Introduction to MDS 3.0 Coding

Presented by the Pennsylvania Department of Health and Office of Long Term Living
August 2010
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Goals

• Become acquainted with MDS 3.0 form
• Understand basic coding for all MDS 3.0 sections
• Know where additional information is available

READ THE MANUAL!

• 1. Resident Assessment Manual
• 2. Instructions and Schedule for Completing the Mandated Clinical and Medicare Assessments
• 3. Item-by-Item Guide to the MDS 3.0
• 4. Care Area Assessment (CAA) Process and Care Planning
• 5. Submission and Correction of the MDS Assessments
• 6. Medicare Skilled Nursing Home Prospective Payment System (SNF PPS)
Appendices

- A. Glossary and Common Acronyms
- B. State Agency and CMS Regional Office RAI/MDS Contacts
- C. Care Area Assessment (CAA) Resources
- D. Interviewing Techniques
- E. Cognitive Performance Scale (CPS) Scoring Rules
- F. MDS 3.0 Draft Matrix
- G. References
- H. Forms

MDS 3.0 Information

  - Timeline
  - RAND Report
  - Data Specifications
  - Edits Report
  - RUG Mapping
  - CAT Specifications

MDS 3.0 Information

  - RAI Manual
  - Item Subsets (forms)
  - Q & As – March 2010
  - Instructor Guides
  - VIVE
  - Training slides
MDS 3.0 Information

- [http://www.cms.gov/NursingHomeQualityInits/40_NHQIMDS30TrainingConferenceInformation.asp#TopOfPage](http://www.cms.gov/NursingHomeQualityInits/40_NHQIMDS30TrainingConferenceInformation.asp#TopOfPage)
  - Las Vegas – August 9 – 13
- [http://www.cms.gov/SNFPPS/02_Spotlight.asp](http://www.cms.gov/SNFPPS/02_Spotlight.asp)
  - RUG-IV and MC PPS information

MDS 3.0 Information

- [http://www.qtso.com](http://www.qtso.com)
  - Detailed manuals for nursing facilities concerning submission, validation reports and edits
- [http://www.dpw.state.pa.us/PartnersProviders/MedicalAssistance/DoingBusiness/LTCCaseMixInfo/](http://www.dpw.state.pa.us/PartnersProviders/MedicalAssistance/DoingBusiness/LTCCaseMixInfo/)
  - Provides information about PA Case Mix and PA MA-specific MDS 3.0 information

Training Materials

- Objectives
- Intent
- Importance
- Repetitive material
- Examples
Assessment

• Ask the resident
• Observe the resident
• Talk with family/significant other
• Talk with staff on all shifts
• Review medical records and any other available documentation

Interviewing

• Resources: Appendix D pages; VIVE; RAI Spotlight; RAI Manual sections
• Basic principles:
  - Establish rapport and obtain consent
  - Quiet private area
  - Hearing assistance, e.g., amplifier, PRN
  - Interpreter PRN
• Follow interview directions and coding instructions very carefully
  - Sections C, D, F, J, Q

MDS 3.0 Form

• Larger font
• More instructions on form, e.g., skip patterns
• Multiple forms called “item subsets”
• Non-sequential numbering
Look-back Period

- Look-back period generally 7 days
  - Exceptions appear on form, e.g., Section J Pain has 5 day lookback
  - Very little may be recorded for services provided prior to admission;
  - Exceptions: K0500A Parenteral/IV, K0500B Feeding tube
  - "7 day lookback (or since admission/reentry if less than 7 days)"
  - More comparisons, e.g., Section H Toileting programs since last assessment or since incontinence first noted in NF

Dates

- A1600 Entry/reentry date
- A2000 Discharge Date
- A2300 Assessment Reference Date
- V0200B2 RNAC Signature – CAAs complete
- V0200C2 Care Plan Complete
- Z0500B RNAC Signature – Assessment complete

Questions

- qa-mds.state.pa.us
Section A
Identification Information

Items A0100 & A0200
Facility Provider Numbers & Type of Provider

A0100 Facility Provider Numbers
• Allows identification of the nursing home submitting the assessment.
• Enter numbers in the spaces provided.
A0200 Type of Provider

- New item for MDS 3.0.
- Designate type of provider.

Items A0310/ A0410

Type of Assessment & Submission Requirement

A0310 Purpose

- Identifies the information required to complete the type of assessment.
- May be completed for more than one reason.
- Must meet all requirements for each type of assessment.
## RAI OBRA-required Assessment Summary

<table>
<thead>
<tr>
<th>Assessment Type</th>
<th>MDS Assessment Code (A0310A or A0310F)</th>
<th>Assessment Reference Date (ARD) (Item A2300) No Later Than</th>
<th>7-day Observation Period (Look Back) Consists Of</th>
<th>14-day Observation Period (Look Back) Consists Of</th>
<th>MDS Completion Date (Item Z0500B) No Later Than</th>
<th>CAA(s) Completion Date (Item V0200B) No Later Than</th>
<th>Care Plan Completion Date (Item V0200C2) No Later Than</th>
<th>Transmission Date No Later Than</th>
<th>Regulatory Requirement</th>
<th>Assessment Combination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission (Comprehensive)</td>
<td>A0310A-01</td>
<td>14th calendar day of the resident’s admission (admission date + 13 calendar days)</td>
<td>ARD + 6 previous calendar days</td>
<td>ARD + 13 previous calendar days</td>
<td>14th calendar day of the resident’s admission (admission date + 13 calendar days)</td>
<td>Same as MDS Completion Date</td>
<td>CAA(s) Completion Date + 7 calendar days</td>
<td>Care Plan Completion Date + 14 calendar days</td>
<td>42 CFR 483.20 (b)(2)(i) (by the 14th day)</td>
<td>May be combined with another assessment</td>
</tr>
<tr>
<td>Annual (Comprehensive)</td>
<td>A0310A-03</td>
<td>ARD of previous OBRA comprehensive assessment + 366 calendar days <strong>AND</strong> ARD of previous OBRA Quarterly assessment + 92 calendar days</td>
<td>ARD + 6 previous calendar days</td>
<td>ARD + 13 previous calendar days</td>
<td>ARD + 14 calendar days</td>
<td>Same as MDS Completion Date</td>
<td>CAA(s) Completion Date + 7 calendar days</td>
<td>Care Plan Completion Date + 14 calendar days</td>
<td>42 CFR 483.20 (b)(2)(ii) (every 12 months)</td>
<td>May be combined with another assessment</td>
</tr>
<tr>
<td>Significant Change in Status (SCSA) (Comprehensive)</td>
<td>A0310A-04</td>
<td>14th calendar day after determination that significant change in resident’s status occurred (determination date + 14 calendar days)</td>
<td>ARD + 6 previous calendar days</td>
<td>ARD + 13 previous calendar days</td>
<td>14th calendar day after determination that significant change in resident’s status occurred (determination date + 14 calendar days)</td>
<td>Same as MDS Completion Date</td>
<td>CAA(s) Completion Date + 7 calendar days</td>
<td>Care Plan Completion Date + 14 calendar days</td>
<td>42 CFR 483.20 (b)(2)(ii) (within 14 days)</td>
<td>May be combined with another assessment</td>
</tr>
<tr>
<td>Significant Correction to Prior Comprehensive (SCPA) (Comprehensive)</td>
<td>A0310A-05</td>
<td>14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)</td>
<td>ARD + 6 previous calendar days</td>
<td>ARD + 13 previous calendar days</td>
<td>14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)</td>
<td>Same as MDS Completion Date</td>
<td>CAA(s) Completion Date + 7 calendar days</td>
<td>Care Plan Completion Date + 14 calendar days</td>
<td>42 CFR 483.20(f)(3)(iv)</td>
<td>May be combined with another assessment</td>
</tr>
</tbody>
</table>
# RAI OBRA-required Assessment Summary (con’t)

