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MISSOURI MEDICAID

CMI Documentation Requirements

CONDITIONS/SERVICES/DIAGNOSES THAT CAN AFFECT CMI

- CP, MS, PNEUMONIA, SEPSIS(NOTE:NEW CODING CRITERIA FROM OCT 1, 2024) HEMIPLEGIA, PARKINSON'S(NOT PARKINSONISM), RESPIRATORY FAILURE, COMA, OXYGEN ADMINISTRATION,COPD/ASTHMA OR ANY RESTRICTIVE LUNG DISEASE & SOB WHILE LYING FLAT DUE TO THAT; HEMIPLEGIA/HEMIPARESIS, DM WITH 2 OR MORE DAYS OF INSULIN ORDER CHANGES, DEPRESSION, IMPAIRED COGNITION ETC

- IV FLUIDS, IV MEDICATIONS, ISOLATION, VENTILATOR/RESPIRATORY SUPPORT, TRACH CARE, RADIATION, CHEMOTHERAPY, DIALYSIS, TRANSFUSION, DRESSINGS, OINTMENTS, FEEDING TUBE, SURGICAL & DIABETIC WOUNDS, PRESSURE/VENOUS & ARTERIAL ULCERS, BURNS, FOOT ULCERS, RESPIRATORY SERVICES, RESTORATIVE ETC

1. **Introduction**

-Brief background on Melinda and Renshaw Reimbursement & Consulting

-Overview of MDS and its importance in reimbursement and care planning

2. **How to validate the cognitive portion of the MDS**

-Tools used for the cognitive assessment (BIMS, staff assessments)

-Ensure accuracy and consistency in documentation (rarely/never understood)

- -Common errors (summarizing and quotes) and how to avoid them

3. **How to validate section GG**

-ADL functional assessments

-POC charting

-Narrative notes

4. **How to select a primary diagnosis**

-Criteria for selecting the most appropriate primary diagnosis

-Aligning clinical documentation with the ICD 10 coding

-Importance in reimbursement and care planning

5. **How to ensure validity with primary diagnosis**

-Supporting the diagnosis with documentation from the medical record

-Consistency across the physician documentation, progress notes, queries

-Linking diagnoses/aftercare to skilled services and therapy in charting

6. **How to validate other diagnoses, procedures, and conditions**

-Reviewing supporting documentation for evidence of comorbidities

-Commonly overlooked diagnoses or conditions that impact reimbursement

-Formulating queries to connect the dots for physicians

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-Staff Interview date requirements

-Interview signature date requirements

-Who is responsible for signing the MDS sections

8. **Questions and discussions**

-Open Q & A

-Real world challenges

-Key takeaways

Cognitive Documentation Requirements

For the following questions B0700, C0700 and & C1000, Myers & Stauffer is looking for the following, per page 19 of the Supportive Documentation Requirements User Guide:

#1-does the resident have memory recall after 5 minutes? Your BIMS interview is still required but that is not what THIS requirement is. With BIMS you are to immediately ask the resident to repeat the sock, blue, bed. THIS requirement is to wait 5 minutes before asking the resident to repeat/recall something. Like telling them it is almost lunch time and then asking after 5 minutes if they remember what meal is coming up. You must put in your note that you waited 5 minutes. Resident answers must be in quotes and are required here. It is not necessary to put the nurse or your questions in quotes, ONLY the resident answers. These are the instructions for C0700 to validate your answers if coded on the MDS.

#2-does the resident have the ability to make themselves understood, the ability to express needs, opinions, requests? Can the resident effectively communicate with the staff and how so? Do they have the ability to tell you what they want? Resident questions and examples are to be listed here and quotes are required to be used for the resident answers. If the resident does not speak, this does include sign language, gestures, speech. It is not necessary to put the nurse or your questions in quotes, ONLY the resident answers. These are the instructions for B0700 to validate your answers coded on the MDS. This question is always asked on the MDS, while the other two may be grayed out. Documentation is required to support this answer regardless of whether the resident has a deficit. We must validate this answer and it is asked on every MDS.

