

**COMMON MDS
CODING ERRORS**

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OVERVIEW OF SS/ACT SECTIONS

- Section B – Vision, Speech, Hearing
- Section C – Cognitive Patterns
- Section D – Mood
- Section E – Behaviors
- Section F – Preferences
- Section Q – Participation in Assmt and Goal Setting (Discharge Planning)

SECTION B

- B0200 - Hearing
- Residents who are unable to respond to a standard hearing assessment due to cognitive impairment will require alternate assessment methods.
- The resident can be observed in their normal environment. Does he or she respond (e.g., turn his or her head) when a noise is made at a normal level? Does the resident seem to respond only to specific noise in a quiet environment? Assess whether the resident responds only to loud noise or do they not respond at all.

SECTION B

- B0600: Speech Clarity
- Determine the quality of the resident's speech, not the content or appropriateness—just words spoken.

Coding Instructions

- **Code 0, clear speech:** if the resident usually utters distinct, intelligible words.
- **Code 1, unclear speech:** if the resident usually utters slurred or mumbled words.
- **Code 2, no speech:** if there is an absence of spoken words.

SECTION B – B0700

- **DEFINITION - MAKES SELF UNDERSTOOD** - Able to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language, whether in speech, writing, sign language, gestures, or a combination of these.
- Deficits in the ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and/or gesturing.

SECTION B – B0700

- **Code 0, understood:** if the resident expresses requests and ideas clearly.
- **Code 1, usually understood:** if the resident has difficulty communicating some words or finishing thoughts **but** is able if prompted or given time. He or she may have delayed responses or may require some prompting to make self understood.
- **Code 2, sometimes understood:** if the resident has limited ability but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, toilet).
- **Code 3, rarely or never understood:** if, at best, the resident's understanding is limited to staff interpretation of highly individual, resident-specific sounds or body language (e.g., indicated presence of pain or need to toilet).

MDS INTERVIEWS

- You **MUST ATTEMPT** MDS interviews if a resident is understood, usually understood, or sometimes understood – from B0700
- Even if you think a resident will not be able to complete the interview, you still must attempt
- Section B – you may code some areas as dashes if you cannot adequately assess
- 3 is the default code for vision if unable to assess

SECTION C

- Biggest mistakes:
- Interviewer not repeating words with category cues
- Interviewer giving hints
- Interviewer allowing others to give hints
- Any questions?
- Any questions about delirium section?

SECTION C - DECISION MAKING

- **DAILY DECISION MAKING – how is this defined?**
- Includes: choosing clothing; knowing when to go to meals;
- using environmental cues to organize and plan (e.g., clocks, calendars, posted event notices);
- in the absence of environmental cues, seeking information appropriately (i.e. not repetitively) from others in order to plan the day;
- using awareness of one's own strengths and limitations to regulate the day's events (e.g., asks for help when necessary);
- acknowledging need to use appropriate assistive equipment such as a walker.

SECTION C - DECISION MAKING

- The intent of this item is to record what the resident is doing (performance).
- Focus on whether or not the resident is actively making these decisions and not whether staff believes the resident might be capable of doing so.
- Focus on the resident's actual performance. Where a staff member takes decision-making responsibility away from the resident regarding tasks of everyday living, or the resident does not participate in decision making, whatever his or her level of capability may be, the resident should be coded as impaired performance in decision making.

SECTION C - DECISION MAKING

- **Coding Instructions**
- Record the resident's actual performance in making everyday decisions about tasks or activities of daily living. Enter one number that corresponds to the most correct response.
- **Code 0, independent:** if the resident's decisions in organizing daily routine and making decisions were consistent, reasonable and organized reflecting lifestyle, culture, values.
- **Code 1, modified independence:** if the resident organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision making when faced with new tasks or situations.
- **Code 2, moderately impaired:** if the resident's decisions were poor; the resident required reminders, cues, and supervision in planning, organizing, and correcting daily routines.
- **Code 3, severely impaired:** if the resident's decision making was severely impaired; the resident never (or rarely) made decisions.

SECTION C - DECISION MAKING

- **Coding Tips**
- If the resident "rarely or never" made decisions, despite being provided with opportunities and appropriate cues, Item C1000 would be **coded 3, severely impaired**. If the resident makes decisions, although poorly, **code 2, moderately impaired**.
- Resident's considered decision to exercise his or her right to decline treatment or recommendations by interdisciplinary team members should **not** be captured as impaired decision making in Item C1000, **Cognitive Skills for Daily Decision Making**.

SECTION D

- Biggest mistakes:
- Not doing the interview
- Not asking the questions verbatim
- Not doing the interview on or before the ARD
- Asking questions too fast
- Asking questions with no concern or care
- Coaching the resident to get a desired response
- Not following up to issues voiced during interview

EXAMPLE

- This is an example of a facility not doing the mood interviews

Medicare Nursing Home Profile			
<i>are better.</i>			
Percent of long-stay residents who have depressive symptoms. <i>Lower percentages are better.</i>	0.0%	1.9%	6.2%

SECTION D INSTRUCTIONS

- Look-back period for this item is 14 days.
- Conduct the interview preferably the day before or day of the ARD.
- Conduct the interview in a private setting.
- If an interpreter is used during resident interviews, the interpreter should not attempt to determine the intent behind what is being translated, the outcome of the interview, or the meaning or significance of the resident's responses. Interpreters are people who translate oral or written language from one language to another.
- Sit so that the resident can see your face. Minimize glare by directing light sources away from the resident's face.

