



Kentucky Department for Medicaid Services
RUG III Supportive Documentation Guidelines for MDS 3.0
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MDS 3.0 Item, Look-Back Period, Manual Location	Definitions and MDS 3.0 Documentation Guidelines for Required Look-Back Periods	Documentation Guidelines and Review Standards for Required Look-Back Periods
<p>B0100 Comatose</p> <p>7-day look-back p. B-1 – B-2</p>	<p>Comatose (coma): A pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; he/she does not open his/her eyes, does not speak and does not move his/her extremities on command or in response to noxious stimuli (e.g. pain). P. B-1</p> <p>Persistent Vegetative State: Sometimes residents, who were comatose after an anoxic-ischemic injury (i.e., not enough oxygen to the brain) from a cardiac arrest, head trauma, or massive stroke, regain wakefulness but do not evidence any purposeful behavior or cognition. Their eyes are open, and they may grunt, yawn, pick with their fingers, and have random body movements. Neurological exam shows extensive damage to both cerebral hemispheres (p. B-2).</p>	<p>Requirement:</p> <ul style="list-style-type: none"> Documentation of a neurological diagnosis of comatose or persistent vegetative state that has been documented by a physician, or nurse practitioner, physician assistant, or clinical nurse specialist, if allowable under state licensure laws, shall be present in the medical record that is applicable during the 7-day look-back period that ends on the ARD. <p>Does NOT Include:</p> <ul style="list-style-type: none"> Residents in advanced stages of progressive neurologic disorders such as Alzheimer’s disease. They may have severe cognitive impairment, be non-communicative and sleep a great deal of time; however, they are usually not comatose or in a persistent vegetative state, as defined here (p. B-2).
<p>B0700 Makes Self Understood</p> <p>7-day look-back p. B-6 – B-7</p>	<p>Makes Self Understood Able to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language, whether in speech, writing, sign language, gestures, or a combination of these. Deficits in the ability to make one’s self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing and/or gesturing (p. B-6).</p>	<p>Requirement:</p> <ul style="list-style-type: none"> Documentation of actual examples of the resident’s ability to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language, whether in speech, writing, sign language, gestures or a combination of these shall be present in the medical record during the 7-day look-back period that ends on the ARD. <p>*A check off sheet would be acceptable IF it includes the MDS 3.0 User’s Manual definition of each area OR an example that fits the definition AND occurs during the 7-day look-back period that ends on the ARD.</p>



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<p>C0200-C0400 BIMS</p> <p>7-day look-back p. C-2 – C-14</p>	<p>Nonsensical Response Any response that is unrelated, incomprehensible, or incoherent; it is not informative with respect to the item being rated (p. C-5).</p>	<p>Requirement:</p> <ul style="list-style-type: none"> • A signed and dated note by the person conducting the interview shall be present in the medical record during the 7-day look-back period that ends on the ARD.
<p>C0500 BIMS Summary Score</p> <p>7-day look-back p. C-14 – C-16</p>	<p>To be considered a completed interview, the resident had to attempt and provide relevant answers to at least four of the questions in C0200-C0400. To be relevant, a response only has to be related to the question (logical); it does not have to be correct (p. C-15).</p>	<p>Brief Interview for Mental Status (BIMS) score defined as: Score range is 0-15</p> <p>BIMS score can be interpreted as follows:</p> <ul style="list-style-type: none"> • 13-15 cognitively intact; • 8-12 moderately impaired; • 0-7 severe impairment.
<p>C0700 Short-Term Memory</p> <p>7-day look-back p. C-18 – C-20</p>	<p>This section is completed to assess the mental state of residents who cannot be interviewed. Staff should complete the Staff Assessment for Mental Status Item, C0700 – C1000.</p>	<p>Requirement:</p> <ul style="list-style-type: none"> • Documentation of actual examples demonstrating how the short-term memory problem was determined shall be present in the medical record during the 7-day look-back period that ends on the ARD.
<p>C1000 Cognitive Skills for Daily Decision Making</p>	<p>Daily Decision Making Includes: choosing clothing; knowing when to go to meals; using environmental cues to organize and plan (e.g., clocks, calendars, posted event notices); in the absence of environmental cues, seeking information appropriately (i.e., not repetitively) from others in order to plan the day; using awareness of one's own strengths and limitations to regulate the day's events (e.g., asks for help when necessary); acknowledging need to use appropriate assistive equipment such as a walker (C-23).</p>	<p>Requirement:</p> <ul style="list-style-type: none"> • Documentation of the resident's ACTUAL performance in making "everyday" decisions about tasks or activities of daily living shall be present in the medical record during the 7-day look-back period that ends on the ARD. <p>*It is NOT a requirement to have "daily" documentation of the decision-making but it is necessary to document the resident's ACTUAL performance. A check off sheet shall be acceptable for validation purposes, IF examples use the MDS 3.0 language.</p> <p>*The statement, "Cognition is severely impaired." is NOT acceptable because it does not give actual examples.</p>