<table>
<thead>
<tr>
<th>Assessment Type</th>
<th>MDS Assessment Code (A0310A or A0310F)</th>
<th>Assessment Reference Date (ARD) (Item A2300) No Later Than</th>
<th>7-day Observation Period (Look Back) Consists Of</th>
<th>14-day Observation Period (Look Back) Consists Of</th>
<th>MDS Completion Date (Item Z0500B) No Later Than</th>
<th>CAA(s) Completion Date (Item V0200B2) No Later Than</th>
<th>Care Plan Completion Date (Item V0200C2) No Later Than</th>
<th>Transmission Date No Later Than</th>
<th>Regulatory Requirement</th>
<th>Assessment Combination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarterly (Non-Comprehensive)</td>
<td>A0310A= 02</td>
<td>ARD of previous OBRA assessment of any type + 92 calendar days</td>
<td>ARD + 6 previous calendar days</td>
<td>ARD + 13 previous calendar days</td>
<td>ARD + 14 calendar days</td>
<td>N/A</td>
<td>N/A</td>
<td>MDS Completion Date + 14 calendar days</td>
<td>42 CFR 483.20(c) (every 3 months)</td>
<td>May be combined with another assessment</td>
</tr>
<tr>
<td>Significant Correction to Prior Quarterly (SCQA) (Non-Comprehensive)</td>
<td>A0310A=06</td>
<td>14th day after determination that significant error in prior quarterly assessment occurred (determination date + 14 calendar days)</td>
<td>ARD + 6 previous calendar days</td>
<td>ARD + 13 previous calendar days</td>
<td>14th day after determination that significant error in prior quarterly assessment occurred (determination date + 14 calendar days)</td>
<td>N/A</td>
<td>N/A</td>
<td>MDS Completion Date + 14 calendar days</td>
<td>42 CFR 483.20(f) (3)(v)</td>
<td>May be combined with another assessment</td>
</tr>
<tr>
<td>Entry tracking record</td>
<td>A0310F= 01</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Entry Date + 7 calendar days</td>
<td>Entry Date + 14 calendar days</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>May not be combined with another assessment</td>
</tr>
<tr>
<td>Discharge Assessment – return not anticipated (Non-Comprehensive)</td>
<td>A0310F= 10</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Discharge Date + 14 calendar days</td>
<td>N/A</td>
<td>MDS Completion Date + 14 calendar days</td>
<td>N/A</td>
<td>N/A</td>
<td>May be combined with another assessment</td>
</tr>
<tr>
<td>Discharge Assessment – return anticipated (Non-Comprehensive)</td>
<td>A0310F= 11</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Discharge Date + 14 calendar days</td>
<td>N/A</td>
<td>MDS Completion Date + 14 calendar days</td>
<td>N/A</td>
<td>N/A</td>
<td>May be combined with another assessment</td>
</tr>
<tr>
<td>Death in facility tracking record</td>
<td>A0310F= 12</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Discharge (death) Date + 7 calendar days</td>
<td>N/A</td>
<td>N/A</td>
<td>Discharge (death) Date +14 calendar days</td>
<td>N/A</td>
<td>May not be combined with another assessment</td>
</tr>
</tbody>
</table>
**Entry and Discharge Reporting**

Entry and discharge reporting are required on all residents in the SNF and swing bed facilities. These MDS assessments and tracking records include a select number of items on the MDS used to track residents and gather important quality data at transition points, such as when they enter or leave a nursing home. Entry/Discharge reporting MDSs include Entry tracking record, Discharge assessment return not anticipated, Discharge assessment return anticipated, and Death in facility tracking record. Tracking records and discharge assessments do not impact payment.

The following chart summarizes the Medicare-required scheduled and unscheduled assessments and entry and discharge reporting:

### Medicare Scheduled and Unscheduled MDS Assessment and Entry and Discharge Reporting Schedule for SNFs and Swing Bed Facilities

<table>
<thead>
<tr>
<th>Codes for Assessments Required for Medicare</th>
<th>Assessment Reference Date (ARD) Can be Set on Any of Following Days</th>
<th>Grace Days ARD Can Also be Set on These Days</th>
<th>Allowed ARD Window</th>
<th>Billing Cycle Used by the Business Office</th>
<th>Special Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-day A0310B = 01 and Readmission/return A0310B = 06</td>
<td>Days 1-5</td>
<td>6-8</td>
<td>Days 1-8</td>
<td>Sets payment rate for days 1-14</td>
<td>• See Section 2.12 for instructions involving beneficiaries who transfer or expire day 8 or earlier. • CAAs must be completed only if the Medicare 5-day scheduled assessment is dually coded as an OBRA Admission or Annual assessment, SCSA or SCPA. • Grace days do not apply when the 14-day scheduled assessment is dually coded as an OBRA Admission.</td>
</tr>
<tr>
<td>14-day A0310B = 02</td>
<td>Days 11-14</td>
<td>15-19</td>
<td>Days 11-19</td>
<td>Sets payment rate for days 15-30</td>
<td>CAAs must be completed only if the 14-day assessment is dually coded as an OBRA Admission or Annual assessment, SCSA or SCPA. Grace days do not apply when the 14-day scheduled assessment is dually coded as an OBRA Admission.</td>
</tr>
<tr>
<td>30-day A0310B = 03</td>
<td>Days 21-29</td>
<td>30-34</td>
<td>Days 21-34</td>
<td>Sets payment rate for days 31-60</td>
<td></td>
</tr>
<tr>
<td>60-day A0310B = 04</td>
<td>Days 50-59</td>
<td>60-64</td>
<td>Days 50-64</td>
<td>Sets payment rate for days 61-90</td>
<td></td>
</tr>
<tr>
<td>90-day A0310B = 05</td>
<td>Days 80-89</td>
<td>90-94</td>
<td>Days 80-94</td>
<td>Sets payment rate for days 91-100</td>
<td>• If combined with the OBRA Quarterly assessment the completion date requirements for the OBRA Quarterly assessment must also be met.</td>
</tr>
</tbody>
</table>

(continued)
# Medicare Scheduled and Unscheduled MDS Assessment Schedule for SNFs (cont.)

