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Please stand by for real time captions. Hello there. It's Jen.

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First of all I like to welcome everyone to today's cold which is entitled MDS 3.0 coding challenges, questions and explanations. My name is Pat Fritz and I'm hosting this call today along with the Wyoming State survey office of licensing, the office of healthcare licensing and survey. War and Julianne are also with us today. In addition to the nursing homes we have invited nursing homes from the state of Alaska, Hawaii and Montana today. The handouts for today's presentation were distributed on Monday. They can also be located in downloaded from the office of healthcare licensing and survey website. If you have not received them and would like to please but your email address in the chat box and I will send them to you shortly.

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To enhance the learning experience for all participants I have placed all phones on mute. Incorporation for the question-and-answer period at the end of the call, you may mute your phones now by hitting either the mute button or 4 star. To not put us on hold because that will interrupt the call for all of us. It anytime as we go through here, I would like to ask the speaker to feel free to put it in the chat box or to go ahead and wait until we have the question-and-answer period at the end of the program. Today's format is a little different than our previous calls. Today we will have the polling questions throughout the presentation. Our speaker will present a scenario and then you will have the opportunity to answer how you feel that MDS should be answered. Following the polling question our speaker will provide the correct answer and given explanation for that answer. So please enjoy this opportunity for active learning.

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At this time I would like to introduce Julia from the office of healthcare licensing and survey will be introducing today's speaker. Julia.

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Good afternoon. Our speaker today began her career as a nurse's assistant and has held various roles and healthcare over more than 20 years. She has extensive clinical experience and has served as a regulatory consultant to the division of nursing homes at CMS. She has also been a master teacher for programs and expertise in all areas of the resident assessment instruments including its clinical, financial and quality reporting aspects. Please join me in welcoming Jen Pettis Thank you so much and welcome everyone. I see we have good attendance we have 51 folks so that's fantastic. We have an interactive session today so we have some time to chat and other times to do the polling questions. For the most part it will be pulling -- polling questions and I wondered if Jennifer from our WebEx company, is there anything that folks need to know about the polling?

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I guess not. We will proceed ahead and I think it will be pretty self-explanatory for you when we get to that.

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Again, Pats mentioned you will have some information about coding and in particular scenario sessions are items in that and I will give you the scenario to code. Once you address that I will address the climate correct coding of it and give you some hopefully helpful insights with that.

Here are the session objectives and it's my hope that at the end of the session you will be able to describe the four late loss ADLs and we're going to use for the four visit ADLs that are use in payment and quality measures and certainly accuracy for care planning patience for these is critical as well. I am hopeful that you will be able to discuss the rule of three for coding the ADLs self performance and will discuss the coding of both columns but self performance is more complex will focus on that a bit more. And hopefully you will be able to list the criteria for coding UTI and coding this is very specifics we will look at a scenario with this but we will also talk about diagnosis coding in general. And then we will discuss the coding in M0800 and then we will finish up with the finding of restraint. I do want to offer you a general reminder before we get started that the information I am providing is up-to-date as of today March 19, 2015. But don't forget about always going to the CMS website for the users manual. The link is provided there any can also just Google the MDS 3.0 RAI manual and it will pop right up for you can get a lot of information including how to contact your state and RAI coordinator on that.

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That's go ahead and start with section G. We will begin by defining the four late loss ADLs. Remember there are a total of about 10 which are also very important and all of them are very important for care planning purposes. But the research indicates that it is the late loss ADLs that are most predictive of resource use and accurately coding these is critical for ensuring that your payment is accurate. Certainly these are the four that are playing into your quality measures the most as well. When reviewing records are interviewing staff and observing the resident, you want to be specific and evaluating each component of each ADL listed in the definitions. All of the components of the ADL activity is listed in the items that and defined in the RAI users manual. If the components aren't listed or if there is a component that you are thinking of that is not listed in a particular ADL don't try to fit it into something. That ADLs are what they are as defined by the RAI manual. When we look at transfer, that includes how the resident moves between services. And includes to and from the bed to chair, the wheelchair. And don't forget about going from seated to standing position. So if you're resident is seated in a wheelchair and goes to stand to begin to walk, that is a transfer. And then once they are upright, that's when ambulation begins. So don't forget about that as considering a transfer. If your residence on an ambulation program, you have an instance of transfer that is happening right along with it. And then when they sit back down in the chair, that is also a transfer. Toilet use would be better described management of elimination that includes everything around that elimination and how the resident uses the toilet room or the bathroom with a commode at the bedpan and the urinal and how they get on and off the toilet and how they cleanse themselves after elimination and how they change their pen are manage their catheter and also their close. Remember that the toilet does not include emptying the bedpan or the bedside commode but you can think about toilet use of the whole job that the parents going down and the resident how they go and how you clean them up after then adjusting the close backup. So sometimes the resident they go to the bathroom and you have to take them back to the bathroom and help them finish the job. That is still part of toileting. So don't forget about that important aspect.

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For bed mobility, it is how the resident moves when they are in bed and including two in from the lying position and how they turned side to side and how they position their body while they are in bed or alternate sleep furniture. Don't forget about with the bed mobility that it really starts with resident kind of the rear end hits on the side of the bed. So how to their feet it up into bed?

To some we have to hold their shoulders to keep them from falling backwards? To the need that boost up in bed? Really turning from side to side is the easiest part of bed mobility. It's all of those other things that tend to be harder for the resident.

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Eating includes how the resident eats and drinks regardless of skill. We're not going to include how they eat and drink during medication pass. We really tend to make a residence a little bit more dependent than they otherwise might be during medication pass often. So don't want to count that. But we do counted if a residence use or having tube feeding or TPM or IV fluid or something along that line that are given for nutrition or hydration. They were being treated in here. And I stress those things that are given for nutrition and hydration. If the residents are receiving IVs as a means to get medication into their body, but it's not for hydration then you are not going to count that in eating.

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So here's your opportunity for your first polling question. Mr. Jones now up to during the day and slept at night in bed with the head of his bed elevated on some days during the look back period. However, most of the time he napped during the day and slept at night in his. Liner in his room. When coding med bed mobility this is a will consider how Mr. Jones moved and positioned his chair. Is the right answer in bed only, in the chair only, or in the bed and in the chair? You will see to the right of the slide on your screen, you should see the question, the polling question. And you have the opportunity to click A, B, or C and you have about 30 seconds left. And then the poll will be closed. And you will debrief the answer.

