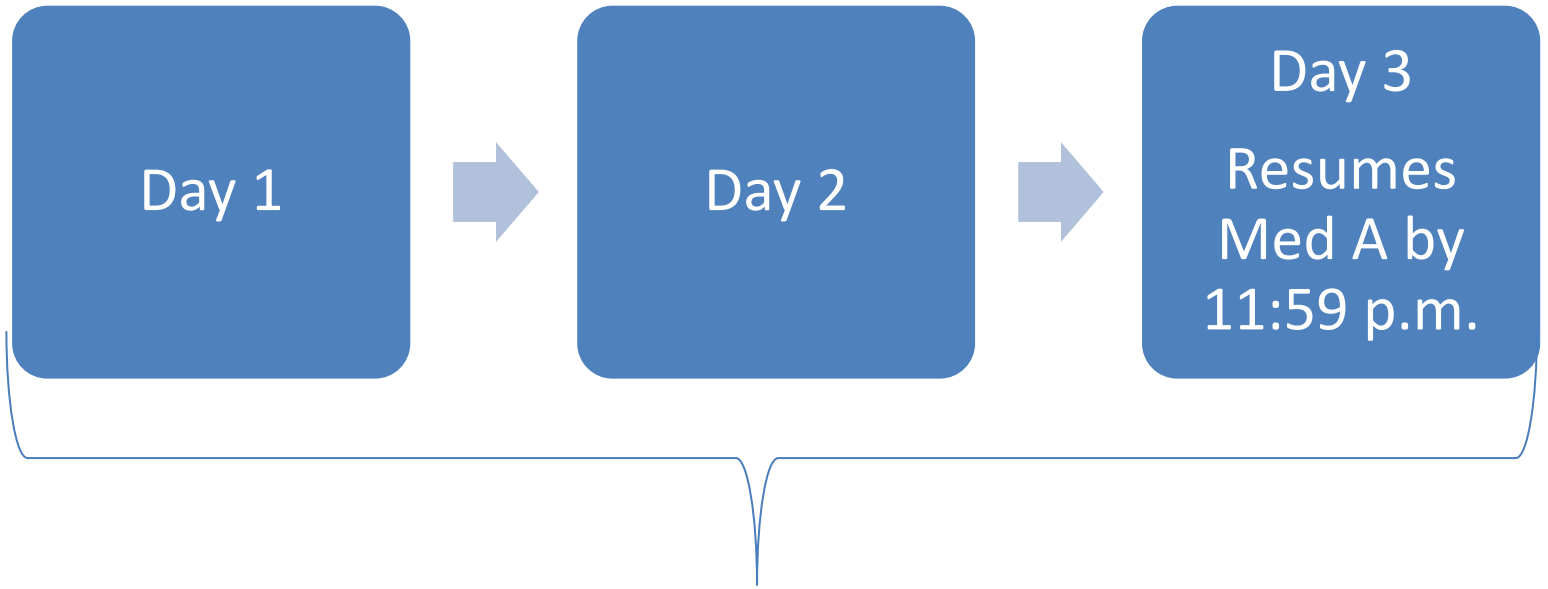
- **A0310F** Entry/discharge reporting
  - Admission or re-entry
  - Discharge return not anticipated
  - Discharge return anticipated
  - Death or while on leave of absence (LOA)
- **A0310G** Type of discharge
  - Planned
  - Unplanned

SECTION A

A0310G1 Is this a SNF Part A interrupted stay?

