Indiana Health Coverage Programs

P R O V I D E R B U L L E T I N

B T 2 0 0 2 5 1 O C T O B E R 1 , 2 0 0 2

To: All Certified Nursing Facilities

Subject: Supportive Documentation Guidelines RUG-III, Version 5.12, 34-Grouper

Overview

The purpose of this bulletin is to update Indiana Health Coverage Programs (IHCP)-certified nursing facilities about the requirements for Minimum Data Set (MDS) supportive documentation. Supportive documentation for all MDS data elements used to classify nursing facility residents in accordance with the Resource Utilization Group (RUG)-III resident classification system must be routinely maintained in each resident's medical chart. The nursing facility must maintain this documentation for all residents.

Tables 1.1 - 1.3 contain revised Supportive Documentation Guidelines that can assist providers with identifying and documenting all MDS data elements used to classify nursing facility residents in accordance with the RUG-III resident classification system.

*Please note: Revisions are in **bold** for convenience.*

Please contact the Myers and Stauffer help desk at (317) 816-4122 with any questions about the information in this bulletin. For questions about the Supportive Documentation Guidelines and the EDS review process, please contact the EDS Long Term Care Unit at (317) 488-5089.

Table 1.1 – Activities of Daily Living

MDS 2.0 Version 5.12, 34 – Grouper			
Activities of Daily Living (ADL)			
MDS 2.0 LOCATION	**FIELD DESCRIPTION**	**CHARTING GUIDELINES**	**POSSIBLE CHART LOCATION**
G1a,b,i **Col. A, B and** **G1h, A** (pages 3-73 to 3-89)	Physical Functioning and Structural Problems ADLs	These four ADLs include bed mobility, transfer, toileting, and eating and must be addressed in the medical chart for purposes of supporting the MDS responses. Consider the resident's self-performance and support provided during all shifts, as functionality may vary.	NN, SSN, SN, CP, NR
K5a (page 3-130)	Parenteral/IV	Evidence of an IV or heparin lock where IV fluids have been given continuously or intermittently must be cited in the medical chart.	NN, SN, PO, PPN, CP, Hospital records
K5b (page 3-130)	Feeding Tube	Documented evidence of a feeding tube that can deliver food/nutritional substances/ fluids/medications directly into the gastrointestinal system.	NN, SN, DN, PO, PPN, CP
K6a (page 3-131)	Calories Intake	Documentation supports evidence of the proportion of all calories ingested (actually received) during the last seven days by IV or tube feeding that the resident actually received. This includes calories taken p.o.	DN, NN, SN, MAR
K6b (page 3-133)	Average Fluid Intake	Actual average amount of fluid by IV or tube feeding the resident received during the last seven days. IV flushes are not included in this calculation.	DN, NN, SN, MAR

STEP 1: To calculate the score of G1a, G1b, and G1i, use the following chart:

When Column A=	**And** Column B=	**Then** ADL score=	SCORE=
0 or 1	**any number**	**= 1**	**G1a=____**
2	**any number**	**= 3**	**G1b=____**
3, 4	**0,1, or 2**	**= 4**	**G1i= ____**
3, 4, or 8	**3 or 8**	**= 5**	**Eating score= ____**

STEP 2: To calculate eating ADL score:

When K5a=checked	**Then ADL Score =3**	**OR**
When K5b=checked + K6a=3 or 4	**Then ADL Score =3**	**OR**
When K5b=checked + K6a =2 AND K6b=2, 3, 4, 5	**Then ADL Score =3**	**If not then go to Step 3**

STEP 3: Return to G1h A to calculate the eating score using the chart:

When Column A=	**Then** ADL score=
0 or 1	**= 1**
2	**= 2**
3,4, or 8	**= 3**

TOTAL ADL SCORE_____

(The total ADL score range possibilities are 4 through 18.)

Page numbers in the left column denote the location of the MDS element in the October 1995 RAI Manual.
Prepared by Myers and Stauffer LC *2002*