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<p>D0600 Total Severity Score (PHQ-9-OV)</p> <p>14-day look-back p. D-14 – D-15</p>	<p>The interview is successfully completed if the staff members were able to answer the frequency responses of at least 7 out of 10 items on the PHQ-9-OV (p. D-15).</p> <p>The software will calculate the Total Severity Score. For detailed instructions on manual calculations and examples, See Appendix E: PHQ-9-OV Total Severity Score Scoring Rules.</p>	<p>Total Severity Score:</p> <ul style="list-style-type: none"> • Add scores for all frequency items (D0500) Column 2 • Maximum score is 30 <p>Total Severity Score can be interpreted as follows:</p> <ul style="list-style-type: none"> • 0-4 minimal depression; • 5-9 mild depression; • 10-14 moderate depression; • 15-19 moderately severe depression; • 20-30 severe depression.
<p>E0100A Hallucinations</p> <p>7-day look-back p. E-1 – E-4</p>	<p>Hallucination</p> <p>The perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch (p. E-1).</p> <p>This section focuses on the resident's actions, NOT the intent of his or her behavior (p. E-1).</p> <p>Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis (p. E-2).</p>	<p>Requirement:</p> <ul style="list-style-type: none"> • Documentation of actual examples of the resident's perception of the presence of something that is not actually there shall be present in the medical record during the 7-day look-back period that ends on the ARD. It may be auditory or visual or involve smells, tastes or touch. <p>*Simply stating, 'Resident is having hallucinations' shall NOT be acceptable for validation purposes.</p>
<p>E0100B Delusions</p>	<p>Delusion</p> <p>A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary (p. E-1).</p> <p>This section focuses on the resident's actions, NOT the intent of his or her behavior (p. E-1).</p> <p>Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis (p. E-2).</p>	<p>Requirement:</p> <ul style="list-style-type: none"> • Documentation of actual examples of the resident's fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary shall be present in the medical record during the 7-day look-back period that ends on the ARD. <p>Does NOT Include:</p> <ul style="list-style-type: none"> • A belief that cannot be objectively shown to be false or it is not possible to determine whether it is false (p. E-3). • A resident's expression of a false belief when he/she easily accepts a reasonable alternative explanation (p. E-3).



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<p>7-day look-back p. E-1 – E-4</p>		<p>*Simply stating 'Resident is delusional' shall NOT be acceptable for validation purposes.</p>
<p>E0200 A – C Behavioral Symptom – Presence and Frequency</p> <p>7-day look-back p. E-4 – E-6</p>	<p>This item is based on whether the symptoms occurred and NOT based on an interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated (p. E-5).</p>	<p>Requirement:</p> <ul style="list-style-type: none"> Documentation of actual examples that the resident exhibited and how the identification of the frequency and the impact of behavioral symptoms on self and on others was determined shall be present in the medical record during the 7-day look-back period that ends on the ARD.
<p>E0800 Rejection of Care – Presence & Frequency</p> <p>7-day look-back p. E-13 – E-17</p>	<p>Rejection of Care Behavior that interrupts or interferes with the delivery or receipt of care. Care rejection may be manifested by verbally declining or statements of refusal or through physical behaviors that convey aversion to or result in avoidance of or interfere with the receipt of care (p. E-14).</p> <p>The intent of this item is to identify potential behavioral problems, not situations in which care has been rejected based on a choice that is consistent with the resident's preferences or goals for health and well-being or a choice made on behalf of the resident by a family member or other proxy decision maker (p. E-15).</p>	<p>Requirement:</p> <ul style="list-style-type: none"> Documentation of actual examples and frequency of the resident's rejection of care that is necessary to achieve the health and well-being of the resident shall be present in the medical record during the 7-day look-back period that ends on the ARD. <p>Does NOT include:</p> <ul style="list-style-type: none"> Behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family) and/or determined to be consistent with resident values, preferences or goals (p. E-15).
<p>E0900 Wandering – Presence and Frequency</p>	<p>Wandering The act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction. Wandering may or may not be aimless. The wandering resident may be oblivious to his or her physical or safety needs. The resident may have a purpose such as searching to find something, but he or she persists without knowing the</p>	<p>Requirement:</p> <ul style="list-style-type: none"> Documentation of actual examples and frequency of wandering shall be present in the medical record during the 7-day look-back period that ends on the ARD. <p>Does NOT Include:</p> <ul style="list-style-type: none"> Pacing (repetitive walking with a driven/pressured quality) within a constrained space (p. E-18). Traveling via a planned course to