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And you are down to last 10 seconds for that. Okay. And our poll has ended and I'm not sure where we get the answers.

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They will pop in and just a second.

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Okay. Okay. We had most of you answer. Thanks for doing that. Over 60% of you got this right. That is in the bed and in the chair. So that mobility is going to consider how the resident moves in that or in alternate sleep furniture. It does not matter which one they spend the most time and. It simply matters where they sleep. So wherever they sleep you will consider that as part of bed mobility. Great job, guys. Now let's go on and talk about how we actually code ADLs. We will begin at the first column. When you think of ADL coding it is a two part of valuation and I think that's really important and a lot of times when folks first learn MDS they are encouraged to code all of the first column first and all of the second column second the problem is your software does not allow you to do that. Very often it has you code the bed mobility of column 1 and in the bed mobility of column 2 but I do encourage you to print out some papers section of the section G and practice the coding on that paper to really figure out that rule of three and figure out the coding conventions for both of those columns.

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So if performance is going to measure how much that resident does for him or herself in the support provided will capture how much the facility staff is supported is needed for that resident to complete their ADL. Each of these sections uses a very different scale . And when you are coding them you will consider all episodes of the activity that occur over 24 hour period for each day in the seven day look back period. Remember that the resident's performance is going to very day today and shift to shift for it will vary between shifts or within chefs even. And it's the

responsibility of the person completed -- completing the MDS and to be sure that they capture the entire picture of the resident when they are coding this. Only facility staff can be considered when voting. So what the facility staff means is basically the people are hoping the resident and who are paid for by your facility. Selected be people who are actually employees of the facility, or could be contract staff. Like nursing agency staff. Or could be therapists who are employees of your facility. Or if you have a contract therapy company, they will count that as well. So that anybody was basically the facilities providing the resources for. It's not going to count folks like hospice staff that comes in to visit the resident or if the family has a companion that maybe sits with the resident and has their meals with them or something like that. That kind of help is not going to be counted in there. Nursing students or CNA students were not paid by your facility are not going to be counted. Like if they are at the local vocational education Center you don't count them. But if they are your staff that are in training and that you guys are funding, those people assistance will be covered there and will be counted there.

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So let's look at the first column is a mention we will look at that first. There we go. Will begin by defining these. We will talk about the role of three and a couple of minutes. But when you first look at all of the ADL activities and how to code that, there's really a process that begins with understanding the definition of the ADL in and moving on an understanding the definitions that go with coding. And from there, once you understand this definitions and how many times each of those occurred at those particular levels that are defined and what type of assistance was provided or what type of support was provided. Over that whole seven day look back, that's when you can make the coding decision. So to first to begin to make those decisions, we define them ADLs and now we move on to define the levels of support. It starts with independent.

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Independent is if the resident is totally independent and if you have no help oversight or any queuing except for that one ADL for the entire seven days 24 seven. And the activity needs to have occurred list three times. So this is a resident who is totally independently gets in and out of bed and the chair. The transfer everywhere independently and you don't need to give them oversight or provide reminders or anything like that. Supervision you can think about as a looking and talking but not touching the resident. These are the residents that you are providing at least three instances of oversight encouragement and queuing in the last three times. This may be a reminder that it's time to speak up your spoon and Ethan come on your juice is there a way to make sure that you have a drink. Folks who need that type of encouragement. You may need to provide oversight to make sure that the resident is continuing to be engaged in their meal.

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Remember supervision is looking and talking but not touching. Once you have three or more instances of touching that we are probably looking at another code. Limited assistance is when the resident is highly involved in activity. And they would receive some kind of guided maneuvering or three or four times. Weight-bearing does not mean that you are bearing the weight of the entire residence body. You may simply be bearing the weight of the limit. So if you are thinking about a resident feeding themselves, guided maneuvering would be you helping them move the spoon from the side of their mouth by their cheek come over to their mouth. Where weight-bearing assistance would be picking that up from the plate to their mouth. So really it's a very subtle difference but it is a difference. It's limited assistance that is not bearing the weight of that resident or their extremities or anything at all.

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And then we go on to extensive assistance. Extensive assistance is where we do get into weight-bearing assistance. Now I do want to notice and I want you to notice that there are couple of sub bullets here to the extensive assistance. Extensive assistance is if the resident performed part of the activity over the last seven days and help of the following types were provided at least three times. Weight-bearing assistance three or more times. Or full stuff performance through more times. Notice that the sub bullets say weight-bearing assistance three or more times in full staff performance three or more times but not all of the last seven days. At this point we are simply defining the ADL you cannot combine weight hearing in full stuff performance. There is a time that you can do that with the rule of three, but a resident who has had two instances of weight-bearing and one instance of full staff performance does not meet the definition for extensive. We will talk about when you may apply the rule of three such that they will. But when you are simply looking at these definitions that it has not yet been met. Total dependences of that resident required full staff performance of an activity with no participation by the resident for any aspect of the ADL and the activity happened at least three times. So when we're looking at total dependence is complete nonparticipation by the resident for the entire seven days. Once they have participated at least once, then it cannot be total.

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And then we go into two kinds of exceptions we look at if the activity occurred less than three times. So here we have a code of seven which means the activity only occurred want to twice. And if the activity never occurred the entire seven days or a family and non-facility staff provided the care 100% of the time, then you would code that as an eight. I would say for the floor Jake late loss ADLs that you do not see a lot of eight. Think of an example of an activity not occurring for eating that would be seven days without no food or fluid or anything for seven days. For resident who had the mobility as an eight, they would have never been repositioned in bed. I would say for the late loss ADLs the bed mobility and transfer and eating in the one that is most likely to be the eight would be not transferring and that may be a resident really near the end up of their life. Or for some other reason is very ill and something is going on with them that they require bedrest for the whole seven days. Otherwise I would venture that you will not see a whole lot of eight for the for less ADLs.

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Now let's go on and talk about this rule of three. With the rule of three, it can be described as a method that will help you to determine what is the right code and the appropriate code to document on the MDS for the ADL self performance. It's important before you attempt the rule of three that you understand the components of the ADLs that lead to the definitions themselves and the ADL so performance definitions I just mentioned and this will of three. Before the exceptions to the rule of three, and what this means is that does not mean that the exceptions that you don't count the occurrences of the ADLs when you are counting up to three times. So if the resident is independent three times and I have done that three times. But with the exceptions what they mean is that these are very well-defined definitions in order to be independent you can only be coded independent if you have no help whatsoever for the whole seven day look back and it happened at least three times. Total dependence means total nonparticipation by the resident before seven. And then the seven and eight are the activity only occurred once or twice or the activity never happened. So those are the exceptions to the rule of three.