<table>
<thead>
<tr>
<th>Codes for Assessments Required for Medicare</th>
<th>Assessment Reference Date (ARD) Can be Set on Any of Following Days</th>
<th>Grace Days ARD Can Also be Set on These Days</th>
<th>Allowed ARD Window</th>
<th>Billing Cycle Used by the Business Office</th>
<th>Special Comment</th>
</tr>
</thead>
</table>
| Start of Therapy Other Medicare-required Assessment (OMRA) A0310B = 07 and/or A0310C = 01 or 03 | • 5-7 days after the start of therapy  
• The first day of therapy counts as day 1 | N/A | N/A | N/A | Modifies payment rate starting on the earliest start of therapy date  
• Voluntary assessment used to establish a Rehabilitation Plus Extensive Services or Rehabilitation RUG. |
| End of Therapy OMRA A0310B = 07 and/or A0310C = 02 or 03 | • 1-3 days after all therapy (PT, OT, SLP) services are discontinued and resident continues to require skilled care.  
• The first non-therapy day counts as day 1. | N/A | N/A | N/A | Modifies payment rate starting on the day after the latest therapy end date  
• Not required if the resident has been determined to no longer meet Medicare skilled level of care.  
• Establishes a new non-therapy RUG Classification.  
• Not required if not in a Rehabilitation Plus Extensive Services or Rehabilitation RUG on most recent PPS assessment. |
| Significant Change in Status Assessment (SCSA) A0310A = 04 | Completed by the end of the 14th calendar day after determination that a significant change has occurred. | N/A | N/A | N/A | Modifies payment rate effective with the ARD when not combined with another assessment*  
May establish a new RUG Classification. |
| Swing Bed Clinical Change Assessment (CCA) A0310B = 07 and A0310D = 1 | Completed by the end of the 14th calendar day after determination that a clinical change has occurred. | N/A | N/A | N/A | Modifies payment rate effective with the ARD when not combined with another assessment*  
May establish a new RUG Classification. |
| Significant Correction to Prior Comprehensive Assessment (SCPA) A0310A = 05 | Completed by the end of the 14th calendar day after identification of a significant, uncorrected error in prior comprehensive assessment. | N/A | N/A | N/A | Modifies payment rate effective with the ARD when not combined with another assessment*  
May establish a new RUG Classification. |

(continued)
### Medicare Scheduled and Unscheduled MDS Assessment Schedule for SNFs (cont.)

<table>
<thead>
<tr>
<th>Codes for Assessments Required for Medicare</th>
<th>Assessment Reference Date (ARD) Can be Set on Any of Following Days</th>
<th>Grace Days ARD Can Also be Set on These Days</th>
<th>Allowed ARD Window</th>
<th>Billing Cycle Used by the Business Office</th>
<th>Special Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry tracking record A0310F = 01</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>May not be combined with another assessment</td>
</tr>
<tr>
<td>Discharge Assessment A0310F = 10 or 11</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>May be combined with another assessment when the date of discharge is the ARD of the Medicare-required assessment</td>
</tr>
<tr>
<td>Death in facility tracking record A0310F = 12</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>May not be combined with another assessment</td>
</tr>
</tbody>
</table>

*NOTE: When SCSA, SCPA, and CCA are combined with another assessment, payment rate may not be effective on the ARD. For example, a provider combines the 30-day Medicare-required assessment with a Significant Change in Status assessment with an ARD of day 33, a grace day, payment rate would become effective on day 31, not day 33. See Chapter 6, Section 6.4.

### 2.9 MDS Medicare Assessments for SNFs

The MDS has been constructed to identify the OBRA Reasons for Assessment and the SNF PPS Reasons for Assessment in Items A0310A and A0310B respectively. If the assessment is being used for Medicare reimbursement, the Medicare Reason for Assessment must be coded in Item A0310B. The OBRA Reason for Assessment is described earlier in this section while the Medicare PPS assessments are described below. A SNF provider may combine assessments to meet both OBRA and Medicare requirements. When combining assessments, all completion deadlines and other requirements for both types of assessments must be met. If all requirements cannot be met, the assessments must be completed separately. The relationship between OBRA and Medicare assessments are discussed below and in more detail in Sections 2.11 and 2.12.

#### PPS Scheduled Assessments for a Medicare Part A Stay

**01. Medicare-required 5-Day Scheduled Assessment**

- ARD (Item A2300) must be set on days 1 through 5 of the Part A SNF covered stay.
- ARD may be extended up to day 8 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 1 through 14 of the stay, as long as the resident meets all criteria for Part A SNF-level services.
- Must be submitted electronically and accepted into the QIES Assessment Submission and Processing (ASAP) system within 14 days after completion (Item Z0500B) (completion + 14 days).
- If combined with the OBRA Admission assessment, the assessment must be completed by the end of day 14 of admission (admission date plus 13 calendar days).
A0310 Type of Assessment

A. Federal OBRA Reason for Assessment
B. PPS Assessment
C. PPS Other Medicare Required Assessment - OMRA
D. Is this a Swing Bed clinical change assessment?
E. Is this assessment the first assessment (OBRA, PPS, or Discharge) since the most recent entry of any kind?
F. Entry/discharge reporting

A0310A Federal OBRA Reason for Assessment

01. Admission
02. Quarterly
03. Annual
04. Significant change in status
05. Significant correction to prior comprehensive
06. Significant correction to prior quarterly
99. Not OBRA required

A0310A Hospice Benefit

Electing or revoking the hospice benefit requires a significant change in status assessment.
A0310B PPS Assessment

- Includes scheduled and unscheduled assessments.

A0310C PPS Other Medicare Required Assessment - OMRA

- Indicates whether the assessment is related to therapy services.
- Complete this item for all assessments.

A0310C OMRA Coding Instructions

- **Code 0.** Not an OMRA assessment.
- **Code 1.** ARD is 5 - 7 days after first day of therapy services.
- **Code 2.** ARD is 1-3 days after last day of therapy services.
- **Code 3.** ARD meets both therapy criteria.
- Except when used as a short stay assessment.
A0310D Swing Bed Clinical Change Assessment

- Complete only if A0200 is coded 2 to designate a swing bed provider.

A0310E First Assessment Since Most Recent Admission

- Indicate whether this is the first OBRA, PPS, or discharge assessment since the most recent admission.
- Complete this item for all assessments.

A0310F Entry/Discharge Reporting

- Indicate an entry or discharge reason for assessment or tracking record.
A0410 Submission Requirement

- Designates the submission authority for the resident assessment.
- Must be a federal or state authority to submit the MDS assessment to the QIES ASAP system.

A0410 Coding Instructions

- Enter the code most appropriate for this assessment.

Items A0500 – A2400

Resident Data
A0500 Legal Name of Resident
- Enter the resident’s name as it appears on the resident’s Medicare card.
- Must match exactly for the purpose of MDS 3.0.
- Used to identify resident and match records.

A0600 Social Security and Medicare Numbers
- Can use a comparable railroad insurance number instead of a Medicare number.
- Do not use an HMO number.

A0700 Medicaid Number
- Record number if resident is a Medicaid recipient.
- Check resident’s Medicaid card, admission or transfer records, or medical record.
- Confirm the resident name on the MDS matches the Medicaid card.
- Not necessary to correct a prior MDS to add a Medicaid number.
- Corrections may be a State requirement.
A0700 Coding Instructions

- Enter "+" in the left space if pending.

- Enter "N" in the left space if not applicable.

A0800 Gender

- Must match data in the Social Security system.

A0900 Birth Date

- Complete any single digit value with a leading zero.
  - For example, January would be coded as 01.
- Provide a complete birth date if known.
- Leave any unknown component blank.
A1000 Race/ Ethnicity

- Categories follow common uniform language.
- NOT used to determine eligibility for participation in any federal program.