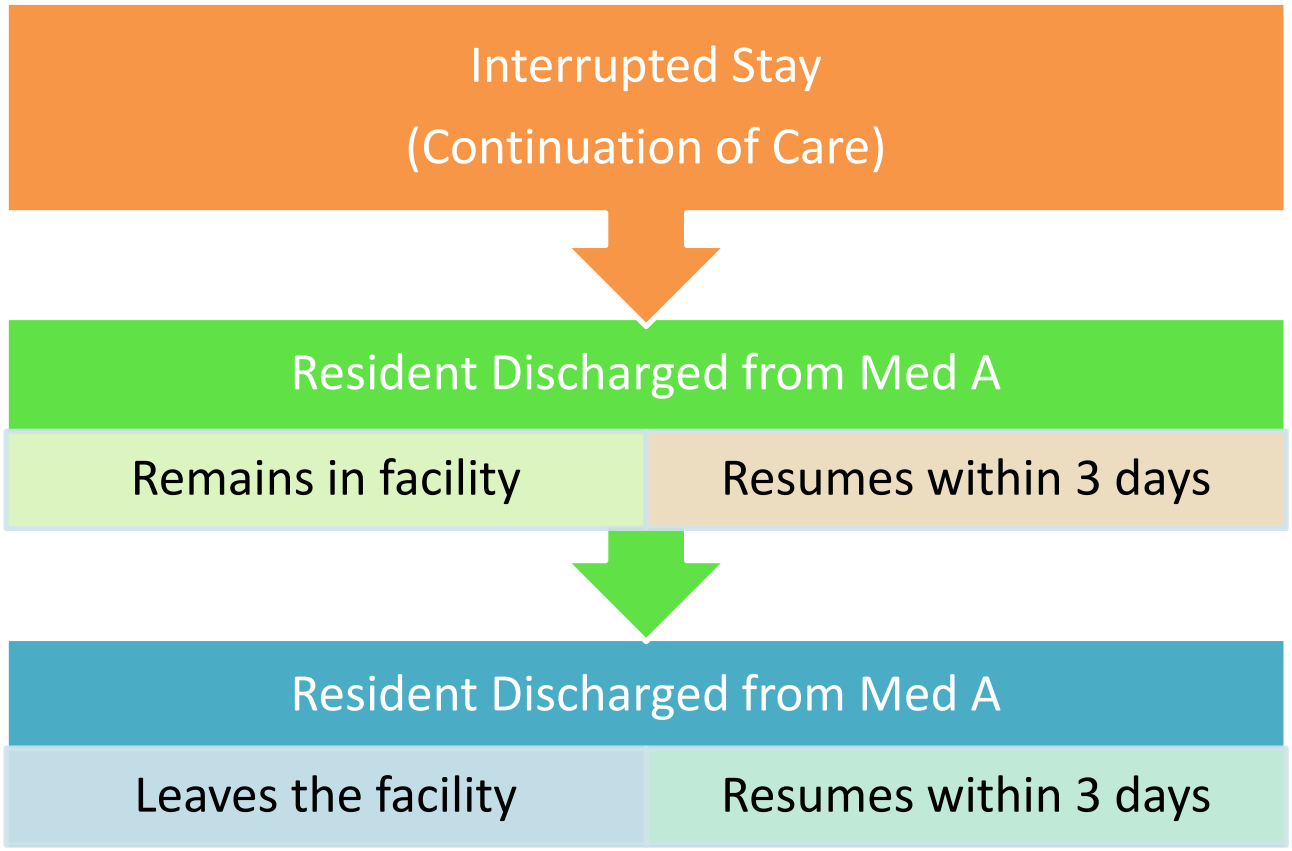
- Interrupted Stay: Resident is discharged from SNF care and resumes SNF care in the same SNF.
- Interruption Window: Three-day period, starts with the calendar day of Part A discharge and including the two immediately following calendar days.

INTERRUPTION WINDOW



Continuation of the previous stay (Variable per diem and PPS assessment completion)

SECTION A



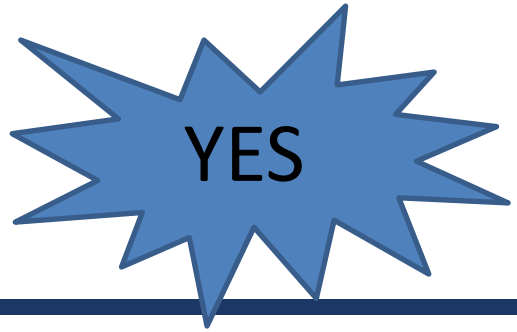
No PPS DC or OBRA DC, nor 5-day or Entry tracking

OBRA DC required, Entry upon return, OBRA admit (if DCRNA), no 5-day

EXAMPLE

- Admitted to SNF November 7, 2019 on Med A
- Transferred and admitted to hospital on November 20, 2019
- Returns to same SNF on November 22, 2019 to resume Med A

Is this considered a continuation of the previous stay?



SECTION A

Not an Interrupted Stay

Resident Discharged from Med A

- Remains in facility
- Doesn't resume within 3 days

PPS DC and a 5-day are required if resuming within the 30-day window

Resident Discharged from Med A

- Leaves the facility
- Doesn't resume within 3 days

PPS DC and OBRA DC required, may be combined

EXAMPLE

- Admitted to the SNF on November 7, 2019 on Med A
- Admitted to a hospital on November 20, 2019
- Returns to same SNF on November 29, 2019 on Med A

Is this considered a continuation of the previous stay?

