Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

A REVIEW OF NURSING FACILITY RESOURCE UTILIZATION GROUPS

Daniel R. Levinson
Inspector General

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EXECUTIVE SUMMARY

OBJECTIVE

To determine the extent to which Resource Utilization Groups (RUGs) on claims submitted by nursing facilities are different from those generated based on evidence in the medical record.

BACKGROUND

This inspection is a followup to a 2001 Office of Inspector General report entitled "Nursing Home Resident Assessment, Resource Utilization Groups" (OEI-02-99-00041). That report found both upcoding and downcoding differences between the RUGs submitted by the skilled nursing facilities and those generated based on a review of the medical record. It further noted that these problems needed continued attention and that we planned to revisit them after the prospective payment system had been implemented.

Medicare pays for Part A skilled nursing facility stays based on a prospective payment system that categorizes each resident into a payment group depending upon his or her care and resource needs. These groups are called RUGs. Skilled nursing facilities determine a RUG based on 108 items on an assessment of the resident known as the Minimum Data Set (MDS). The Centers for Medicare & Medicaid Services (CMS) requires skilled nursing facilities to complete the MDS for each resident covered by Medicare Part A by approximately the 5th, 14th, and 30th day of the resident's stay, and every 30 days thereafter, as appropriate. CMS considers the MDS to be part of the medical record and expects information contained in the rest of the medical record to support the MDS.

The results of this inspection are based on an independent review of the MDS and other documentation in the medical record for a random sample of 272 claims submitted by skilled nursing facilities and from interviews with staff who are responsible for completing the MDS at the skilled nursing facilities.

The reviewers determined whether the responses submitted by skilled nursing facilities on the 108 MDS items used to generate the RUG were consistent with documentation in the rest of the medical record. If a particular response to an MDS item was not consistent with the rest of the medical record, the reviewer recoded that item and used the recoded item to calculate a new RUG.

For each resident, reviewers made a determination based on the documentation available. If they did not find any documentation in the medical record or the medical record contained information that was not clear enough to make a judgment, they did not make an independent determination.

This inspection does not determine the extent to which claims submitted by skilled nursing facilities are medically necessary or adequately supported by medical documentation. It is limited in scope to whether the MDS is consistent with the rest of the medical record.

FINDINGS

Twenty-six percent of RUGs on claims were different from the ones generated based on evidence in the medical record. Based on a comparison of the MDS and the rest of the medical record, we found that 26 percent of RUGs on claims submitted by skilled nursing facilities (71 of the 272 claims in our sample) were different from the ones generated based on evidence in the rest of the medical record. More specifically, 22 percent of claims, or 59 of the 272 claims in our sample, had a RUG with a higher associated payment rate than the one generated based on evidence in the medical record. These differences represented potential overpayments. The remaining 4 percent of claims, or 12 of the 272 claims in our sample, had a RUG with a lower associated payment rate than the one generated based on evidence in the medical record, representing potential underpayments.

To determine the potential effects of these differences on total Medicare payments, we calculated the net difference between the payment amounts for the RUGs on the claims submitted by nursing facilities and the payment amounts for RUGs generated from evidence in the medical record. The net difference represented $542 million in potential Medicare overpayments for fiscal year 2002, when projected to all claims with RUGs generated from a 5-day, 14-day, or 30-day MDS assessment.

Minimum Data Set items that require look-back periods, multiple assessors, or calculations contributed to differences in RUGs. RUGs are generated from 108 items on the MDS resident assessment. In the 71 claims in our sample that had a RUG different from the one generated based on evidence in the medical record, 11 MDS items accounted for 54 percent of all such instances. These 11 items had one or more of the following characteristics: a look-back period (i.e., observation over time), multiple assessors (i.e., assessment by two or more staff), or calculations.

RECOMMENDATION

We recommend that CMS take steps to ensure that skilled nursing facilities complete the MDS accurately and assign each resident to the correct RUG. These steps could include (1) continuing the type of analysis conducted by the Data Assessment and Verification (DAVE) project and (2) more carefully examining the 11 MDS items that we found were most often inconsistent with the rest of the medical record.

In addition, we have forwarded to CMS for appropriate action information on the 71 claims in our sample that had a RUG with a payment rate different from the one generated based on evidence in the medical record.

AGENCY COMMENTS

CMS concurred with our recommendation. CMS sees this report as showing a significant improvement in the assignment of RUG categories at the facility level compared to our 2001 report. CMS commented that it would continue current efforts to improve the accuracy of the MDS and has taken, or agreed to take, the following actions:

- CMS recently awarded a contract to expand upon the DAVE project, called DAVE2. The purpose of this new project is to assess the accuracy and reliability of national CMS data through focused onsite reviews of the MDS assessment.
- CMS will take the findings of this report into consideration in developing a Web-based training program for the Resident Assessment Instrument Manual.
- CMS will maintain ongoing communications with stakeholders, such as State and regional staff, consultants, and trade associations, regarding the MDS.

- CMS will have fiscal intermediaries and Program Safeguard Contractors continue to assess MDS information through the routine medical review process.
- CMS will incorporate the findings of this report into educational efforts to improve the accuracy of the MDS.

OFFICE OF INSPECTOR GENERAL RESPONSE

We agree with the actions CMS plans to take to improve the accuracy of the MDS. However, it is important to note that, because of methodological differences, the results of this report cannot be compared to the results of the previous OIG report.

The methodologies of the two reports differed in two main ways. First, for the previous report, reviewers completed an MDS based on the resident's medical record without referring to the original MDS and then compared the results of the two assessments. In its comments to the previous report, CMS noted that the MDS is a part of the medical record. Therefore, for the current report, the reviewers included the MDS in their review of the medical record. They compared the original MDS to the rest of the medical record to determine whether they were consistent. Second, for the previous report, we only reviewed the 14-day MDS, while for the current report we reviewed the 5-day, 14-day, and 30-day MDS assessments. Because of these differences, the current report cannot necessarily be used as evidence to show that MDS accuracy has improved over time.

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INTRODUCTION

OBJECTIVE

To determine the extent to which Resource Utilization Groups (RUGs) on claims submitted by nursing facilities are different from those generated based on evidence in the medical record.

BACKGROUND

This inspection is a followup to a 2001 Office of Inspector General report entitled "Nursing Home Resident Assessment, Resource Utilization Groups" (OEI-02-99-00041). That report found both upcoding and downcoding differences between RUGs submitted by the skilled nursing facilities and those generated based on a review of the medical record. Specifically, it found that 46 percent of residents in an overall sample of 640 received an upcoded RUG, whereas 30 percent of residents received a downcoded RUG. It further noted that these problems needed continued attention and that we planned to revisit them after the prospective payment system had been implemented.

This inspection determines the extent to which RUGs on claims submitted by skilled nursing facilities are different from the ones that would be generated based on evidence in the medical record. The results of this review are determined from an independent review of the resident assessment known as the Minimum Data Set (MDS) and looks at whether the responses on the MDS are consistent with other documentation in the medical record.

Resource Utilization Groups

Medicare pays skilled nursing facilities a daily rate to cover services provided to Medicare residents during each day of a covered skilled nursing facility stay. Medicare pays skilled nursing facilities based on a prospective payment system that categorizes each resident into a different group depending upon his or her care and resource needs. These groups are called RUGs, and each represents a different Medicare payment rate. CMS requires that each covered resident be correctly assigned to one of the RUGs designated as representing the required level of care.[1]

Skilled nursing facilities determine each resident's RUG based on the MDS. The Social Security Act, as amended by the Omnibus Budget

[1] 42 CFR § 424.20(a)(ii).

Reconciliation Act of 1987, requires Medicare skilled nursing facilities to complete the MDS for each resident.[2] CMS further requires that the MDS be completed by the 5th, 14th, and 30th day of the resident's stay, and every 30 days thereafter, as appropriate for each resident covered by Medicare Part A.[3] CMS also requires that the MDS be conducted or coordinated by a registered nurse in the skilled nursing facility. See Appendix A for a copy of the MDS.

There are 553 items on the MDS. Data from 108 of the items are used to determine the RUG and, therefore, the payment rate for each resident covered in a Medicare Part A stay. There are seven major RUG categories: Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Function. These categories are further divided into 44 subcategories, each of which has a different Medicare payment rate. See Appendix B for a list of the RUGs.

CMS considers the MDS to be part of the medical record and does not require duplicative documentation.[4] CMS expects that information contained in the rest of the medical record supports, rather than conflicts, with the MDS. Specifically, CMS's Resident Assessment Instrument Manual states that CMS expects that documentation maintained by a skilled nursing facility in a resident's medical record will "chronicle, support, and be consistent with the findings of each MDS assessment."[5] The manual further states that the MDS can be "verified by a review of the entire record to verify that the medical record supports and is consistent with the responses on the MDS."[6]

CMS oversight

CMS conducts or has conducted five main oversight activities to monitor the accuracy of the MDS:

- CMS contracts with fiscal intermediaries to process Medicare Part A skilled nursing facility claims. Fiscal intermediaries

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[2] 42 USC § 1395i-3(b)(3)(A).

