

CH.	Sect.	Pg.	January 2008 Revision
NA	Title Page	NA	Change the revised date to <b>January 2008</b>
CH 3	I2j	3-136	Add the following after the first sentence: <b>“Symptomatic” refers to both chronic and acute infections; if symptoms are not present, do not code this item.</b>
CH 3	I3	3-137	Revise the I3 title to include within the parenthesis: (7-day look back except for all Quarterly Assessment forms which require a 90-day look back) Add the following at the end of the Intent section: <b>When using Quarterly Assessment Forms (MDS Quarterly Assessment Form, MDS Quarterly Assessment Form Optional Version for RUG-III, or MDS Quarterly Form Optional Version for RUG-III 1997 Update), Section I3 is coded using a 90-day look back period. The intent of this item on the Quarterly Assessment Form is to update newly diagnosed diseases; however, only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, mood or behavior status, medical treatments, nursing monitoring, or risk of death should be coded in this section.</b>
CH 3	K2a	3-150	Add the following at the end of the Coding section: <b>If a resident cannot stand to obtain a current height or is missing limbs, use another means of determining height per current standards of clinical practice.</b>
CH 3	K3	3-152	Add the following as a third bullet point under Clarifications: <b>MDS coding for items K3a and K3b captures the resident’s weight at the 30-day and 180-day time points. K3a and K3b capture the resident’s weight at these two distinct points in time only and note if there has been a weight loss or gain in either of those time periods.</b>
CH 3	K3	3-152	Remove the following sentence from the third paragraph in the current third bullet point under Clarifications: <b>For example, a 10% loss/gain within 4 months should also be coded here, and carefully evaluated.</b>
CH 3	L1e	3-158	Revise the Intent to delete the ‘or’ before ‘Rashes’: <b>Inflamed Gums (Gingiva); Swollen or Bleeding Gums; Oral Abscesses; Ulcers <del>or</del> Rashes</b> Add “,” after Ulcers and “or Lesions”. Should read as follows: <b>Inflamed Gums (Gingiva); Swollen or Bleeding Gums;</b>

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			<b>Oral Abscesses; Ulcers, Rashes or Lesions</b>
CH 3	M Introduction	3- 159	Add the following sentence to the end of the first paragraph: <b>Skin does not include eyes or oral mucosa.</b>
CH 3	M4	3- 165	Add the following sentence to the end of the Intent section: <b>Skin does not include eyes or oral mucosa.</b>
CH 3	M4g	3- 166	Revise the second sentence as follows: <b>This category does not include surgical wounds of the eyes or oral mucosa,</b> healed surgical sites, stomas, or lacerations that require suturing or butterfly closure as surgical wounds.
CH 3	M5e	3- 167	Revise the first sentence to read: Includes any intervention for treating skin problems coded in M1, M2, and/or M4c.

	Appendix	Page	January 2008 Revision
	B	B-2 through B-4	Update contact information for MDS RAI Coordinators for the following states: California, Iowa, Missouri, Nebraska, Nevada, New Mexico, North Dakota, Pennsylvania, South Dakota, Texas, Utah, West Virginia and Wyoming.
	B	B-5 through B-7	Update contact information for MDS RAI Automation Coordinators for the following states: California, Massachusetts, Missouri, Nevada, New Mexico, and Wyoming.
	B	B-8, B-9	Update contact information for Region III, IV, V, VII and IX.

- j. Urinary Tract Infection** - Includes chronic and acute symptomatic infection(s) in the last 30 days. **“Symptomatic” refers to both chronic and acute infections; if symptoms are not present, do not code this item.** Check this item only if there is current supporting documentation and significant laboratory findings in the clinical record. For a new UTI condition identified during the observation period, a physician’s working diagnosis of UTI provides sufficient documentation to code the UTI at Item I2j, as long as the urine culture has been done and you are waiting for results. The diagnosis of UTI, along with lab results when available, must be documented in the resident’s clinical record. However, if it is later determined that the UTI was not present, staff should complete a correction to remove the diagnosis from the MDS record.