A1000 Coding Instructions

- Check all that apply.
- More than one category may be selected.

A1100 Language

- Inability to make needs known and engage in social interaction:
  - Can be frustrating.
  - Can result in isolation, depression, and unmet needs.
- Language barriers can interfere with accurate assessment.
- Identifies residents who may need an interpreter:
  - To answer MDS 3.0 interview items.
  - To participate in the consent process.
### A1100A Coding Instructions

- **Code 0.** Interpreter not wanted or needed.
- **Code 1.** Interpreter is wanted or needed.
- **Code 9.** Unable to determine.

### A1100B Coding Instructions

- Complete only if an interpreter is needed or wanted.

### A1200 Coding Instructions

- Enter the code that reflects the resident’s current marital status.
A1300 Optional Resident Items

- Document data helpful to the facility.
- Track resident data.
- Improve resident interaction and care.

A1500 PASRR Overview

- PASRR is a preadmission screening process.
- Applies to the Medicaid unit of a facility only.
- A positive screen indicates that resident has a mental illness, mental retardation, or a related condition.
- A1500 documents whether a PASRR Level II determination has been issued.
- Does not call for judgment about an individual’s mental illness, mental retardation, or a related condition.
- Only reports on the results of the PASRR process.

1500 PASRR/ Medicaid

- All individuals admitted to Medicaid NFs must complete a Level I PASRR.
- If the Level I screen is positive, a Level II evaluation is performed.
- Individuals suspected to have MI/ MR or a related condition may not be admitted unless approved through a Level II PASRR determination.
- Consult your state Medicaid agency for PASRR procedures.
A1500 PASRR Reporting

- Required for an Admission MDS only.
- If completing a significant change in status MDS for a resident on a Level II PASRR, provider is required to notify:
  - State mental health authority
  - Mental retardation or developmental disability authority

A1500 Coding Instructions

1. Code 0. No
   - Level I screening did not result in a referral.
   - Level II screening determined that resident does not have serious MI/MR or a related condition.
   - PASRR screening not required when resident is:
     - Admitted from hospital after acute inpatient care AND
     - Receiving services for condition that received care for in the hospital AND
     - Certified before admission to likely require less than 30 days of nursing home care

2. Code 1. Yes
   - Level II screening determined that resident has a serious mental illness and/or mental retardation or a related condition.
   - Code 9. Not a Medicaid certified unit
     - Bed not in a Medicaid-certified nursing home.
     - Requirement based on the certification of the part of the nursing home the resident will occupy.
• Document conditions associated with mental retardation (MR) or developmental disabilities (DD).

• Resident is 22 years or older on assessment date:
  o Admission assessment only (A0310A = 01)

• Resident is 21 years or younger on assessment date:
  o Admission assessment (A0310A = 01)
  o Annual assessment (A0310A = 03)
  o Significant change in status assessment (A0310A = 04)
  o Significant correction to prior comprehensive assessment (A0310A = 05)

• Check all conditions related to MR/ DD status present before age 22.
• When age of onset if not specified, assume that the condition meets this criterion **AND** is likely to continue indefinitely.

• A1600 Entry Date
  - Reflects whether A1600 is an admission or reentry date.
A1700 Coding Instructions

- **Code 1.** Admission when **one** of the following occurs:
  - Resident never admitted to the facility before.
  - OR
  - Resident discharged prior to completion of OBRA assessment.
  - OR
  - Resident discharged return not anticipated.
  - OR
  - Resident discharged return anticipated and did not return within 30 days.

A1700 Coding Instructions

- **Code 2.** Reentry when **all** of the following occur prior to entry:
  - Resident was admitted to this nursing home (i.e., OBRA admission assessment was completed) **AND**
  - Resident was discharged return anticipated **AND**
  - Resident returned to facility within 30 days of discharge.
  - Day of discharge from the facility is not counted in the 30 days.
  - Swing bed facilities always code resident's entry as an admission.

A1800 Coding Instructions

- Enter the two-digit code that corresponds to the location or program the resident was admitted from for this admission.
**A2000 Discharge Date**

- Enter the date the resident leaves the facility.
- Do not consider whether return is anticipated or not.
- Discharge date and ARD must be the same for discharge assessments.
- Discharge date may be later than the end of Medicare stay date if resident is receiving services under SNF Part A PPS.
- Do not include leaves of absence.
- Do not include hospital observational stays less than 24 hours unless resident is admitted to the hospital.
- Obtain data from medical, admissions, or transfer records.

**A2100 Discharge Status**

- Review the medical record including the discharge plan and discharge orders.
- Select the code that corresponds to the resident’s discharge status.

**A2200 Previous ARD for a Significant Correction**

- Required only for a significant correction to a prior annual or quarterly assessment.
- Enter the ARD of the prior assessment for which a significant error has been identified and a correction is required.
A2300 Assessment Reference Date

- Designates the end of the look-back period.
- All assessment items for that section refer to the resident’s status during the same period of time.
- Serves as the reference point for determining what care and services are captured on the MDS assessment.
- Anything that happens after the ARD will not be captured on the MDS.
- Look-back period includes observations and events through midnight of the ARD.

A2300 Assessment Guidelines

- Team members should select the ARD:
  - Reason for the assessment
  - Compliance with timing and scheduling requirements outlined in Chapter 2
- Adjust ARD to equal the discharge date if resident dies or is discharged prior to end of the look-back period.

A2300 Assessment Guidelines

- Look-back period may not be extended because resident was out of the facility during part of the period.
- Leave days are considered part of the look-back period.
- May use data from the time the resident is absent if the MDS item permits.
**A2400 Medicare Stay**

- Identifies when a resident is receiving services under the SNF PPS.
- Identifies when a resident's Medicare Part A stay begins and ends.
- The end date is used to determine if the resident's stay qualifies for the short stay assessment.

**A2400A Medicare Stay**

- Indicate whether the resident has had a Medicare-covered stay since the most recent entry.

**A2400B Start Date**

- If A2400A is coded 1. Yes:
  - B. Enter start date of most recent Medicare stay
  - C. Enter end date of most recent Medicare stay
A2400C End Date Guidelines

- Code whichever occurs first:
  - Date SNF benefit exhausts
  - Date of last day covered as recorded on the ABN
  - Date the resident’s payer source changes from Medicare A to another payer
  - Date the resident was discharged from the facility (A2000)
- Returning from therapeutic leave of absence or hospital observation stay of less than 24 hours is a continuation of a Medicare Part A stay.
- May be earlier than discharge date.

Scenario #2

- Mr. N began receiving services under Medicare Part A on December 11, 2010.
- He was sent to the ER on December 19, 2010 at 8:30pm and was not admitted to the hospital.
- He returned to the facility on December 20, 2010, at 11:00 am.
- The facility completed his 14-day PPS assessment with an ARD of December 23, 2010.