#3-can the resident make decisions daily about daily activities/ADL's, what they want to wear, what they want to eat etc? Resident questions and examples must be in listed here and quotes are required for the resident answers. It is not necessary to put the nurse or your questions in quotes, ONLY the resident answers. It does include if they pick out their clothes. Do they know without prompting that it is mealtime, that their show is coming on tv, that they have an appointment? Charting these items can help validate that the resident has the cognitive skills for daily decisions. These are the instructions for C1000 to validate your answers if coded on the MDS.

#4-it is best practice to chart a brief note regarding hearing, vision, dental, and that you have asked the social determinants of health in your progress note too. This does not require the same level of detail and specificity, but it is needed. With the new section R in October, (if we get it) these questions peppered throughout the MDS will be no more.

Cog charting example:

Writer went to resident's room to complete her BIMS assessment. Resident was sitting in her recliner with her feet up and reading a book. Writer told resident that I have a few questions for her. Resident responded "okay." Resident was asked to repeat back 3 words (sock, blue, bed.) "sock, blue, bed, but what is for dinner?" Resident was then told what is for dinner and asked what year it is. "2025, but what is for dinner?" Resident was told again what is for dinner and then asked what month it is, she responded "March." She was then asked what the day of the week is and responded "I am not sure, where are we eating dinner?" Writer told resident where to go for dinner. After waiting 5 minutes, writer asked resident if she could repeat back those 3 words from our previous conversation and she did not respond. Writer provided cues and she responded, "I am not sure what you are talking about. "Can I get iced tea with 2 pink sweeteners please?" Writer provided resident with her drink. Resident denies any other need at this time.

Per page 19 of the Supportive Documentation Requirements User Guide:above is a timed nurse's note entry.

1-B0700-yes✅(examples and dates of the resident's **ability to** express themselves or **communicate**)

2-C0700-yes✅(examples and dates that document the resident's ability to recall an event **5 minutes** after it occurred or follow through with directions given 5 minutes earlier)complete but not a positive outcome

3-C1000-yes✅(examples & dates of the resident's **actual** performance that documents the resident's degree of decision making ability regarding everyday decisions, tasks, and daily activities.)

Cog charting example:

Completed residents cognitive assessment for residents quarterly assessment. Resident is pleasant and his speech is clear. When asking resident to recall sock, blue, and bed resident said, "sock, blue, bed" Resident could recall the month, he could not recall the year and day of week. Writer asked resident what meal he was getting to have resident stated " I'm going to the dining room for lunch." After 5 minute wait writer asked resident if he could recall the 3 words resident stated "shit I will try," resident was able to recall the 3 words. Resident has no vision or hearing impairment. Interviewed resident about transportation, ethnicity, language, race, and health literacy.

Per page 19 of the Supportive Documentation Requirements User Guide:above is a timed nurse's note entry.

1-B0700-yes✅(examples and dates of the resident's **ability to** express themselves or **communicate**)many of these in this example

2-C0700-yes✅(examples and dates that document the resident's ability to recall an event **5 minutes** after it occurred or follow through with directions given 5 minutes earlier)I would count this but the answer would be better in quotes here.

3-C1000-yes✅(examples & dates of the resident's **actual** performance that documents the resident's degree of decision making ability regarding everyday decisions, tasks, and daily activities.)