SECTION A

- **A0310H** SNF PPS Part A Discharge Assessment?
- **A0410** Unit certification or licensure designation
  - Unit is Medicare and/or Medicaid certified
- **A0500** Legal name of resident
- **A0600** Social security and Medicare numbers
  - If recent immigrant or a child, leave blank if not available
- **A0700** Medicaid number
- **A0800** Gender
  - Must match what is in the social security system

SECTION A

- **A0900** Birth date
  - If only a portion known, enter what is known
- **A1000** Race/Ethnicity
- **A1100** Language
- **A1200** Marital Status
- ~~**A1300** Optional resident items~~

PASRR

- Requires all applicants of a Medicaid-certified nursing facility be assessed to determine whether they might have an intellectual disability or mental illness (Level 1).
- Those that test positive at a Level 1 are then evaluated in depth to confirm the determination of an intellectual disability or mental illness (Level 2).

PASRR

- **Level 2 completed by Behavioral Consulting Services**
  - Summarizes the results of the Level 2
  - Determines nursing facility placement
  - Specialized services determinations

- Request a new PASRR Level 2 screen for an individual who has a significant change in condition where a decline in mental health status negatively impacts the individual's ability to function at their highest level of independence.

PASRR

When to do a Level 2 evaluation:

- CHF
- COPD
- A-Fib
- Dementia
- CKD
- DM
- **Anxiety – receives Ativan as needed (PRN) on a regular basis and more days than not.**

PASRR

When **not** to do a level 2 evaluation:

- CHF
- COPD
- Parkinson's
- **Dementia** with depression

SECTION A

- **A1500** Preadmission Screening and Resident Review (PASRR)
- **A1510** Level II PASRR conditions
  - Serious mental illness, intellectual disability, other related conditions
- **A1550** Conditions related to ID/DD status
  - 22 years of age and admission assessment
  - 21 years of age or younger and is an admission, annual, significant change or significant correction
  - Down syndrome, autism, epilepsy, other organic condition related to intellectual/developmental disability (ID/DD), or ID/DD with no organic condition

SECTION A

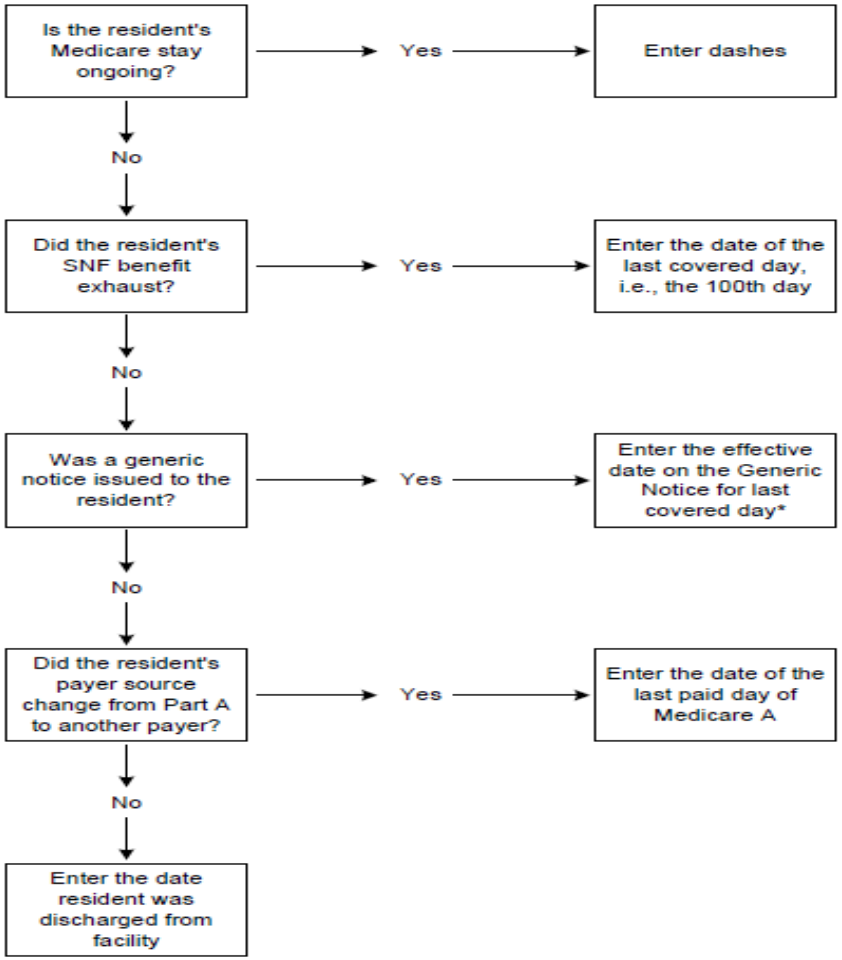
- **A1600** Entry date
  - Date entered facility
- **A1700** Type of entry
  - Admission/entry
  - Reentry
- **A1800** Entered from
- **A1900** Admission date
  - Date episode of care began