Scenario #2 Coding

- Code A2400A as 1. Yes.
- Code A2400B Start Date as 12-11-2010.
- Code A2400C End Date as all dashes to indicate an ongoing stay.
Section A

Summary

Section A

• Section A helps set the parameters for completing the MDS 3.0.
• Define the requirements for completing the assessment
• Ensure that any resources for completing the assessment are identified
  o Interpreter
  o Current documentation

Facility & Assessment Data

• Provide data to identify facility where the resident resides.
• Provide assessment data.
  o Purpose (type of assessment) is critical to define the requirements for the assessment.
  o Identify the submission authority.
Resident Data

- Provide information to identify the resident.
- Provide additional information describing the resident.
- Provide information defining the resident’s Medicare stay.
Section B
Hearing, Speech, and Vision

Item B0100
Comatose

B0100 Assessment Guidelines
• A diagnosis must be documented in the resident’s medical record.
• Residents in advanced stages of progressive neurological disorders may:
  o Display severe cognitive impairment.
  o Be non-communicative.
  o Sleep a great deal of the time.
• This does not meet the definition of comatose or persistent vegetative state.
**B0100 Coding Instructions**

- **Code 0, No**
  - Diagnosis is not present in the look-back period.
  - Continue to B0200 Hearing.
- **Code 1, Yes**
  - Skip to Section G Functional Status, Item G0100.
  - Do not complete Sections C, D, E, and F.

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**Item B0200 & B0300**

**Hearing & Hearing Aid**

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**B0200 & B0300**

**Conduct the Assessment**

- Determine if the resident uses a hearing aid or other appliance before beginning the hearing assessment.
  - Ask the resident.
  - Write the question down if the resident cannot respond.
  - Check with family and care staff if the resident still cannot respond.
  - Check the medical record for evidence of a hearing appliance.
B0200 Coding Instructions

• Code the response option that best reflects the resident’s hearing ability.

B0300 Coding Instructions

• Indicate whether the resident used a hearing appliance during the hearing assessment for B0200.
• Does not document whether a resident owns a hearing appliance.

Item B0600

Speech Clarity
B0600 Assessment Guidelines

- Focus on the quality of speech only.
- Do not consider the content or appropriateness of the resident’s speech.

B0600 Coding Instructions

- Select best description:
  0. Clear speech - could be understood
  1. Unclear speech
  2. No speech

Item B0700

Makes Self Understood
B0700 Definition

- Makes self understood if:
  - Express or communicate requests, needs, and opinions.
  - Conduct social conversation.
  - Use an alternative method of communicating.
- Deficits can include
  - Reduced voice volume
  - Difficulty producing sounds
  - Difficulty in expression

B0700 Assessment Guidelines

- Conduct the assessment in the resident's preferred language.
- Need for an interpreter is not an inability to make self understood.
- Interpreter needs to provide guidance on speech clarity for residents that speak a foreign language.
- Consider both verbal and non-verbal expression.

B0700 Coding Instructions

- Enter the code that best reflects the resident's ability to express ideas and wants.
Item B0800

Ability to Understand Others

B0800 Assessment Guidelines

- Conduct the assessment in the resident's preferred language.
- Do not include comprehension problems due to lack of an interpreter.
- Use normal hearing and communication devices.
- Make sure any devices are operational.

B0800 Coding Instructions

- Enter the code that best reflects the resident's ability to understand verbal content however able.
Item B1000 & B1200
Vision and Corrective Lenses

B1000 & B1200
Conduct the Assessment

• Determine if the resident uses eyeglasses or another vision aid before beginning the hearing assessment.
  o Ask the resident.
  o Check with family and care staff.
  o Check the medical record for evidence of corrective lenses.

B1000 & B1200
Conduct the Assessment

• Test the accuracy of these findings.
  o Ensure visual appliance for close vision is in place.
  o Ensure adequate lighting.
  o Provide reading material.
  o Have the resident read aloud.
• For residents who cannot read out loud.
  o Ask to read numbers.
  o Ask to name items in small pictures.
• Check gross measures of visual acuity.
B1000 Coding Instructions

- Document whether the resident used corrective lenses or other visual aids during the vision assessment.
- Does not document whether the resident uses corrective lenses or another visual aid.

B1200 Coding Instructions

- Document whether the resident used corrective lenses or other visual aids during the vision assessment.
- Does not document whether the resident uses corrective lenses or another visual aid.

Section B
Q&A Activity
What is the purpose of Section B0600 Speech Clarity?

A. Determine the quality of a resident’s speech.
B. Determine the resident’s ability to follow simple directions.
C. Determine the resident’s ability to answer simple questions correctly.
D. Determine the resident’s ability to express needs and requests.

Section B Summary

• Evaluate a resident’s ability to interact with the environment and people around him or her and the ability to make needs or wishes known.
• An accurate assessment is essential to ensure that resident’s are not misdiagnosed with other conditions or problems and receive appropriate care and support.
Section C

Cognitive Patterns (BIMS)

MDS Assessment Based on Brief Interview for Mental Status

- Consists of a structured resident interview.
- Opportunity to observe for signs and symptoms of delirium.
- Can be completed or attempted for most residents.
- Complete the staff assessment as an alternative.
- Do not conduct both an interview and a staff assessment.

Item C0100

Should Brief Interview for Mental Status be Conducted?
Attempt Resident Interview

• Determine whether to attempt an interview.
• Most residents are able to attempt the interview.

C0100 Conduct the Assessment

• Attempt interview if resident can be understood at least some of the time.
• Make every effort to provide an interpreter if needed.

C0100 Coding Instructions

• Code whether the cognitive interview should be attempted with the resident.
Brief Interview for Mental Status (BIMS)

Structure of BIMS

- Consists of three components.
  - C0200 Repetition of Three Words
  - C0300 Temporal Orientation
  - C0400 Recall
- Results are compiled into a Summary Score.

Stopping the Interview

- Stop the interview if necessary.
- Stop after C0300 Temporal Orientation if:
  - All responses have been nonsensical.
  - There has been no verbal or written response to any items up to that point.
  - There has been no verbal or written response to some items and nonsensical responses to the other questions.
Assessment for Cognitive Patterns

- An assessment must be completed even if the interview cannot be conducted.
- Complete the Staff Assessment for Mental Status (C0700-C1100).

Item C0200

Repetition of Three Words

- Ask resident to repeat three words.
  - Sock
  - Blue
  - Bed

- Inability to repeat three words on the first attempt may indicate:
  - Hearing impairment
  - Language barrier
  - Inattention (may be a sign of delirium)
C0200 Conduct the Assessment

• Ask the question exactly as written.
• Immediately prompt for a response.
• If the resident repeats all three words correctly on the first attempt:
  o Reinforce recall by repeating the words with category cues.
  o This reinforcement is essential to evaluate the resident’s ability to recall later in the interview.
  o Code the response.
  o Move on to the next interview question (C0300).

Category Cue

• A phrase that puts a word in context.
  o Helps prompt resident’s recall ability.
  o Stimulates learning.
  o Fosters memory even among residents able to repeat the words immediately.
• Cues for C0200 are:
  o For sock: something to wear
  o For blue: a color
  o For bed: a piece of furniture
• May be provided verbally or in writing.

C0200 Conduct the Assessment

• If the resident recalls two or fewer words on the first attempt:
  o Make a second attempt.
  o Prompt using category cues.
• If the resident does not recall all the words on the second attempt:
  o Make a third attempt.
  o Repeat the words and use cues.
C0200 Conduct the Assessment

• If resident does not repeat all three words after three attempts:
  o Reassess the resident’s ability to hear.
  o If the resident can hear, move on to the next question.
  o If the resident cannot hear, attempt to optimize hearing before proceeding.