SECTION D INSTRUCTIONS

- Be sure the resident can hear you.
- Residents with a hearing impairment should be tested using their usual communication devices/techniques, as applicable.
- Try an external assistive device (headphones or hearing amplifier) if you have any doubt about hearing ability.
- Minimize background noise.
- 7. If you are administering the PHQ-9© in paper form, be sure that the resident can see the print. Provide large print or assistive device (e.g., page magnifier) if necessary.

SECTION D INSTRUCTIONS

- 8. Explain the reason for the interview before beginning.
- Suggested language: "I am going to ask you some questions about your mood and feelings over the past 2 weeks. I will also ask about some common problems that are known to go along with feeling down. Some of the questions might seem personal, but everyone is asked to answer them. This will help us provide you with better care."

SECTION D INSTRUCTIONS

- 9. Explain and /or show the interview response choices. A cue card with the response choices clearly written in large print might help the resident comprehend the response choices.
- Suggested language: "I am going to ask you how often you have been bothered by a particular problem over the last 2 weeks. I will give you the choices that you see on this card."
- (Say while pointing to cue card): "0-1 days—never or 1 day, 2-6 days—several days, 7-11 days—half or more of the days, or 12-14 days—nearly every day."

SECTION D INSTRUCTIONS

- 10. Interview the resident.
- Suggested language: "Over the last 2 weeks, have you been bothered by any of the following problems?"
- Then, for each question in Resident Mood Interview (D0200):
- Read the item as it is written.
- Do not provide definitions because the meaning must be based on the resident's interpretation. For example, the resident defines for himself what "fired" means; the item should be scored based on the resident's interpretation.

SECTION D INSTRUCTIONS

- Each question must be asked in sequence to assess presence (column 1) and frequency (column 2) before proceeding to the next question.
- Enter code 9 for any response that is unrelated, incomprehensible, or incoherent or if the resident's response is not informative with respect to the item being rated; this is considered a nonsensical response

SECTION D INSTRUCTIONS

- Staff assmt:
- Interview staff from all shifts who know the resident best. Conduct interview in a location that protects resident privacy.
- The same administration techniques outlined above for the PHQ-9© **Resident Mood Interview** (pages D-4-D-6) and Interviewing Tips & Techniques (pages D-6-D-8) should also be followed when staff are interviewed.

SECTION D

- The following should be addressed in SS documentation AND in the plan of care:
- Dx of depression, anxiety, or other mental health issue
- Mood indicators voiced during the mood interview
- Mood indicators observed by staff (not necessarily voiced during the mood interview)
- Any underlying issue that a psychotropic medication is prescribed for

SECTION E

- Biggest mistakes:
- Not looking at chart documentation for look back period
- Not understanding the definitions of the behaviors
- Not interviewing staff to determine if there have been behaviors that have not been documented
- If there are behaviors reported that have not yet been documented, either have nursing make a late entry, or include the reported behavior(s) in social service assmt note
- For annual assessments, refer to the RAI if/when needed to clarify impact to resident and others

SECTION E

- **Definition of Hallucination** - The perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch.
- **Definition of Delusion** - fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary.
- The RAI does not further define behaviors listed in E0200 on the MDS (physical, verbal, other)
- Use your clinical judgment, but be able to defend your rationale for your coding

SECTION E - 0800

- Rejection of Care – E0800
- Definition – Rejection of Care – behavior that interrupts or interferes with the delivery or receipt of care. May be verbal decline, statements of refusal, or physical behaviors that convey aversion to or result in avoidance of or interfere with the receipt of care
- Definition – Interference with Care – hindering the delivery or receipt of care by disrupting the usual routines or processes by which care is given, or by exceeding the level or intensity of resources that are usually available for the provision of care

SECTION E - 0800

- This is defined as rejection of care that is necessary to achieve the resident's goals for health and well-being
- Goals for health and well-being reflect the resident's wishes and objectives for health, function, and life satisfaction that define an acceptable quality of life for that individual.
- The resident's care preferences reflect desires, wishes, inclinations, or choices for care.
- Preferences do not have to appear logical or rational to the clinician.
- Similarly, preferences are not necessarily informed by facts or scientific knowledge and may not be consistent with "good judgment."

SECTION E - 0800

- It is really a matter of resident choice. When rejection/decline of care is first identified, the team then investigates and determines the rejection/decline of care is really a matter of resident's choice. Education is provided and the resident's choices become part of the plan of care.
- On future assessments, this behavior would not be coded in this item.
- A resident might reject/decline care because the care conflicts with his or her preferences and goals. In such cases, care rejection behavior is not considered a problem that warrants treatment to modify or eliminate the behavior.