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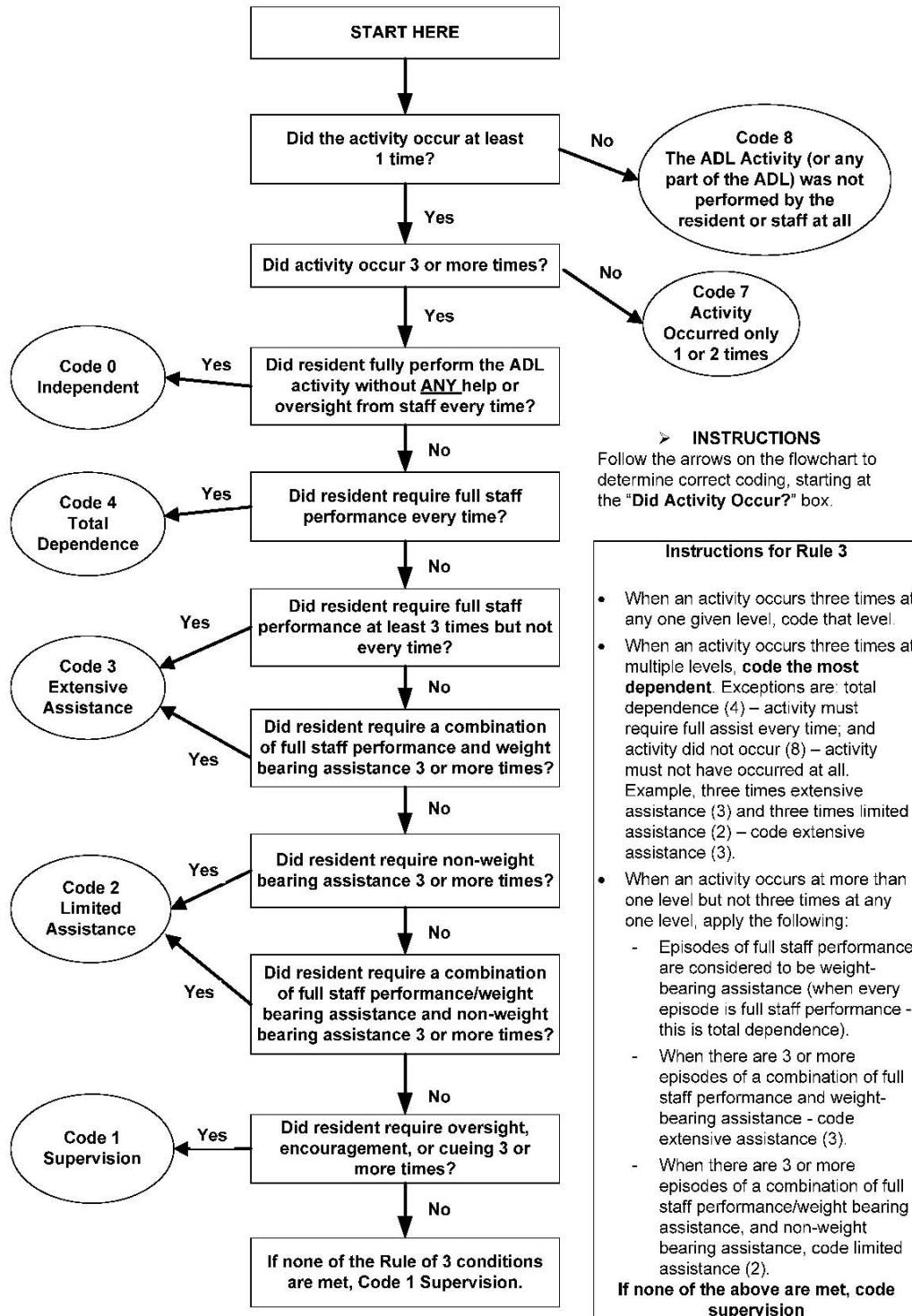
<p>E0900</p> <p>7-day look-back p. E-17 – E-18</p>	<p>exact direction or location of the object, person or place. The behavior may or may not be driven by confused thoughts or delusional ideas (e.g., when a resident believes she must find her mother, who staff knows is deceased). p. E-18</p>	<p>another specific place (such as going to the dining room to eat a meal or to an activity). p. E-18</p>
<p>G0110A, Bed Mobility G0110B, Transfers G0110H, Eating G0110I, Toilet Use</p>	<p>ADL Self-Performance Measures what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last 7 days according to a performance-based scale (p. G-2).</p> <ul style="list-style-type: none"> • Differentiating between guided maneuvering and weight-bearing assistance: determine who is supporting the weight of the resident’s extremity or body. For example, if the staff member supports some of the weight of the resident’s hand while helping the resident to eat (e.g., lifting a spoon or a cup to mouth), or performs part of the activity for the resident, this is “weight-bearing” assistance for this activity. If the resident can lift the utensil or cup, but staff assistance is needed to guide the resident’s hand to his or her mouth, this is guided maneuvering (p. G-7). <p>ADL Support Provided Measures the most support provided by staff over the last 7 days, even if that level of support only occurred once (p. G-3).</p> <ul style="list-style-type: none"> • The ADL self-performance coding options are intended to reflect real world situations where slight variations in self-performance are common (p. G-4). 	<p>DMS Minimum Requirements: If an ADL tracking tool is used to code self-performance (what resident actually did) and support provided for coding bed mobility, transfer, toilet use and eating (while in the facility); the following shall be clearly documented during the 7-day look-back period that ends on the ARD:</p> <ul style="list-style-type: none"> • An observation period with the month, day, year and resident’s name clearly identified; • An ADL “key” for self-performance and support provided shall meet the definition of the MDS 3.0 key; • Initials and dates to support the services were provided; • Signatures to identify initials. (Signature logs are acceptable); • When the ADL’s are NOT captured on a tracking tool, the above criteria shall be established and clearly documented. <p>*If using an ADL tracking form, each day or shift shall be initialed or signed by the person(s).</p> <p>*One signature/initial <u>with or without</u> a line drawn through the 7-day look-back period on an ADL tracking form shall not be accepted for validation purposes. If this practice is observed, the review nurse(s) would be required to see time records of that employee and days the employee did not work would not be validated. ADL tracking documentation shall be done “daily or every shift by the employee that worked that day or shift”.</p>



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MDS 3.0 ADL Decision Flow Sheet

ADL Self Performance Algorithm



INSTRUCTIONS

Follow the arrows on the flowchart to determine correct coding, starting at the "Did Activity Occur?" box.