[3] 63 Federal Register 26265, May 12 ,1998.

[4] Centers for Medicare & Medicaid Services, "Resident Assessment Instrument Version 2.0 Manual, FY 2002," Chapter 1.14, Clarifications Regarding Documentation Requirements, p. 1-23.

[5] Ibid.

[6] Ibid.

identify outlier payments for extensive onsite and offsite medical record reviews as part of their review of these claims.

- CMS uses its Comprehensive Error Rate Testing (CERT) Program to produce national error rates and error rates by contractor, provider type, and benefit category-specific paid claims. The project's independent medical reviewers periodically conduct medical reviews on random samples of Medicare claims.
- CMS contracts with State agencies to conduct standard surveys of nursing homes as part of the survey and certification process. The State agencies look at MDS accuracy as part of the survey.
- CMS regional offices monitor States' nursing home survey and certification processes by conducting comparative and observational surveys, both of which assess MDS accuracy.
- From 2001 to 2005, CMS contracted with Computer Science Corporation for the Data Assessment and Verification project. One of the primary goals of this project was to improve the accuracy of MDS data through the establishment of State, territory, and national MDS accuracy thresholds. The project conducted both onsite and offsite medical record reviews to determine these thresholds.[7] It has not released any findings.

[7] To do this analysis, the project selected a sample of skilled nursing facility stays which contained multiple RUGs. The project compared the RUGs based on a medical record review to the RUGs generated from the State MDS database (which are the data submitted to the National Repository), the RUGs billed on the claim, and the RUGs submitted by the skilled nursing facilities.

METHODOLOGY

Scope

This inspection determines the extent to which RUGs submitted on skilled nursing facility claims are different from the ones that would be generated based on evidence in the medical record. The results of this review are determined from an independent review of the MDS and documentation in the rest of the medical record for a random sample of 272 claims submitted by skilled nursing facilities and from interviews with staff responsible for completing the MDS at the skilled nursing facilities.

This inspection does not determine the extent to which claims submitted by skilled nursing facilities are medically necessary or adequately supported by medical documentation. It also does not compute total improper payments for nursing facilities. Rather, it focuses on whether the MDS is consistent with the rest of the medical record.

Sample

We selected a simple random sample of 300 skilled nursing facility claim line items from the National Claims History File. The population from which we selected our sample included all claim line items that contained a RUG calculated from a 5-day, 14-day, or 30-day MDS assessment that had been submitted between October 1, 2001, and September 30, 2002. We excluded 60-day and 90-day assessments, readmission/return assessments, and other Medicare- or State-required assessments from the population to simplify the medical record review. [8] For ease of presentation, we refer to claim line items as claims throughout this report. Please see Appendix C for the number of claims in each RUG for our sample.

For each of the 300 claims, we requested the resident's medical record from the skilled nursing facility for the date of admission through the first 35 days of residence. We received medical records for 272 of the 300 claims.[9] For the remaining 28 claims, we contacted each of the facilities at least three times to obtain the medical records, but we

[8] The 5-day, 14-day, and 30-day assessments represent about 87 percent of all Medicare prospective payment system MDS assessments.

[9] These claims were submitted by 267 skilled nursing facilities.

were unsuccessful. For these claims, we were unable to make key comparisons between respondents and nonrespondents because we did not have the medical records.

Medical Record Reviews

We contracted with an independent consulting firm to conduct a medical record review. The medical record reviewers, two registered nurses,[10] followed guidelines defined in the "Revised Long Term Care Resident Assessment Instrument User's Manual for the Minimum Data Set Version 2.0." They limited their review to the time period that coincided with the assessment, i.e., the assessment reference date for the 5-day, 14-day, or 30-day assessment. The reviewers also considered information from other time periods if it enhanced their understanding of the case.

The reviewers focused their review on the 108 items on the MDS that determine payment rates for Medicare Part A skilled nursing facility stays. The reviewers determined whether the responses submitted by skilled nursing facilities for these 108 MDS items were consistent with evidence in the rest of the medical record. For example, if item J1h, fever, was not indicated on the MDS, but the medical record indicated that the resident had a fever in the last 7 days, reviewers considered item J1h to be inconsistent with evidence in the rest of the medical record.[11]

The reviewers made a determination based on the documentation available. They did not draw any conclusion about an MDS item if there was no documentation in the rest of the medical record or if, for some other reason, they could not determine the appropriate response to that item. This does not mean that the MDS item was accurate, only that it was not possible to compare it to any related documentation in the medical record.

The medical record reviewers generated a new RUG for each RUG in our sample based on their review of the MDS and documentation in the rest of the medical record. The reviewers used CMS's Statistical Analytical Software program script to generate a RUG. If a particular

[10] One reviewer has a Ph.D. and the other is Masters-prepared.

[11] As explained earlier, this methodology is consistent with CMS's Resident Assessment Instrument Manual, which states that the MDS can be verified by a review of the medical record that verifies that the record supports and is consistent with the responses on the MDS.

MDS item was inconsistent with the rest of the medical record, the reviewer recoded that item based on the evidence in the rest of the medical record. Reviewers used the recoded item to recalculate the RUG. In 155 of the 272 claims, the reviewers did not find any documentation in the rest of the medical record or the medical record did not contain enough information to make a judgment for at least one item on the MDS. For these items, the reviewers did not make an independent determination. This method resulted in a conservative estimate of RUG differences.

Finally, we determined the potential effects of the RUG differences on total Medicare payments. We calculated the net difference between the payment amounts for the RUGs on the claims submitted by nursing facilities and the payment amounts for the RUGs generated from evidence in the medical record. For each RUG, we multiplied the urban payment rate[12] by the number of days on the claim and calculated the difference. We then calculated the total net difference and projected it to all claims with a RUG based on a 5-day, 14-day, and 30-day MDS assessment in fiscal year 2002.

Interviews

MDS coordinators are responsible for overseeing and processing MDS assessments for their nursing homes. We conducted a mail survey of the 300 MDS coordinators in the skilled nursing facilities with a resident in our sample of claims and received a response from 245. We asked them about their experiences with the MDS and about any problems they may have with the MDS.

Limitations

The size of our sample was not large enough to determine whether there were certain RUGs that were more likely than others to differ from those generated based on evidence in the medical record.

Standards

Our review was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

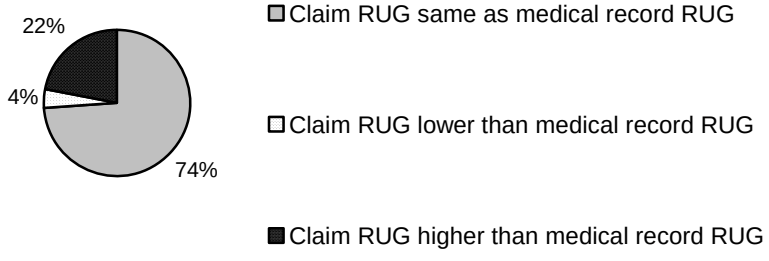
[12] There is an urban and a rural payment rate for each RUG. The urban payment rate is lower than the rural rate for the rehabilitation RUGs, which comprise 80 percent of the RUGs in our sample. We used the urban rate to provide a more conservative estimate.

Twenty-six percent of Resource Utilization Groups on claims were different from the ones generated based on evidence in the medical record

Based on a comparison of the MDS and the rest of the medical record, we found that 26 percent of RUGs on claims submitted by skilled nursing facilities (71 of 272 claims in our sample) differed from the ones generated based on evidence in the rest of the medical record. The medical record reviewers identified differences by reviewing the responses to the 108 MDS items used to generate the RUG and documentation in the rest of the medical record.

The differences between the RUGs on the claims and the ones generated based on evidence in the medical record resulted in both potential underpayments and overpayments. As shown in Chart 1, 22 percent of claims, or 59 of the 272 claims in our sample, had a RUG with a higher associated payment rate than the one generated based on evidence in the medical record. These differences represented potential overpayments. The remaining 4 percent of claims, or 12 of the 272 claims in our sample, had a RUG with a lower associated payment rate than the one generated based on evidence in the medical record, representing potential underpayments. Appendix D includes a list of the differences between the RUGs on the skilled nursing facility claims and the ones generated based on evidence in the medical record for our sample. Appendix E includes the confidence intervals for the key estimates.

CHART 1
A Comparison of Claim RUGs to Medical Record RUGs



Source: OIG medical record review, 2003.