SECTION A

- **A2000** Discharge date
  - Leaves the facility
- **A2100** Discharge status
- **A2200** Previous assessment reference date for significant correction
- **A2300** Assessment reference date (ARD)
  - End point for the look back period
- **A2400** Medicare stay
  - Starts and ends

SECTION A

Medicare Stay End Date Algorithm
A2400C



KNOWLEDGE CHECK

The facility received communication from an acute care hospital discharge planner stating that Mrs. H, a former resident of the facility who was discharged home return not anticipated on November 2, 2018 after a successful recovery and rehabilitation, was admitted to their hospital on February 8, 2019 and wished to return to the facility for rehabilitation after hospital discharge. Mrs. H returned to the facility on February 15, 2019.

KNOWELEDGE CHECK

How would you code:

- A1600, Entry date
- A1700, Type of admission
- A1800, Entered from
- A1900, Admission date

KNOWLEDGE CHECK

An interrupted stay is defined as all the following except:

1. Is a Medicare Part A resident
2. Resident is discharged from Med Part A stay and subsequently resumes SNF care in the same SNF for a covered stay
3. Resident is discharged from Med Part A stay and subsequently resumes SNF care in a different SNF for a covered stay
4. Resident returns to Med A benefits within three days

SECTION B

- Interview Techniques Video
- **B0100** Comatose
  - Diagnosis of comatose and persistent vegetative state
- **B0200** Hearing
  - Use appliances
- **B0300** Hearing aid
  - Any appliance
- **B0600** Speech clarity
  - Quality of speech

SECTION B

- **B0700** Makes self understood
  - Ability to express or communicate requests, needs, opinions, and to conduct social conversation
- **B0800** Ability to understand others
  - Comprehension of direct person to person communication

SECTION B

- **B1000** Vision
  - Adequate light
  - Glasses or visual appliances
  - Consider alternatives
- **B1200** Corrective lenses
  - Eyeglasses or other visual aides
  - Do not include surgical lens implants

SECTION C

C0100 Should brief interview for mental status be conducted

- Preferred language (offer alternatives, interpreter)
- If rarely or never understood, skip to C0700
- PDPM component

SECTION C

- **Brief Interview for Mental Status (BIMS):** Written format
  - **Appendix E**
- **C0200** Repetition of three words
- **C0300** Temporal orientation
  - C0300C – Rules for stopping the interview before it is completed
    - If stopped: dash C0400A, B and C, C0500 = 99, conduct staff assessment
- **C0400** Recall

SECTION C

- **C0500** BIMS summary score
  - 13-15: Cognitively intact
  - 8-12: Moderately impaired
  - 0-7: Severe impairment
- **C0600** Should the staff assessment for mental status be conducted
  - Chose not to participate or if four or more items were coded 0 (nonsensical responses or didn't answer)
- **C0700-C1000** Staff assessment of mental status

SECTION C

- **C1310 A-D** Signs and symptoms of delirium
  - Definition: Mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness or hallucinations.
  - Observe behaviors during the BIMS
  - Staff assessment completed for BIMS
  - Review medical record
  - Interview staff, family members and others
- **Pages C-29 through C-32, Appendix C**

SECTION C

Delirium

C1310. Signs and Symptoms of Delirium (from CAM©)

Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

A. Acute Onset Mental Status Change

Enter Code ☐

Is there evidence of an acute change in mental status from the resident's baseline?

0. No
1. Yes

Coding:

0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

↓ **Enter Codes in Boxes**

1 or 2 ☐ **B. Inattention** - Did the resident have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?

1 or 2 ☐ **C. Disorganized Thinking** - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?

OR

1 or 2 ☐ **D. Altered Level of Consciousness** - Did the resident have altered level of consciousness, as indicated by any of the following criteria?

- **vigilant** - startled easily to any sound or touch
- **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch
- **stuporous** - very difficult to arouse and keep aroused for the interview
- **comatose** - could not be aroused

SECTION D

- **Appendix E**
- **D0100** Should mood interview be conducted
  - B0700 Makes self understood
  - Offer alternatives
  - Day before or day of the ARD
- **D0300** Total severity score
  - Doesn't diagnose
  - Completed if 7/9 answered
  - Not complete if three or more items blank = 99
  - Max score is 27 and indicates severe depression

SECTION E

- **E0100** Potential indicators of psychosis
  - Hallucinations and/or delusions
  - Observations and/or thoughts expressed
- **E0200A-C** Behavior symptoms presence and frequency
  - Symptoms occurred, not interpretation of behavior's meaning, judgement, or should be tolerated
  - Code as present or not present whether they might represent a rejection of care
  - No not code wandering in C