C0200 Assessment Guidelines

• Words may be recalled in any order.
• Words may be recalled in any context.
  o Repeating words in a sentence counts as repeating the words.
• Score the number of words repeated on the first attempt only.
  o Do not score the number of words repeated on the second or third attempts.
  o Do not record the number of attempts that the resident needed to complete this item.

C0200 Coding Instructions

• Record the maximum number of words repeated correctly on the first attempt only.
C0200 Scenario #1

- The interviewer says, “The words are sock, blue, and bed. Now please tell me the three words.”
- The resident replies, “Bed, sock, and blue.”
- The interviewer repeats the three words with category cues, by saying:
  - “That’s right, the words are sock, something to wear; blue, a color; and bed, a piece of furniture.”

C0200 Scenario #1 Coding

- Code C0200 as 3. Three.
- The resident repeated all three items on the first attempt.
- The order of repetition does not affect the score.

C0200 Scenario #2

- The interviewer says, “The words are sock, blue, and bed. Now please tell me the three words.”
- The resident replies, “What were those three words?”
- The interviewer repeats the three words plus category cues.
C0200 Scenario #2 Coding

- Code C0200 as 0. None.
- The resident did not repeat any of the three words the first time the interviewer said them.
- Code the results of the first attempt only.

C0200 Practice #4

- Interviewer: “The words are sock, blue, and bed. Now please tell me the three words.”
- Resident: “My husband always left his socks under the bed.”
- The interviewer repeats the three words plus the category cues.

How should C0200 be coded?

A. Code 0. None
B. Code 1. One
C. Code 2. Two
D. Code 3. Three
C0200 Practice #4 Coding

• The correct code is 2. Two.
• The resident repeated two of the three words – bed and sock.
• The resident put the words into a sentence, resulting in the resident repeating two of the three words.

Item C0300
Temporal Orientation

C0300 Conduct the Assessment

• Ask each of the three questions one at a time.
  o C0300A: Current year
  o C0300B: Current month
  o C0300C: Day of the week
• Allow up to 30 seconds for a response.
• Do not provide clues.
• If residents specifically ask for clues, tell them you need to know if they can answer without any assistance.
**C0300A Coding: Year**

- Assess ability to report the correct year.
- Code 0 if the resident does not answer.

**C0300B Coding: Month**

- Assess ability to report the correct month.
- Count the current day as day 1.

**C0300C Coding: Day**

- Assess the resident’s ability to report the correct day of the week.
How should C0300A be coded?

A. Code 0. Missed by > 5 years or no answer

B. Code 1. Missed by 2 – 5 years

C. Code 2. Missed by 1 year

D. Code 3. Correct

C0300 Practice #3

- The date of the interview is April 1, 2010.
- The resident, responding to the statement, "Please tell me what year it is right now," states that it is "10."
- The interviewer asks, "Can you tell me the full year?"
- If the resident still responds "10," the interviewer should state again, "Can you tell me the full year, for example, nineteen-eighty-two."
- The resident states "2010."

C0300 Practice #3 Coding

- The correct code is 3. Correct.
- Even though "10" is partially correct, the only correct answer is the exact year.
- The resident must state "2010," not "10" or "1810" or "1910."
- In this example, the resident correctly stated the year.
C0300 Practice #8

• The day of the interview is Monday, June 25, 2010.
• The resident, responding to the question, “What day of the week is it today?” states, “Today is a good day.”

C0300 Practice #8 Coding

• The correct code is 0. Incorrect or no answer.
• The resident did not answer the question correctly.

Item C0400

Recall
C0400 Conduct the Assessment

• Ask the resident to repeat the words from the earlier question.
  o Read question as it appears on the MDS form.
• Allow up to five seconds for spontaneous recall.
• Provide category cues for any word not correctly recalled after five seconds.
• Use category cues only after resident is unable to recall one or more words.
• Allow up to five seconds after category cue for recall.

C0400 Assessment Guidelines

• Each word is coded separately.
  o C0400A is sock.
  o C0400B is blue.
  o C0400C is bed.
• Recall without cueing
  o Resident names the item on the first attempt.
  o Resident may list other items in the same category.
  o Interviewer does not provide cues.
• Recall with cueing
  o Interviewer must give a cue.
  o Resident says the item in a list of other terms.

C0400 Coding Instructions

• Code 0. No
  o Cannot recall the word even after cueing.
  o Responds with a nonsensical answer.
  o Chooses not to answer.
• Code 1. Yes after cueing
  o Requires a cue to remember the word.
• Code 2. Yes, no cue required
  o Correctly remembers the word without cueing.
C0400 Coding Example

- Resident replies, “Socks, shoes, bed.”
- Interviewer cues, “One word was a color.”
- Resident replies, “Oh, the shoes were blue.”

C0400 Practice #1

- The resident is asked to recall the three words that were initially presented.
- The resident refuses to answer the question and states, “I'm tired, and I don't want to do this anymore.”

C0400 Practice #1 Coding

- The correct code is 0. No – could not recall.
- Choosing not to answer a question often indicates an inability to answer the question.
- This is the most accurate way to score cognitive function, even though on occasion, the resident might choose not to answer for other reasons.
Item C0500
Summary Score

C0500 Conduct the Assessment

- Add up the values for all BIMS questions.
- Lowest possible summary score is 00.
- Maximum possible summary score is 15.

C0500 Assessment Guidelines

- Do not add up the total score while you are interviewing the resident.
- Focus your full attention on the interview.
- Apply the guidelines for determining if the interview is complete or incomplete.
- Total score reflects cognitive status.
  - 13 – 15 Cognitively Intact
  - 08 - 12 Moderate Impairment
  - 00 - 07 Severe Impairment
C0500 Coding Instructions

- Code the total score as a two-digit number.
- Include leading zero (0) for scores less than 10.
- The score will range from 00 to 15.
- Code 99 if unable to complete the interview.
- A zero score does not mean the interview was incomplete.

Item C0500
Complete/ Incomplete Interview

BIMS Completion Guidelines

- For the BIMS to be complete:
  - Resident has to attempt to answer at least 4 of the items in C0200 through C0400.
  - The answers have to be relevant.
  - To be relevant, a response only has to be related to the question (logical).
  - Responses do not have to be correct.
- A score of zero (00) does not mean the BIMS is incomplete.
What Constitutes an Incomplete Interview?

- Resident can communicate but chooses not to participate in the BIMS.
  - Minority of residents are unable or unwilling to participate in the BIMS.
- Resident gives a nonsensical response to four or more items in C0200 - C0400.
- An incorrect but relevant answer is not a nonsensical response or no answer.

Incomplete Interview Guidelines 1

- Conduct C0200 and C0300 with all residents attempting the interview.
- Stop the interview after C0300 if the resident:
  - Refuses to answer.
  - Provides nonsensical responses to all items in C0200 and C0300.

Incomplete Interview Guidelines 2

- Finish the interview after C0300 if the resident provides a relevant response to at least one question in C0200 or C0300.
- The resident must provide relevant responses to at least 4 items in C0200 - C0400 for the interview to be complete.
- If the resident provides nonsensical responses or refuses to answer 4 or more items in C0200 - C0400, the interview is incomplete.
Incomplete Interview Coding Instructions,

- If the interview is stopped after C0300:
  - Code C0200 and C0300 as 0.
  - Code C0400 with a dash (-).
  - Code C0500 Summary Score as 99 to indicate an incomplete interview.
- Complete the Staff Assessment for Mental Status.