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Then you go down into the rules themselves. Do remember that there is an algorithm to help you through this and the algorithm has some very specific definitions and some boxes have asterisks in them and things along that line to really guide you to use that algorithm appropriately. I do want to caution you that the ADL coding our them for section G for the first column there is to be used to augment the instructions. It does not replace the 17 or however many pages that there are the instructions regarding coding this column. It's really meant to help guide you. I kind of like and it to when I put were set up a computer printer or some other computer thing and I kind of use that cheat sheet that's in there that has the pictures of them up on it. But in all honesty that helps me to open the box and get it set up but I still need to get into those definitions and directions to really understand how to set the. Drop or whatever it is I'm setting up. So don't be fooled by the algorithm and don't let that take you over and lose sight of all of the other information in that RAI manual. So let's go on down through the steps of the rule of three. When a resident has there ADL activity that occurred three or more times, the assessor will apply the steps of the rule of three, keeping the ADL coding exceptions in mind to determine the code to enter in column one. This is a key point. The steps must be use it in sequence. When the assessor encounters the definition or the step in the rule of three that they have met then they stop and that is the correct code. This is not a multiple coach. -- Multiple-choice this is to get to the first one that your resident meets and then stop there. So the first one is that when an activity occurs three or more times that anyone level then code that level. So if there are three instances of the code extensive than the code of three would be the correct code to enter on the MDS. Then when you have an activity occurring three or more times at multiple levels, code the most dependent level that occurs through more times. An example of this is when there are three instances of limited which would be a two and three instances of extensive which would be threes so you would code the highest and therefore code extensive or three on your MDS. That seem simple enough. Here's where we get a little more confusing. The third rule is really the one that I think is perhaps led to the most questions. This is only to be applied when the first or second rule do not fit the coding scenario. The third rule is an activity occurs three or more times at multiple levels, but not three times that anyone level. And that collate case you could write your episodes of full staff performance to weight-bearing when applying the rule of three. And then when there is a combination of full staff performance and weight-bearing you code extensive if that happened at least three or more times. And then if three or more times and if there was a combination of full staff performance and weight-bearing and not weight-bearing the happen through more times than you would code limited. So here's the case we could have one episode of extensive and two episodes of total and then count that as a three. You cannot do that until you have exhausted all of the other possibilities for coding. Then we get to the final bullet which says none of the above being met then code supervision. The example of where none of the above would be met would be if your resident was independent 20 times. But then twice they had supervision or let me have the be limited worked as they have limited. You cannot code limited assist because it only happen twice. But you cannot code them independent because they want independent 24 seven. In that case you would code supervision. And I have a question about where can you get the all agree them for section G but that is in the RAI users manual. That users manual is available in the link that I had I think in the third slide it was. The third or fourth slide you can go right to that slide and open your users manual and in there you should look for section G so would be chapter 3 section G and that's where you could find the outgrown on. I will try to get you the exact page before we and the webinar. So you folks have another question here. We have our resident to it has a coding opportunity for you and she would cry requires the following help with the transfer

during the look back period. She required supervision nine times and limited assistance three times. And extensive assistance it twice and total assistance twice. So nine time supervision, Limited three and extensive two and total two. What is the correct code for column 1? You have just about 45 seconds left to go ahead and answer that question.

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While you folks are answering I'm really quickly flipping through my RAI manual to find you the exact page of that algorithm. I want to say it's G 13 want to doublecheck. Notes GH. So you find chapter 3 page G8. So you have about six or seven seconds left to code this scenario and then we will debrief about this case before we move on and have another scenario. All right I think your time is up. In the pool has ended in just a moment we will debrief the answer.

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Okay. We had the majority that did good on this and the majority it was correct in that this is limited or I'm sorry let me go back I'm looking at my next scenario. She needed limited assists three times a so the answer is B limited assists. It may be tempting to combine the two episodes of extensive along with episodes of total but remember that these two levels of assistance that they were two levels of assistance that happened two or at least three times that had supervision and limited. So limited is the correct answer here and it's the highest level of the two that happened at least three times. So now we remove right into another scenario. Our next scenario is misses Coetzer who is only in the facility for a short time. While there she require the following help for toileting. She needed supervision twice, limited to price and extensive ties. So she was there not long enough to have the whole 70 look back but I would like to know for toilet use for her, what would be her correct code. So she had to instances of supervision, to instances of limited assistance and extensive assistance happening place for her. Take a minute and coded that and remember your rules of three and the coding definitions as you go here.

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This would be an opportunity where you may want to refer to that algorithm that I mentioned before. This would be the type of scenario where that would be really helpful to you. And really when you are finding that instance of the ADL happening at least three times and you probably don't need that out of them. But it's these kind of scenarios that is kind of the crazy coding scenarios and where you will look to that algorithm to help you figure out the correct coding.

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So now we are going to see the correct answer here in just a moment.

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Okay good job for her as well. She is also a limited assists. Now she is limited because we are applying the third part of the third rule. She did not have any level of assistance happen at least three times. Fishing is the third part of the third rule of three that states with is a combination of full staff performance our weight during and/or nonweightbearing assistance three or more times than the code is limited. Well done folks, things. Thank you for your participation I appreciate it.

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Okay and now the bad news is that the second column has a completely different set of coding rules. The good news is that it's a hole easier. So when you're looking at the second column your coding for the most short support provided for all shifts. This is the highest number of support that they have an is no rule of three to apply to the column and assessor must code the column according to the instructions and regardless of how column 1 is coded. And the coding as I said is pretty simple. Here's the rules. If there was no set up help at all you would code no set up a physical help and that would be zero. If the resident had set up help only it's one. For if one

person physically helps them at least one time and that seven days, then you coded as two. If two or more people help you reflect on three. And then if that never happened the entire seven-day period then you would go ahead and code as eight.

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So this time of going to challenge you to put all of that coding that we just went over together. I think this is your last coding scenario. Let me take a look here.