SECTION E

- **E0300** Overall presence of behavioral symptoms
  - E0200 A-C coded as 1, 2 or 3?
  - Yes – code E0500 and E0600
  - No – go to E0800
- **E0500A-C** Impact on resident
- **E0600A-C** Impact on others
- **E0800** Rejection of care
  - Resident choice

SECTION E

- **E0900** Wandering
  - Assess for underlying causes
- **E1000A-B** Wandering impact
  - Outside in heavy traffic, stairs
  - Another room where that resident is known to be aggressive
- **E1100** Change in behavioral or other symptoms
  - Compare prior assessment responses in E0100-E1000 to present

SECTION F

- **F0300** Should interview for daily and activity preferences be conducted
  - How was B0700 coded, if
    - No: Skip to and complete F0800
    - Yes: Continue to F0400
- **F0400A-H** Interview for daily preferences
- **F0500A-H** Interview for activity preferences

SECTION F

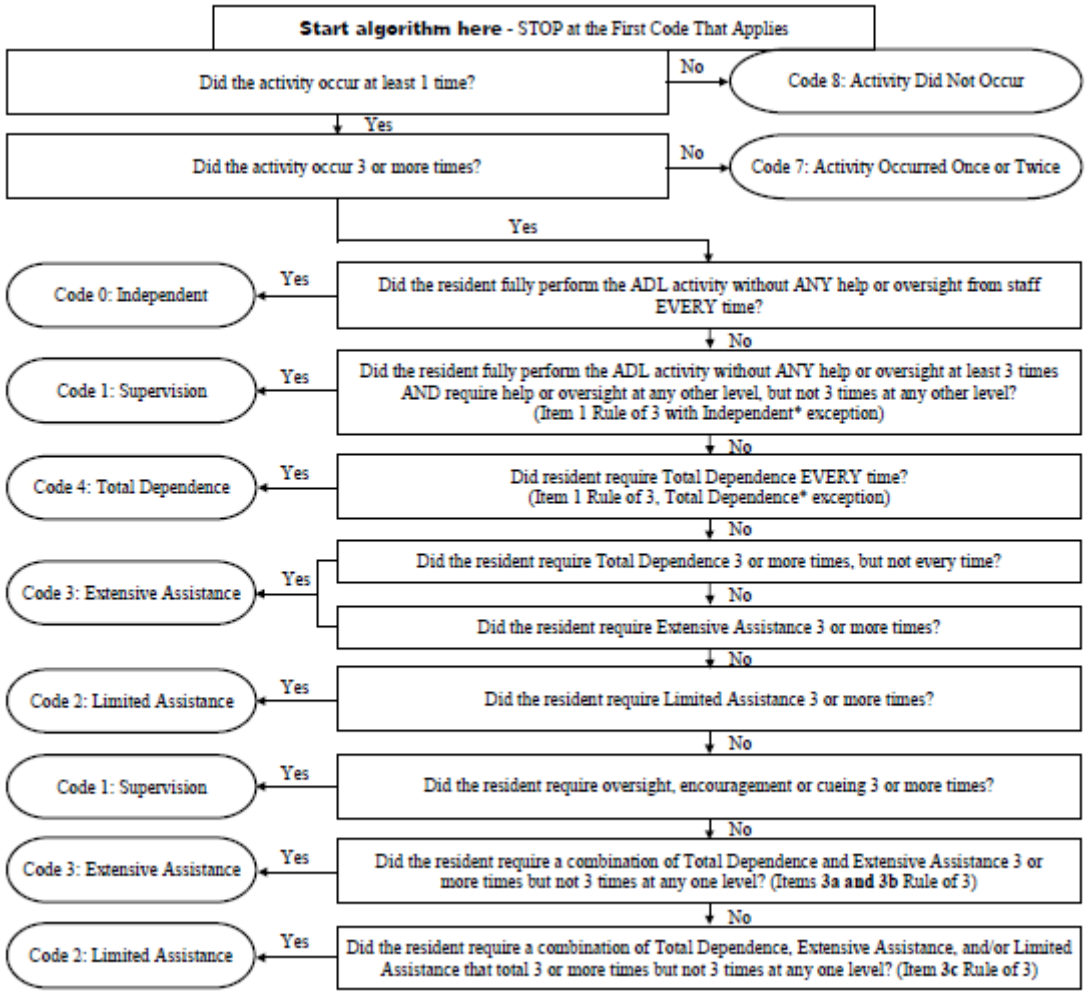
- **F0600** Daily and activity preferences primary respondent
- **F0700** Should the staff assessment of daily and activity preferences be conducted
- **F0800** Staff assessment of daily and activity preferences