These differences represented a net $542 million in potential Medicare overpayments for fiscal year 2002

To determine the potential effects of these differences on total Medicare payments, we calculated the net difference between the payment amounts for the RUGs on the claims submitted by nursing facilities and the payments for the RUGs generated from evidence in the medical record. We found the net difference to be about $36,000 for our sample. We then projected this estimate to all claims with a RUG based on a 5-day, 14-day, and 30-day MDS assessment in fiscal year 2002. This estimate amounted to a net $542 million in potential Medicare overpayments for fiscal year 2002.[13]

Minimum Data Set items that require look-back periods, multiple assessors, or calculations contributed to differences in Resource Utilization Groups

RUGs are generated from 108 items on the MDS. In the 71 claims in our sample that had a RUG different from the one generated based on evidence in the medical record, 11 MDS items were most frequently inconsistent with documentation in the rest of the medical record. These 11 MDS items accounted for 54 percent of the 291 total instances in which a response on the MDS was inconsistent with the rest of the medical record for the 71 claims.

These 11 MDS items have one or more of the following characteristics: a look-back period (i.e., observation over time), multiple assessors (i.e., two or more staff assess a resident to determine these items), or calculations. These measures are described below and are shown in Table 1 on page 10.

Look-back

All 11 items require that the nurse completing the MDS evaluate the resident by looking back over a period of time. For example, item P1bba is the total number of days the resident has received occupational therapy out of the last 7 days.

The look-back periods for these 11 MDS items range from 7 to 30 days and can be difficult to code. For example, one MDS coordinator noted that the varying number of days in the look-back is a particularly confusing component of the MDS process. Also, several of these

[13] In fiscal year 2002, Medicare payments to skilled nursing facilities totaled $14.2 billion.

look-back periods require information about the period prior to admission, such as when the resident was in the hospital, which can be difficult to obtain.

Determination by multiple assessors

Seven of the eleven items require a determination of the resident's performance by multiple assessors (i.e., two or more staff assess a resident to determine these items). More than 25 percent of MDS coordinators we interviewed suggested that one of the following factors may contribute to differences between the MDS and the rest of the medical record for these types of items:

- Different staff may have added varying observations of a resident's abilities to the medical record.
- A resident's condition can change daily or throughout the day, making it difficult to code these items.
- Guidelines for these measures are not always clear, causing some confusion about the appropriate coding.

Calculations

Four of the eleven items require the nurse completing the MDS to calculate the total number of treatments, therapies, or physicians' visits received by a resident during a specified time period. For example, item P1bcb requires the assessor to calculate the total number of therapy minutes the resident received during the prior 7 days.

We found that the most common issue for these items was that the number of minutes or days of therapy recorded on the MDS did not match the number recorded in the rest of the medical record. These inconsistencies may be due in part to miscalculations. For example, one MDS coordinator pointed out that it is particularly difficult to calculate the number of doctors' visits when there are multiple visits on 1 day.

Table 1: The 11 MDS Items Most Frequently Inconsistent With the Rest of the Medical Record in Claims With RUG Differences

MDS Item Description	Characteristics of Item	Number of Claims With Conflicts (n = 71)
P1bbb - Occupational Therapy, Minutes	Calculation, look-back	25
P1bcb - Physical Therapy, Minutes	Calculation, look-back	24
P1bba - Occupational Therapy, Days	Calculation, look-back	19
P1bca - Physical Therapy, Days	Calculation, look-back	15
G1aA - Bed Mobility Self-Performance, How Resident Moves From Lying Position, Turns Side to Side, and Positions Body	Multiple assessors, look-back	13
G1aB - Bed Mobility Support	Multiple assessors, look-back	12
G1bB - Resident's Transfer Support	Multiple assessors, look-back	11
G1iA - Resident's Self-Performance With Toileting	Multiple assessors, look-back	11
G1bA - Resident's Self-Performance for Transfer	Multiple assessors, look-back	10
G1ib - Resident's Support for Toilet	Multiple assessors, look-back	9
G1Ha - Resident's Self-Performance With Eating	Multiple assessors, look-back	9
Total occurrences		158

Source: OIG medical record review, 2003.

RECOMMENDATION

Based on a comparison of the MDS and the rest of the medical record, we found that approximately one-quarter of RUGs on claims submitted by skilled nursing facilities differed from the ones generated based on evidence in the medical record. These differences represented a net $542 million in potential Medicare overpayments for fiscal year 2002.

We recommend that CMS take steps to ensure that skilled nursing facilities complete the MDS accurately and assign each resident to the correct RUG. These steps could include (1) continuing the type of analysis conducted by the Data Assessment and Verification (DAVE) project and (2) more carefully examining the 11 MDS items that we found were most often inconsistent with the rest of the medical record.

In addition, we have forwarded to CMS for appropriate action information on the 71 claims in our sample that had a RUG with a payment rate different from the one generated based on evidence in the medical record.

AGENCY COMMENTS

CMS concurred with our recommendation. CMS sees this report as showing a significant improvement in the assignment of RUG categories at the facility level compared to our 2001 report. CMS commented that it would continue current efforts to improve the accuracy of the MDS and has taken, or has agreed to take, the following actions:

- CMS recently awarded a contract to expand upon the DAVE project, called DAVE2. The purpose of this new project is to assess the accuracy and reliability of national CMS data through focused onsite reviews of the MDS assessment.
- CMS will take the findings of this report into consideration in developing a Web-based training program for the Resident Assessment Instrument Manual.
- CMS will maintain ongoing communications with stakeholders, such as State and regional staff, consultants, and trade associations, regarding the MDS.
- CMS will have fiscal intermediaries and Program Safeguard Contractors continue to assess MDS information through the routine medical review process.

- CMS will incorporate the findings of this report into educational efforts to improve the accuracy of the MDS.

The full text of CMS's comments is included in Appendix F.

OFFICE OF INSPECTOR GENERAL RESPONSE

We agree with the actions CMS plans to take to improve the accuracy of the MDS. However, it is important to note that, because of methodological differences, the results of this report cannot be compared to the results of the previous OIG report.

The methodologies of the two reports differed in two main ways. First, for the previous report, reviewers completed an MDS based on the resident's medical record without referring to the original MDS and then compared the results of the two assessments. In its comments to the previous report, CMS noted that the MDS is a part of the medical record. Therefore, for the current report, the reviewers included the MDS in their review of the medical record. They compared the original MDS to the rest of the medical record to determine whether they were consistent. Second, for the previous report, we only reviewed the 14-day MDS, while for the current report we reviewed the 5-day, 14-day, and 30-day MDS assessments. Because of these differences, the current report cannot necessarily be used as evidence to show that MDS accuracy has improved over time.

Numeric Identifier_____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME⊙	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER⊙	1. Male 2. Female
3.	BIRTHDATE⊙	Month — Day — Year
4.	RACE/⊙ ETHNICITY	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY⊙ AND MEDICARE NUMBERS⊙ [C in 1st box if non med. no.]	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO.⊙	a. State No. b. Federal No.
7.	MEDICAID NO. ["+" *if pending, "N" if not a Medicaid recipient*]⊙	
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] a. Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. *NONE OF ABOVE* b. ***Codes for assessments required for Medicare PPS or the State*** *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

	Signature and Title	Sections	Date
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			
i.			
j.			
k.			
l.			

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

⊙ = Key items for computerized resident tracking

[ ] = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

MDS 2.0 September, 2000

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1.	DATE OF ENTRY	*Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date* Month — Day — Year
2.	ADMITTED FROM (AT ENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other
3.	LIVED ALONE (PRIOR TO ENTRY)	0. No 1. Yes 2. In other facility
4.	ZIP CODE OF PRIOR PRIMARY RESIDENCE	
5.	RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	(***Check all settings*** *resident* ***lived in*** *during 5 years prior to date of entry given in item AB1 above)* Prior stay at this nursing home — a. Stay in other nursing home — b. Other residential facility—board and care home, assisted living, group home — c. MH/psychiatric setting — d. MR/DD setting — e. *NONE OF ABOVE* — f.
6.	LIFETIME OCCUPATION(S) [Put "/" between two occupations]	
7.	EDUCATION (*Highest Level Completed*)	1. No schooling 2. 8th grade/less 3. 9-11 grades 4. High school 5. Technical or trade school 6. Some college 7. Bachelor's degree 8. Graduate degree
8.	LANGUAGE	(*Code for correct response*) a. Primary Language 0. English 1. Spanish 2. French 3. Other b. If other, specify
9.	MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem? 0. No 1. Yes
10.	CONDITIONS RELATED TO MR/DD STATUS	(***Check all conditions*** *that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely)* Not applicable—no MR/DD (Skip to AB11) — a. MR/DD with organic condition Down's syndrome — b. Autism — c. Epilepsy — d. Other organic condition related to MR/DD — e. MR/DD with no organic condition — f.
11.	DATE BACKGROUND INFORMATION COMPLETED	Month — Day — Year

SECTION AC. CUSTOMARY ROUTINE

1.	CUSTOMARY ROUTINE (*In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home*)	(***Check all that apply.*** *If all information UNKNOWN, check last box only)*
		CYCLE OF DAILY EVENTS
		Stays up late at night (e.g., after 9 pm) — a.
		Naps regularly during day (at least 1 hour) — b.
		Goes out 1+ days a week — c.
		Stays busy with hobbies, reading, or fixed daily routine — d.
		Spends most of time alone or watching TV — e.
		Moves independently indoors (with appliances, if used) — f.
		Use of tobacco products at least daily — g.
		NONE OF ABOVE — h.
		EATING PATTERNS
		Distinct food preferences — i.
		Eats between meals all or most days — j.
		Use of alcoholic beverage(s) at least weekly — k.
		NONE OF ABOVE — l.
		ADL PATTERNS
		In bedclothes much of day — m.
		Wakens to toilet all or most nights — n.
		Has irregular bowel movement pattern — o.
		Showers for bathing — p.
		Bathing in PM — q.
		NONE OF ABOVE — r.
		INVOLVEMENT PATTERNS
		Daily contact with relatives/close friends — s.
		Usually attends church, temple, synagogue (etc.) — t.
		Finds strength in faith — u.
		Daily animal companion/presence — v.
		Involved in group activities — w.
		NONE OF ABOVE — x.
		UNKNOWN—Resident/family unable to provide information — y.