**In response to questions regarding the resident with colonized MRSA, we consulted with the Centers for Disease Control (CDC) who provided the following information:**

A physician often prescribes empiric antimicrobial therapy for a suspected infection **after a culture is obtained, but prior to receiving the culture results.** The confirmed diagnosis of UTI will depend on the culture results and other clinical assessment to determine appropriateness and continuation of antimicrobial therapy. This should not be any different, even if the resident is known to be colonized with an antibiotic resistant organism. An appropriate culture will help to ensure the diagnosis of infection is correct, and the appropriate antimicrobial is prescribed to treat the infection. The CDC does not recommend routine antimicrobial treatment for the purposes of attempting to eradicate colonization of MRSA or any other antimicrobial resistant organism.

- k. Viral Hepatitis** - Inflammation of the liver of viral origin. This category includes diagnoses of hepatitis A, hepatitis B, hepatitis non-A non-B, hepatitis C, and hepatitis E.
- l. Wound infection** - Infection of any type of wound (e.g., postoperative; traumatic; pressure) on any part of the body.
- m. NONE OF ABOVE**

**Process:** Consult transfer documentation and the resident’s clinical record (including current physician treatment orders and nursing care plans). Accept statements by the resident that seem to have clinical validity. Consult with physician for **confirmation. A physician diagnosis is required to code the MDS.**

Physician involvement in this part of the assessment process is crucial.

**Coding:** Check an item only if the infection has a relationship to current ADL status, cognitive status, mood and behavior status, medical treatment, nursing monitoring, or risk of death. Do not record any conditions that have been resolved and no longer affect the resident's functional status or care plan. For example, do not check "tuberculosis" if the resident had TB several years ago unless the TB is either currently being controlled with medications or is being regularly monitored to detect a recurrence.

Check all that apply. If none of the conditions apply, check *NONE OF ABOVE*. If you have more detailed information available in the clinical record for a more definitive diagnosis, check the appropriate box in I2 and enter the more detailed information (with ICD-9-CM code) under I3.

### **I3. Other Current Diagnoses and ICD-9-CM Codes (7-day look back except for all Quarterly Assessment forms which require a 90-day look back)**

**Intent:** To identify additional conditions not listed in Item I1 and I2 that affect the resident's current ADL status, mood and behavioral status, medical treatments, nursing monitoring, or risk of death. If space permits, may also be used to record more specific designations for general disease categories listed under I1 and I2. When using Quarterly Assessment Forms (MDS Quarterly Assessment Form, MDS Quarterly Assessment Form Optional Version for RUG-III, or MDS Quarterly Form Optional Version for RUG-III 1997 Update), Section I3 is coded using a 90-day look back period. The intent of this item on the Quarterly Assessment Form is to update newly diagnosed diseases; however, only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, mood or behavior status, medical treatments, nursing monitoring, or risk of death should be coded in this section.

**Coding:** Enter the description of the diagnoses on the lines provided. For each diagnosis, an ICD-9-CM code must be entered in the boxes to the right of the line. If this information is not available in the medical records, consult the most recent version of the full set of volumes of ICD-9-CM codes. V codes may be used if they affect the resident's current ADL status, mood and behavior status, medical treatments, nursing monitoring, or risk of death.

“pockets food,” etc. Inspect the mouth for abnormalities that could contribute to chewing or swallowing problems or mouth pain.

**Coding:** Check all that apply. If none apply, check *NONE OF ABOVE*.

## K2. Height and Weight (30-day look back)

**Intent:** To record a current height and weight in order to monitor nutrition and hydration status over time; also, to provide a mechanism for monitoring stability of weight over time. For example, a resident who has had edema can have an intended and expected weight loss as a result of taking a diuretic. Or weight loss could be the result of poor intake, or adequate intake accompanied by recent participation in a fitness program.

### a. Height

**Process:** **New Admissions** - Measure height in inches.

**Current Resident** - Check the clinical records. If the last height recorded was more than one year ago, measure the resident's height again.

