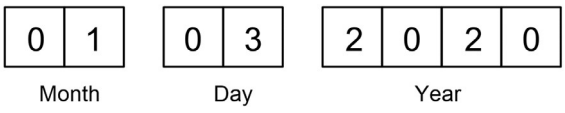
3.3 Coding Conventions

There are several standard conventions to be used when completing the MDS assessment, as follows.

- The standard look-back period for the MDS 3.0 is **7 days**, unless otherwise stated.
- **With the exception of certain items (e.g., some items in Sections *J,* K and O), the look-back period does not extend into the preadmission period unless the item instructions state otherwise.** In the case of reentry, the look-back period does not extend into time prior to the reentry, unless instructions state otherwise.
- When determining the response to items that have a look-back period *relating back* to the Admission/Entry, Reentry, or Prior OBRA or scheduled PPS assessment, whichever is most recent, staff must only consider those assessments that are required to be submitted to *i*QIES. PPS assessments that are completed for private insurance and Medicare Advantage Plans must **not** be submitted to *i*QIES and therefore should not be considered when determining the "prior assessment."
- There are a few instances in which scoring on one item will govern how scoring is completed for one or more additional items. This is called a skip pattern. The instructions direct the assessor to "skip" over the next item (or several items) and go on to another. When you encounter a skip pattern, leave the item blank and move on to the next item as directed (e.g., item B0100, **Comatose**, *if B0100 is answered* ***code 1, yes,*** the assessor *is instructed* to skip to item G*G*0110, **Activities of Daily Living *(ADL)* Assistance**. The intervening items from B0200–F0800 would not be coded (i.e., left blank). If B0100 was *answered* **code 0, no,** then the assessor would continue to code the MDS at the next item, B0200, ***Hearing***).
- Use a check mark for boxes where the instructions state to "check all that apply," if the specified condition is met; otherwise, these boxes *should* remain blank (e.g., F0800, **Staff Assessment of Daily and Activity Preferences**, boxes A-Z).
- Use a numeric response (a number or pre-assigned value) for blank boxes (e.g., M1030, **Number of Venous and Arterial Ulcers**).
- When completing hard copy forms to be used for data entry, capital letters may be easiest to read. Print legibly *to ensure accurate encoding of data*.
- When recording month, day, and year for dates, enter two digits for the month and the day and four digits for the year. For example, the third day of January in the year 20*20* is recorded as



- Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to *i*QIES.
  - A dash value indicates that an item was not assessed. This most often occurs when a resident is discharged before the item could be assessed.
  - Dash values allow a partial assessment to be submitted when an assessment is required for payment purposes.

  - There are four date items (A2400C, O0400A6, O0400B6, and O0400C6) that use a dash-filled value to indicate that the event has not yet occurred. For example, if there is an ongoing Medicare stay, then the end date for that Medicare stay (A2400C) has not occurred, therefore, this item would be dash-filled.
  - The few items that do not allow dash values include identification items in Section A [e.g., Legal Name of Resident (Item A0500), Assessment Reference Date (Item A2300), Type of Assessment (Item A0310), and Gender (Item A0800)] and ICD diagnosis codes (Item I8000). All items for which a dash is not an acceptable value can be found on the CMS MDS 3.0 Technical Information web page at the following link http//www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html.

- When the term "physician" is used in this manual, it should be interpreted as including nurse practitioners, physician assistants, or clinical nurse specialists, if allowable under state licensure laws and Medicare.
- Residents should be the primary source of information for resident assessment items. Should the resident not be able to participate in the assessment, the resident's family, significant other, and guardian or legally authorized representative should be consulted.
- Several times throughout the manual the word "significant" is used. The term may have different connotations depending on the circumstance in which it is used. For the MDS 3.0, the term "significant" when discussing clinical, medical, or laboratory findings refers to measures of supporting evidence that are considered when developing or assigning a diagnosis, and therefore reflects clinical judgment. When the term "significant" is used in discussing relationships between people, as in "significant other," it means a person, who may be a family member or a close friend that is important or influential in the life of the resident.
- When completing the MDS 3.0, there are some items that require a count or measurement, however, there are instances where the actual results of the count or measurement are greater than the number of available boxes. For example, number of pressure ulcers, or weight. When the result of a count or measurement is greater than the number of available boxes, facilities are instructed to maximize the count/measurement by placing a "9" in each box (e.g., for item K0200B, if the weight was 1010 lbs., you would enter 999 in the available boxes). Even though the number is not exact, the facility should document the correct number in the resident's medical record and ensure that an appropriate plan of care is completed that addresses the additional counts/measurements.

SECTION A IDENTIFICATION INFORMATION

Intent The intent of this section is to obtain *the reasons for assessment, administrative information, and* key *demographic* information to uniquely identify each resident*, potential care needs including access to transportation, and* the home in which *they* reside.