

MDS Coding Tips Sheet

Includes terminology and definitions from RAI Manual Section J, P, State Operations Manual and Appendix PP. Refer to RAI Manual for more details.

MDS FALL CODING

DEFINITION: Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital, or a nursing home. Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident). An intercepted fall occurs when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person – this is still considered a fall. (RAI Manual J-27)

CODING (RAI MANUAL J 27-33):

1. J1700A - Did the resident have a fall any time in the last month prior to admission/entry or reentry
2. J1700B - Did the resident have a fall any time in the last 2-6 months prior to admission/entry or reentry
3. J1700C - Did the resident have any fracture related to a fall in the 6 months prior to admission/ entry or reentry
4. J1800 - Any falls since admission/entry or prior assessment (OBRA or scheduled PPS) whichever is more recent.
5. J1900 - Number of falls since admission/entry or prior assessment (OBRA or scheduled PPS) whichever is more recent.
6. J1900A - No injury
7. J1900B - Injury (Except major)
8. J1900C - Major Injury

PROCESS:

1. Complete J1700 only if it is the first assessment since admission/entry or reentry.
2. Complete J1800 and J1900 from admission to the ARD date of the first assessment and then subsequent assessments from the day after the ARD of the last assessment to the ARD of the current assessment.
3. Review all available resources since the last assessment, for example, the medical record (physician, nursing, and therapy notes) including nursing home incident reports.
4. Question the resident, staff, and family about any falls that may have occurred during the look back period.
5. Include any information as to if the resident had sustained multiple injuries for a single fall, code the fall for the highest level of injury in J1900.

PLANNING FOR CARE:

1. Identify residents who are high risk for falls as a top priority for care planning.
2. Falls indicate functional decline and other serious conditions such as delirium, adverse drug reactions, dehydration, and infections.
3. External risk factors include medication side effects, use of appliance/equipment , restrictive devices, and environmental factors. A fall should stimulate evaluation of the resident's need for rehabilitation or the need for ambulatory aids, increased monitoring, or assessment, and /or modification of the physical environment.

MDS SKIN Condition

DEFINITION: Pressure ulcer localized to skin and/or underlying tissue usually over bony prominence, as a result of pressure or pressure in combination with shear and/or friction. (RAI Manual, Pg M-4)

CODING

1. M0100/ M0150- Determination of Pressure Ulcer Risk /Risk of Pressure Ulcer
2. M0210 - Unhealed Pressure Ulcer(s)
3. M0300 - Current number of Unhealed Pressure Ulcers at Each Stage
4. M0610 - Dimensions of Unhealed Stage 3 or 4 PU or eschar
5. M0700 - Most Severe Tissue Type for Any Pressure Ulcer
6. M0800 - Worsening in PU Status since prior assessment or last Admission or Reentry
7. M0900 - Healed PU
8. M1030 - Number of Venous and Arterial Ulcers
9. M1040 - Other Ulcers, Wounds and Skin Problems
10. M1200 - Skin and Ulcer Treatments

PROCESS

1. Determine steps taken to assess pressure ulcer risk.
2. Review record and check with appropriate nursing staff for presence of skin problems.
3. Document PU stage, dimensions, tissue type and worsening in M0300-M0900. Must use CMS definitions, not NPUAP (National Pressure Ulcer Advisory Panel).
4. Include in M1030 number of venous or arterial ulcers.
5. Include in M1040 this specific subset of skin conditions.
6. Include in M1200 skin treatments which include prevention and skin health intervention.

CLARIFICATION

1. Good clinical practice dictates that ulcer be re-examined and re-staged after debridement.
2. If ulcer arises from combination of problems but **primary** cause is pressure, code as pressure ulcer.
3. If a skin ulcer is repaired with a flap graft, it is coded as a surgical wound and not as a skin ulcer.
4. If in M0700 the most severe PU is a Stage II it must be coded at a 1 epithelial tissue.
5. M0800: If a pressure ulcer worsens to a more severe stage during a hospital admission, it should also be coded "present on admission" and not included in counts of worsening pressure ulcers.
6. Pressure Ulcers are not to be reversed staged as they heal.
7. Do not code pressure ulcers that have been surgically debrided as surgical wounds.
8. If skin ulcers/conditions are captured in section M, good clinical practice would also have something documented in M1200 under treatment.

DOCUMENTATION

1. For clinical practice facilities need to follow the NPUAP standards in regards to pressure ulcer documentation.
2. Document weekly assessments of the wound healing progress or lack of. Documentation should include a thorough description of size, drainage, stage, most severe tissue type, etc.
3. Care planning should identify risk factors and interventions based on the identified level of risk, as well as interventions to facilitate healing of existing skin problems.

MDS RESTRAINT CODING

DEFINITION: Any manual method, or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. (RAI Manual, P-1) (State Operations Manual, Appendix PP)

PROCESS:

1. Review resident's medical record (e.g., physician orders, nurses' notes, nursing assistant documentation); determine if restraints were used during the 7-day look-back period.
2. Consult nursing staff to determine resident's cognitive and physical status/limitations.
3. Considering physical restraint definition , observe the resident to determine the effect the restraint has on the resident's normal function. Do not focus on the type of device, intent, or reason behind the use of the device.
4. Evaluate whether resident can easily and voluntarily remove device, material, or equipment—if resident can't, continue with assessment to determine whether device restricts freedom of movement or the resident's access to his or her own body.
5. Device classifies as a restraint only when it meets criteria of the restraint definition. This can only be determined on a case-by-case basis by individually assessing each and every device (whether or not it is listed specifically on the MDS) and its effect on the resident.
6. Determine if device, material, or equipment meets the definition of a physical restraint as clarified below. Decision about coding any device, material, equipment, or physical or manual method as a restraint depends on the effect the device has on the resident.
7. Any device, material, or equipment that meets definition of a physical restraint must have:
 - physician documentation of a medical symptom that supports the use of the restraint,
 - physician's order for the type of restraint and parameters of use, and
 - care plan and process in place for systematic gradual restraint reduction or elimination.

To determine if the device is listed in MDS Item P0100 Physical Restraints:

- | | |
|---------------------|-------------------------------------|
| - Used in Bed (A-D) | - Used in Chair or Out of Bed (E-F) |
| A. Bed rail | E. Trunk restraint |
| B. Trunk restraint | F. Limb restraint |
| C. Limb restraint | G. Chair prevents rising |
| D. Other | H. Other |

After determining if a device listed in (P0100) is a restraint and was used during the 7-day look-back period, code the frequency of use:

1. **Code 0, not used:** if the device was not used during the 7-day look-back or it was used but did not meet the definition.
2. **Code 1, used less than daily:** if the device met the definition and was used less than daily.
3. **Code 2, used daily:** if the device met the definition and was used on a daily basis during the look-back period.

DOCUMENTATION:

1. If the device or situation meets the definition of a restraint, a physician's order and the medical reason for the restraint are required.
2. Inform the family of the risks and benefits of the device and documentation of the conversation.
3. Record the team evaluation and process for how it was determined to use that particular device for that resident.
4. Care plan for the effects of any device or situation whether it meets the definition of a restraint or not.