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET:

a. Signature of RN Assessment Coordinator — Date

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

	Signature and Title	Sections	Date
b.			
c.			
d.			
e.			
f.			
g.			

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

MDS 2.0 September, 2000

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
FULL ASSESSMENT FORM

(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1.	RESIDENT NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	ROOM NUMBER	
3.	ASSESSMENT REFERENCE DATE	a. *Last day of MDS observation period* Month Day Year b. Original (0) or corrected copy of form (enter number of correction)
4a.	DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) Month Day Year
5.	MARITAL STATUS	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced
6.	MEDICAL RECORD NO.	
7.	CURRENT PAYMENT SOURCES FOR N.H. STAY	(*Billing Office to indicate; **check all that apply in last 30 days***) a. Medicaid per diem b. Medicare per diem c. Medicare ancillary part A d. Medicare ancillary part B e. CHAMPUS per diem f. VA per diem g. Self or family pays for full per diem h. Medicaid resident liability or Medicare co-payment i. Private insurance per diem (including co-payment) j. Other per diem
8.	REASONS FOR ASSESSMENT [*Note—If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed.*]	a. Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment 9. Reentry 10. Significant correction of prior quarterly assessment 0. *NONE OF ABOVE* b. ***Codes for assessments required for Medicare PPS or the State*** *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*
9.	RESPONSIBILITY/ LEGAL GUARDIAN	(***Check all that apply***) a. Legal guardian b. Other legal oversight c. Durable power of attorney/health care d. Durable power attorney/financial e. Family member responsible f. Patient responsible for self g. *NONE OF ABOVE*
10.	ADVANCED DIRECTIVES	(*For those items with supporting **documentation** in the medical record, **check all that apply***) a. Living will b. Do not resuscitate c. Do not hospitalize d. Organ donation e. Autopsy request f. Feeding restrictions g. Medication restrictions h. Other treatment restrictions i. *NONE OF ABOVE*

SECTION B. COGNITIVE PATTERNS

1.	COMATOSE	(*Persistent vegetative state/no discernible consciousness*) 0. No 1. Yes (**If yes, skip to Section G**)
2.	MEMORY	(*Recall of what was learned or known*) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem
3.	MEMORY/ RECALL ABILITY	(***Check all** that resident was **normally able to recall during last 7 days***) a. Current season b. Location of own room c. Staff names/faces That he/she is in a nursing home *NONE OF ABOVE* are recalled
4.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING	(*Made decisions regarding tasks of daily life*) 0. *INDEPENDENT*—decisions consistent/reasonable 1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only 2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required 3. *SEVERELY IMPAIRED*—never/rarely made decisions
5.	INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS	(*Code for behavior in the **last 7 days.**) [**Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time***]. 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening) a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked) b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out) e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement) f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)
6.	CHANGE IN COGNITIVE STATUS	Resident's cognitive status, skills, or abilities have changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1.	HEARING	(*With hearing appliance, if used*) 0. *HEARS ADEQUATELY*—normal talk, TV, phone 1. *MINIMAL DIFFICULTY* when not in quiet setting 2. *HEARS IN SPECIAL SITUATIONS ONLY*—speaker has to adjust tonal quality and speak distinctly 3. *HIGHLY IMPAIRED/absence of useful hearing*
2.	COMMUNICATION DEVICES/ TECHNIQUES	(***Check all that apply** during last 7 days*) a. Hearing aid, present and used b. Hearing aid, present and not used regularly c. Other receptive comm. techniques used (e.g., lip reading) d. *NONE OF ABOVE*
3.	MODES OF EXPRESSION	(***Check all used** by resident to make needs known*) a. Speech b. Writing messages to express or clarify needs c. American sign language or Braille d. Signs/gestures/sounds e. Communication board f. Other g. *NONE OF ABOVE*
4.	MAKING SELF UNDERSTOOD	(*Expressing information content—however able*) 0. *UNDERSTOOD* 1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts 2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests 3. *RARELY/NEVER UNDERSTOOD*
5.	SPEECH CLARITY	(*Code for speech in the **last 7 days***) 0. *CLEAR SPEECH*—distinct, intelligible words 1. *UNCLEAR SPEECH*—slurred, mumbled words 2. *NO SPEECH*—absence of spoken words
6.	ABILITY TO UNDERSTAND OTHERS	(*Understanding verbal information content—however able*) 0. *UNDERSTANDS* 1. *USUALLY UNDERSTANDS*—may miss some part/intent of message 2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication 3. *RARELY/NEVER UNDERSTANDS*
7.	CHANGE IN COMMUNICATION/ HEARING	Resident's ability to express, understand, or hear information has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

MDS 2.0 September, 2000

Resident _____ Numeric Identifier _____

SECTION D. VISION PATTERNS

1.	VISION	(*Ability to see in adequate light and with glasses if used*) 0. *ADEQUATE*—sees fine detail, including regular print in newspapers/books 1. *IMPAIRED*—sees large print, but not regular print in newspapers/books 2. *MODERATELY IMPAIRED*—limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED*—object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED*—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	
2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self)	a.
		Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes	b.
		NONE OF ABOVE	c.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	(***Code for indicators observed in last 30 days, irrespective of the assumed cause***) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)	
		VERBAL EXPRESSIONS OF DISTRESS	
		a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"	
		b. Repetitive questions—e.g., "*Where do I go; What do I do?*"	
		c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")	
		d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received	
		e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"	
		f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others	
		g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack	
		h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions	
		i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues	
		SLEEP-CYCLE ISSUES	
		j. Unpleasant mood in morning	
		k. Insomnia/change in usual sleep pattern	
		SAD, APATHETIC, ANXIOUS APPEARANCE	
		l. Sad, pained, worried facial expressions—e.g., furrowed brows	
		m. Crying, tearfulness	
		n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking	
		LOSS OF INTEREST	
		o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends	
		p. Reduced social interaction	
2.	MOOD PERSISTENCE	**One or more indicators** of depressed, sad or anxious mood **were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days** 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	
3.	CHANGE IN MOOD	Resident's mood status has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	
4.	BEHAVIORAL SYMPTOMS	(A) ***Behavioral** symptom **frequency in last 7 days*** 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily (B) ***Behavioral** symptom **alterability in last 7 days*** 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered	(A) (B)
		a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)	
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)	
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)	
		e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)	

5.	CHANGE IN BEHAVIORAL SYMPTOMS	Resident's behavior status has changed as compared to **status of 90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT	At ease interacting with others	a.
		At ease doing planned or structured activities	b.
		At ease doing self-initiated activities	c.
		Establishes own goals	d.
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		Accepts invitations into most group activities	f.
		NONE OF ABOVE	g.
2.	UNSETTLED RELATIONSHIPS	Covert/open conflict with or repeated criticism of staff	a.
		Unhappy with roommate	b.
		Unhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family/friends	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Does not adjust easily to change in routines	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status	a.
		Expresses sadness/anger/empty feeling over lost roles/status	b.
		Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	c.
		NONE OF ABOVE	d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE—(***Code** for resident's **PERFORMANCE OVER ALL SHIFTS during last 7 days**—Not including setup*)
   - 0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
   - 1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
   - 2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
   - 3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
—Weight-bearing support
— Full staff performance during part (but not all) of last 7 days
   - 4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
   - 8. *ACTIVITY DID NOT OCCUR* during entire 7 days

   (B) ADL SUPPORT PROVIDED—(***Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless** of resident's self-performance classification*)
   - 0. No setup or physical help from staff
   - 1. Setup help only
   - 2. One person physical assist
   - 3. Two+ persons physical assist
   - 8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of street **clothing**, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