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Yes this is your last chance to show your stuff with ADLs for this webinar. This is misses Brune and she was very ill and unable to be there during the look back period except for one time which he transferred in and out of bed by mechanical lift with two of the staff. She did this to attend a religious service with the family. The correct coding for the transfer for her in column 1 and in column 2 is which of the following? Is at the total dependence with two of the assist or is it total dependence and activity did not occur or is it activity only occurred once or twice with two of the assists? Ordered the activity only occur once or twice but with eight meaning that the account activity did not occur in the second column?

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Member you are looking at two very different sets of coding rules of the very well-defined definitions for the first column and when you get into the second column you're looking for the highest level of support that happened at least one time. You just have a couple of seconds left for this and then we will debrief on the answer and then we will move into section I.

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And we're just waiting for our answer to come up here. Okay. You guys did great on this one. Over half of you got this right. Activity occurred only once or twice so code 7 into that first column. And then in the second column it is two assists. So the correct code would be a three in the second column. Well done. That does it for ADLs. Again if there are questions about that ADLs I welcome to put them in the chat box. We will probably go back and revisit the questions at the end of the program. But do go ahead and type those in there as well.

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Okay. Let's move on to section I with active disease diagnosis. Items in this are intended to capture diseases that have a direct relationship to that residence current functional status, cognitive status, motor behavior status, medical treatments, nursing monitoring or risk of death. The are to look back period for this. There is the diagnosis identification which is a step one that has a 60 day look back period. The disease conditions in this section require a physician documented diagnoses. And that can be a physician, if your state allows nurse practitioners or physician assistants or clinical nurse specialists to diagnose, then that would be allowable here as well.

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Anytime the MDS manual refers to a physician, that is the case. If it is that and TPA or CNS or if your state allows them to do the function that is being discussed at that time, then they can certainly fulfill that role from the MDS coding standpoint.

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The RAI users manual offers several possible sources for physician diagnoses. Included but not certainly limited to progress notes, recent history and physical transfer documents and diagnoses list and anything along those lines. A member of the diagnosis list is use that it needs to be signed by the physician.

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The second look back period is when you determine the diagnosis status. That is what the assessor determines if the diagnosis is actually active in the seven-day look back. That's the case for all disease diagnoses here with the exception of the UTI. They utilize a 30 day look back. So once the diagnosis has been identified in step one, the assessor that looks to say does this have a direct relationship on that residence status? One things that you may look to for the direct relationship is to take a look to say is something going on in this person's plan of care for this? So it may not be that you have a medication or treatment. You may have an enhanced monitoring or some kind of symptom management or something going on to prevent an exacerbation of that through your care mortalities. All of those things are going to help you identify that they are in fact with active diagnoses.

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A member that definitions of diagnoses are not provided. It's up to the medical provider to determine the residence diagnoses. The assessor will check all that applies and of the disease or condition is not specifically listed, then he do have the opportunity to write in the ICD code. And we are looking at that in our country, moving from ICD-9 to ICD 10. The MDS is arty set up to do that and your MDS and the software folks will be doing some stuff but MDS is kind of you guys in them MDS world in this facility you should be all set with that .

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The diagnoses as listed by major disease category. There are some examples that are provided with that. Those are examples and that's exactly what they are. They are not the lists of examples that are not meant to be all-inclusive. For instance, when you look at the zero 200 and email it includes the anemia of any etiology including those that are listed such as plastic deficiency and sickle cell. Any type of anemia can be captured in that item. You will check off every diagnoses that applies and again the I 8000 is there for you if something is not otherwise listed on the MDS.

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So with UTI it's a little more specific. You have the look back of 30 days instead of seven. They are very clearly defined criteria. There are four of them. There are four criteria and. The physician or other authorized person has to diagnose that that resident has the UTI in the last 30 days. They need to have a sign or symptom attributed to UTI and they may be fever or sign and symptoms are pain and tenderness. Don't forget about cognitive changes and don't forget about change in character of the year in. If you are sending a UA or CNS because the resident has foul-smelling urine then you have a change in the character of the urine and you have a symptom. Significant lab findings not say that there must be a culture. It says that there needs to be significant lab findings. It's up to the physician to determine if they consider them significant. For instance if they have a urinalysis and they say that we are treating based on the significance of the findings of that, then that has met your criteria. And then they need to have a mad or treatment the last 30 days.

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So now I have a coding scenario for you here. And the coding scenario this time his missus Thomas and she was hospitalized with pneumonia prior to being admitted to the nursing home last week. She has finished her antibiotics, but she continues with a cough. Her exercise tolerance is improving the therapy. She continues to where her oxygen. Would the 2000 ammonia be coded here? You do have just about 45 seconds or so to code this. So remember that you are looking at two pieces of information that we want to find on her. One is do you have the documentation in the last 60 days that the number on yam was a documented by a physician? We have here that it was in her transfer summary. So your real challenge in this scenario is to make a

determination of if this is an active diagnoses. Antibiotics are done. So we need to make a decision if we are still impacting her plan of care.

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While you are finishing up coding this, I want to address a question. The question is if our biggest challenge with ADL coding is educating staff on how to correctly and accurately code ADLs. You have suggestions to address this challenge? I do. My first suggestion would be to go out and work with the staff at the residence. When you go out and assist that resident and that staff with the resident transfer and talk to them about was it extensive or limited at the time you are doing that. Helped to move people in bed and give them the insights as to what is included in bed mobility. To make that education real for your front-line staff and explain to them why they are doing that, is going to make a huge impact on the accuracy of the documentation that they provide.

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Let's get back to missus Flanagan here are resident and I'm sorry if the guy read misses Thomas so sorry about that. But anyways which the money would be checked for her? It would. It's an active diagnoses. The antibiotic has ended but she still getting therapy and that is helping with her exercise tolerance. She's also still buying her oxygen. Sometimes folks antibiotics will end in your just be doing a heightened level of monitoring for a few days. And may be continuing with vital sign monitoring or something along those lines. Those are all indications that in fact the diagnosis is active. A great job and a lot of you got that right about 60% got that right.

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Now let's go on and talk about my very favorite section and if any of you have done trainings with me before you know that this is one of my favorites. We talked about it before. And they continue to be a lot of opportunities for enhancing accuracy in section M. I'm just in a time check here and where just about halfway through the slides and just about halfway to the programs I think that we are on track.

