

The MDS Mentor

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 The MDS Mentor is published in March, June, September, and December each year.

ACRONYMS:

Assessment Reference Date (ARD)

Centers for Medicare & Medicaid Services (CMS)

CMS Long-Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 (RAIM3)

Interdisciplinary Team (IDT)

Minimum Data Set (MDS)

Omnibus Budget Reconciliation Act (OBRA)

Prospective Payment System (PPS)

Quality Measures User's Manual Version 9.0 (QMUM9)

Registered Nurse (RN)

Resource Utilization Group (RUG)

Resident Assessment Instrument (RAI)

Skilled Nursing Facility/ Nursing Facility (SNF/NF)

Section H: Bladder and Bowel Coding

The "Item Rationale" for the first item in this section, H0100: Appliances, notes "It is important to know what appliances are in use and the history and rationale for such use." (RAIM3, page H-1).

Moving on in the manual to page H-2, a coding tip for item H0100 clarifies: "Do not code gastrostomies or other feeding ostomies in this section. Only appliances used for elimination are coded here." In addition, on the same page, the "Coding Instructions" for item H0100 inform staff to: "Check next to each appliance that was used at any time in the past 7 days. Select none of the above if none of the appliances A-D were used in the past 7 days." The list of H0100 options follows:

- H0100A, indwelling catheter (including suprapubic catheter and nephrostomy tube)
- H0100B, external catheter
- H0100C, ostomy (including urostomy, ileostomy, and colostomy)
- H0100D, intermittent catheterization
- H0100Z, none of the above

The wording in the RAIM3 on page H-1 admonishes: "Indwelling catheters should not be used unless there is valid medical justification. Assessment should include consideration of the risk and benefits of an indwelling catheter, the anticipated duration of use, and consideration of complications resulting from the use of an indwelling catheter." However, remember that staff must check H0100A if

an indwelling catheter was present during the 7-day look-back period, regardless if a valid medical justification exists in the clinical record. Also, as both the list and the coding tips on page H-2 of the RAIM3 indicate: "Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter (H0100A) only and not as an ostomy (H0100C)."

Furthermore, "Condom catheters (males) and external urinary pouches (females) are often used intermittently or at night only; these should be coded as external catheters." (RAIM3, page H-2.) If used in the 7-day look back period, these items would be coded in H0100B.

And, as a final point in this section, "Do not include one time catheterization for urine specimen during look back period as intermittent catheterization." As a matter of fact, the very definition of "Intermittent Catheterization" is "Sterile insertion and removal of a catheter through the urethra for bladder drainage." (RAIM3, page H-2.) Therefore, even two or three intermittent catheterizations for urine specimens during the look back period would not be coded in H0100D because the catheterizations were not for bladder drainage.

The next item coded in this section is H0200: Urinary Toileting Program. Both the "Steps for Assessment" and the "Coding Instructions" for item H0200A, B and C are clearly detailed in pages H-3 to H-6 of the RAIM3. In the five years



Section H: Bladder and Bowel Coding

(Continued from previous page.)

since MDS 3.0 began, the H0200 instruction often overlooked is: “If the toileting program or bladder retraining leads to a decrease or resolution of incontinence, the program should be maintained.”

The next item coded in this section is H0300: Urinary Continence. As always, to have confidence in coding this item correctly, it is very important to read the definitions. CMS defines “Urinary Incontinence” as “The involuntary loss of urine.” On the other hand, “Continence” is defined as “Any void that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting.” (RAIM3, page H-7.) As a result of these definitions, a resident that decides to void in a potted plant, their roommate’s closet or another resident’s bedside commode is continent. It may be that these are not appropriate places to void and these behaviors should be addressed in the care plan, but the resident is still coded as continent.

To code H0300 correctly, the “Steps for Assessment:” on page H-8 of the RAIM3 must be followed:

1. Review the medical record for bladder or incontinence records or flow sheets, nursing assessments and progress notes, physician history, and physical examination.
2. Interview the resident if he or she is capable of reliably reporting his or her continence. Speak with family members or significant others if the resident is not able to report on continence.
3. Ask direct care staff who routinely work with the resident on all shifts about incontinence episodes.