SECTION E

- Wandering E1000 – not well defined in the RAI. Read the definition and use clinical judgment
- Change in behavior E1100 – technically this should be based on MDS coding, not on a general assmt
- E1100 answered only on comprehensive assmts

SECTION F

- Biggest mistakes:
- Not asking the questions
- Not using response choice prompts
- Not care planning/informing direct care staff of preferences
- If resident is able to be understood, you should interview them
- If resident cannot complete interview, family is next option
- Staff assmt is last option

F0300

- F0300: Should Interview for Daily and Activity Preferences Be Conducted?
- **Coding Instructions**
- Record whether the resident preference interview should be attempted.
- **Code 0, no:** if the interview should not be attempted with the resident. This option should be selected for residents who are rarely/never understood, who need an interpreter but one was not available, and who do not have a family member or significant other available for interview. Skip to F0800, (Staff Assessment of Daily and Activity Preferences).
- **Code 1, yes:** if the resident interview should be attempted. This option should be selected for residents who are able to be understood, for whom an interpreter is not needed or is present, or who have a family member or significant other available for interview.

SECTION F

- No look-back is provided for resident. He or she is being asked about current preferences while in the nursing home but is not limited to a 7-day look-back period
- The facility is still obligated to complete the assessment within the 7-day look-back period.

SECTION F

- Definitions:
- Bed bath – bath taken in bed using wash clothes and a water basin or other method
- Sponge bath – bath taken sitting or standing at sink
- Shower – bath taken standing, using a shower chair, or using a gurney in the shower
- Bath – bath taken in a bath tub

SECTION Q

- Many mistakes in this section
- The family or legal representative participating in assmt
- This means all of the assmt, not just SS sections
- Q0100 C - Do not code 9, no legal representative, if the resident has a HC agent
- Do not code 0 or 1 if the resident does not have a HC agent

SECTION Q

- Q0300 – Resident’s overall expectations
- **Code 2, expects to remain in this facility:** if the resident indicates that he or she expects to remain in the nursing home.
- **Code 3, expects to be discharged to another facility/institution:** if the resident expects to be discharged to another nursing home, rehabilitation facility, or another institution.
- This item is individualized and resident-driven rather than what the nursing home staff judge to be in the best interest of the resident. This item focuses on exploring the resident’s expectations; not whether or not the staff considers them to be realistic or not.

SECTION Q

- Q0400 – Discharge Plan
- Code 1 if the plan is short term placement and you are planning on discharge to the community, even if you are not actively setting up discharge services
- If you are not sure about discharge plans, code 0

SECTION Q - CARE PLANNING

- If there are plans for discharge, the care plan should include:
- the name and contact information of a primary care provider chosen by the resident, family, significant other, guardian or legally authorized representative
- arrangements for the durable medical equipment (if needed)
- formal and informal supports that will be available, the persons and provider(s) in the community who will meet the resident’s needs, and the place the resident is going to be living.
- See RAI for instructions of what to include for discharge instructions

SECTION Q

- Q0490 – Does clinical record document resident's preference that Q0500B be asked only on comprehensive assmts?
- Answer yes only if/when there is documentation in the chart that resident only wants to be asked about discharge on comprehensive assmts
- Also, make sure clinical documentation honors resident preferences if resident is able to make his/her own decisions

SECTION Q

- If Q0490 is coded 0, No, ask again if resident wants to talk to someone about discharge to the community and record the response (Q0500)
- Answering yes does not commit the resident to leave the nursing home at a specific time; nor does it ensure that the resident will be able to move back to the community.
- Answering no is also not a permanent commitment. Also inform the resident that he or she can change his or her decision (i.e., whether or not he or she wants to speak with someone) at any time.

SECTION Q

- A "yes" response to item Q0500B will trigger follow-up care planning and contact with the designated local contact agency about the resident's request within approximately 10 business days of a yes response being given.
- This code is intended to initiate contact with the local agency for follow-up as the resident desires.

SECTION Q

- Q0550 - Resident's Preference to Avoid Being Asked Question Q0500B again
- If the resident answers no, that he or she does not want to be asked again on quarterly assessments about returning to the community, then document in resident's clinical record and ask question Q0500B again only on the next comprehensive assessment.

SECTION Q

- If the resident wants to talk to somebody about return to the community, make a referral to the LCA
- How to make a referral to LCA
- The LCA contact referral for email is: gclportal@medicaid.alabama.gov
- Also there is an online referral system: <https://gclportal.medicaid.alabama.gov/>
- If there are any questions, Ann Duncan can assist you. She can be reached at [334-353-3273](tel:334-353-3273).
- Website general information:
- http://www.medicaid.alabama.gov/CONTENT/4.0_Programs/4.3.0_LTC/4.3.5_Gateway_To_Living.aspx
- I recommend also sending a cc email to your local Ombudsman if/when you make a referral to the LCA.
- Care plan per RAI guidelines
- Make sure to document!

ANY QUESTIONS?



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