Summarizing😟

Excellent bonus charting for social determinants of health questions

Cog charting example:

Met with resident to complete his pain and cognitive assessment. This nurse asked resident if he was having any pain in the last 5 days. He states, "No one will help me." This nurse asked what he needed help with and he states, "I hurt, I want to get in bed." This nurse assured resident that this nurse and staff will assist him to bed shortly. Resident states, "ok." This nurse repeated the question again and he states, yes. This nurse asked how often and resident replied with frequently. He also reports pain has frequently affected his sleep and rates his worst pain a 4/10 in the last 5 days. When asking resident if he feels the pain has affected his therapy activities and day to day activities resident does not answer this nurse and just looks down and then turns his head to the right as if he is looking at his television. Resident speech is slurred at times a well during the assessment, but able to make self understood. This nurse then asked resident to recall sock, blue, and bed. Resident states, "1,2,3." This nurse then asked resident if he could recall the year and resident correct states, "2025." When asking if resident can recall the month he states, "2025" and when asking what day of the week it is he states, "2026." This nurse then asked resident if he could recall those 3 words I had asked before and resident only shakes his head. Attempted to cue resident for each word and resident would only shake his head. This nurse, DON, and ADON assisted resident to bed at this time with hoyer lift. Require constant cueing to keep hands to his chest as he wanted to grab ahold of the hoyer bar or straps during transfer. Assisted resident with bed mobility and required x2 assist with use of mobility rail. This nurse attempted to speak to resident again, but resident eyes already closed and appeared to have fall asleep. Bed placed in low position and call light within reach. Fall mat in place. Will continue to monitor resident.

Per page 19 of the Supportive Documentation Requirements User Guide: above is a timed nurse's note entry.

1-B0700-yes✅(examples and dates of the resident's **ability to** express themselves or **communicate**)

2-C0700-no🚫(examples and dates that document the resident's ability to recall an event **5 minutes** after it occurred or follow through with directions given 5 minutes earlier)documentation does not say 5 minutes. Cueing is a BIMS direction. This is not listed in the instructions for page 19 of SDRUG.

3-C1000-no🚫(examples & dates of the resident's **actual** performance that documents the resident's degree of decision making ability regarding everyday decisions, tasks, and daily activities, when to go to meals, what she wants to wear.)no choosing clothing, seeking information from others to plan day etc documented.

summarizing😣

Cog charting example:

Resident is crying today off and on, teary. I asked resident why she was crying, and she stated, "I miss my mom." I asked her where her mom was and she said, "at home." This nurse reassured resident that everything would be OK and gave her a snack. This nurse then told resident that her mom would likely be by later. Resident asked this nurse again, about 5 minutes had passed, "When is my mom coming?" Nurse told her again, probably after work. I asked resident how old she was. Resident told this nurse "14." Resident eating cookies and not crying now. This nurse asked resident is she knew what meal we were having next. Resident said "I don't know." Nurse asked resident if she wanted to pick out her clothes for bed later and she just looked at this nurse.

Per page 19 of the Supportive Documentation Requirements User Guide: above is a timed nurse's note entry.

1-B0700-yes✅(examples and dates of the resident's **ability to** express themselves or **communicate**)

2-C0700-yes✅(examples and dates that document the resident's ability to recall an event **5 minutes** after it occurred or follow through with directions given 5 minutes earlier)documentation states 5 minutes, res memory recall clearly demonstrated.

3-C1000-yes✅(examples & dates of the resident's **actual** performance that documents the resident's degree of decision making ability regarding everyday decisions, tasks, and daily activities, when to go to meals, what she wants to wear.)choosing clothing, seeking information from others to plan day etc is documented that the resident does not perform these tasks.

Cog charting example:

Elder is alert and oriented as to person, She is generally pleasant and cooperative. Speech is clear, but generally only says one or so words and can be nonsensical at times. When asking BIMs questions, Frances was able to repeat back "blue and sock", but not "bed". When asked when asked what year it is, Frances said "1990", when asked the month, Frances said "Friday"; and when asked the day of week, Frances said "Monday". Frances declined answering when asked what the three words (blue, sock, bed). She participates/observes activities of choice. She receives telephone calls from a family member weekly. One or both of her daughters that live locally visit generally twice a week. Staff provides set up, direction, and assist with ADLs. Her daughters provide for personal and financial needs.

Per page 19 of the Supportive Documentation Requirements User Guide: above is a timed nurse's note entry.