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We talk about putting pressure all servers are looking at first defining if it's a pressure ulcer or if it isn't and then defining the stage. The first question that we are asked in the MDS is if there is an unhealed pressure ulcer in the last seven days. Understanding the pressure also definition as a skin injury a localized injury to the skin or tissue that is usually over on a prominence but it does not have to be. You could certainly have a resident of the pressure ulcer from a catheter on SI or something along those lines. That could certainly happen. But most often we see these on bony prominences. And it is the primary etiology of these ulcers is pressure. It could be pressure and combination of friction and share which is very likely to cause undermining in particular with the pressure also and then the resident perhaps a sliding down in bed too much or something along those lines. So what we will do here is before we move on and talk about the coding want to remind you in the advisory panel definition is what the MDS definitions are based on. However they are not perfectly aligned and coding the MDS will be potentially slightly different from the documentation than the staging in the chart. So keep in mind the subtle differences and make sure that you are actually using the definitions that is provided in section M of the RAI users manual.

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Then if there's an unhealed pressure also and if you skip those items you may go to zero 900 and a status address the stasis ulcers. If they do have a pressure ulcer you will continue down to section M. This ability next item. These are the excerpts of the coding trips so keep that in mind

that there are very comprehensive coding tips in section M. Please be sure to review those in the manual the very extensive and a lot of coding examples. If the also arises from a combination of factors but as per merely caused by pressure then you'll code that here as a pressure ulcer.

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Oral ulcers will not be coded in section M. Now they put out a statement that said the pressure all servers are still pressure ulcers but it is appropriate to stage them using the staging system. And even the partial thickness also appears kind of white is vote is full of Slough although it really isn't. So you will not stage those. Then it would be coded in section L for abnormal tissue but it does not get coded here. Then as the bone if you did have exposed cartilage of would be stage IV just as though you had exposed bone. Then this is the tip that says if a pressure ulcer healed during the look back but was not present on the prior assessment code 0. And if your last MDS was done April 1 in a look back period had ended March 31. To the resident at a pressure also on May 15 that healed in June 1 and then we will do the next MDS sometime in June. Then that will not be captured on the MDS. That's the key point and its hidden in the coding tips in a really want to stress that to you. So if it healed in the seven-day look back period where you are looking at your documentation and if it's not on your MDS or if it's not here on that assessment. And it healed by then even if it was there at the beginning of the seven days and not present on the prior assessment then did not code that also.

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You deepen the anatomical stage and remember you will not be backstage but you will consider current and historical levels of tissue involvement. The look and feel for the base of the war and and any of those pressure ulcers. Review the history of that and the medical record and be sure to be backstage and iterative document the highest to stage and remember for the pressure also stage to you are also documenting the date of origin of the oldest stage II. The stages are listed here and I don't want to review all of them with you now. I mentioned that they were adopted and I wanted to encourage you to look on them RAI and in it in the users manual itself to get information. But I just want to highlight a couple of things. Stage to ones are partial thickness ones. Then once they have Slough and in it then it may not be stage II or cannot be. Then once you have something of tissue in the ones then you at least have your stage III. I want to stress that point. The other thing I want to stress is the on stage about. So there are three of them due to the nonremovable dressing. This me to have not been able to remove the whole thing for the whole seven days and look at what's going on under that dressing. There's probably not a whole lot of those the go in the nursing home. It may be chaos or something along those lines. So you cannot see the base of the one but if you have warned 90% covered with Slough then if you see the tendon then you can pretty confidently say that you have got a stage for all searches because you cannot perhaps measure the full depth of the one that you can certainly see the underlying structure. And then deep tissue injuries are really suspected deep tissue injuries and evolution involved -- evolve quickly. Often a deep tissue injury you have dark purple or otherwise discolored depending on the person's skin. And soft or warm or cool in the area will just feel different in a different texture and temperature and all of the tissue around there is very often leads to a problem for the resident from a pressure ulcer standpoint. Usually we see the deep tissue injury to that's pretty extensive damage for those folks.

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But do remember that it could look warmer or cooler or firmer or softer and it's really variable when you are looking at the deep tissue.

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Then you will identify again your second step with the stage and to identify those onstage Bulls that I mentioned. With you are intact skin that you think is suspected deep tissue injury, you will code that as onstage above and certainly if you have a pink area or a stage to that would be coded appropriately or the stage one would be coded appropriately. So remember that a deep tissue injury is intact skin. So that will be coded as onstage a bowl so keep the intact skin mentioned in mind.

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You will code the admission and this is where folks tend to get a little bit mixed up from time to time. For each also you will determine if the also was present at the time of admission or reentry. Admission or entry or reentry and not acquired by the resident in care of the nursing home. So you will consider historical and current levels of tissue involvement and review the medical record for the history of the also. So that if that did not occur in your nursing home then you could find out what happened prior to them coming to you.

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Then if they were present on admission and subsequently increases in the medical stage. Then this is an example of the resident who had the stage to on admissions and it worsens to stage III. Now that is no longer present on admissions. If the resident had an unstable also are on admission or entry, but then it becomes a stage about, then you consider that doesn't at that stage so you resident have the altar All-Star and they came in a cannot stage it but it was obscured with Slough or eschar but now it has degraded to a stage III. But now to stage III on admission. But now if it worsens to a four then it's no longer considered present on admission.

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Then if the resident has a pressure ulcer and is hospitalized in return and with the same stage that it's not present on admission then this is the resident the goes I was stage II and comes back in with the same stage II. And that will not be considered present on admission. So the have's prior to going in the hospital and your nursing home and then if the resident goes to the hospital with an All-Star that increases in stage during the hospitalization and they come back to and it is present on admission. So here's a resident that had stage to going to the hospital and coming back and out stage III. That will be considered present on admission.

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So sometimes folks say what is exactly considered on admission. What the users manual says is that it's close to the actual time of admission as possible. Want to stress to you that the guidance to serve errors in the pressure ulcer tab reminds us that the facilities have to ensure that systems and procedures are in place to ensure that residents get a proper preventative care and a pre-care of their pressure ulcers. And that excludes that there timely or appropriate so I would say it may be pretty darn soon after the comment your facility.

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Now we have that Mr. Ester who has a full thickness pressure also than other one of the coding scenarios for you. And he has this pressure ulcer on his right issue then this could be one point to 5 cm deep or I'm sorry 1.2 cm wide and zero. 5 cm deep. The wound free of issues at that however at the deepest point there was visible bone at the base of the wound. What stage is is All-Star -- is is also? You have about 30 seconds left to code this.