SECTION G

G0110A-J Activities of daily living (ADL) assistance

- Review records, interview staff on all shifts, and observe the resident
- Residents can use special adaptive devices
- Facility staff direct employees and facility contracted employees

SECTION G


Start algorithm here - STOP at the First Code That Applies
Did the activity occur at least 1 time?
No
Code 8: Activity Did Not Occur
Yes
Did the activity occur 3 or more times?
No
Code 7: Activity Occurred Once or Twice
Yes
Code 0: Independent
Yes
Did the resident fully perform the ADL activity without ANY help or oversight from staff EVERY time?
No
Code 1: Supervision
Yes
Did the resident fully perform the ADL activity without ANY help or oversight at least 3 times AND require help or oversight at any other level, but not 3 times at any other level? (Item 1 Rule of 3 with Independent* exception)
No
Code 4: Total Dependence
Yes
Did resident require Total Dependence EVERY time? (Item 1 Rule of 3, Total Dependence* exception)
No
Code 3: Extensive Assistance
Yes
Did the resident require Total Dependence 3 or more times, but not every time?
No
Did the resident require Extensive Assistance 3 or more times?
No
Code 2: Limited Assistance
Yes
Did the resident require Limited Assistance 3 or more times?
No
Code 1: Supervision
Yes
Did the resident require oversight, encouragement or cueing 3 or more times?
No
Code 3: Extensive Assistance
Yes
Did the resident require a combination of Total Dependence and Extensive Assistance 3 or more times but not 3 times at any one level? (Items 3a and 3b Rule of 3)
No
Code 2: Limited Assistance
Yes
Did the resident require a combination of Total Dependence, Extensive Assistance, and/or Limited Assistance that total 3 or more times but not 3 times at any one level? (Item 3c Rule of 3)

SECTION G

If none of the above are met, code supervision.

1. ADL Self-Performance
Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

2. ADL Support Provided
Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
A. **Bed mobility** - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture	☐	☐
B. **Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)	☐	☐
C. **Walk in room** - how resident walks between locations in his/her room	☐	☐
D. **Walk in corridor** - how resident walks in corridor on unit	☐	☐
E. **Locomotion on unit** - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	☐	☐
F. **Locomotion off unit** - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor,** how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	☐	☐
G. **Dressing** - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses	☐	☐
H. **Eating** - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)	☐	☐
I. **Toilet use** - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag	☐	☐
J. **Personal hygiene** - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** baths and showers)	☐	☐

SECTION G

Do not code

- Emptying of bedpan, urinal, bedside commode, catheter or ostomy bag
- Staff's assessment of the resident's potential capability to perform the ADL activity
- Type and level of assistance that the resident should be receiving according to the plan of care
- Assistance provided by family or other visitors

SECTION G

Do code

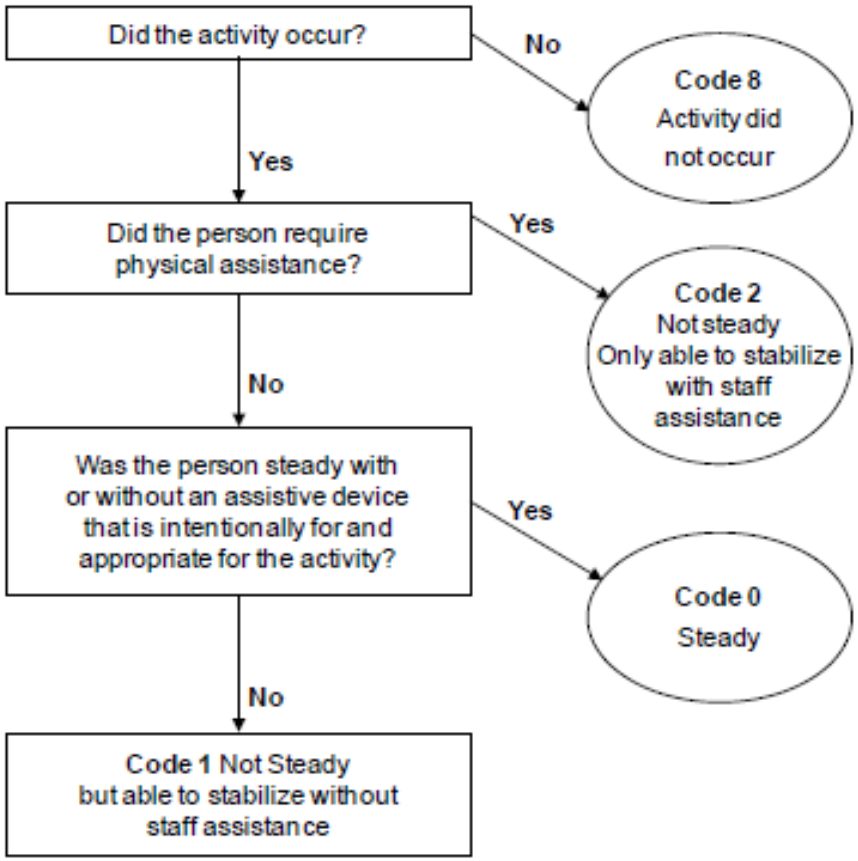
- Transfer with weight bearing assist as extensive assistance
- Turns side to side in the bed during incontinent care is part of bed mobility
- Resident is transferred into or out of bed or a chair for incontinent care or to use the bedpan or urinal, code in transfers
- How they use the bedpan or urinal code in toilet use