Instructions for Rule 3

- When an activity occurs three times at any one given level, code that level.
 - When an activity occurs three times at multiple levels, **code the most dependent**. Exceptions are total dependence (4) – activity must require full assist every time; and activity did not occur (8) – activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2) – code extensive assistance (3).
 - When an activity occurs at more than one level but not three times at any one level, apply the following:
 - Episodes of full staff performance are considered to be weight-bearing assistance (when every episode is full staff performance - this is total dependence).
 - When there are 3 or more episodes of a combination of full staff performance and weight-bearing assistance - code extensive assistance (3).
 - When there are 3 or more episodes of a combination of full staff performance/weight bearing assistance, and non-weight bearing assistance, code limited assistance (2).
- If none of the above are met, code supervision**



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Section I: ACTIVE Diagnoses in the Last 7 Days		
<p>Step 1: Requirement for Diagnosis Identification: A physician documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days ending on the ARD (p. I-3).</p> <p>Functional Limitations: Loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis or paralysis.</p>		<p>Step 2: Requirement for ACTIVE Diagnosis: Once a diagnosis has been identified, it must be determined if the diagnosis is ACTIVE.</p> <p>ACTIVE Diagnoses: Diagnoses that have a direct relationship to the resident's functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period that ends on the ARD (p. I-3).</p>
<p>I2000 Pneumonia</p> <p>I2100 Septicemia</p> <p>I2900 Diabetes Mellitus (DM) (e.g., Diabetic Retinopathy, Nephropathy, Neuropathy)</p> <p>I4300 Aphasia</p> <p>I4400 Cerebral Palsy</p> <p>I4900 Hemiplegia/ Hemiparesis</p> <p>I5100 Quadriplegia</p> <p>I5200 Multiple Sclerosis (MS)</p>	<p>Listing a disease/diagnosis (e.g., arthritis) on the resident's medical record problem list is NOT sufficient for determining ACTIVE or inactive status.</p> <p>To determine if arthritis, for example, is an "ACTIVE" diagnosis, the reviewer would check progress notes (including the history and physical) during the 7-day look-back period for notation of treatment of symptoms of arthritis, doctor's orders for medication for arthritis, and documentation of physical or other therapy for functional limitations caused by arthritis (p. I-8).</p> <p>Ongoing therapy with medications or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor potentially severe side effects in the last 7 days. A medication indicates an ACTIVE diagnosis if that medication is prescribed to manage an ongoing</p>	<p>Requirement: See Steps 1 and 2 listed above.</p> <p>Documentation of ACTIVE diagnoses that have a direct relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death shall be present in the medical record during the 7-day look-back period that ends on the ARD.</p> <p>The review nurse(s) will check the following information sources in the medical record for the last 7 days that end on the ARD to identify ACTIVE diagnoses:</p> <ul style="list-style-type: none"> • Transfer documents; physician, nurse practitioner (NP), physician assistant (PA), or clinic nurse specialist (CNS) 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 (p. I-4). • In the absence of specific documentation that a disease is ACTIVE, the following indicators may be used to confirm ACTIVE disease:



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<p>K0500A Parenteral /IV Feeding</p>	<p>Parenteral/IV Feeding Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous). p. K-8</p> <ul style="list-style-type: none">• Guidelines on basic fluid and electrolyte replacement can be found online at: http://www.merck.com/mmpe/sec19/ch276/ch276b.html• Enteral feeding formulas:<ul style="list-style-type: none">○ Should NOT be coded as a mechanically altered diet.○ Should only be coded as K0400D, Therapeutic Diet when the enteral formula is to manage problematic health conditions, e.g. enteral formulas specific to diabetics (p. K-10).	<p>Requirement: Documentation of any and all nutrition and hydration received by the nursing home resident either at the nursing home, at the hospital as an outpatient or an inpatient, provided they were administered for nutrition or hydration shall be present in the medical record during the 7-day look-back period that ends on the ARD.</p> <p>The following fluids may be included when there is supporting documentation that reflects the need for additional fluid intake specifically addressing nutrition or hydration needs. This supporting documentation should be noted in the resident’s medical record according to State and/or internal facility policy:</p> <ul style="list-style-type: none">• IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently;• IV fluids running at KVO (Keep Vein Open);• IV fluids contained in IV Piggybacks;• Hypodermoclysis and subcutaneous ports in hydration therapy (p. K-9). <p>Does NOT Include:</p> <ul style="list-style-type: none">• IV medications – Code these in O0100H, IV Medications (K-9);• Additives, such as electrolytes and insulin, that are added to TPN or IV fluids – Code these in O0100H, IV Medications;• IV fluids administered solely for the purpose of “prevention” of dehydration. ACTIVE diagnosis of dehydration must be present in order to code this fluid in K0500A;• IV fluids used to reconstitute and/or dilute medications for IV administration;• IV fluids administered as a routine
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<p>K0700B Average Fluid Intake per Day by IV or Tube Feeding in the Last 7 Days</p> <p>7-day look-back p. K-12 – K-13</p>	<ol style="list-style-type: none"> 1. Review intake records from the last 7 days. 2. Add up the total amount of fluid received each day by IV and/or tube feedings only. 3. Divide the week’s total fluid intake by 7 to calculate the average of fluid intake per day. 4. Divide by 7 even if the resident did NOT receive IV fluids and/or tube feeding on each of the 7 days (p. K-12). 	<p>Requirement: Documentation of how the average number of cc of fluid the resident actually received per day was determined shall be present in the medical record during the 7-day look-back period that ends on the ARD. (Divide the 7 day total fluid intake by 7 to validate the average number of cc of fluid intake per day.) See examples on p. K-12 – K-13</p> <p>Record what was actually received by the resident, NOT what was ordered (p. K-12).</p>
<p>Current Number of Unhealed Pressure Ulcers at Each Stage</p> <p>M0300A – Stage 1</p> <p>M0300B1 – Stage 2</p> <p>M0300C1 – Stage 3</p> <p>M0300D1 – Stage 4</p> <p>M0300F1 – Unstageable Related to Slough and/or Eschar</p>	<p>Stage 1 Pressure Ulcer An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues (p. M-7).</p> <p>Non-Blanchable Reddened areas of tissue that do not turn white or pale when firmly pressed with a finger or device (p. M-7).</p> <p>Stage 2 Pressure Ulcer Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough.</p> <p>May also present as an intact or open/ruptured blister (p. M-8).</p>	<p>Requirement: Documentation to identify the presence of a pressure ulcer(s) with each ulcer’s deepest visible anatomical stage shall be present in the medical record during the 7-day look-back period that ends on the ARD (p. M-6).</p> <p>Determine that each lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is NOT the primary cause, do NOT code in this section (p. M-7, 8, 10, 13).</p> <p>Documentation in the care plan should include individualized interventions and evidence that the interventions have been monitored and modified as appropriate (p. M-8).</p> <p>M0300A – Stage 1:</p> <ul style="list-style-type: none"> • Pressure ulcers with intact skin that are suspected deep tissue injury should NOT be coded as Stage 1 pressure ulcers. They should be coded as Unstageable – Deep tissue (M0300G). p. M-8