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I like to remind you that we never backstage but the were stage of the residents also as we look at historical information as well as the current visual and tactile assessment of the resident.

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We just have a couple of minutes left. Or not minutes but seconds.

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The poll has ended and we should get results shortly.

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Okay guys great job on that one. Most of you know most everybody said stage IV for that one. Excellent. It is stage IV and had visible bone at one time at the deepest point see you are doing a great job in healing up ulcer. But it still has the stage for a. A great job. Here we go developing the stage to pressure also are while at the nursing facility. She was hospitalized for six days and returned with the stage III pressure ulcer. In the same location.

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What a pressure ulcer be considered present on admission? Yes it is considered pressure present on admission then know the pressure also should not be considered present on admission. So the have the stage to pressure also while at the nursing home and hospitalized for six days. And with the stage III Fisher also you need to make a determination of if that is now present on admission or not.

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You have just about 10 seconds left. All right. The poll is closed. Because of doing a great job. To keep in mind that you can question type or questions and to chat as well and become for all participants to see and you could address the questions as we go or at the end of the program. What you see how we are doing.

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Something I didn't mention but we do have our results here that the majority of you got this one right then it is considered present on admission even the resident had an All-Star before she went to the hospital, it worsens in the hospital. So will be considered present on admission because it at the higher stage.

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Now let's move on and talk about zero 800 which is worsening the pressure also status of the prior assessment or the last admission entry or reentry. And the worsening pressure also is not simply that gets deeper but it's and also that gets a deeper such that it is stage to the higher number. Using the numerical stage as compared to the previous assessment.

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The look back period for this item is a unique one in that it looks back to the ARD of the prior assessment. So if this is the first scheduled PPS the near actually not going to code this item but you'd skip this and go down to a number of altar ulcers. So the assessors will review the history of each current pressure also here and compare the current stage to any prior stage and determine if the current assessment is new or add an increased numerical stage but looking at the prior MDS assessment. Then this is where the worsening pressure ulcer assessment sense prior assessment. It is the scheduled PPS assessment that the last assessment for the resident that was carded -- coded in M in M0 310 A. And so if you are using OMRA the assessment of the other Medicare required assessment that is required then that will not be considered your primary assessment. C will go back and take a look for the assessment that occurs the last PPS are OMRA. But the key point for coding this question. And then if the also numerically stage purser also increases in stage shooting considered worsening. Then we would share some of these with

you. For the pressure also than stage of on admission or reentry don't consider it to be were sent on the first assessment that it is determined to be numerically staged. If it subsequently worsens however, then you have to consider that to have four send. If a pressure also was numerically staged a becomes on sufferable the do not consider that is worsened so once that is remove then he would make a determination. Note clinically if you where the stage to ulcer and it's not covered with Slough or eschar and critically it's were send but from our standpoint you cannot make that determination yet but if they have merged it's not considered worsened miss the numerical stage increase so if you have to of these that are now one stage to it's not were send but if they become one of the stage threes than it is. And then if the pressure also has acquired during hospital admission the stage will be coded on admission and it will not be considered new or worsening unless it is subsequently worsens in your facility.

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I see that I have some questions in the chat so now I will and address these as you have the next coding scenario. And this is on the right hip which was reclassified as a stage IV then the current assessment that shows a stage IV and whether could be considered to have worsened. Just A to indicate yes and B to indicate that no it is not considered a new or worsened.

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Okay we have one question about ADLs and I'm actually going to say that a go back to that one. We have a comment that somebody recently had a person say to them that they could decrease the stage of the pressure also are as it was healing. You cannot according to MDS definitions or a cake according to the NPUAP guideline so if you're using the NPUAP guidelines then he would not do that. Source you have a question about pain some going to address the one later as well. And then we would address at the end and it talks about the reporting to someone and I don't think it will be sent in the nude access that at a later time to access the program if it will be made available and I'm not sure of that yet. Then it would be considered a new or worsened? This would not be considered new or worsened. Most of you got this right so great job. The pressure ulcer is going to be considered the stage for. Remember they came in on stage about. And they will reclassify the stage for. This is the initial time at stage and it will not be considered new or worsening.

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Good job and we have another scenario for you. And Pat just sent a text or a message or recording of this program that will be available Mountain Pacific in the Mountain Pacific website that assisted there for you and it just takes a couple of weeks but it would be up there for you and in the slides you remember you can get those by taping your email that you lead not the slides but the handouts. Those are available to you. So now we have our next president here and she has obtained a stage III pressure ulcer while in the nursing home. It was subsequently covered with Slough and covered in the next assessment is on stage about. After this the pressure also's clean and reassessed and determined to still be stage III. On the current assessment with the pressure ulcer be considered to have worsened? It was covered with Slough but it's not anymore.

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I do want to mention in our objectives that are told you we were going to cover skin and then we were going to cover restraints. I do want you to stick around with me after we're done with restraints because I'm also going to mention some of the things that came out in our document that was recently released in February. Some kind of new updates from CMS and I did include those at the end of the program so please a stick around for that and then we will wrap up with any of the remaining questions that we have as well.

It looks like our poll has code closed so we just have a couple of seconds and then will get the answer for that. Then you guys are only going to have one more question that I'm going to ask you to give me some input on and that will be where I will ask you to chat and use the chat feature.

I do appreciate all of you that are participating. I hope it has been a good learning experience for you. All right. Most of you said no that the pressure ulcer is not considered worsening and that is the right answer. Ms. Kirby had stage III and it was covered with Slough or eschar. It still stage III so it's not new or worsened. Clinically something happen in there were became covered with Slough or eschar so the MDS did not say worsened you may have been concern from a clinical standpoint about the resident. Great job on section M a. Let's go on and talk about restraints. Overwhelmingly restraint use in our country is pretty low. However, I do want to make sure that you are really making corrected determinations about restraints.

Restraints are coded any time that the resident has a manual method, physical or mechanical device, material or equipment and take a look at the word bolded there. Attached to or adjacent to the residence body and that the cannot remove easily. It restricts their movement or their normal access to their body. So let's think about some of the words there. And actually look at some of these definitions. I think they are important.