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			(A)	(B)
2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) ***Code for most dependent*** *in self-performance and support.* **(A)** BATHING SELF-PERFORMANCE codes appear below		
		0. Independent—No help provided		
		1. Supervision—Oversight help only		
		2. Physical help limited to transfer only		
		3. Physical help in part of bathing activity		
		4. Total dependence		
		8. Activity itself did not occur during entire 7 days (*Bathing support codes are as defined in* ***Item 1, code B above***)		
3.	TEST FOR BALANCE (see training manual)	(*Code for ability during test in the* ***last 7 days***) 0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test; or stands (sits) but does not follow directions for test 3. Not able to attempt test without physical help		
		a. Balance while standing		
		b. Balance while sitting—position, trunk control		
4.	FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)	(*Code for limitations during* ***last 7 days*** *that interfered with daily functions or placed resident at risk of injury*) **(A)** *RANGE OF MOTION* 0. No limitation 1. Limitation on one side 2. Limitation on both sides **(B)** *VOLUNTARY MOVEMENT* 0. No loss 1. Partial loss 2. Full loss	(A)	(B)
		a. Neck		
		b. Arm—Including shoulder or elbow		
		c. Hand—Including wrist or fingers		
		d. Leg—Including hip or knee		
		e. Foot—Including ankle or toes		
		f. Other limitation or loss		

5.	MODES OF LOCOMOTION	(***Check all that apply*** *during* ***last 7 days***)				
		Cane/walker/crutch	a.	Wheelchair primary mode of locomotion	d.	
		Wheeled self	b.			
		Other person wheeled	c.	*NONE OF ABOVE*	e.	
6.	MODES OF TRANSFER	(***Check all that apply*** *during* ***last 7 days***)				
		Bedfast all or most of time	a.	Lifted mechanically	d.	
		Bed rails used for bed mobility or transfer	b.	Transfer aid (e.g., slide board, trapeze, cane, walker, brace)	e.	
		Lifted manually	c.	*NONE OF ABOVE*	f.	
7.	TASK SEGMENTATION	Some or all of ADL activities were broken into subtasks during **last 7 days** so that resident could perform them 0. No 1. Yes				
8.	ADL FUNCTIONAL REHABILITATION POTENTIAL	Resident believes he/she is capable of increased independence in at least some ADLs			a.	
		Direct care staff believe resident is capable of increased independence in at least some ADLs			b.	
		Resident able to perform tasks/activity but is very slow			c.	
		Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings			d.	
		NONE OF ABOVE			e.	
9.	CHANGE IN ADL FUNCTION	Resident's ADL self-performance status has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated				

SECTION H. CONTINENCE IN LAST 14 DAYS

1.	CONTINENCE SELF-CONTROL CATEGORIES (***Code for resident's PERFORMANCE OVER ALL SHIFTS***) 0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]* 1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly 2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week 3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week 4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time	
a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed	
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	

2.	BOWEL ELIMINATION PATTERN	Bowel elimination pattern regular—at least one movement every three days	a.	Diarrhea	c.	
				Fecal impaction	d.	
		Constipation	b.	*NONE OF ABOVE*	e.	

3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan	a.	Did not use toilet room/ commode/urinal	f.	
		Bladder retraining program	b.	Pads/briefs used	g.	
		External (condom) catheter	c.	Enemas/irrigation	h.	
		Indwelling catheter	d.	Ostomy present	i.	
		Intermittent catheter	e.	*NONE OF ABOVE*	j.	
4.	CHANGE IN URINARY CONTINENCE	Resident's urinary continence has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated				

SECTION I. DISEASE DIAGNOSES

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

1.	DISEASES	(***If none apply, CHECK the NONE OF ABOVE box***)			
		ENDOCRINE/METABOLIC/ NUTRITIONAL		Hemiplegia/Hemiparesis	v.
		Diabetes mellitus	a.	Multiple sclerosis	w.
		Hyperthyroidism	b.	Paraplegia	x.
		Hypothyroidism	c.	Parkinson's disease	y.
		HEART/CIRCULATION		Quadriplegia	z.
		Arteriosclerotic heart disease (ASHD)	d.	Seizure disorder	aa.
		Cardiac dysrhythmias	e.	Transient ischemic attack (TIA)	bb.
		Congestive heart failure	f.	Traumatic brain injury	cc.
		Deep vein thrombosis	g.	**PSYCHIATRIC/MOOD**	
		Hypertension	h.	Anxiety disorder	dd.
		Hypotension	i.	Depression	ee.
		Peripheral vascular disease	j.	Manic depression (bipolar disease)	ff.
		Other cardiovascular disease	k.	Schizophrenia	gg.
		MUSCULOSKELETAL		**PULMONARY**	
		Arthritis	l.	Asthma	hh.
		Hip fracture	m.	Emphysema/COPD	ii.
		Missing limb (e.g., amputation)	n.	**SENSORY**	
		Osteoporosis	o.	Cataracts	jj.
		Pathological bone fracture	p.	Diabetic retinopathy	kk.
		NEUROLOGICAL		Glaucoma	ll.
		Alzheimer's disease	q.	Macular degeneration	mm.
		Aphasia	r.	**OTHER**	
		Cerebral palsy	s.	Allergies	nn.
		Cerebrovascular accident (stroke)	t.	Anemia	oo.
		Dementia other than Alzheimer's disease	u.	Cancer	pp.
				Renal failure	qq.
				NONE OF ABOVE	rr.
2.	INFECTIONS	(***If none apply, CHECK the NONE OF ABOVE box***)			
		Antibiotic resistant infection (e.g., Methicillin resistant staph)	a.	Septicemia	g.
		Clostridium difficile (c. diff.)	b.	Sexually transmitted diseases	h.
		Conjunctivitis	c.	Tuberculosis	i.
		HIV infection	d.	Urinary tract infection **in last 30 days**	j.
		Pneumonia	e.	Viral hepatitis	k.
		Respiratory infection	f.	Wound infection	l.
				NONE OF ABOVE	m.
3.	OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES	a. _____			
		b. _____			
		c. _____			
		d. _____			
		e. _____			

SECTION J. HEALTH CONDITIONS

1.	PROBLEM CONDITIONS	(*Check all problems present in* ***last 7 days*** *unless other time frame is indicated*)			
		INDICATORS OF FLUID STATUS		Dizziness/Vertigo	f.
		Weight gain or loss of 3 or more pounds within a 7 day period	a.	Edema	g.
				Fever	h.
		Inability to lie flat due to shortness of breath	b.	Hallucinations	i.
				Internal bleeding	j.
		Dehydrated; output exceeds input	c.	Recurrent lung aspirations in **last 90 days**	k.
				Shortness of breath	l.
		Insufficient fluid; did **NOT** consume all/almost all liquids provided during **last 3 days**	d.	Syncope (fainting)	m.
				Unsteady gait	n.
		OTHER		Vomiting	o.
		Delusions	e.	*NONE OF ABOVE*	p.

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2.	PAIN SYMPTOMS	(*Code the **highest level of pain** present in the **last 7 days***)			
		a. FREQUENCY with which resident complains or shows evidence of pain 0. No pain (***skip to J4***) 1. Pain less than daily 2. Pain daily		**b. INTENSITY** of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating	
3.	PAIN SITE	(*If pain present, **check all sites** that apply in **last 7 days***)			
		Back pain	a.	Incisional pain	f.
		Bone pain	b.	Joint pain (other than hip)	g.
		Chest pain while doing usual activities	c.	Soft tissue pain (e.g., lesion, muscle)	h.
		Headache	d.	Stomach pain	i.
		Hip pain	e.	Other	j.
4.	ACCIDENTS	(*Check all that apply*)			
		Fell in **past 30 days**	a.	Hip fracture in **last 180 days**	c.
		Fell in **past 31-180 days**	b.	Other fracture in **last 180 days**	d.
				NONE OF ABOVE	e.
5.	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating)			a.
		Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem			b.
		End-stage disease, 6 or fewer months to live			c.
		NONE OF ABOVE			d.