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<p>Current Number of Unhealed Pressure Ulcers at Each Stage</p>	<p>Stage 3 Pressure Ulcer Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is NOT exposed. Slough may be present but does NOT obscure the depth of tissue loss. May include undermining or tunneling (p. M-10).</p> <p>Stage 4 Pressure Ulcer Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling (p. M-13).</p> <p>Tunneling A passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound (p. M-13).</p> <p>Undermining The destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface (p. M-13).</p> <p>Slough Tissue Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed (p. M-15).</p> <p>Eschar Tissue Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound (p. M-15).</p>	<p>M0300B1 – Stage 2:</p> <ul style="list-style-type: none"> • Stage 2 pressure ulcers are often related to friction and/or shearing force, and the care plan should incorporate efforts to limit these forces on the skin and tissues (p. M-8). • A Stage 2 pressure ulcer presents as a shiny or dry shallow ulcer without slough or bruising (p. M-9). • Do NOT code skin tears, tape burns, perineal dermatitis, maceration, excoriation, or suspected deep tissue injury here (p. M-9). • When a lesion that is related to pressure presents with an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury is determined, do NOT code as a Stage 2 (p. M-9). <p>M0300C1 – Stage 3:</p> <ul style="list-style-type: none"> • Stage 3 pressure ulcers can be shallow, particularly on areas that do NOT have subcutaneous tissue, such as the bridge of the nose, ear, occiput, and malleolus (p. M-11). • In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure ulcers (p. M-11). • Bone/tendon/muscle is NOT visible or directly palpable in a Stage 3 pressure ulcer (p. M-11). <p>M0300D1 – Stage 4:</p> <ul style="list-style-type: none"> • The depth of a Stage 4 pressure ulcer varies by anatomical location and can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule) making osteomyelitis possible (p. M-14).
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<p>Current Number of Unhealed Pressure Ulcers at Each Stage</p>	<p>Fluctuance Used to describe the texture of wound tissue indicative of underlying unexposed fluid (p. M-16)</p> <p>For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or sDTI that declares itself, should be coded in terms of what is assessed (seen and palpated, i.e., visible tissue, palpable bone) during the look-back period. Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. However, since CMS has adapted the NPUAP guidelines for MDS purposes, the definitions do NOT perfectly correlate with each stage as described by NPUAP. Therefore, you CANNOT use the NPUAP definitions to code the MDS. You must code the MDS according to the instructions in this manual (p. M-4).</p> <p>If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the resident's overall clinical condition should be reassessed (p. M-13).</p> <p>Most Stage 2 pressure ulcers should heal in a reasonable time frame (e.g., 60 days) p. M-8</p>	<p>M0300F1 – Unstageable Pressure Ulcers Related to Slough and/or Eschar</p> <ul style="list-style-type: none">• Pressure ulcers that are covered with slough and/or eschar should be coded as unstageable because the true depth (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the depth of the tissue layers involved, can the stage of the wound be determined (p. M-16).• Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heels serves as “the body’s natural (biological) cover” and should only be removed after careful clinical consideration, including ruling out ischemia, and consultation with the resident’s physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws (p. M-16).• Once the pressure ulcer is debrided of slough and/or eschar such that the tissues involved can be determined, then code the ulcer for the reclassified stage. The pressure ulcer does NOT have to be completely debrided or free of all slough and/or eschar tissue in order for reclassification of stage to occur (p. M-16). <p>Does NOT Include:</p> <ul style="list-style-type: none">• Reverse or back staging (p. M-5);• Pressure ulcers that are healed before the look-back period. Code under Healed Pressure Ulcers (M0900). p. M-6;• A pressure ulcer surgically repaired with a flap or graft. It should be coded as a surgical wound and NOT as a pressure ulcer. If the flap or graft fails, continue to code it as a surgical wound until healed (p. M-5);
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<p>M1030</p>	<p>The surrounding tissues may be erythematous or reddened, or appear brown-tinged due to hemosiderin staining. Leg edema may also be present (p. M-28).</p> <ul style="list-style-type: none">• The wound may start with some kind of minor trauma, such as hitting the leg on a wheelchair. The wound does not typically occur over a bony prominence, and pressure forces play virtually NO role in the development of the ulcer (p. M-29). <p>Hemosiderin An intracellular storage form of iron; the granules consist of an ill-defined complex of ferric hydroxides, polysaccharides, and proteins having an iron content of approximately 33% by weight. It appears as a dark yellow-brown pigment (p. M-28).</p> <p>Arterial Ulcers Ulcers caused by peripheral arterial disease, which commonly occur on the tips and tops of toes, tops of the foot, or distal to the medial malleolus (p. M-28).</p> <ul style="list-style-type: none">• Arterial ulcers are often painful and have a pale pink wound bed, necrotic tissue, minimal exudate, and minimal bleeding (p. M-28).• Include trophic skin changes (e.g., dry skin, loss of hair growth, muscle atrophy, brittle nails) may also be present. The wound may start with some kind of minor trauma, such as hitting the leg on a wheelchair. The wound does NOT typically occur over a bony prominence, however, can occur on the tops of the toes. Pressure forces play virtually no role in the development of the ulcer, however, for some residents, pressure may play a part. Ischemia is the major etiology of	<p>*OIG is responsible for determining the effectiveness of an ulcer treatment. The review nurse(s) may observe an ulcer, at his/her discretion, if the ulcer was documented as present during the 7-day look-back period that ends on the ARD and remains under treatment at the time of the review. (The review nurse(s) shall take into consideration that the ulcer may have improved or deteriorated since the time of the MDS look-back period.)</p>
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<p>7-day look-back p. M-29 – M-32</p>		<p>*A cyst, not otherwise described, would NOT be coded as an open lesion. Documentation of a cyst does NOT meet the criteria of being “open”.</p>
<p>M1040E Surgical Wound(s)</p> <p>7-day look-back p. M-29 – M-32</p>	<p>Surgical Wounds Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites (p. M-30).</p>	<p>Requirement: Documentation of the location, appearance and a corresponding physician order for treatment of the surgical wound shall be present in the medical record, including skin care flow sheet or other skin tracking form during the 7-day look-back period that ends on the ARD.</p> <p>Pressure ulcers that are surgically repaired with grafts and flap procedures are appropriate here (p. M-31)</p> <p>Does NOT Include:</p> <ul style="list-style-type: none"> • Healed surgical sites and stomas or lacerations that require suturing or butterfly closure; • PICC sites, central line sites and peripheral IV sites; • Pressure ulcers that have been surgically debrided. They continue to be coded as pressure ulcers (p. M-31)
<p>M1040F Burn(s)</p> <p>7-day look-back p. M-29 – M-32</p>	<p>Burns (Second or Third Degree) Skin and tissue injury caused by heat or chemicals and may be in any stage of healing (p. M-30).</p>	<p>Requirement: Documentation of burns (second or third degree only) caused by heat or chemicals including location, appearance and a corresponding physician order for treatment of the burn shall be present in the medical record, including skin care flow sheet or other skin tracking form during the 7-day look-back period that ends on the ARD.</p> <p>Does NOT Include:</p> <ul style="list-style-type: none"> • First-degree burns (changes in skin color only). p. M-31