**Coding:** Round height upward to the nearest whole inch. Measure height consistently over time in accord with standard facility practice (shoes off, etc.). **If a resident cannot stand to obtain a current height or is missing limbs, use another means of determining height per current standards of clinical practice.**

### b. Weight

**Process:** Check the clinical records. If the last recorded weight was taken more than one month ago or previous weight is not available, weigh the resident again. If the resident has experienced a decline in intake at meals, snacks, or fluid intake, weigh the resident again. If the resident's weight was taken more than once during the preceding month, record the most recent weight.

**Coding:** Round weight upward to the nearest whole pound. Measure weight consistently over time in accord with standard facility practice (after voiding, before meal, etc.). There may be circumstances when a resident cannot be weighed, for example: extreme pain, immobility, or risk of pathological fractures. If, as a matter of professional judgment, a resident cannot be weighed, use the standard no-information code (-). Document rationale on resident's record.

## K3. Weight Change (30 and 180-day look backs)

**Intent:** To record variations in the resident's weight over time.

### a. Weight Loss

This page revised—January 2008, August 2003

- ◆ MDS coding for items K3a and K3b captures the resident's weight at the 30-day and 180-day points. K3a and K3b capture the resident's weight at these two distinct points in time only and note if there has been a weight loss or gain in either of those time periods.
- ◆ There are no specific regulations that address the desirable weight and time frames for weight gain or weight loss. However, there is some general information in the interpretive guidelines and in the Nutritional RAP that may provide guidance in this area. The amount of weight gain or loss is reflective of individual differences. Guidelines related to acceptable parameters of weight gain and loss are addressed in the OBRA regulations at 42 CFR 483.25, nutrition (F325 and F 326) and 483.20(b)2(xi), resident assessment nutritional status and requirements (F 272), which corresponds to the MDS 2.0 Section K, Oral/Nutritional status.

The parameters for weight loss identified in the guidelines referenced above are:

- 1 month 5% significant >5% severe
- 3 months 7.5% significant >7.5% severe
- 6 months 10% significant >10% severe

The measurement of weight is a guide in determining nutritional status. Therefore, the evaluation of the significance of weight gain or loss over a specific time frame is a crucial part of the assessment process.

However, if the resident is losing/gaining a significant amount of weight, the facility should not wait for the 30 or 180-day timeframe to address the problem. Weight changes of 5% in one month, 7.5% in three months, or 10% in six months should prompt a thorough assessment of the resident's nutritional status. An adequate assessment should result in a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's needs and expressed desires.

#### K4. Nutritional Problems (7-day look back)

**Intent:** To identify specific problems, conditions, and risk factors for functional decline present in the last seven days that affect or could affect the resident's health or functional status. Such problems can often be reversed and the resident can improve.

- Definition:**
- a. **Complains About the Taste of Many Foods** - The sense of taste can change as a result of health conditions or medications. Also, complaints can be culturally based - e.g., someone used to eating spicy foods may find nursing facility meals bland.
  - b. **Regular or Repetitive Complaints of Hunger** - On most days (at least 2 out of 3), resident asks for more food or repetitively complains of feeling hungry (even after eating a meal).

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- Clarifications:** ♦ The basic TPN solution itself (that is, the protein/carbohydrate mixture or a fat emulsion) is not counted as a medication. The use of TPN is coded in Item K6a. When medications such as electrolytes, vitamins, or insulin have been added to the TPN solution, they are considered medications and should be coded in O1.
- ♦ The amount of heparinized saline solution used to flush a heparin lock is not included in the average fluid intake calculation. The amount of fluid in an IV piggyback solution is included in the calculation.

## SECTION L. ORAL/DENTAL STATUS

### L1. Oral Status and Disease Prevention (7-day look back)

**Intent:** To document the resident's oral and dental status as well as any problematic conditions.

- a. **Debris (Soft, Easily Movable Substances) Present in Mouth Prior to Going to Bed at Night**
- b. **Has Dentures or Removable Bridge**
- c. **Some/All Natural Teeth Lost-Does Not Have or Does Not Use Dentures (or Partial Plates)**
- d. **Broken, Loose, or Carious Teeth**
- e. **Inflamed Gums (Gingiva); Swollen or Bleeding Gums; Oral Abscesses; Ulcers, Rashes or Lesions**
- f. **Daily Cleaning of Teeth/Dentures or Daily Mouth Care-by Resident or Staff**
- g. ***NONE OF ABOVE***

**Definition:** **Carious** - Pertains to tooth decay and disintegration (cavities).

**Process:** Ask the resident, and examine the resident's mouth. Ask direct care staff if they have noticed any problems.