Table 1.2 – RUG Items

MDS 2.0 Version 5.12, 34 – Grouper			
Element Listing of RUG Items			
MDS 2.0 LOCATION	**FIELD DESCRIPTION**	**CHARTING GUIDELINES**	**POSSIBLE CHART LOCATION**
B1 (page 3-42)	Comatose	Must have a documented neurological diagnosis of coma or persistent vegetative state from physician.	PO, PPN, H&P
B2a (page 3-42)	Short-Term Memory	Short-term memory loss must be supported in the body of the medical chart with specific examples of the loss. (E.g., can't describe breakfast meal or an activity just completed). If there is no positive indication of memory ability, documentation must be cited in the medical record. Identify the most representative level of function, not the highest.	NN, SSN, SN, NR, CP
B4 (page 3-44 to 3-45)	Cognitive Skills for Daily Decision Making	Evidence by example must be found in the medical chart of the resident's ability to actively make decisions, and not whether staff believe the resident might be capable of doing so.	NN, SSN, SN, NR, CP
C4 (page 3-52 to 3-53)	Making Self Understood	Evidence by example of the resident's ability to express or communicate requests, needs, opinions, problems, etc., whether in speech, writing, sign language, or a combination of these.	CP, DN, CNAN, NN, SN, SSN, NR
E1a-p (page 3-58 to 3-60)	Indicators of Depression, Anxiety, Sad Mood (1 or 2)	Examples of verbal and/or non-verbal expressions of distress i.e., depression, anxiety, and sad mood must be found in the medical chart irrespective of the cause. See MDS (E1) for specific details.	NN, SSN, SN, NR, CP
E4a-e **Col.A** (page 3-62 to 3-65)	Behavioral Symptoms (2 or 3)	Acknowledgment and examples of the resident's behavior symptom patterns must be provided in the medical chart. The record must reflect the frequency of the behavioral symptoms manifested by the resident.	NN, SSN, SN, NR, CP
H3a NURSING RESTORE SCORE ONLY (page 3-108)	Any Scheduled Toileting Plan	Evidence in the medical chart must support a plan whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a urinal, or remind the resident to go to the toilet.	NN, NR, SN, CP, CNAN

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MDS 2.0 LOCATION	**FIELD DESCRIPTION**	**CHARTING GUIDELINES**	**POSSIBLE CHART LOCATION**
H3b NURSING RESTORE SCORE ONLY (page 3-108)	Bladder Retraining Program	Evidence in the medical chart must support a retraining program where the resident is taught to delay urinating or resist the urgency to void. Residents are encouraged to void on a schedule rather than according to their urge to void.	NN, NR, SN, CP, CNAN
I1a (page 3-111)	Diabetes Mellitus	An active physician diagnosis must be present in the medical chart. Includes insulin-dependent and diet-controlled.	PO, PPN, H&P
I1r (page 3-111)	Aphasia	An active physician diagnosis must be present in the medical chart. Aphasia is defined as difficulty in communicating orally, through sign, or in writing, or the inability to understand such communication. This difficulty must be cited in the medical chart.	PO, PPN, H&P
I1s (page 3-111)	Cerebral Palsy	An active physician diagnosis must be present in the medical chart with evidence of paralysis related to developmental brain defects or birth trauma.	PO, PPN, H&P
I1v (page 3-112)	Hemiplegia/ Hemiparesis	An active physician diagnosis must be present in the medical chart. Left or right-sided paralysis is acceptable as a diagnosis.	PO, PPN, H&P
I1w (page 3-115)	Multiple Sclerosis	An active physician diagnosis must be present in the medical chart.	PO, PPN, H&P
I1z (page 3-112)	Quadriplegia	An active physician diagnosis must be present in the medical chart. Paralysis of all four limbs must be cited in the medical record. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury**. It is insufficient to code I1z with a diagnosis of spastic quadriplegia or functional quadriplegia**.	PO, PPN, H&P
I2e (page 3-116 to 3-117)	Pneumonia	An active physician diagnosis must be present in the medical chart. Often there is a chest x-ray, medication order and notation of fever and symptoms.	PO, PPN, H&P

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MDS 2.0 LOCATION	**FIELD DESCRIPTION**	**CHARTING GUIDELINES**	**POSSIBLE CHART LOCATION**
I2g (page 3-116)	Septicemia	An active physician diagnosis must be present in the medical chart and may be coded when blood cultures have been drawn but "results" are not yet confirmed. Septicemia is a morbid condition associated with bacterial growth in the blood. Urosepsis is not considered for audit verification.	PO, PPN, H&P
J1c (page 3-119)	Dehydration; output exceeds intake	Supporting documentation might include intake/output records and thorough nurses' documentation describing the resident's symptoms and/or fluid loss that exceeds intake.	PO, PPN, NN, CP, SN, LAB
J1e (page 3-120)	Delusions	Evidence in the medical chart must describe examples of resident's fixed, false beliefs not shared by others even when there is obvious proof or evidence to the contrary.	PO, PPN, NN, SN, CP, SSN
J1h (page 3-120)	Fever	Recorded temperature 2.4 degrees greater than the baseline temperature. The route (rectal, oral, etc.) of temperature measurement must be consistent between the baseline and the elevated temperature.	NN, SN Vital sign sheet
J1i (page 3-120)	Hallucinations	Evidence in the medical chart that describes examples of resident's auditory, visual, tactile, olfactory or gustatory false perceptions that occur in the absence of any real stimuli.	NN, SN, PO, PPN, SSN, CP
J1j (page 3-120)	Internal Bleeding	Clinical evidence must be cited in the medical chart such as: black, tarry stools; vomiting "coffee grounds"; hematuria; hemoptysis; or severe epistaxis.	DN, NN, PO, PPN, SN
J1o (page 3-121)	Vomiting	Documented evidence of regurgitation of stomach contents.	DN, NN, PO, PPN, SN
K3a (page 3-128)	Weight Loss	Documented evidence in the medical chart of the resident's weight loss as defined on the MDS.	NN, SN, DN, CP, SSN, PPN Weight sheet
K5a (page 3-130)	Parenteral / IV	Evidence of an IV or heparin lock where IV fluids have been given continuously or intermittently must be cited in the medical chart.	NN, SN, PO, PPN, CP Hospital records