Continuing on the same page of the RAIM3 are the “Coding Instructions:” (Editor’s Note: These instructions could also be called the Rule of Seven.)

- **Code 0, always continent:** if throughout the 7-day look-back period the resident has been continent of urine, without any episodes of incontinence.
- **Code 1, occasionally incontinent:** if during the 7-day look-back period the resident was incontinent less than seven (7) episodes. This includes incontinence of any amount of urine sufficient to dampen undergarments, briefs, or pads during daytime or nighttime.
- **Code 2, frequently incontinent:** if during the 7-day look-back period, the resident was incontinent of urine during seven (7) or more episodes but had at least one continent void. This includes incontinence of any amount of urine, day and night.
- **Code 3, always incontinent:** if during the 7-day look-back period, the resident had no continent voids.
- **Code 9, not rated:** if during the 7-day look-back period the resident had an indwelling bladder catheter,

ter, condom catheter, ostomy, or no urine output (e.g., is on chronic dialysis with no urine output) for the entire 7 days.

A final coding tip educates staff: “If intermittent catheterization is used to drain the bladder, code continence level based on continence between catheterizations.” (RAIM3, page H-8.)

One common coding error in item H0300 is coding a resident as **always incontinent** even if, during the look back period, the resident voluntarily urinated once in a potted plant or was assisted or made it to the toilet once and voided. A resident can be incontinent 7, 10, 16 or 25 times during the 7-day look back period, but one continent void at any time during this timeframe makes the correct coding for item H0300 **frequently incontinent**.

Next, to code H0400 correctly, follow these “Steps for Assessment:” (RAIM3, page H-10)

1. Review the medical record for bowel records and incontinence flow sheets, nursing assessments and progress notes, physician history and physical examination.
2. Interview the resident if he or she is capable of reliably reporting his or her bowel habits. Speak with family members or significant other if the resident is unable to report on continence.
3. Ask direct care staff who routinely work with the resident on all shifts about incontinence episodes.

Page H-10 also has “Coding Instructions:”

- **Code 0, always continent:** if during the 7-day look-back period the resident has been continent of bowel on all occasions of bowel movements, without any episodes of incontinence.
 - **Code 1, occasionally incontinent:** if during the 7-day look-back period the resident was incontinent of stool once. This includes incontinence of any amount of stool day or night.
 - **Code 2, frequently incontinent:** if during the 7-day look-back period, the resident was incontinent of bowel more than once, but had at least one continent bowel movement. This includes incontinence of any amount of stool day or night.
 - **Code 3, always incontinent:** if during the 7-day look-back period, the resident was incontinent of bowel for all bowel movements and had no continent bowel movements.
 - **Code 9, not rated:** if during the 7-day look-back period the resident had an ostomy or did not have a bowel movement for the entire 7 days. (These residents should be checked for fecal impaction and evaluated for constipation.)
- Note: Rectal Tube use is also coded as a 9.



The length of a film should be directly related to the endurance of the human bladder.

- Alfred Hitchcock

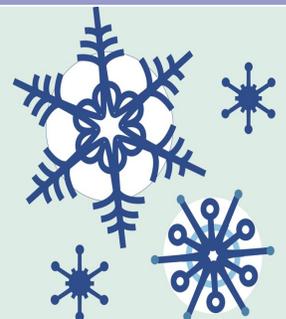
I don't need you to remind me of my age.

I have a bladder to do that for me.

- Stephen Fry

I remember when a Coke came in a six-ounce bottle, and delicious it was. Now it comes in sizes so big that I question how the human bladder can deal with the intake.

- Roger Ebert





Long-stay Quality Measure for Bowel and Bladder Loss

The full title of this CASPER Quality Measure is, “Percent of Low Risk Residents Who Lose Control of their Bowel or Bladder” and attempts to report on the percentage of long-stay residents who frequently lose control of their bowel or bladder. As the QM title indicates, it also attempts to categorize those residents, by risk, and only report on those who have been determined to fit into a lower risk category.