1-B0700-yes✅(examples and dates of the resident's **ability to** express themselves or **communicate**)

2-C0700-no🚫(examples and dates that document the resident's ability to recall an event **5 minutes** after it occurred or follow through with directions given 5 minutes earlier)

3-C1000-no🚫(examples & dates of the resident's **actual** performance that documents the resident's degree of decision making ability regarding everyday decisions, tasks, and daily activities.)

Summarizing 😣, and words not coming from the resident directly do not need to be in quotes

Charting example:

During resident interview resident stated "no" when asked if she has little interest in doing things. Resident does try to be involved in activities, but sometimes gets upset. "no" when asked if shes feeling down or depressed, but resident at times seems down when she's so confused on why she's here, or where her husband is, or her car. Resident stated "no" when asked if she has trouble falling or staying asleep. Resident stated "no" when asked if she feels tired or has little energy but resident does fall asleep sitting at the dining room table sometimes. Resident stated "no" when asked if she has poor appetite. Resident does eat well for the most part. Resident did not make any statements indicating that her life is not worth living or that she feels bad about herself. Resident has trouble sometimes concentrating on things, she gets confused at times and wants to go home, or can't find her room, or forgets that she was heading to the bathroom. Resident does not move or speak slower than normal for her, resident does have trouble walking due to knee pain at times uses a w/c. Resident stated "no" when asked if she gets easily annoyed or has a short temper. But resident does often get upset when we try to redirect her when she wants to go home. Resident does not know what the current season is, or the location of her room, she does notice her room when she gets to it and knows which bed and closet is hers and where the bathroom is once she gets there. Resident does not know staff names but recognizes our faces. Resident does not realize that she is in a nursing home at times she thinks that she is in the casino. Resident usually chooses what she wants to wear each day, staff asks what she wants to eat, resident chooses yes or no when asked if she's ready to take a shower. Resident is incontinent of bladder and mostly continent of bowel, resident often gets upset if staff tries to take her soiled clothes to laundry. Resident needs reminded at times to brush teeth, always remembers to brush her hair and is concerned with her looks. Resident walks with a walker and sometimes uses a w/c depending on her leg pain that day.

Per page 19 of the Supportive Documentation Requirements User Guide: above is a timed nurse's note entry.

1-B0700-yes✅(examples and dates of the resident's **ability to** express themselves or **communicate**)

2-C0700-no🚫(examples and dates that document the resident's ability to recall an event **5 minutes** after it occurred or follow through with directions given 5 minutes earlier)

3-C1000-no🚫(examples & dates of the resident's **actual** performance that documents the resident's degree of decision making ability regarding everyday decisions, tasks, and daily activities, when to go to meals, what she wants to wear.)

Summarizing😣 *Beware of using words like sometimes, seems, usually, often, regularly, always.

Cog charting example:

Res does not talk. Opens eyes only. Res has no reply when asked how she is today. Res will moan with turning. Res is incontinent of B & B.

Per page 19 of the Supportive Documentation Requirements User Guide: above is a timed nurse's note entry.

1-B0700-no 🚫(examples and dates of the resident's **ability to** express themselves or **communicate**)

2-C0700-no🚫(examples and dates that document the resident's ability to recall an event **5 minutes** after it occurred or follow through with directions given 5 minutes earlier)

3-C1000-no🚫(examples & dates of the resident's **actual** performance that documents the resident's degree of decision making ability regarding everyday decisions, tasks, and daily activities.)

Summarizing

Cog charting example:

Entered into res room. Ask resident if she was ready for supper. Res did not respond to this nurse verbally. Nurse attempted to start dressing resident for meal and res swung her arms in the direction of this nurse. Res then threw a box of kleenex at this nurse. Res unable to speak. Nurse asked resident if she wanted to go to dinner later, res shook head yes. Nurse asked res if she wanted to wear her blue duster later to dinner and res shook her head yes.

Per page 19 of the Supportive Documentation Requirements User Guide: above is a timed nurse's note entry.