(Continued)

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MDS 2.0 Version 5.12, 34 – Grouper			
Element Listing of RUG Items			
MDS 2.0 LOCATION	**FIELD DESCRIPTION**	**CHARTING GUIDELINES**	**POSSIBLE CHART LOCATION**
K5b (page 3-130)	Feeding Tube	Documented evidence of a feeding tube that can deliver food/nutritional substances/ fluids/medications directly into the gastrointestinal system.	NN, SN, DN, PO, PPN, CP
K6a (page 3-131)	Calorie Intake	Documentation supports evidence of the proportion of all calories ingested (actually received) during the last seven days by IV or tube feeding that the resident actually received. This includes calories taken p.o.	DN, NN, SN, MAR
K6b (page 3-133)	Average Fluid Intake	Actual average amount of fluid by IV or tube feeding the resident received during the last seven days. IV flushes are not included in this calculation.	DN, NN, SN, MAR
M1a-d (page 3-134 to 3-135)	Ulcers/Staging	Evidence of the number of ulcers, of any type, at each stage, on any part of the body. Reverse staging is required on the MDS.	CP, DN, MAR, NN, PPN, SN, TN Skin sheet
M2a (page 3-135)	Pressure Ulcer	Recording the highest stage caused by pressure resulting in damage of underlying tissues.	CP, DN, MAR, NN, PPN, SN, TN Skin sheet
M4b (page 3-137)	Burns	All second and third degree burns must be documented in the medical chart.	NN, SN, PO, PPN, CP, DN, TN Skin sheet
M4c (page 3-137)	Open Lesions-other than ulcers, rashes, cuts	All open lesions must be documented in the medical chart. Documentation might include appearance, measurement, treatment, color, odor, etc.	NN, SN, PO, PPN, CP, DN, TN, TAR Skin sheet
M4g (page 3-138)	Surgical Wounds	Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. Documentation might include appearance, measurement, treatment, color, odor, etc. Does not include healed surgical sites or stomas, or central line.	NN, SN, PO, PPN, CP, DN, TN, TAR Skin sheet
M5a (page 3-139)	Pressure Relieving Device/chair	Includes gel, air, or other cushioning placed on a chair or wheelchair. Does not include egg crate cushions.	CP, MAR, NN, PO, PPN, SN, NR, TN, TAR

(Continued)

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Element Listing of RUG Items			
MDS 2.0 LOCATION	**FIELD DESCRIPTION**	**CHARTING GUIDELINES**	**POSSIBLE CHART LOCATION**
M5b (page 3-139)	Pressure Relieving Device/bed	Includes air fluidized, low airloss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Does not include egg crate mattresses.	CP, MAR, NN, PO, PPN, SN, NR, TN, TAR
M5c (page 3-139)	Turning/ repositioning program	Evidence of continuous, consistent program for changing the resident's position and realigning the body.	CP, MAR, NN, PO, PPN, SN, NR, TN, TAR
M5d (page 3-139)	Nutrition/hydration intervention to manage skin problems	Evidence of dietary intervention received by the resident for the purpose of preventing or treating specific skin conditions.	CP, DN, MAR, NN, PO, PPN, SN, TAR
M5e (page 3-139)	Ulcer Care	Evidence includes any intervention for treating an ulcer at any ulcer stage.	CP, DN, MAR, NN, PPN, SN, TN, TAR Skin sheet
M5f (page 3-139)	Surgical Wound Care	Includes any intervention for treating or protecting any type of surgical wound. Evidence of wound care must be documented in the medical chart.	NN, SN, PO, PPN, CP, DN, TN, TAR Skin sheet
M5g (page 3-139)	Application of dressings; other than to feet	Evidence of any type of dressing application (with or without topical medications) to the body.	NN, SN, PO, PPN, CP, DN, TN, MAR, TAR, Skin sheet
M5h (page 3-139)	Application of ointments/ medications (other than to feet)	Evidence includes ointments or medications used to treat a skin condition.	NN, SN, PO, PPN, CP, DN, TN, MAR, TAR, Skin sheet
M6b (page 3-140)	Infection of the foot	Clinical evidence noted in the medical chart to indicate signs and symptoms of infection.	NN, SN, PO, PPN, CP, DN, TN, MAR, TAR, Skin sheet
M6c (page 3-140)	Open lesion on the foot	Evidence of cuts, ulcers, or fissures.	NN, SN, PO, PPN, CP, DN, TN, MAR, TAR, Skin sheet