SECTION G

- **G0120 Bathing**
  - Full body bath, shower, or sponge bath
  - Transfers in and out of the tub or shower
  - Doesn't include washing of back or hair
  - Facility policy to supervise those in the bath or shower, code as supervision
- **G0300 Balance during transitions and walking**
  - Sitting to standing, walking, turning, transferring on and off the toilet, and transferring from wheelchair to bed and bed to wheelchair

SECTION G

Balance During Transitions and Walking Algorithm



SECTION G

G0400 Functional limitation in range of motion

- Three step process
  - Test upper and lower extremity range of motion (ROM)
  - Limitation, noted, review G0110 and/or directly observe resident
- Lower extremity: Hip, knee, ankle, and foot
- Upper extremity: Shoulder, elbow, wrist, and fingers
- Do not look at limited ROM in isolation

SECTION G

- **G0600** Mobility devices
  - Mobility devices the resident normally uses
- **G0900A** Functional rehabilitation potential
  - Code only on OBRA admission
  - Listen to and record what the resident believes

SECTION GG

- **GG0100A-D** Prior functioning: Everyday activities
  - Usual ability prior to current illness, exacerbation, or injury
  - Interview resident, family, and/or medical record
- **GG0110A-E** Prior device use
  - Determine the resident's use of prior devices and aids
  - Interview resident, family and/or medical record
  - Mechanical lift includes sit-to-stand, stand assist, stair lift, and full body style lifts

EXAMPLE

What consideration should be taken when assessing a resident's prior function and prior device use for GG0100 and GG0110?

A. The resident's current performance with activities and devices used.

B. The resident's potential for improvement, stabilization, or decline.

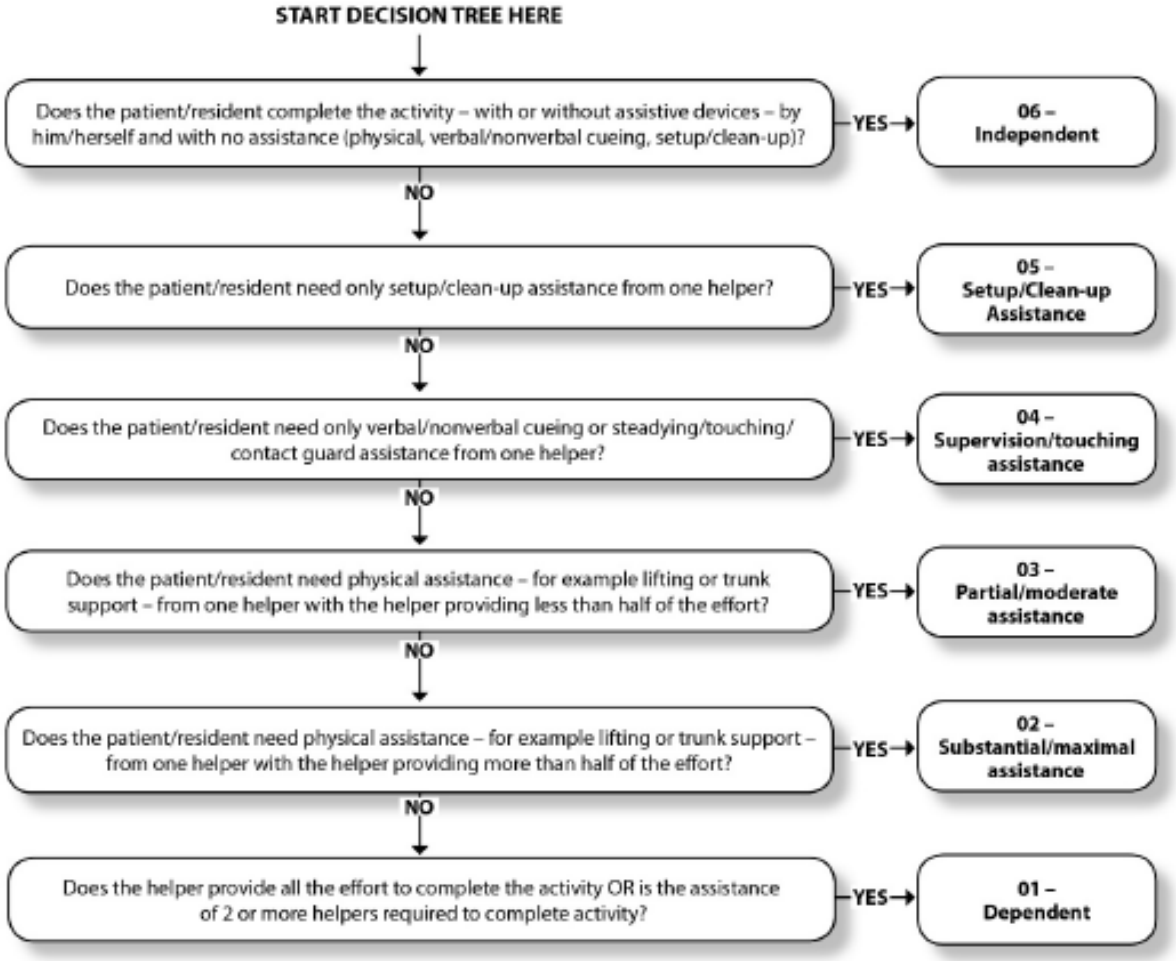
C. The resident's function and device use prior to the current illness, exacerbation, or injury.