1-B0700-yes ✅(examples and dates of the resident's **ability to** express themselves or **communicate**)

2-C0700-no🚫(examples and dates that document the resident's ability to recall an event **5 minutes** after it occurred or follow through with directions given 5 minutes earlier)

3-C1000-yes ✅(examples & dates of the resident's **actual** performance that documents the resident's degree of decision making ability regarding everyday decisions, tasks, and daily activities.)not summarizing, res actual performance is demonstrated. Make sure you read the "also includes" and "does not include" on every page of the guide. Source: for cog documentation multiple emails from MSLC

Cog charting example we sent to MSLC with response:

"MDS Charting Resident alert and oriented x 1. Unclear speech. Can sometimes make wants and needs known with gestures. Does say a few words like yes, no and mama."

B0700 requires examples and dates of the resident's ability to make self understood and should clearly demonstrate the code transmitted (e.g. 0 for understood, 1 for usually understood, etc.) The provided examples does not state what code is to be validated. I would offer the following critique – The statement "can sometimes make wants and needs known with gestures….." is a summary of the resident's ability and does not state the resident's actual performance in the time frame.

The examples should state the resident's actual ability and the date it occurred – for example, "8.14.24 Today during the resident interview he was unable to make his wants and needs known. The resident was only able to verbalize the words "yes", "no", and "mama." Staff interpret resident-specific sounds and gestures in order to meet resident needs." Mind you – this is just a potential example and not meant to be interpreted as instruction for documentation when coding B0700. C0700There is no example above documenting the resident's ability to describe an event 5 minutes after it occurred or follow through on a direction given 5 minutes earlier during the observation period. The above example would not be sufficient for validating C0700.

C1000There is no example above referencing the resident's ability to make daily decisions for tasks of daily activities during the observation period. The above example would not be sufficient for validating C1000.

WHAT ABOUT STAFF INTERVIEWING STAFF FOR COG ETC?

Per the MO Supportive Documentation Guidelines page 15:

(For the Mood interviews) ***Does require:***

- Documentation of the date(s) staff member(s) interviewed across all shifts, dates of staff observations, and the frequency reported for each applicable item D0500 A-J.
- If family member(s) or significant other(s) were interviewed, the date the interview was conducted, dates of family member(s) or significant other(s) observations and the frequency reported for each applicable item at D0500 A-J.

For Cognitive items (short term memory/daily decision making/makes self understood as well as behaviors the expectation is:

Documentation of the date(s) the staff interview was conducted and the date(s), including a description of (item specifics)…

So we should always have the date of the interview, staff name, credentials (possibly shift worked if for mood) as well as name and credentials of person doing the interview. Of course the entry should also include the documentation of the specifics gleaned from said interview hopefully including the information outlined in the SDR's.

Please not that although the staff mood interview is a 14d look back the interviews should be done within the 7 day window.

Per MSLC we follow these guidelines for all staff interviews-

For items such as short term memory, daily decision, etc…. quotes can be used from staff but at times you may cite things you observed or the writer making the note within the look back observed, for example: 4/1/2024 0814 Patient ambulating on unit calling for her mother. She was redirected and within 5 minutes she began calling for her mother again. source: email to RRC from MSLC 4/28/25

In summary for staff interviews:

The first question on section C and D, whether or not the res is “rarely or never understood” is C0100 and D0100. It is also asked in the directions for J0200(whether or not a pain assessment should be conducted based on rarely or never understood). It is **not** okay to not interview the resident and write observations only unless the resident is always “rarely or never understood”.

Observations are key with staff interviews. Reviewers do not want to see the staff summarizing observations, not saying the MDS will not be validated, just an FYI. Real time observations when possible should be included when staff interviews are completed. If this is new (compared to how was the last MDS coded?), if so did you do a sig change? What I am seeing from homes is the resident is sometimes “rarely or never understood” and in other parts of the MDS they are interviewable.(Could the staff be marking that for convenience?) It should be consistent throughout the MDS.