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<p>M1200C Turning/ Repositioning Program</p> <p>7-day look-back p. M-32 – M-52</p>	<p>Turning/Repositioning Program Includes a consistent program for changing the resident's position and realigning the body. “Program is defined as a specific approach that is organized, planned, documented, monitored and evaluated based on an assessment of the resident’s needs.” (p. M-33).</p>	<p>Requirement: Documentation of a program specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours). Progress notes, assessments and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention and shall be present in the medical record during the 7-day look-back period that ends on the ARD (p. M-34).</p>
<p>M1200D Nutrition or Hydration Intervention to Manage Skin Problems</p> <p>7-day look-back p. M-32 – M-52</p>	<p>Nutrition or Hydration Intervention to Manage Skin Problems Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions, (e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplements to prevent skin breakdown, high protein supplements for wound healing). p. M-33</p>	<p>Requirement: Documentation of dietary measures received by the resident for the purpose of preventing or treating any specific documented skin conditions(s) with a corresponding physician order shall be present in the medical record during the 7-day look-back period that ends on the ARD (p. M-33).</p>
<p>M1200E Ulcer Care</p> <p>7-day look-back p. M-32 – M-52</p>	<p>Ulcer care includes any intervention for treating pressure ulcers coded in Current Number of Unhealed Pressure Ulcers at Each Stage, (M0300). Examples may include the use of topical dressings, chemical or surgical debridement, wound irrigations, negative pressure wound therapy (NPWT), and/or hydrotherapy (p. M-34).</p>	<p>Requirement: Documentation of ulcer care with a corresponding physician order shall be present in the medical record during the 7-day look-back period that ends on the ARD. Examples may include:</p> <ul style="list-style-type: none"> • Use of topical dressings; • Chemical or surgical debridement; • Wound irrigations; • Negative pressure wound therapy (NPWT); AND/OR • Hydrotherapy (p. M-34).



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<p>14-day look-back p. O-1 – O-2</p>		<p>3 months, it should NOT be coded unless it was given within the 14-day look-back period that ends on the ARD.</p>
<p>O0100B 1 or 2 Radiation</p> <p>14-day look back p. O-2</p>		<p>Requirement: Documentation of the resident receiving intermittent radiation therapy, as well as, radiation administered via radiation implant with a corresponding physician order shall be present in the medical record during the 14-day look-back period that ends on the ARD.</p>
<p>O0100C 1 or 2 Oxygen Therapy</p> <p>14-day look-back p. O-2</p>	<p>*The use of “emergency oxygen” <u>without a physician’s order</u> will still apply when supporting documentation is present in the medical record during the 14-day look-back period that ends on the ARD.</p>	<p>Requirement: Documentation of continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia or oxygen used in BiPAP/CPAP with a corresponding physician order shall be present in the medical record during the 14-day look-back period that ends on the ARD.</p> <p>Does NOT Include: Hyperbaric oxygen for wound therapy (p. O-2).</p>
<p>O0100D 1 or 2 Suctioning</p> <p>14-day look-back p. O-2</p>		<p>Requirement: Documentation of the resident receiving <u>tracheal and/or nasopharyngeal</u> suctioning with a corresponding physician order shall be present in the medical record during the 14-day look-back period that ends on the ARD.</p> <p>Does NOT Include:</p> <ul style="list-style-type: none"> • Oral suctioning (p. O-2).
<p>O0100E 1 or 2 Tracheostomy Care</p> <p>14-day look-back p. O-2</p>		<p>Requirement: Documentation of cleansing of the tracheostomy and/or cannula with a corresponding physician order shall be present in the medical record during the 14-day look-back period that ends on the ARD (p. O-2).</p>