How does CASPER determine which residents qualify as ‘low risk’? The key to that is found in the measure’s exclusions, which keep a resident’s assessments from being included in the measure.

This particular measure has eight distinct exclusions, which attempt to remove from the equation, those assessments with conditions for which bowel and/or bladder issues are most common, as well as those assessments where the relevant data items were not assessed (dashed or skipped). The complete list is on page 33 of the MDS 3.0 Quality Measures User’s Manual, v9.0. Here are a few that would certainly put the resident into a higher risk of bowel or bladder issues and so CASPER tries to exclude assessments where these items appear, where bowel and/or bladder continence triggered as ‘frequently incontinent’ or ‘always incontinent’:

- Residents who have severe cognitive impairment where they have been assessed with a BIMS summary score less than or equal to a 7, or indicate problems with short-term memory and have cognitive skills for daily decision making assessed as severely impaired; OR some of those cognitive items were not assessed.
- Those totally dependent in bed mobility self-performance, or transfer self-performance, or locomotion on unit self-performance; OR where any of these same items were not assessed.
- Resident is comatose; OR the coma-

tose status is missing.

- Resident has an indwelling catheter or ostomy; OR those items were not assessed.

As you can see, CASPER is not only looking for assessments with high risk categories, but is also attempting to exclude those assessments where such high risk conditions were not assessed and therefore not known.

As with all QMs, you should ensure assessments were coded correctly for any residents who trigger. As a long-stay measure, CMS allows the look-back scan period to go back up to 275 days from the ARD of the target assessment, to cover up to three quarterly OBRA assessments. As the earliest of those quarterlies should cover it’s own look back period of up to 93 days (ARD + 92 days), this gives the measure about a year of data. All assessments with a target date during this period are examined to see if the event or condition occurred, so when you are reviewing the resident’s assessments for coding errors, be sure to go back far enough.

Provided the assessments were coded correctly, you should also think of this QM as a flag that prompts you to review the toileting needs for those residents that do trigger. As they are categorized as ‘low risk’, the facility should ask itself if there are any steps they can take to improve a resident’s continence.

However, there will likely be some residents who consistently trigger this QM, because they just miss being included in one of the exclusion categories (maybe their BIMS summary is an 8 or they have some slight ability to assist with transfer). In such cases, all a facility can do is ensure they are coding their assessments correctly and handling the resident’s toileting needs appropriately. While this QM appears on the CMS Nursing Home Compare website, it is not one of the eleven QMs that are involved in the calculation of the facility’s 5-Star rating.

I consider looseness with words no less of a defect than looseness of the bowels.

- John Calvin

Living on the edge - that's what I feel like when I don't know what my bowels are going to do next.

— Jane Wilson-Howarth

Scientists are not these guys in lab coats deep in the inner bowels of universities and hospitals with their Bunsen burners.

They're the people molding the culture that we live in, the future of our culture, and the technology we rely on every day.

- Johnny Galecki



MDS News in Review

- ◆ **IMPORTANT NOTICE**—Please be aware that CMS and the QIES Technical Support Office (QTSO) are planning on an extended downtime for QIES systems, beginning Wednesday, March 16, 2016, after 8:00 PM Eastern Time and continuing through Monday, March 21, 2016 at 11:59 PM Eastern Time.

During this time the national systems will not be available, which includes both CASPER, the MDS 3.0 Submission system, and the QIES User Maintenance system. No provider will be able to transmit any type of MDS assessment (new, modification, or inactivation) during this 5+ day maintenance window.

This also means no ability to either submit new MDS assessments for Medicaid claims or to modify the MDS assessments of existing claims during this window. Providers need to be sure to get their LTCMI's done timely, to avoid having this maintenance negatively affect their RUG timeframes.

Nursing facilities must plan for this downtime, in advance. CMS has said it will post notices on the affected systems prior to the event.