Quotes are required with resident interviews. A rarely or never understood resident necessitates staff interviews/observations and real time information is best. These residents are the minority and not every dementia or Alzheimer’s resident by far is “rarely or never understood”.

I would chart the resident’s response to an attempted interview. Use real time information/observations. It is best practice to not summarize/diagnose. With all staff interviews follow the preceding slide 13 guidelines. Examples:

GOOD: Interviewed XX, CNA today at 1300. She stated resident just looked at her when asked what meal she would be soon attending. She then started rocking in her chair singing “God bless America.” Staff told her it was lunch time and res had no reply. Staff then said res then took all her clothes off at the table. After redirection and 5 minutes later, res did it again. Nancy Nice Nurse, RN

NOT GOOD: Interviewed XX, CNA today at 1300. She said res has memory issues. She does not know what time of day it is. She can not remember one thing to the next. Sometimes, she gets naked. Nancy Nice Nurse, RN

How to validate section GG

Supportive ADL documentation is required for the appropriate 3 day window lookback. The look back window for PPS assessments is the 1st day of the stay +2 days. For OBRA admissions it is the entry date + 2 days.

-the supportive documentation should accurately capture the resident's **USUAL** performance. CMS anticipates an IDT of qualified clinicians will be involved in assessing the resident, document the decision and enter it into the medical record. (This is the IDT note that MSLC is not currently looking for but the requirement has not changed)…source email MSLC 2-11-25

~When asked about the timeline on this note, MSLC said before the assessment is transmitted, after the ARD~

-the self-care performance is based on direct observation, incorporating self-reports, and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period.

-the narrative notes or designated collection tool must include all tasks and components and the wording must be equivalent to MDS key definitions. If using narrative charting for eating, it would be "the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident."

What if our ADL assessments do not have the exact language as the MDS?

If the designated collection ADL tool/assessment does not have the exact MDS language, and the “intent” in any way changes it may not be accepted, and all functional abilities coded under that item would not be supported. Source: Email to RRC from MSLC 1-27-25

SELECTING A PRIMARY DIAGNOSIS

-Read **ALL** the progress notes from the outside hospital, labs, H & P's, summary of current illness, current problems, active dx, inactive dx list, dx history, therapy notes, dietary notes, med list, physician rounds, dr office notes etc.

-Find the reason the resident was in the hospital for new admissions. This may or may not be the reason for a SNF admission. Are they coming to the facility for continuation of care for the same dx as the hospital or is the resident's underlying health state the reason they can not go home? Maybe they have aspiration pneumonia from dysphagia from an old stroke, and then I would choose stroke as primary. If they have pneumonia, diabetic wounds, & COPD underlying, I would choose the pneumonia or maybe the COPD. The primary dx should be why the resident is in the facility. Best practice is to reconcile the dx list and review why the resident is in your facility with every quarterly, comprehensive MDS and readmission.

-Parkinson's, CP, MS, hemiplegia/hemiparesis are automatically special care low or clinically complex with CMI if the ADL score is less than 11. For PPS residents, look for anything acute neuro related like stroke,dysarthria, aphasia, apraxia, dysphagia, ALS. If the resident has any of these, take note as acute neuro is the highest paying medical condition category for the skilled residents with the exception of extensive services. Choose the appropriate dx category to match your admitting dx.

YOU MUST VALIDATE THE DX ON THE MDS

Your diagnosis must be **active** to be **validated.** Active Diagnosis Definition: A physician-documented diagnosis in the last 60 days that has a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period-except for UTI. You can make a dx active by including charting functional limitations(contractures/decreased ability to perform ADL's/paresis/paralysis) and nursing monitoring(blood sugar/blood pressure/medication management)-these are especially important for dx that are not treated with daily meds and are difficult to validate). Ex: CP or hemiplegia

Charting: "resident with bilateral upper extremity contractures d/t CP, can not make purposeful movements of upper extremities. Res can not move LE. Dependent on staff for all cares" charted in the look back period validates CP.