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<p>O0100I, 1 or 2 Transfusions</p> <p>14-day look-back p. O-3</p>		<p>Requirement: Documentation of transfusions of blood or any blood products (e.g., platelets, synthetic blood products) which are administered directly into the bloodstream with a corresponding physician order shall be present in the medical record during the 14-day look-back period that ends on the ARD.</p> <p>Does NOT Include:</p> <ul style="list-style-type: none"> • Transfusions that were administered during dialysis or chemotherapy (p. O-3).
<p>O0100J, 1 or 2 Dialysis</p> <p>14-day look-back p. O-3</p>		<p>Requirement: Documentation of peritoneal or renal dialysis that occurs at the nursing home or at another facility and treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) with a corresponding physician order shall be present in the medical record during the 14-day look-back period that ends on the ARD.</p> <ul style="list-style-type: none"> • IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are NOT to be coded under K0500A (Parenteral/IV), O0100H (IV medications) and O0100I (Transfusions), (p. O-3).
<p>O0400A, Speech-Language Pathology and Audiology Services 1, 2 & 3</p> <p>O0400B, Occupational Therapy 1, 2 & 3</p>	<ol style="list-style-type: none"> 1. Individual minutes: total number of minutes of therapy that were provided on an individual basis in the last 7 days. Individual services are provided by one therapist or assistant to one resident at a time (p. O-15). 2. Concurrent minutes: total number of minutes of therapy 	<p>Requirement: Documentation of actual therapy minutes with associated initials/signature(s) shall be present in the medical record (e.g., rehabilitation therapy evaluation and treatment records, therapy notes and progress notes) on a daily basis to support the total number of minutes of therapy provided with a corresponding physician order during the 7-day look-back period that ends on the ARD.</p>