SECTION GG

GG0130 Self-care

- Direct observation, resident's self reports, reports from qualified clinicians, care staff, or family documented in medical record
- Perform as independently as possible
- Helper: Direct employees and facility contracted employees
- With assistive devices if applicable
- True admission baseline functional status

SECTION GG


START DECISION TREE HERE
Does the patient/resident complete the activity – with or without assistive devices – by him/herself and with no assistance (physical, verbal/nonverbal cueing, setup/clean-up)?
YES
06 – Independent
NO
Does the patient/resident need only setup/clean-up assistance from one helper?
YES
05 – Setup/Clean-up Assistance
NO
Does the patient/resident need only verbal/nonverbal cueing or steadying/touching/ contact guard assistance from one helper?
YES
04 – Supervision/touching assistance
NO
Does the patient/resident need physical assistance – for example lifting or trunk support – from one helper with the helper providing less than half of the effort?
YES
03 – Partial/moderate assistance
NO
Does the patient/resident need physical assistance – for example lifting or trunk support – from one helper with the helper providing more than half of the effort?
YES
02 – Substantial/maximal assistance
NO
Does the helper provide all the effort to complete the activity OR is the assistance of 2 or more helpers required to complete activity?
YES
01 – Dependent

SECTION GG

- Not attempted = 09
- Not able to attempt due to environmental limitations = 10
- Not able to attempt due to medical condition or safety concerns = 88
- Two or more helpers are required to assist = 01
- Dash (-) = no information

SECTION GG

Usual performance

- Not the best or worst but what is usual
- Type and amount of assistance a helper provides for the activity to be completed
- Six-point rating scale: Setup or cleanup, touching assistance, verbal cueing, and lifting assistance
- Do not record staff's assessment of the potential capability to perform activity

SECTION GG

- Discharge goals are coded with each admission assessment
- Minimum of one self-care or mobility discharge goal must be coded, remaining can be dashed
- Six-point scale

SECTION GG

Timing

- Five-day PPS
  - Day of admission and includes the following two days ending at 11:59 p.m.
  - GG0130 and GG0170
- IPA PPS and OBRA
  - ARD date and two prior calendar days
  - GG0130 and GG0170

SECTION GG

Timing

- Discharge PPS
  - Day of discharge (A2400C) and the two calendar days prior to the day of discharge
  - PPS planned discharge
  - A2400C – A2400B = greater than two days and discharge was not to acute hospital

SECTION GG

Assessments and documentation

- Who?
- Federal, state, and facility policies/regulations
- Interdisciplinary approach
  - Understand definitions
  - Differences between therapy and nursing

SECTION GG

Resources

- Pocket guide
- Job aides
- Section GG training materials

SUMMARY

- RAI User's Manual, Version 3.0
- Facility policy and procedures
- Federal and state regulations
- Interview/assess the resident
- Allow independence
- Adaptive equipment present
- Perform interviews on ARD or day prior
- Does everyone that is coding the MDS know the coding definitions?

QUESTIONS?

THANK YOU!

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MDS DHS WEBSITE

http://www.dhs.wisconsin.gov/

- Go to A-Z at the top of the page
- Go to M (minimum data set)

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