If you have any questions, please contact the QIES Help Desk at 1.800.477.7876 or help@qtso.com.

- ◆ Draft version 1.14.0 of the MDS 3.0 Item Sets was posted to the [CMS MDS 3.0 Technical Information website](#). There are many item changes in this version, including a new section, GG.

Also, there are two new item subsets for PPS Part A Discharge (End of Stay) assessments – one for nursing homes and the other for swing bed facilities.

This version is scheduled to become

effective October 1, 2016, in conjunction with the new version of the Data Specifications, v2.00.0.

- ◆ Draft version 2.00.0 of the MDS 3.0 Data Specifications was posted to the [CMS MDS 3.0 Technical Information website](#). These specifications include many edit additions/revisions.

Details about the changes in this version are contained in the Edit Change Report and the Item Change Report.

This version is scheduled to become effective October 1, 2016, in conjunction with the new version of the Item Sets, v1.14.0.

- ◆ Version 1.02.0 of the Care Area Trigger (CAT) specifications for OBRA comprehensive assessments with an assessment reference date on or after 10/01/2016 was posted to the [CMS MDS 3.0 Technical Information website](#).

Please note the changes to CATs 1 and 2, which were necessary due to the removal of the C1300 items in v1.14.0 of the MDS 3.0 Item Sets.

- ◆ Electronic submission of staffing data through the Payroll-Based Journal (PBJ) is required of all Long Term Care Facilities in July 2016. ALL nursing homes will need to register to submit data in order to comply with this requirement. Providers are strongly encouraged to sign up now to ensure system compatibility and a smooth transition. For more information, visit the PBJ website at [CMS Staffing Data Submission PBJ](#).





Contact Us

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This guidance is being provided on the published date of *The MDS Mentor* (January 22, 2016).

The reader should be aware that guidance regarding topics in *The MDS Mentor* may be time-limited and may be superseded by guidance published by CMS or DADS at a later date.

It is each provider's responsibility to stay abreast of the latest CMS and DADS guidance.

Useful Web Links

DADS MDS Web Site: Texas MDS site for MDS policy, procedures, clinical and technical information, Texas Medicaid MDS settings, notifications and *The MDS Mentor*;

<http://www.dads.state.tx.us/providers/MDS/>

Sign up for MDS Resource E-mail updates: Go to <http://www.dads.state.tx.us/>, click on the "Subscribe" tab and follow the directions. The "DADS Texas Minimum Data Set (MDS) Resources" emails are the key line of communication for MDS updates and alerts to nursing home and swing bed facilities from the DADS MDS staff. Consider signing up for other nursing home related information, as well.

Centers for Medicare & Medicaid Services (CMS) Nursing Home Quality Initiative website: MDS 3.0 RAI Manual, Quality Measures, Technical Information (MDS 3.0 Item Sets (forms), data specifications, RUG information, jRAVEN), MDS Training and SNF Quality Reporting;

<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html>

Centers for Medicare & Medicaid Services (CMS) FY 2012 RUG-IV Education & Training: Clarification and follow-up documents related to Medicare MDS;

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSP/RUGIVEDu12.html>

QIES Technical Support Office (QTSO): MDS 3.0 provider materials (including MDS 3.0 Provider User's Guide, CASPER Reporting User's Guide for MDS Providers, notices on 5 Star preview reports availability and MDS access forms), system downtime notices, jRAVEN, CMSNet (Verizon) information and online submission access, and links to CMS websites. This site also contains information specific to MDS software developers and vendors, including notices for vendor calls, call minutes, the latest MDS Validation Utility Tool (VUT) and Vendor Q&A documents; <https://www.qtso.com/>

Quality Reporting System (QRS): DADS rating site for all Texas nursing homes;

<http://facilityquality.dads.state.tx.us/qrs/public/qrs.do>

Nursing Home Compare: CMS rating site for nursing homes across the country;

<http://www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteria.asp>

5 Star Technical Manual: Explains data used to create the 5 Star Report;

<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/FSQRS.html>

Let's Share What We Know



World Wide Web