Incomplete Interview Coding Instructions,

- If the interview is finished (attempt C0400) but incomplete:
  - Code any relevant response(s) as appropriate.
  - Code all nonsensical responses or no answer as 0.
  - Code C0500 Summary Score as 99 to indicate an incomplete interview.
- Conduct the Staff Assessment for Mental Status.

Item C0600

Should the Staff Assessment be Conducted?
**C0600 Conduct the Assessment**

- Review the C0500 Summary Score.
- Determine if the BIMS was completed successfully or was incomplete.
- Conduct the Staff Assessment only if the Summary Score is **99**.
- A score of **99** indicates the BIMS could not be completed.

**C0600 Coding Instructions**

- **Code 0. No**
  - Interview completed.
  - Summary score equals **00 – 15**.
- **Code 1. Yes**
  - Interview not completed.
  - Summary score is **99**.

---

**Section C (Resident Interview) Summary**
**BIMS**

- Section C uses a performance-based tool to assess mental status.
- Attempt the BIMS for all residents that can be understood at least some of the time.
- BIMS consists of three components:
  - Repetition of 3 Words
  - Temporal Orientation
  - Recall
- Results are compiled into a Summary Score.

**Conduct the Interview**

- Establish a conducive environment.
- Make sure the resident can hear.
- Provide an interpreter if needed.
- Introduce the interview and address any concerns.
- Read the questions as written.
- Follow the guidelines for conducting each component of the BIMS.

**Complete/ Incomplete Interview**

- The interview is complete if the resident responds to at least 4 questions in C0200 – C0400.
  - Resident provides relevant or logical answers.
  - Answers do not have to be correct to be relevant.
- Otherwise the interview is incomplete.
  - Follow guidelines for stopping an interview.
  - Follow guidelines for coding an incomplete interview.
Score the Interview

- To score a complete interview:
  - Total the values for all items in C0200 – C0400.
  - A valid score will range from 00 - 15.
  - Enter this score in C0500 Summary Score.

- To score an incomplete interview:
  - Enter 99 in C0500 Summary Score to indicate an incomplete interview.

- Code C0600:
  - Indicate whether the interview was complete.
  - Determine if staff assessment should be conducted.
Section C

Staff Assessment & Delirium

BIMS & Staff Assessment

- Make every effort to complete the Brief Interview for Mental Status (BIMS).
- Conduct the staff assessment only if C0500 is coded as 99 (incomplete interview).
- Do not conduct the staff assessment if BIMS was completed (C0500 ranges from 00 – 15).

C0600 Should the Staff Assessment for Mental Status be Conducted?

- If C0600 is coded 0. No:
  o Do not do the staff assessment (interview is complete).
  o Skip to C1300 and complete the assessment for Delirium.
- If C0600 is coded 1. Yes:
  o Continue to C0700 and complete the staff assessment.
Item C0700

Short-term Memory OK

C0700 Importance

- An intact 5-minute recall indicates greater likelihood of normal cognition.
- An observed “memory problem” should be taken into consideration in planning for care.

C0700 Conduct the Assessment

- Determine the resident’s short-term memory status.
  - Ask resident to describe an event 5 minutes after it occurred.
  - Ask resident to follow through on a direction given 5 minutes earlier.
- Observe how often resident has to be re-oriented to an activity or instructions.
**C0700 Assessment Guidelines**

- Base coding decision on all information collected during the look-back period.
- Identify and code according to the most representative level of function.
- Use the no-information code (-) if:
  - Test cannot be conducted.
  - Staff are not able to make a determination based on observation.

**C0700 Coding Instructions**

- Code 0 if resident recalls information after 5 minutes.
- Code 1 if resident is unable to recall after 5 minutes.

**C0700 Scenario**

- A resident has just returned from the activities room where she and other residents were playing bingo.
- You ask her if she enjoyed herself playing bingo, but she returns a blank stare.
- When you ask her if she was just playing bingo, she says, “no.”
C0700 Scenario Coding

• Code 1. Memory problem.
• The resident could not recall an event that took place within the past 5 minutes.

C0800 Conduct the Assessment

• Determine long-term memory status.
  o Engage resident in conversation.
  o Review memorabilia with resident.
  o Observe response to family who visit.
• Ask questions that can be validated.
  o Are you married?
  o What is your spouse’s name?
  o Do you have any children? How many?
  o When is your birthday?
C0800 Assessment Guidelines

- Use the no-information code (−) if:
  - Test cannot be conducted.
  - Staff are not able to make a determination based on observation.
  - Indicates this information is not available.

C0800 Coding Instructions

- Code 0 if resident accurately recalls long past information.
- Code 1 if the resident did not recall long past information or did not recall it correctly.

Item C0900

Memory/Recall Ability
C0900 Conduct the Assessment,

- Ask the resident about each item in C0900.
  - Is it fall, winter, spring, or summer?
  - What is the name of this place?
- Ask resident to show the way to his or her room.
- Observe the resident’s ability to find the way.

C0900 Coding Instructions

- Check each item the resident recalls.
- Check Z, None of the above if resident recalls none of the items listed.

<table>
<thead>
<tr>
<th>C0900: Memory/Recall Ability</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Current season</td>
</tr>
<tr>
<td>B. Location of own room</td>
</tr>
<tr>
<td>C. Staff names and location</td>
</tr>
<tr>
<td>D. That he or she lives in a nursing home</td>
</tr>
<tr>
<td>Z. None of the above (unselected)</td>
</tr>
</tbody>
</table>

Item C1000

Cognitive Skills for Daily Decision Making
C1000 Overview

- Determine resident’s ability to make daily decisions.
  - Choose clothes.
  - Know when to go to meals.
  - Uses environmental cues such as clock, calendars, and notices to plan the day.
  - Acknowledge need to use appropriate assistive equipment.

C1000 Assessment Guidelines

1. Intent is to record what the resident is doing.
2. Focus on whether the resident is actually making decisions.
3. Do not consider whether staff believes the resident might be capable of doing so.
4. Impaired performance in decision making is characterized by:
   - Staff member takes decision-making responsibility away from the resident.
   - Resident does not participate in decision making.

C1000 Assessment Guidelines

1. Moderately impaired is defined as the resident makes decisions, although poorly.
2. Severely impaired is defined as:
   - Resident “rarely or never” makes decisions.
   - Resident was provided opportunities and appropriate cues.
3. Do not include a resident’s deliberate decision to exercise the right to decline treatment or recommendations by the team.
C1000 Coding Instructions

- Record the resident’s actual performance in making everyday decisions.
- Enter the code that corresponds to the most correct response.

C1000 Scenario

- Mrs. C. does not generally make conversation or make her needs known, but replies “yes” when asked if she would like to take a nap.