SECTION K. ORAL/NUTRITIONAL STATUS

1.	ORAL PROBLEMS	Chewing problem			a.
		Swallowing problem			b.
		Mouth pain			c.
		NONE OF ABOVE			d.
2.	HEIGHT AND WEIGHT	*Record (a.) **height in inches** and (b.) **weight in pounds**. Base weight on most recent measure in **last 30 days**; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes* a. HT (in.) b. WT (lb.)			
3.	WEIGHT CHANGE	**a. Weight loss**—5 % or more in **last 30 days**; or 10 % or more in **last 180 days** 0. No 1. Yes			
		b. Weight gain—5 % or more in **last 30 days**; or 10 % or more in **last 180 days** 0. No 1. Yes			
4.	NUTRITIONAL PROBLEMS	Complains about the taste of many foods	a.	Leaves 25% or more of food uneaten at most meals	c.
		Regular or repetitive complaints of hunger	b.	*NONE OF ABOVE*	d.
5.	NUTRITIONAL APPROACHES	(***Check all that apply in last 7 days***)			
		Parenteral/IV	a.	Dietary supplement between meals	f.
		Feeding tube	b.	Plate guard, stabilized built-up utensil, etc.	g.
		Mechanically altered diet	c.	On a planned weight change program	h.
		Syringe (oral feeding)	d.	*NONE OF ABOVE*	i.
		Therapeutic diet	e.		
6.	PARENTERAL OR ENTERAL INTAKE	(***Skip to Section L if neither 5a nor 5b is checked***) **a.** Code the proportion of **total calories** the resident received through parenteral or tube feedings in the **last 7 days** 0. None 3. 51% to 75% 1. 1% to 25% 4. 76% to 100% 2. 26% to 50% **b.** Code the average **fluid intake** per day by IV or tube in **last 7 days** 0. None 3. 1001 to 1500 cc/day 1. 1 to 500 cc/day 4. 1501 to 2000 cc/day 2. 501 to 1000 cc/day 5. 2001 or more cc/day			

SECTION L. ORAL/DENTAL STATUS

1.	ORAL STATUS AND DISEASE PREVENTION	Debris (soft, easily movable substances) present in mouth prior to going to bed at night		a.
		Has dentures or removable bridge		b.
		Some/all natural teeth lost—does not have or does not use dentures (or partial plates)		c.
		Broken, loose, or carious teeth		d.
		Inflamed gums (gingiva); swollen or bleeding gums; oral abcesses; ulcers or rashes		e.
		Daily cleaning of teeth/dentures or daily mouth care—by resident or staff		f.
		NONE OF ABOVE		g.

SECTION M. SKIN CONDITION

1.	ULCERS (Due to any cause)	(*Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during **last 7 days**. Code 9 = 9 or more.) **[Requires full body exam.]***			**Number at Stage**
		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, 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.			
2.	TYPE OF ULCER	(*For each type of ulcer, **code for the highest stage in the last 7 days** using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4*)			
		a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue			
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities			
3.	HISTORY OF RESOLVED ULCERS	Resident had an ulcer that was resolved or cured **in LAST 90 DAYS** 0. No 1. Yes			
4.	OTHER SKIN PROBLEMS OR LESIONS PRESENT	(***Check all that apply** during **last 7 days***)			
		Abrasions, bruises			a.
		Burns (second or third degree)			b.
		Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)			c.
		Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster			d.
		Skin desensitized to pain or pressure			e.
		Skin tears or cuts (other than surgery)			f.
		Surgical wounds			g.
		NONE OF ABOVE			h.
5.	SKIN TREATMENTS	(***Check all that apply** during **last 7 days***)			
		Pressure relieving device(s) for chair			a.
		Pressure relieving device(s) for bed			b.
		Turning/repositioning program			c.
		Nutrition or hydration intervention to manage skin problems			d.
		Ulcer care			e.
		Surgical wound care			f.
		Application of dressings (with or without topical medications) other than to feet			g.
		Application of ointments/medications (other than to feet)			h.
		Other preventative or protective skin care (other than to feet)			i.
		NONE OF ABOVE			j.
6.	FOOT PROBLEMS AND CARE	(***Check all that apply** during **last 7 days***)			
		Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems			a.
		Infection of the foot—e.g., cellulitis, purulent drainage			b.
		Open lesions on the foot			c.
		Nails/calluses trimmed during **last 90 days**			d.
		Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)			e.
		Application of dressings (with or without topical medications)			f.
		NONE OF ABOVE			g.

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	(***Check appropriate time periods over last 7 days***) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:			
		Morning	a.	Evening	c.
		Afternoon	b.	*NONE OF ABOVE*	d.
(If resident is comatose, skip to Section O)					
2.	AVERAGE TIME INVOLVED IN ACTIVITIES	(**When awake and not receiving treatments or ADL care**) 0. Most—more than 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None			
3.	PREFERRED ACTIVITY SETTINGS	(***Check all settings** in which activities are **preferred***)			
		Own room	a.	Outside facility	d.
		Day/activity room	b.		
		Inside NH/off unit	c.	*NONE OF ABOVE*	e.
4.	GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)	(***Check all PREFERENCES** whether or not activity is currently available to resident*)			
		Cards/other games	a.	Trips/shopping	g.
		Crafts/arts	b.	Walking/wheeling outdoors	h.
		Exercise/sports	c.	Watching TV	i.
		Music	d.	Gardening or plants	j.
		Reading/writing	e.	Talking or conversing	k.
		Spiritual/religious activities	f.	Helping others	l.
				NONE OF ABOVE	m.

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5.	PREFERS CHANGE IN DAILY ROUTINE	*Code for resident preferences in daily routines* 0. No change 1. Slight change 2. Major change a. Type of activities in which resident is currently involved b. Extent of resident involvement in activities

SECTION O. MEDICATIONS

1.	NUMBER OF MEDICATIONS	(***Record the number of different*** *medications used in the* ***last 7 days***; *enter "0" if none used*)
2.	NEW MEDICATIONS	(*Resident currently receiving medications that were initiated during the* ***last 90 days***) 0. No 1. Yes
3.	INJECTIONS	(***Record the number of DAYS*** *injections of any type received during the* ***last 7 days***; *enter "0" if none used*)
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	(***Record the number of DAYS*** *during* ***last 7 days***; *enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly*) a. Antipsychotic b. Antianxiety c. Antidepressant d. Hypnotic e. Diuretic

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1.	SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. **SPECIAL CARE—*Check*** *treatments or programs received during the* ***last 14 days*** **TREATMENTS** Chemotherapy (a.) Dialysis (b.) IV medication (c.) Intake/output (d.) Monitoring acute medical condition (e.) Ostomy care (f.) Oxygen therapy (g.) Radiation (h.) Suctioning (i.) Tracheostomy care (j.) Transfusions (k.) Ventilator or respirator (l.) **PROGRAMS** Alcohol/drug treatment program (m.) Alzheimer's/dementia special care unit (n.) Hospice care (o.) Pediatric unit (p.) Respite care (q.) Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) (r.) *NONE OF ABOVE* (s.) b. **THERAPIES** - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the* ***last 7 calendar days*** *(Enter 0 if none or less than 15 min. daily)* **[Note—count only post admission therapies]** **(A) = # of days** administered for **15 minutes or more** **(B) = total # of minutes** provided in **last 7 days** DAYS (A) MIN (B) a. Speech - language pathology and audiology services b. Occupational therapy c. Physical therapy d. Respiratory therapy e. Psychological therapy (by any licensed mental health professional)
2.	INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS	(**Check all interventions or strategies used in last 7 days**—no matter where received) Special behavior symptom evaluation program (a.) Evaluation by a licensed mental health specialist in **last 90 days** (b.) Group therapy (c.) Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage (d.) Reorientation—e.g., cueing (e.) *NONE OF ABOVE* (f.)
3.	NURSING REHABILITATION/ RESTORATIVE CARE	*Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was* ***provided to the resident for more than or equal to 15 minutes per day in the last 7 days*** *(Enter 0 if none or less than 15 min. daily.)* a. Range of motion (passive) b. Range of motion (active) c. Splint or brace assistance **TRAINING AND SKILL PRACTICE IN:** d. Bed mobility e. Transfer f. Walking g. Dressing or grooming h. Eating or swallowing i. Amputation/prosthesis care j. Communication k. Other

4.	DEVICES AND RESTRAINTS	(*Use the following codes for* ***last 7 days***:) 0. Not used 1. Used less than daily 2. Used daily Bed rails a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side) c. Trunk restraint d. Limb restraint e. Chair prevents rising
5.	HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay **in last 90 days** (or since last assessment if less than 90 days). (*Enter 0 if no hospital admissions*)
6.	EMERGENCY ROOM (ER) VISIT(S)	Record number of times resident visited ER without an overnight stay **in last 90 days** (or since last assessment if less than 90 days). (*Enter 0 if no ER visits*)
7.	PHYSICIAN VISITS	In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (*Enter 0 if none*)
8.	PHYSICIAN ORDERS	In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change.* (*Enter 0 if none*)
9.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the **last 90 days** (or since admission)? 0. No 1. Yes

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1.	DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community 0. No 1. Yes b. Resident has a support person who is positive towards discharge 0. No 1. Yes c. Stay projected to be of a short duration— discharge projected **within 90 days** (do not include expected discharge due to death) 0. No 2. Within 31-90 days 1. Within 30 days 3. Discharge status uncertain
2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support

SECTION R. ASSESSMENT INFORMATION

1.	PARTICIPATION IN ASSESSMENT	a. Resident: 0. No 1. Yes b. Family: 0. No 1. Yes 2. No family c. Significant other: 0. No 1. Yes 2. None
2.	SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:	a. Signature of RN Assessment Coordinator (sign on above line) b. Date RN Assessment Coordinator signed as complete ___ ___ — ___ ___ — ___ ___ ___ ___ (Month — Day — Year)

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SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

1. SPECIAL TREATMENTS AND PROCEDURES

a. RECREATION THERAPY—*Enter number of days and total minutes of recreation therapy administered (**for at least 15 minutes a day**) in the **last 7 days** (Enter 0 if none)*

	DAYS (A)	MIN (B)
(A) = # of days administered for 15 minutes or more **(B) = total # of minutes** provided in last 7 days		

Skip unless this is a Medicare 5 day or Medicare readmission/ return assessment.

b. ORDERED THERAPIES—*Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service?*
0. No 1. Yes

If not ordered, skip to item 2

c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.

d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?