**Coding:** Check all that apply. If none apply, check *NONE OF ABOVE*.

## SECTION M. SKIN CONDITION

To determine the condition of the resident's skin, identify the presence, stage, type, and number of ulcers, and document other problematic skin conditions. Additionally, to document any skin treatments for active conditions as well as any protective or preventive skin or foot care treatments the resident has received in the last seven days. **Skin does not include eyes or oral mucosa.**

For the MDS assessment, staging of ulcers should be coded in terms of what is seen (i.e., visible tissue) during the look back period. For example, a healing Stage 3 pressure ulcer that has the appearance (i.e., presence of granulation tissue, size, depth, and color) of a Stage 2 pressure ulcer must be coded as a "2" for purposes of the MDS assessment. Facilities certainly may adopt the National Pressure Ulcer Advisory Panel (NPUAP) standards in their clinical practice. However, the NPUAP standards cannot be used for coding on the MDS.

### M1. Ulcers (7-day look back)

**Intent:** To record the number of skin ulcers, at each ulcer stage, on any part of the body.

**Definition:** For coding in this section, a skin ulcer can be defined as a local loss of epidermis and variable levels of dermis and subcutaneous tissue, or in the case of Stage 1 pressure ulcers, persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. Skin ulcers that develop because of circulatory problems or pressure are coded in item M1. Rashes without open areas, burns, desensitized skin, ulcers related to diseases such as syphilis and cancer, and surgical wounds are **NOT** coded here, but are included in Item M4. Skin tears/shears are coded in Item M4 unless pressure was a contributing factor.

- a. **Stage 1.** A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.
- b. **Stage 2.** A partial thickness loss of skin layers that presents clinically as an abrasion, blister, scab or shallow crater.
- c. **Stage 3.** A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.
- d. **Stage 4.** A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

**Process:** Review the resident's record and consult with the nurse assistant about the presence of any skin ulcers. Examine the resident and determine the stage and number of any ulcers present. Without a full body check, a skin ulcer can be missed.

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### M3. History of Resolved/Cured Ulcers (90 days ago)

- Intent:** To determine if the resident previously had a skin ulcer that was resolved or cured during the past 90 days. Identification of this condition is important because it places the resident at risk for development of subsequent ulcers. The definition of “skin ulcer” for this item is the same as the definition used for item M1.
- Process:** Review clinical records, including the last Quarterly or Medicare PPS assessment.
- Coding:** Code “0” for No or “1” for Yes.

### M4. Other Skin Problems or Lesions Present (7-day look back)

- Intent:** To document the presence of skin problems or lesions (other than pressure or circulatory skin ulcers) and conditions that are risk factors for more serious problems. **Skin does not include eyes or oral mucosa.**
- Definition:**
- a. **Abrasions, Bruises** - Includes skin scrapes, skin shears, skin tears not penetrating to subcutaneous tissue (also see M4f), ecchymoses, localized areas of swelling, tenderness and discoloration.
  - b. **Burns (Second or Third Degree)** - Includes burns from any cause (e.g., heat, chemicals) in any stage of healing. This category does not include first degree burns (changes in skin color only).
  - c. **Open Lesions/Sores (e.g. cancer lesions)** - Code in M4c any skin lesions that are not coded elsewhere in Section M. Include skin ulcers that developed as a result of diseases and conditions such as syphilis and cancer. Do NOT code skin tears or cuts here.
  - d. **Rashes (e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster)** - Includes inflammation or eruption of the skin that may include change in color, spotting, blistering, etc. and symptoms such as itching, burning, or pain. Record rashes from any cause (e.g., heat, drugs, bacteria, viruses, contact with irritating substances such as urine or detergents, allergies, shingles, etc.). Intertrigo refers to rashes (dermatitis) within skin folds.
  - e. **Skin Desensitized to Pain or Pressure** - The resident is unable to perceive sensations of pain or pressure.