Charting: "resident paralyzed on the left side after CVA. res has no motor function of her left leg and left arm." charted in the look back period validates hemiplegia.

DIAGNOSIS VALIDATION continued:

Again, check the following information sources in the medical record for the last 7 days to identify “active” diagnoses: transfer documents, physician progress notes, recent history and physical, recent discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor’s orders, consults and official diagnostic reports, and other sources as available. Active dx does not include: conditions that have been resolved or do not drive the resident’s plan of care within the 7-day look-back period.

There is special criteria for some dx ie sepsis(more specific as of Oct 2024), restrictive lung disease, pneumonia etc. Please review the guide from MSLC.

Don’t skimp on the dx. Maybe there is a LONG list but you must code every active medical condition to paint the most accurate picture of the resident. *For PPS assessments, CMS uses some non-reimbursable dx for covariates when figuring the discharge function score.*

DIAGNOSIS VALIDATION review:

- link a dx to a medication given daily as the medication indication
- link a dx to a PRN medication that you know will be used in the look back period as the medication indication
- obtain a signed fax from the provider stating the dx is active in the look back period
- speak with the physician about what dx are active and make a detailed progress note detailing the dx review with the provider etc.
- chart specific signs/symptoms in the last 7 days that are indicating ongoing or decompensated disease ie leg and calf pain when ambulating when there is a dx of PVD on the medical record.
- Recent onset or acute exacerbation of a disease or condition indicated by a positive study, test or procedure, hospitalization for acute symptoms and/or recent change in therapy in the last 7 days. Like rec blood for anemia or a +chest x ray for pneumonia.

TREATMENT VALIDATION

- **Respiratory therapy** requires documentation of the training the licensed nurse has received for **all** the modalities provided among other things, see page 11 of the manual from MSLC.
- **Oxygen therapy** PRN requires documentation of the precipitating event for PRN usage, see page 12 of the manual from MSLC.
- **Pressure and other ulcers and also skin lesions** requires specific identification of the wound(dx), location and description in the look back period. See pages 13-14 of the manual from MSLC.
- **Dialysis and radiation** requires weights before and after dialysis or documentation from the ancillary providers of the actual services, see pages 14-15 of the manual from MSLC.
- **Hallucinations, delusions, behaviors, and wandering** examples and dates of the events and all require specific documentation during the look back period, see pages 20-21 of the manual from MSLC.
- **Restorative nursing** the licensed nurse program evaluations are required during the look back and there other specific documentation requirements during the look back period, see pages 24 of the manual from MSLC.
- **Wounds/dressings/ointments** must be actual tx, just not observing a wound. Other specific documentation required during the look back period, see page 26 of the manual from MSLC.

FORMULATING QUERIES FOR DX

-Queries should offer the physician 3 choices. I normally provide the choices to the physician. For PPS residents, R codes do not pay.

-If the resident is using oxygen, query for the dx of respiratory failure.

If the resident has COPD or any other restrictive lung disease, query for an order to "keep HOB elevated to prevent SOB while lying flat for or due to ……". This can be put on the TAR for nsg to check shiftly or charted in the nurses notes during the look back with the same verbiage.

Good afternoon, Dr Health,

Resident Niceguy, a resident of yours currently here following hospitalization for aspiration pneumonia and old CVA has the dx code of dysphagia R13.10 provided by the hospital for his certification/part of his admitting dx list. Although it is effectual for that purpose, it is not specific enough to provide the clearest picture possible of your patient. Would I69.828, or I69.891, or I69.928 be an appropriate adjunct diagnosis for this resident?