2. WALKING WHEN MOST SELF SUFFICIENT

Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0,1,2, or 3 AND at least one of the following are present:

- Resident received physical therapy involving gait training (P1.b.c)
- Physical therapy was ordered for the resident involving gait training (T.1.b)
- Resident received nursing rehabilitation for walking (P3.f)
- Physical therapy involving walking has been discontinued within the past 180 days

Skip to item 3 if resident did not walk in last 7 days

(FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.)

a. Furthest distance walked without sitting down during this episode.

0. 150+ feet
1. 51-149 feet
2. 26-50 feet
3. 10-25 feet
4. Less than 10 feet

b. Time walked without sitting down during this episode.

0. 1-2 minutes
1. 3-4 minutes
2. 5-10 minutes
3. 11-15 minutes
4. 16-30 minutes
5. 31+ minutes

c. Self-Performance in walking during this episode.

0. *INDEPENDENT*—No help or oversight
1. *SUPERVISION*—Oversight, encouragement or cueing provided
2. *LIMITED ASSISTANCE*—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance
3. *EXTENSIVE ASSISTANCE*—Resident received weight bearing assistance while walking

d. Walking support provided associated with this episode (code regardless of resident's self-performance classification).

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist

e. Parallel bars used by resident in association with this episode.

0. No 1. Yes

3. CASE MIX GROUP

Medicare _____ **State** _____

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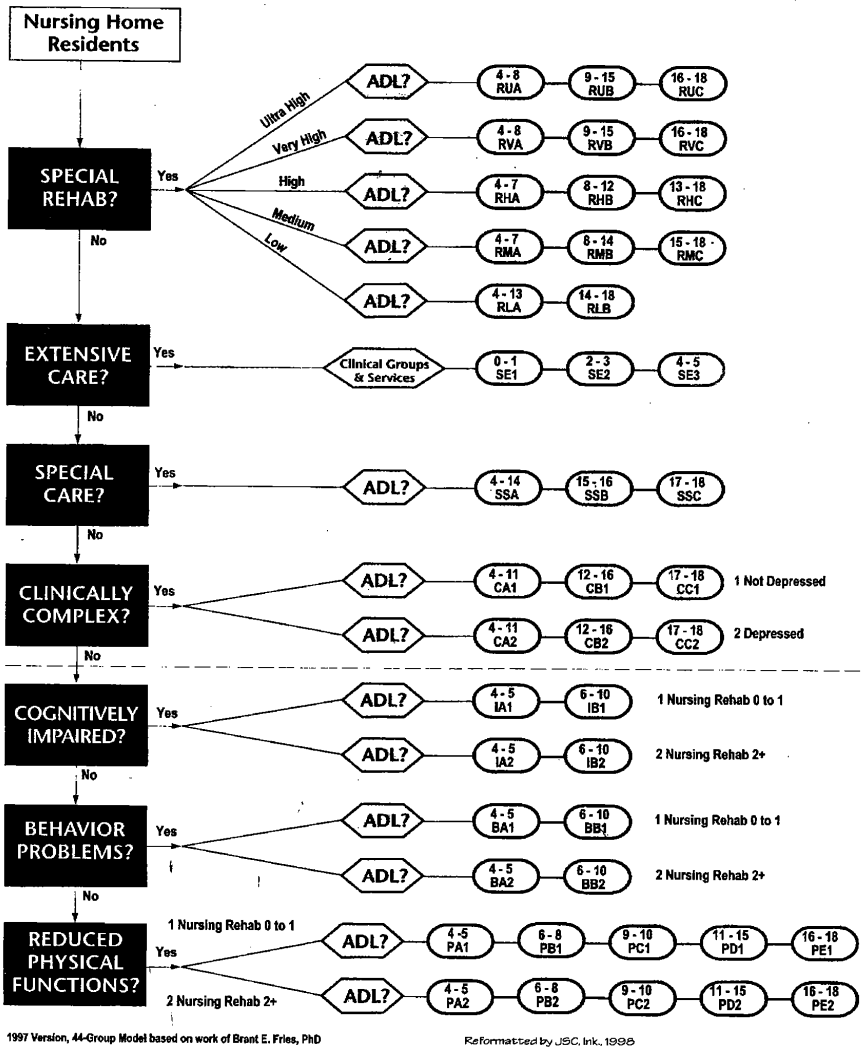
RUG-III Classification System



APPENDIX C

Sampled RUGs

RUG Group	Number in Sample	Percentage of Sample	Number in Reviewed Sample	Percentage of Reviewed Sample
RUC - Rehabilitation Ultra High C	5	1.8%	5	1.8%
RUB - Rehabilitation Ultra High B	10	3.3%	8	2.9%
RUA - Rehabilitation Ultra High A	4	1.4%	4	1.4%
RVC - Rehabilitation Very High C	9	3.0%	8	2.9%
RVB - Rehabilitation Very High B	32	11.0%	30	11.0%
RVA - Rehabilitation Very High A	14	4.6%	13	4.7%
RHC - Rehabilitation High C	53	17.6%	46	16.9%
RHB - Rehabilitation High B	48	16.0%	46	16.9%
RHA - Rehabilitation High A	19	6.3%	17	6.2%
RMC - Rehabilitation Medium C	14	4.6%	13	4.7%
RMB - Rehabilitation Medium B	22	7.3%	20	7.3%
RMA - Rehabilitation Medium A	11	3.6%	10	3.6%
RLA - Rehabilitation Low A	1	0.3%	1	0.3%
Total Rehabilitation	**242**	**80.6%**	**221**	**81.2%**
SE3 - Extensive Services 3	13	0.4%	9	3.3%
SE2 - Extensive Services 2	12	4.0%	11	4.0%
SE1 - Extensive Services 1	1	0.3%	1	0.3%
Total Extensive Services	**26**	**8.6%**	**21**	**7.7%**
SSC - Special Care C	3	1.0%	3	1.1%
SSB - Special Care B	6	2.0%	6	2.2%
SSA - Special Care A	10	3.3%	10	3.6%
Total Special Care	**19**	**6.3%**	**19**	**6.9%**
CC2 - Clinically Complex C2	2	0.6%	2	0.7%
CC1 - Clinically Complex C1	1	0.3%	1	0.3%
CB2 - Clinically Complex B2	1	0.3%	1	0.3%
CB1 - Clinically Complex B1	1	0.3%	2	0.7%
CA1 - Clinically Complex A1	4	1.3%	4	1.4%
Total Clinically Complex	**10**	**3.3%**	**10**	**3.3%**
IB1 Impaired Cognition 1	1	0.3%	0	0.0%
Total Impaired Cognition	**1**	0.3%	**0**	0.0%
Total Behavior Problems	**0**	0.0%	**0**	0.0%
PD1 Reduced Physical Functioning 1	2	0.6%	1	0.3%
Total Physical Functioning Reduced	**2**	**0.6%**	**1**	**0.3%**
Totals All RUG Categories	**300**		**272**	**100%**

Source: OIG medical record review, 2003.

APPENDIX D

Differences in RUGs Between Claim and Reviewer

Claim RUG	Daily Payment Rate for Claim RUG	Reviewer RUG	Daily Payment Rate for Reviewer RUG	Difference
RUC	$441.18	RUB	$391.65	$49.53
RUC	$441.18	RUB	$391.65	$49.53
RUC	$441.18	RVC	$341.68	$99.50
RUC	$441.18	RHC	$317.76	$123.42
RUB	$392.78	RVB	$330.22	$62.56
RUB	$392.78	RVB	$330.22	$62.56
RUB	$392.78	RVB	$330.22	$62.56
RUB	$392.78	RHB	$291.02	$101.76
RVC	$342.67	RHC	$318.68	$23.99
RVC	$342.67	RHC	$318.68	$23.99
RVC	$342.67	RVB	$330.22	$12.45
RVB	$330.22	RVA	$298.41	$31.81
RVB	$330.22	RHC	$318.68	$11.54
RVB	$330.22	RHB	$291.02	$39.20
RVB	$330.22	RHB	$291.02	$39.20
RVB	$330.22	RHB	$291.02	$39.20
RVB	$330.22	RHB	$291.02	$39.20
RVB	$330.22	RMB	$279.99	$50.23
RVB	$330.22	RMB	$279.99	$50.23
RVB	$330.22	CB1	$188.42	$141.80
RVA	$298.41	RVB	$330.22	($31.81)
RVA	$298.41	RHB	$291.02	$7.39
RVA	$298.41	RHA	$264.74	$33.67
RVA	$298.41	RHA	$264.74	$33.67
RHC	$318.68	RHB	$291.02	$27.66
RHC	$318.68	RHB	$291.02	$27.66
RHC	$318.68	RHB	$291.02	$27.66
RHC	$318.68	RHB	$291.02	$27.66
RHC	$318.68	RMC	$315.94	$2.74
RHC	$318.68	RMB	$279.99	$38.69
RHC	$318.68	RMB	$279.99	$38.69
RHC	$318.68	SSA	$211.93	$106.75
RHB	$291.02	RVB	$330.22	($39.20)
RHB	$291.02	RHA	$264.74	$26.28
RHB	$291.02	RHA	$264.74	$26.28
RHB	$291.02	RMB	$279.99	$11.03

Source: OIG medical record review, 2003.