Remove easily means that the device or equipment or material can be removed intentionally by the resident in the same manner in which it was applied. So that does not mean the resident who has a Lapa buddy and then we goes it and stretches it around and then finally is able to get that thing off the side of their wheelchair somehow. Chances are that is still a restraint. A resident with a Lapa buddy we could say could you take that Lapa buddy often imitate deeming this blue phone right here? They pull it off and handed back to you. That is promoting it easily. So that is perhaps one of the biggest discrepancies that I seem is of folks and defining restraints. What does remove easily mean? It doesn't mean that Houdini got out of his restraints. It does not mean that that was easy the same manner that they were applied. It has to be that the folks got out of them and the way that you put them on them.

Freedom of movement is if the person can change their place or their position. Can access their own body? Consider the devices affect on the resident and not the intent of its use. So if I am unable to move because of complete paralysis in my body, that device is not restraining me. I would sure question why you had it on them on a person like that. Consider what is happening with the resident. Exclude items typically due to their provision of medical care. For instance if you have a resident has a sling, their arm is restrained because they cannot move it so the shoulder heals. That's not a restraint but it's the usual capacity to meet their medical needs. The biggest question I get on this one is the Domino binder. If you have abdominal fine. Because they have a giant incision on your belly then it's used in the usual capacity to meet the medical needs. If you have a tube that you don't want them to them to pull out and that is not the usual capacity of the abdominal binder. You need to revisit if that is a restraining device for your resident. I'm not there and I cannot make a decision however I would look closely at that if that was my facility.

Coding instructions and you can identify any restraints that were used in the 70 look back period. You can code is zero if they were not used and one is used a less daily and two is if there use daily. So this is where I would like to chat any have a chat feature in front of you putting questions and. And I have a resident here that uses the Jerry chair and they are replying when out of bed. What are some of the issues with the interdisciplinary team should consider when determining if the chairs are restraints?

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You don't have to write long questions. Just a couple of words here to say that if this was a resident and you were reclining the Jerry chair than what would you look at to say if this is a restraint or if it isn't? So somebody could get out of the chair easily? Excellent. What else might you look at?

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In the resident get out of the chair on their own? Does the resident have freedom of movement? Excellent. What else could we ask here? Where you using it? Okay. Anything else? What is the intent of the reclining chair? Is it being used for comfort? Can access their body? Can he get out of the chair himself or not? Can you change positions? If you have an excellent question that you can see here that the resident 10 on what climate get out themselves. Great job you guys.

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Think about with our chair. If we're using a chair for resident who has no mobility and is not attempting to get out of that chair, then maybe you would use a sling type of left to get that resident into the chair. They don't make any attempts to move. Their condition restraints them. The chair doesn't. But if the resident could get up or even attempted to get up or down and they cannot when they're up then it's the restraint. And if someone it talks about it and ask the question about if their mobile or if they can move themselves independently. If you have a resident has down in the chair and under client or in another scooting chair or wheelchair and if there able to use their feet to pedal around the facility but the now their feet up they are immobile, that's restraints.

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Some people were asking about what is the intent of the chair. Again it's not the intent of the device but the effective on the resident. Now someone has off the question how does the resident responded if there time to get up. If you put me in the chair because I say to you that I would like to set with my feet up and maybe I just need a good now and then would you put the chair up and ringing in our and when we got it get up. That is still a restraint. I cannot get up without ringing for you to bring it up. Does not mean it's bad and I hope you have a good care plan and that you will have that call in the reach and hopefully you have examined some opportunities to make me mobile myself and maybe I say this is my favorite chair and I've had it for 30 years and I'm not doing it up and I will bring it when I'm ready. That's my choice and that's not bad for the resident. But it's here good individualized care planning that would tell me why that's okay. It still a restraint.

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Have a question for maybe a comment and maybe it's not a restraint but it could cause a fall if the resident tries to get out of it. Sure if you see a resident with her legs were trying to the chair in the have 1 foot over each side in entering to wrap the chair back and forth of the chances are that's a restraint. I have a question here that and acute-care kidding restraints are bad but it does not seem like there so taboo in long-term care is that the case? Restraints, people die in restraints. It's not that they are not allowed but if they are used you need a medical symptoms and makes

the need for them there. You have got ongoing assessment always for if there is a less restrictive alternatives or if there is a time that the cannot be restraint. I had a question related to restraints and that was that if a person has a wheelchair brakes applied. For example at the dinner table, is there considered a restraint? But if you have that resident, to the dinner table and you apply the brakes because they want to get out of the dining room and you say know that you're going to stay here while you are eating them yes that is absolutely restraint if that resident cannot get them off. Could that resident respond just as well to being seated in a chair but maybe not a wheelchair? Maybe it's not a dining room chair but maybe just other people they enjoy dining with. Again then we could do it and look at the whole picture. One time a nursing home is our resident seated up at the desk and then they had a magazine in front and then they would say the have the magazine there and they read it and it's not a restraint. Then its activity and it's still a restraint and is the affect the device has on the resident and they could move the brakes if they were not on and it's not bad are good but it just is the way it is any folks need to make those determinations as a clinical team.

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We did have a couple of things regarding the document then the version of the users manual the had some revisions and it in the second revisions came in the form of the document. Then when the resident is considered admissions those who changed annual see on the slide there that are crossed out the second bullet. Then I had a resident that in order to be considered the reentry they had to have had the over assessment completed. Then the pressure refers to the admission date refers to when they enter and admitted as a resident in the day begins with 12 AM an answer with 11:59 PM. Then the time that they come in. Then complete your OMRA admission has to be completed of the resident has never been admitted before. Then these are discharged returns not anticipated and they could have gone home. Dennis there been in the facility previously and was discharged more than anticipated but if they did not come back within 30 days and that do is discharge assessment below. Then we will look at this on page 2 -- seven. We want to give two -- seven to find the discharge assessment information. Then all three of these as they were previously in the facility than that they came back within 30 days. In the past and ultra and to have the reentry the resident had to have the admission assessment which is not the case anymore. Then as long as the discharge return anticipated in back within 30 days that they are considered the reentry. Then for this admission than the admission date and the entry date are going to be the same. But if the type of entry for this admission is a reentry, then admission date stays the same as it was during an initial admission and now the entry date will be later. We should be able to see now a little better progression of when the resident is in the nursing home. Then we know that we have a few on chat. Then if they state the pain on the day of assessment and do not have any other source of documented pain that if you know the resident has a new AFO causing the pain that day. Then whatever level they say it is done that's what you code that the pain is always exactly what the resident says it is. Then how would you code the resident that transfers with an easy stand and one assist? The have right side paralysis. They would guess that the easy stand is what they would call the left which is a list that goes around their back under the shoulder and if they hold on with one hand and a can of cranks them up and if I'm wrong on that for free to chat again. Then it's probably extensive but I'm not there to look at it but it's homesick that would be the case.