Thank you for your help,

Nancy Nice Nurse,

MDS SECTION SIGNATURE/INTERVIEW REQUIREMENTS

Section A

- A social determinants of health assessment or a single progress note is to be completed to validate interview questions at A1005, A1010, A1110, & A1250 before the ARD. These are to be signed on the ARD or before during the lookback. *One progress note will cover all the social determinants of health MDS sections' questions as these questions do not all appear in section A. EX: "Interviewed resident about transportation, ethnicity, race, language and health literacy."

- All other section A questions to be signed after the ARD

Section B

- B1300 to be signed on the ARD or before during the lookback.

- All other section B questions to be signed after the ARD

Section C

- BIMS assessment/section C0200-C0500 should be completed/signed on the ARD or prior during the lookback.

- If resident unable to complete BIMS (due to being rarely/never understood) section C0700-C1000 is needed and should be signed on the ARD or prior during the lookback. ***See directions below for staff interview specific directions.**

- Please see slides for cognitive validation for the Medicaid residents.

- All other questions of section C to be signed after the ARD

Section D

- PHQ2-9 assessment/section D0150-D0160 should be completed/signed on the ARD or prior during the lookback.

- If resident unable to complete PHQ2-9(due to being rarely/never understood), section D0500-D0600 is needed and should be signed on the ARD or prior during the lookback. ***See directions below for staff interview specific directions.**

- D0700 to be signed on the ARD or prior during the lookback, as it is a social determinates of health question.

- All other questions of section D to be signed after the ARD

Section E

- All questions to be signed after the ARD

Section F

- Section F activity assessment F0400 A-H & F0500 A-H answered from interview for daily activities preferences.

- If resident is unable to complete the interview, F0800 A-Z should be completed/signed on the ARD or prior during the lookback. ***See directions below for staff interview specific directions.**

- All other questions of section F to be signed after the ARD

Section GG

- ALL to be signed after the ARD.

- The IDT meeting note discussing section GG/functional ability should note who attended the meeting, their credentials and

contain language like “resident’s complete functional status reviewed from what sources and resident’s usual performance applied to the MDS”. This note is **not currently** required by CMS or Medicaid, but it is best practice and subject to change. This note must come after the ARD. The RAI and the SDRUG both indicate this is expected.

- OBRA MDS: functional abilities GG assessments to be completed on the ARD, 1 day prior, & 2 days prior to equal 3 days total.
- Skilled MDS: functional abilities GG Assessment to be completed on admission date, day 2 of stay, and day 3 of stay to equal 3 days total.

Section H

- All to be signed after the ARD.

Section I

All to be signed after the ARD. All dx put on the MDS must be validated with daily use of meds or treatments, documented necessary care, symptoms, interventions, monitoring etc., regardless of a paying dx or not. The entire MDS can be unvalidated and given a CMI of .62 for the Medicaid resident without this.

Section J

- J0300-J0600B: Comes from the pain interview assessment.
- If J0410=9, then J0700-J0850 should be completed and signed on the ARD or prior during the lookback. ***See directions below for staff interview specific directions.**
- All other questions of section J should be signed after the ARD

- All other questions of section J should be signed after the ARD

Section K

- All to be signed after the ARD

Section L

- All to be signed after the ARD

Section M

- All to be signed after the ARD

Section N

- All to be signed after the ARD

Section O

- All to be signed after the ARD

Section P

- All to be signed after the ARD

Section Q

- Q0310A-C, Q0500 B-C, Q0550 A-C should be signed on the ARD or prior during the lookback.
- All other questions of section Q should be signed after the ARD.

Please note, **only questions that are **interview questions MUST** be **signed on the ARD or before during the lookback period. This includes staff interviews.**

For Medicaid to validate staff interviews, a progress note is required for Medicaid residents with information regarding who was interviewed, when (date & time), and the staff credentials. Do interviews when you can (unless rarely or never understood & this should not change throughout the MDS). Do not summarize. Include what the resident's response was when you attempted to do the interview, then do staff interviews when needed and include observations to get the most accurate picture of your resident.

BROUGHT TO YOU BY RENSHAW REIMBURSEMENT & CONSULTING LLC

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THANK YOU!