Daily payment rates are based on FY 2002 urban rates.

Differences in RUGs Between Claim and Reviewer (continued)

Claim RUG	Daily Payment Rate for Claim RUG	Reviewer RUG	Daily Payment Rate for Reviewer RUG	Difference
RHB	$291.02	RMB	$279.99	$11.03
RHB	$291.02	RMB	$279.99	$11.03
RHB	$291.02	RMB	$279.99	$11.03
RHB	$291.02	RMA	$262.01	$29.01
RHB	$291.02	SE2	$264.48	$26.54
RHB	$291.02	SE2	$264.48	$26.54
RHB	$291.02	SE2	$264.48	$26.54
RHA	$264.74	RUA	$369.27	($104.53)
RHA	$264.74	RMA	$262.01	$2.73
RHA	$264.74	RMA	$262.01	$2.73
RHA	$264.74	RMA	$262.01	$2.73
RHA	$264.74	SSA	$211.93	$52.81
RMC	$315.94	RMB	$279.99	$35.95
RMC	$315.94	SSC	$228.53	$87.41
RMC	$315.94	CB1	$188.42	$127.52
RMB	$279.99	RHC	$318.68	($38.69)
RMB	$279.99	SE2	$264.48	$15.51
RMB	$279.99	PB1	$141.14	$138.85
RMA	$262.01	RHA	$264.74	($2.73)
SE3	$307.35	RHB	$291.02	$16.33
SE3	$307.35	RMB	$279.99	$27.36
SE3	$307.35	CC1	$209.17	$98.18
SE3	$307.35	PA1	$135.87	$171.48
SE2	$264.48	RUB	$392.78	($128.30)
SE2	$264.48	SSA	$211.93	$52.55
SE2	$264.48	CA2	$187.55	$76.93
SE2	$264.48	IA1	$145.55	$118.93
SE1	$234.06	SE3	$307.35	($73.29)
SSC	$228.53	RMC	$315.94	($87.41)
SSB	$217.46	CB1	$188.42	$29.04
SSA	$211.93	SE1	$234.06	($22.13)
CC1	$209.17	SSC	$228.53	($19.36)
CB1	$188.42	CC1	$209.17	($20.75)
CA1	$175.98	PA1	$135.87	$40.11
PD1	$169.06	SSA	$211.93	($42.87)

Source: OIG medical record review, 2003.

Daily payment rates are based on FY 2002 urban rates.

APPENDIX E

Confidence Intervals for Key Findings

Key Findings	Point Estimate	Confidence Interval
26 percent of RUGs on claims submitted by skilled nursing facilities were different from the ones generated based on evidence in the medical record (n=272)	**26.1%**	**20.9% - 31.3%**
These differences in RUGs represent a net $542 million in potential Medicare overpayments for fiscal year 2002 (n=272)	**$542,173,340**	**$258,705,071 - $825,641,610**

Source: OIG medical record review, 2003.

APPENDIX F

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DEC 2 2 2005

TO: Daniel R. Levinson
Inspector General
Office of Inspector General

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: "A Review of Nursing Facility Resource Utilization Groups" (OEI-02-02-00830)

Thank you for the opportunity to comment on the above OIG draft report. As part of the ongoing administration of the skilled nursing facility prospective payment system (SNF PPS), we have worked closely with the States, providers, long-term care associations, and fiscal intermediaries (FIs) to educate providers by using a variety of educational approaches including written clarifications of coding instructions, training conferences and videos, and an on-going series of phone conferences. We are pleased to see that our efforts to improve the accuracy of the data on the Minimum Data Set (MDS) have been effective.

We commend the OIG for their follow-up study in determining if the Resource Utilization Groups (RUGs) on claims submitted by SNFs are the same as the ones generated by review of the medical record. As noted in this report, there appears to have been a significant improvement in the assignment of RUG category at the facility level. In an earlier OIG report, the discrepancy rate was 76 percent. Though this current report went a step further than the initial study by examining the RUG category submitted on claims, the discrepancy rate has decreased to 26 percent.

We attribute this significant improvement to many efforts at the Centers for Medicare & Medicaid Services (CMS), which include, but are not limited to, updated versions of the Long-term Care Resident Assessment Instrument (RAI) Manual, provider education and outreach by CMS and state RAI coordinators, and various oversight activities, such as the Data Assessment and Verification (DAVE) project. We agree that we should continue with efforts to improve the accuracy of completion of the MDS data, and thus payment.

OIG Recommendation

We recommend that CMS take all necessary steps to ensure that skilled nursing facilities complete the MDS accurately and assign each resident to the correct RUG. These steps

could include 1) continuing the type of analysis conducted by the Data Assessment and Verification Project, and 2) more carefully examining the 11 MDS items that are most often inconsistent with the rest of the medical record.

CMS Response

We concur. We recently completed a Program Safeguard Contract (PSC), the DAVE Project, which reviewed medical records both on-site and off-site. Through these efforts, we learned that with on-site medical review we are able to obtain other pertinent information related to the resident's status via staff and resident interviews, which may not be documented in the medical record. In fact, one of the MDS sections that relies heavily on resident observation are the activities of daily living, the items located in section G.

Completion of the MDS should be based not only on information contained in the medical record but should also include data obtained through communication and observation of the resident, and communication with direct-care staff, licensed professionals, including physicians, and the resident's family. We consider the MDS to be an integral part of the medical record. In addition to information contained in the medical record, we also expect the MDS to contain information gathered from resident and staff interviews. In fact, many facilities utilize worksheets and other documentation forms that are not considered part of the medical record but assist with the completion of the MDS, development of care plans, and quality assurance monitoring and improvement. Since these forms are not considered part of the medical record, this information may not be readily available when conducting a medical review and therefore the information contained in these files are not available for validating MDS data. While we expect a majority of the data contained in the MDS to have supportive documentation, we do not require, nor encourage, duplicative documentation.

The Quality Measurement and Health Assessment Group in the Office of Clinical Standards and Quality has awarded a contract to expand upon the DAVE project that recently ended, called DAVE2. The primary purposes of DAVE2 are to 1) assess the accuracy and reliability of national CMS data through focused on-site reviews of the MDS assessments and pertinent clinical information; 2) develop targeting protocols and conduct analysis; and 3) improve accuracy by developing process improvements, training and educational materials and assessment tool improvements for State RAI coordinators, facility staff, State surveyors and FIs. We will continue to provide clarifications to coding instructions for MDS items and revise the RAI manual as indicated.

In addition, we are in the development stages of a Web-based training program for the RAI manual. We will take the findings of this report into consideration for the material contained in this and future educational tools.

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We will maintain our ongoing communications with multiple stakeholders. For example, we host monthly calls with State and regional staff, responds to questions submitted to MDSQuestions@cms.hhs.gov, and include consultants and the trade associations in the revision of MDS coding instructions. In addition, FIs and PSCs will continue to assess MDS information through the routine medical review process in order to ensure proper Medicare payment.

We have already begun to incorporate the DAVE findings, and other analyses, into our educational efforts on improving the accuracy of the MDS. We plan to incorporate your findings into these efforts as well. We will focus on the items that are deemed "problem prone" and the ones that are inaccurate as indicated by on-going analyses.

We appreciate the OIG's efforts in helping us ensure that we are properly reimbursing services provided to our beneficiaries. We will continue our efforts to improve the accuracy of the data entered into the MDS. As noted, our past and current efforts are having a significant positive effect on accuracy. However, there remains room for improvement.

Through the DAVE2 project, other contracts, and analyses, we will continue to develop educational and training material, communicate with the various stakeholders, and revise coding instructions to decrease discrepancies in MDS data.

We look forward to working with the OIG to ensure accuracy of the MDS items and, thus, reimbursement.

ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office. Other principal Office of Evaluation and Inspections staff who contributed include:

Miriam Anderson, *Team Leader*

Judy Kellis, *Program Analyst*

Patricia Banta, *Program Analyst*

Tricia Davis, *Director, Medicare and Medicaid Branch*

Sandy Khoury, *Program Specialist*

Technical Assistance

Barbara Tedesco, *Mathematical Statistician*

Scott Horning, *Program Analyst*