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<p>O0400C, Physical Therapy 1, 2 & 3</p> <p><u>Therapy Minutes</u></p>	<p>that were provided on a concurrent basis in the last 7 days (p. O-15).</p> <p>Concurrent therapy is defined as the treatment of 2 residents at the same time, when the residents are not performing the same or similar activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant for Medicare Part A. For Part B, residents may NOT be treated concurrently: a therapist may treat one resident at a time, and the minutes during the day when the resident is treated individually are added, even if the therapist provides that treatment intermittently (first to one resident and then to another). P. O-15</p> <p>3. Group minutes: total number of minutes of therapy that were provided in a group in the last 7 days (p. O-15).</p> <p>Group therapy is defined for Part A as the treatment of 2 to 4 residents, regardless of payer source, who are performing similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals (p. O-25).</p> <p>For Medicare Part B, treatment of two residents (or more), regardless of payer source, at the same time is documented as group treatment (p. O-15).</p> <p>Co-treatment is defined as two clinicians, each from a different discipline, treating</p>	<p>The medically necessary therapies shall meet ALL of the following criteria:</p> <ol style="list-style-type: none"> 1. Ordered by a physician (physician’s assistant, nurse practitioner, and/or clinical nurse specialist) based on a qualified therapist’s assessment (i.e., one who meets Medicare requirements or, in some instances, under such a person’s direct supervision) and treatment plan, 2. Documented in the resident’s medical record AND 3. Care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective (p. O-14). <p>Includes:</p> <ul style="list-style-type: none"> • Only medically necessary therapies that were provided once the individual is actually living/being cared for at the long-term care facility; • If a resident returns from a hospital stay, an initial evaluation must be performed after entry to the facility, and only those therapies that occurred since admission/reentry to the facility and after the initial evaluation shall be counted; • Actual therapy minutes ONLY; • Time provided for each therapy must be documented separately; • Therapist’s time spent on subsequent reevaluations, conducted as part of the treatment process; • Set-up time required to adjust equipment or otherwise prepare for the resident’s individual therapy session (p. O-16); • Co-treatment when minutes are split between two disciplines and when added together, do not exceed the
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<p>O0500C, Splint or Brace Assistance</p> <p><u>Training and Skill Practice</u> Activities including repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse.</p> <p>O0500D, Bed Mobility</p> <p>O0500E, Transfer</p>	<p>to the resident's needs, planned, monitored, evaluated and documented in the resident's medical record. Include active ROM and active-assisted ROM (p. O-28).</p> <ul style="list-style-type: none"> For range of motion (active): any participation by the resident in the ROM activity should be coded here (p. O-30). <p>Provision of (1) verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint; OR (2) a scheduled program of applying and removing a splint or brace. These sessions are individualized to the resident's needs, planned, monitored and documented in the resident's medical record (p. O-28).</p> <ul style="list-style-type: none"> For splint or brace assistance: assess the resident's skin and circulation under the device, and reposition the limb in correct alignment (p. O-30). <p>Activities provided to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side and positioning himself or herself in bed. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record (p. O-29).</p> <p>Activities provided to improve or maintain the resident's self-performance in moving between</p>	<p>reassess progress, goals and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this reassessment should be documented in the record.</p> <ol style="list-style-type: none"> Evidence of periodic evaluation by the licensed nurse must be present in the medical record. Nursing assistants/aides must be skilled in the techniques that promote resident involvement in the activity. *The field review nurse(s) shall look for training IF a nursing assistant/aide provides the services. A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a nursing restorative program. This category does NOT include groups with more than four residents per supervising helper or caregiver (p. O-27). <ul style="list-style-type: none"> The use of continuous passive motion (CPM) devices as nursing restorative care can be coded when the following criteria are met: <ol style="list-style-type: none"> Ordered by a physician; Nursing staff have been trained in technique (e.g., properly aligning resident's limb in device, adjusting available range of motion) AND Monitoring of the device. Nursing staff should document the application of the device and the effects on the resident. Do NOT include the time the resident is receiving treatment in the device. <u>Include only the actual time staff was engaged</u>
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<p>14-day look-back p. O-33 – O-34</p>	<p>treatment as a result of the examination (p. O-34).</p> <p>If a resident has multiple physicians (e.g., surgeon, cardiologist, internal medicine), and they all visit and write orders on the same day, the MDS must be coded as 1 day during which a physician visited (p. O-35).</p>	<p>The licensed psychological therapy by a Psychologist (PhD) should be recorded in O0400E, Psychological Therapy (p. O-34).</p>
<p>O0700 Physician Orders</p>	<p>Includes orders written by medical doctors, doctors of osteopathy, podiatrists, dentists, and physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law (p. O-35).</p> <p>If a resident has multiple physicians (e.g., surgeon, cardiologist, internal medicine), and they all visit and write orders on the same day, the MDS must be coded as 1 day in which orders were changed (p.O-35)</p> <p>*A lab order is considered to be a physician's order for validation purposes if the order is documented in the medical record and dated during the 14-day look-back period that ends on the ARD.</p> <p>An order written on the last day of the MDS observation period for a consultation planned 3-6 months in the future should be carefully reviewed (p. O-35).</p>	<p>Requirement: Documentation shall establish the number of days the *physician changed the resident's orders in the medical record during the 14-day look-back period that ends on the ARD. This may include:</p> <ul style="list-style-type: none"> • Written, telephone, fax, or consultation orders for new or altered treatment • Orders written on the day of admission as a result of an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes; • Orders requesting a consultation by another physician may be counted. However, the order must be reasonable (e.g., for a new or altered treatment). P. O-35 <p>Does NOT Include:</p> <ul style="list-style-type: none"> • Standard admission orders; return admission orders, renewal orders, or clarifying orders without changes; • Standard admission or readmission orders that are given at one time or are received at different times on the date of admission or readmission; • Orders prior to the date of admission or re-entry; • A sliding scale dosage schedule that is written to cover different dosages depending on lab values, simply because a different does is administered based on the sliding scale guidelines; • When a PRN (as needed) order was already on file, the potential need for



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Activities of Daily Living

MDS 3.0 Items	MDS 2.0 Items	MDS Descriptions
G0110A (1 & 2)	G1a (A & B)	Bed mobility
G0110B (1 & 2)	G1b (A & B)	Transfer
G0110I (1 & 2)	G1i (A & B)	Toilet Use
G0110H (1)	G1hA	Eating

The ADL (Activities of Daily Living) score calculation includes bed mobility, transfer, toilet use and eating. Below is the calculation process.

STEP # 1

Use the following chart to calculate the ADL score for bed mobility, transfers, and toilet use. Record the associated ADL scores to the right. *The eating ADL score will be calculated in Step #2.*

When <u>Column 1</u> =	AND	<u>Column 2</u> =	Then	<u>ADL Score</u> =	(Record below)
0, 1 or 7*		any number		1	
2		any number		3	Bed mobility = _____
3 or 4		0, 1, or 2		4	Transfers = _____
3, 4, or 8		3 or 8		5	Toilet use = _____

**A code of 7 is equal to 0 in the RUG-III "revised" system.*

STEP # 2

MDS 3.0 Items	MDS 2.0 Items	MDS Descriptions
K0500A	K5a	Parenteral / IV
K0500B	K5b	Feeding Tube
K0700A	K6a	Total Calories
K0700B	K6b	Average Fluid Intake

To complete the eating ADL score calculation use the criteria below. Record the associated ADL score to the right.

- If Parenteral / IV is checked, the eating ADL Score = 3. Proceed to Step # 3.
 - If not checked then;*
- If Feeding Tube is checked AND total calories is 51% or more calories, the eating ADL Score = 3. Proceed to Step # 3.
 - If not then;*
- If Feeding Tube is checked AND total calories is 26% to 50% calories AND average fluid intake is 501cc. or more fluid, the eating ADL Score = 3. Proceed to Step # 3.
 - If not then;*
- When neither Parenteral / IV nor Feeding Tube (with appropriate intake) are checked, evaluate the chart below for eating self-performance. Proceed to Step # 3.

When <u>Column 1</u> (Only)	Then	<u>ADL score</u> =	(Record below)
0, 1 or 7*		1	
2		2	
3, 4, or 8		3	Eating = _____

**A code of 7 is equal to 0 in the RUG-III "revised" system.*

STEP # 3

Total the 4-ADL elements and record:

TOTAL RUG-III ADL SCORE _____
The total ADL Score range possibilities are 4 through 18.