Review the resident’s record for documentation of impairment of this type. An obvious example of a resident with this problem is someone who is comatose. Other residents at high risk include those with quadriplegia, paraplegia, hemiplegia or hemiparesis, peripheral vascular disease and

neurological disorders. In the absence of documentation in the clinical record, sensation can be tested in the following way:

- To test for pain, use a new, disposable safety pin or wooden “orange stick” (usually used for nail care). Always dispose of the pin or stick after each use to prevent contamination.
  - Ask the resident to close his or her eyes. If the resident cannot keep his or her eyes closed or cannot follow directions to close eyes, block what you are doing (in local areas of legs and feet) from view with a cupped hand or towel.
  - Lightly press the pointed end of the pin or stick against the resident’s skin. Do not press hard enough to cause pain, injury, or break in the skin. Use the pointed and blunt ends of the pin or stick alternately to test sensations on the resident’s arms, trunk, and legs. Ask the resident to report if the sensation is “sharp” or “dull.”
  - Compare the sensations in symmetrical areas on both sides of the body.
  - If the resident is unable to feel the sensation, or cannot differentiate sharp from dull, the area is considered desensitized to pain sensation.
  - For residents who are unable to make themselves understood or who have difficulty understanding your directions, rely on their facial expressions (e.g., wincing, grimacing, surprise), body motions (e.g., pulling the limb away, pushing the examiner) or sounds (e.g., “Ouch!”) to determine if they can feel pain.
  - Do not use pins with agitated or restless residents. Abrupt movements can cause injury.
- f. **Skin Tears or Cuts (Other Than Surgery)** - Any traumatic break in the skin penetrating to subcutaneous tissue. Examples include skin tears, skin shears, lacerations, etc. Code skin tears or cuts that do not penetrate to the subcutaneous tissue in M4a.
- g. **Surgical Wounds** - Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. This category does not include **surgical wounds of the eyes or oral mucosa**, healed surgical sites, stomas, or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.
- h. **NONE OF ABOVE**

**Process:** Ask the resident if he or she has any problem areas. Examine the resident. Ask the nurse assistant. Review the resident’s record.

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**Coding:** Determine the proper response for each skin condition identified in the assessment. Multiple items may be checked only when coding for multiple skin conditions. For example, a skin tear can be coded in either M4a or M4f, not both. Pressure or stasis ulcers coded in M2 should **NOT** be coded here. If there is no evidence of such problems in the last seven days, check *NONE OF ABOVE*.

**Clarification:** ♦ It may be difficult to distinguish between an abrasion and a skin tear/shear if you did not witness the injury. Use your best clinical judgment to code the wound.

## M5. Skin Treatments (7-day look back)

**Intent:** To document any specific or generic skin treatments the resident has received in the past seven days.

- Definition:**
- a. **Pressure Relieving Device(s) for Chair** - Includes gel, air (e.g., Roho), or other cushioning placed on a chair or wheelchair. Include pressure relieving, pressure reducing, and pressure redistributing devices. Do not include egg crate cushions in this category.
  - b. **Pressure Relieving Device(s) for Bed** - Includes air fluidized, low air loss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Include pressure relieving, pressure reducing, and pressure redistributing devices. Do not include egg crate mattresses in this category.
  - c. **Turning/Repositioning Program** - Includes a continuous, 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."
  - d. **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. Vitamins and minerals, such as Vitamin C and Zinc, which are used to manage a potential or active skin problem, should be coded here.
  - e. **Ulcer Care** - Includes any intervention for treating skin problems coded in M1, M2, and/or M4c. Examples include use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.
  - f. **Surgical Wound Care** - Includes any intervention for treating or protecting any type of surgical wound. Examples of care include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture removal, and warm soaks or heat application.