C1000 Scenario Coding

- Code C1000 as 3. Severely impaired.
- Resident is primarily non-verbal and does not make needs known.
- Gives basic verbal/non-verbal responses to simple gestures or questions regarding care routines.
Item C1300

Signs and Symptoms of Delirium (from CAM®)

Confusion Assessment Method (CAM®)

- Standardized instrument developed to facilitate detection of delirium.
- Consists of 4 components:
  - Inattention
  - Disorganized thinking
  - Altered level of consciousness
  - Psychomotor retardation

C1300 Conduct the Assessment,

- If conducting a BIMS:
  - Observe resident behavior for signs and symptoms of delirium.
- If conducting a staff assessment:
  - Ask staff members who conducted the interview about observations of signs and symptoms of delirium.
C1300 Assessment Guidelines

- The assessment for delirium is completed for **ALL** residents.
- Appendix C contains guidance on the signs and symptoms of delirium.
- Behavior may fluctuate over short or longer intervals.
  - During an interview
  - During the look-back period

C1300 Coding Instructions

- Determine the presence and frequency of each symptom.
- Code each symptom separately.

C1300A Inattention

- Reduced ability to:
  - Maintain attention to external stimuli
  - Appropriately shift attention to new external stimuli
- Assess attention separately from level of consciousness.
C1300A Inattention Coding Instructions

- Code 0. Resident attentive during interview and activities.
- Code 1. Sources agree that inattention is consistently present (does not fluctuate).
- Code 2. Resident’s attention varies or sources disagree in assessing level of attention (fluctuates).

C1300A Scenario

- The resident tries to answer all questions during the BIMS.
- Although she answers several items incorrectly and responds “I don’t know” to others, she pays attention to the interviewer.
- The medical record and staff indicate that this is her consistent behavior.

C1300A Scenario Coding

- Code C1300A as 0. Behavior not present.
- Resident remained focused throughout interview.
- This was constant during the look-back period.
C1300A Practice #2

- Resident is dazedly staring out the window for the first several questions.
- When you ask a question, she looks at you momentarily but does not answer.
- Midway through questioning, she seems to pay more attention and tries to answer.

C1300A Practice #2 Coding

- The correct code is 2. Behavior present, fluctuates.
- Resident’s attention fluctuated during the interview.
- If as few as one source notes fluctuation, then the behavior should be coded 2.

C1300B Disorganized Thinking

- Evidenced by rambling, irrelevant, or incoherent speech.
  - Unclear or illogical flow of ideas
  - Unpredictable switching from subject to subject
### C1300B Disorganized Thinking Coding Instructions

- Code 0. Resident thinking is organized and coherent.
- Code 1. Sources agree that resident’s responses are consistently disorganized or incoherent.
- Code 2. Resident’s responses fluctuated between disorganized/incoherent and organized/clear.

### C1300B Scenario

- The resident was able to tell the interviewer her name, the year and where she was.
- She was able to talk about the activity she just attended and the residents and staff that also attended.
- Then the resident suddenly asked the interviewer, “Who are you? What are you doing in my daughter’s home?”

### C1300B Scenario Coding

- Code C1300B as 2. Behavior present, fluctuates.
- The resident’s thinking fluctuated between coherent and incoherent at least once.
- If as few as one source notes fluctuation, then the behavior should be coded 2.
C1300B Practice #2 Coding

- The correct code is Code 1. Behavior continuously present, does not fluctuate.
- All sources agree that the disorganized thinking is constant.

C1300C Altered Level of Consciousness

- Vigilant: startles easily to any sound or touch
- Lethargic: repeatedly dozes off when asked questions but responds to voice or touch
- Stupor: very difficult to arouse and keep aroused for the interview
- Comatose: cannot be aroused despite shaking and shouting
  - Comatose relates to unresponsiveness.
  - Diagnosis of coma or stupor does not have to be present.

C1300C Altered Level of Consciousness Coding Instructions

- Code 0. Resident was alert and maintained wakefulness.
- Code 1. Sources agree that resident was consistently lethargic, stuporous, vigilant, or comatose.
- Code 2. Resident varied in levels of consciousness.
C1300C Practice #2

- Resident is usually alert, oriented to time, place, and person.
- Today, at the time of the BIMS interview, resident is conversant at the beginning of the interview but becomes lethargic and difficult to arouse.

C1300C Practice #2 Coding

- The correct code is Code 2. Behavior present, fluctuates.
- The level of consciousness fluctuated during the interview.
- If as few as one source notes fluctuation, then the behavior should be coded 2, fluctuating.

C1300D Psychomotor Retardation

- Greatly reduced or slowed level of activity or mental processing
  - Sluggishness
  - Staring into space
  - Staying in one position
  - Moving or speaking very slowly
- Differs from altered level of consciousness.
- May be present with normal level of consciousness.
C1300D Psychomotor Retardation Coding Instructions

- Code 0. Resident movement and responses noted to be appropriate.
- Code 1. Resident consistently had an unusually decreased level of activity.
- Code 2. Resident showed slowness or decreased movement and activity which varied.

C1300D Practice #1

- The resident is alert, but has a prolonged delay before answering the interviewer’s question.
- Staff reports that the resident has always been very slow in answering questions.
- The medical record does not mention behaviors related to levels or pace of activity.

C1300D Practice #1 Coding

- The correct code is Code 1. Behavior continuously present, does not fluctuate.
- The psychomotor retardation was continuously present according to sources that described the resident’s response speed for questions.
Item C1600

Acute Onset Mental Status Change

C1600 Conduct the Assessment

- Interview resident’s family or significant others.
- Review medical record prior to the 7-day look-back period.

C1600 Assessment Guidelines

- Examples of acute onset mental change status include:
  - Resident who is usually noisy or belligerent becomes quiet, lethargic, or inattentive.
  - Resident who is normally quiet and content suddenly becomes restless or noisy.
  - Resident who is usually able to find his or her way around the unit begins to get lost.
C1600 Coding Instructions

- Code 0. No if there is no evidence of acute mental status change from the resident’s baseline.
- Code 1. Yes if resident has an alteration in mental status observed in the past 7 days or in the BIMS that represents a change from baseline.

C1600 Scenario #1

- A resident was admitted to the nursing home 4 days ago.
- Her family reports that she was alert and oriented prior to admission.
- During the BIMS interview, she is lethargic and incoherent.

C1600 Scenario #1 Coding

- C1600 would be coded 1. Yes.
- There is an acute change of the resident’s behavior from alert and oriented (family report) to lethargic and incoherent during the interview.
Section C
(Staff Assessment & Delirium)

Summary

Section C Staff Assessment

- Conduct a resident interview if at all possible.
- Review C0600 to determine if an interview was complete or attempted.
- Conduct the staff assessment if the interview was incomplete.
- Staff assessment consists of four components.
  - Short-term Memory OK
  - Long-term Memory OK
  - Memory/Recall Ability
  - Cognitive Skills for Decision Making

Assessment for Delirium

- Conduct the assessment for delirium for all residents.
- Confusion Assessment Method (CAM) © assesses four signs and symptoms of delirium.
  - Inattention (easily distracted or out of touch)
  - Disorganized thinking (disorganized or incoherent thinking or conversation)
  - Altered level of consciousness (vigilant, lethargic, stuporous, or comatose)
  - Psychomotor retardation (unusually decreased level of activity)
Acute Onset of Mental Change

- Determine if there has been an acute onset of mental change in the 7-day look-back period or in the BiMS.
- Review the resident’s medical record prior to the look-back period.