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I think I have all the questions from chat so far. Then we have the handouts and if there are any questions that I don't know who want to try opening the phones if there any additional? Then no

symptoms of the lab result is available so how should I coded? Then you would meet all four criteria in order to coded but they showed be documented that they tried the lab result and it's not available and that it would be interviewing the patient and the family and the resident to find out why they had that antibiotic started and if they had any symptoms or anything along those lines. I would want to get attempt at that.

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This is part. There are couple of other questions and there's the resident in the recliner the cannot put the foot rest out on their own is considered a restraint question mark.

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Okay. It is not necessarily. If the resident could get up otherwise but can't because of their feet being more fought work -- reclined then it's a restraint but if the resident cannot move anyway and if you are providing them with that care or that transferred to get into the chair and that those feet are elevated for comfort or for whatever just because they like them but if they can't get up, and that is not a restraint. So it's truly looking at each individual and determining the affect that that device has on that individual resident.

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Someone says restraint are needed at times but that they sure carry risks. They sure do. And our community we hand out trays at me as a place of a where each resident hand as well as assisting with chest protectors. Many CNEs consider this set up. What do I think works I think a couple of things. One is I wonder if every resident in your facility gets their meal on a tray and a chest protector? If so, is that truly a dignified dining environment for them? To the really want to chest protector and our meals with trays providing them with the homelike dining experience? I would wonder those things. But also I care that if you just routinely open up everybody's milk carton, that is not individualized to set up. However, I would question why you are doing that. Why do places silverware in each resident hand? RFID in reach of the resident 10. Sorry. -- The resident hand. If I go to a restaurant, a which is gives me my silverware within the reach. A waitress or waiter but that does not mean there providing me a set up, that means they're just giving me my stuff. So think you want to look to individualized setups. To make sure that folks are not automatically opening containers are buttering bread or things like that if the resident doesn't need it or doesn't want it. But I do think that that is something that you need to that I would not have everybody in the facility get the same set up.

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What about if a resident said that I dining table but if they cannot push the chair by themselves? Is that a restraint? The resident needs the help to get in and out of the chair. Again I think you need to look at everyone in particular. I would not say everyone in a dining room chairs restraint if they need a little help. But I think you need to look at what is going on on an individual basis with those residents. If they are in a particular chair because you know that that prevents them from being able to move, then you probably have something going on there.

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We have one here that says when a resident who regularly has pain has a scheduled pain medication then rates the viewer on the interview than what do do?

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Excellent question. Again you are coding and the interview is with the resident says it is. So if they say that they are pain free then if it was me and I know that they have pain and they tell me that they don't and I would say because I want to do some probing questions which the MDS tells you that you should do. So I would say to them, I saw that you had some pain medication

today . In response to your back aching. If you have aches and things don't to know about them as well. But I see here though is that the resident has scheduled pain medication. If the resident has a painful condition and you are providing them a scheduled pain medication, that is controlling their pain and when he say do have any pain or hurting in the last five days and they say no, then it's no in your doing a good job managing that person's painful condition with that painful -- with that scheduled pain medication.

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Will just take a couple of more here. It's as if the resident receives skilled services with primary paid sources and private insurance and Medicare secondary, is the PBS assessment completed and transmitted?

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I'm going to refer you on this question. And I would refer you to either your state RAI coordinator for more details on giving insurance information and things like that. The ultimate authority on this is going to beer Medicare administrative contractor and actually really want to find out from your billing office if there billing based on the PPS a scheduler not select question I will really refer you back to put its way to patient specific to be answering here. Overwhelmingly them is if the primary payware is not Medicare then we will not be submitting the assessments. I would do them and have them available and we would not submit them but you really want to close the network in the business office and for the Medicare administrative contractor and perhaps for the private insurance to get some insight into what is going on. With that billing. But the billing is way too specific to answer and out webinar.

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So there I additionally pulling out tubes applied and is the still considered a restraint? The use of the abdominal binder is not intended for keeping residents with dementia from pulling out their tubes. Again I'm not there and I would make an individual determination. But an abdominal binder is limiting the resident's usual access to their body.

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For someone who never uses the toilet and requires a suppository and hanging slaying is this continent are incontinent? The resident is not usually have that outside of this. If you have a resident any give them a suppository and then they void or not void but the have the BM on the receptacle, then they are going to and that resident is continent even though you are providing them with care.

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Providing them with care to make them continent. And, was the resident taken zero after pain meds was the question? I'm not sure exactly what that means but if the resident says that they have no pain because you are controlling a well with medication, then you are good. A response to an earlier comment, okay.

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Okay think this is our last one. If the patient is placed in a juried prayer chair to hold them up bright then if the physician prevents aspiration and is only used in meals with one-to-one eating. Assuming you're asking me if it's a restraint. Again look at the individual resident and look at what is going on with them. And make that determination based on the fact that the device has on the resident.

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Jennifer Thank you very much. I think that we learned a lot today and obviously all of these questions are very complex in many ways.

They are. Think all of you guys and all of our participants. We had great participation today and Pat and Laura, thank you guys for having me present with you. It's always a pleasure to work with everybody out there in the West and even further west in Alaska and Hawaii. And certainly in Montana and Wyoming as well so we think you guys very much. And Pat, any other instructions for us?

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I think if anyone had any questions that they felt were unanswered of that we didn't get to them, please send an email to your state representative and the QIO will send those on and see if Jen can answer them but again the recording will be available on the Mountain Pacific website in about two weeks and at the end of the program here there should be an evaluation point in a link question that should pop up. If you could complete those than that is the one piece of information that we can assess of our programs are of value to you. I would also -- also like to think the office of surveys for cohosting the program with this and Laura and Lindy -- and Julia and making the programs available to programs outside of Alaska and Hawaii and Montana. That things had, thank you again Jennifer. Great program and this will be the conclusion of our call.

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Thanks everybody very much. Everybody keep doing great things in the nursing homes.

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Thank you.

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[ Event concluded ]