(Continued)

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MDS 2.0 LOCATION	**FIELD DESCRIPTION**	**CHARTING GUIDELINES**	**POSSIBLE CHART LOCATION**
M6f (page 3-140)	Applications of Dressings (feet)	Evidence of dressing changes to the feet must be documented in the medical chart.	NN, SN, PO, PPN, CP, TN, TAR, Skin sheet
N1a,b,c (page 3-141)	Time Awake (total checked equal 0 or 1)	Evidence of time awake or nap frequency should be cited in the medical chart to validate the answer.	NN, SN, PPN, CP, SSN, NR, CNAN
O3 (page 3-146)	Injections	Evidence includes the number of days during the last seven that the resident received any medication by subcutaneous, intramuscular, or intradermal injection. This does include antigen and vaccines. This does not include IV fluids or IV medications.	CP, DN, MAR, NN, PO, PPN, SN
P1a,a (page 3-148)	Chemotherapy	Includes any type of chemotherapy (anticancer drug) given by any route for the sole purpose of chemotherapy treatment. Evidence must be cited in the medical chart.	NN, SN, PO, PPN, CP, DN, SSN, MAR Hospital records
P1a,b (page 3-149)	Dialysis	Includes peritoneal or renal dialysis that occurs at the nursing facility or at another facility. Evidence must be cited in the medical chart.	NN, SN, PO, PPN, CP, DN, SSN Hospital records
P1a,c (page 3-149)	IV Medication	Documentation of IV med administered must be present in the medical chart.	NN, MAR, PO, CP Hospital records
P1a,g (page 3-149)	Oxygen Therapy	Oxygen therapy shall be defined as the administration of oxygen continuously or intermittently via mask, cannula, etc. Evidence of administration must be cited on the medical chart.	NN, SN, PO, PPN, CP, SSN, TN Hospital records
P1a,h (page 3-149)	Radiation	Evidence includes radiation therapy or a radiation implant.	CP, MAR, NN, PO, PPN, SN, SSN Hospital records
P1a,i (page 3-149)	Suctioning	Evidence of nasopharyngeal or tracheal aspiration must be cited in the medical chart. Oral suctioning is not permitted to be coded in this field.	NN, SN, PO, PPN, CP, TN Hospital records

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Element Listing of RUG Items			
MDS 2.0 LOCATION	**FIELD DESCRIPTION**	**CHARTING GUIDELINES**	**POSSIBLE CHART LOCATION**
P1a,j (page 3-149)	Tracheostomy Care	Evidence of tracheostomy and cannula cleansing administered by staff must be cited in the medical chart.	NN, SN, PO, PPN, CP, TN Hospital records
P1a,k (page 3-149)	Transfusions	Evidence of transfusions of blood or any blood products administered by staff must be cited in the medical chart.	NN, SN, PO, PPN, CP Hospital records
P1a,l (page 3-149)	Ventilator or Respirator	Evidence of ventilator or respirator assistance must be cited in the medical chart. Any resident who was in the process of being weaned off the ventilator or respirator in the last 14 days should be coded. Neither CPAP nor BiPAP are considered ventilator devices and are not permitted to be coded in this field.	NN, SN, PO, PPN, CP, TN Hospital records
P1b **a,b,c** **Col. A,B** (page 3-150)	Therapies	Days and minutes of each therapy must be cited in the medical chart on a daily basis to support the total days and minutes of direct therapy provided.	TN, PO
P1b,d A (page 3-151)	Respiratory Therapy	Days and minutes of respiratory therapy must be cited in the medical chart on a daily basis to support the total days and minutes of direct therapy provided.	TN, PO
P3a-j NURSING RESTORE SCORE ONLY (page 3-153 to 3-155)	Nursing Rehab/Restorative SEE NOTE	Days of restorative nursing must be cited in the medical chart on a daily basis. Minutes of service must be provided daily to support the program and total time that is then converted to days on the MDS.	NR, NN, SN, CP
P7 (page 3-160 to 3-161)	Physician visits	Evidence includes the **number of days** (NOT NUMBER OF VISITS) in the last 14 days a physician examined the resident. Can occur in the facility or in the physician's office. A licensed psychologist may not be included for a visit.	PO, PPN, NN

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Table 1.2 – RUG Items

MDS 2.0 Version 5.12, 34 – Grouper			
Element Listing of RUG Items			
MDS 2.0 LOCATION	**FIELD DESCRIPTION**	**CHARTING GUIDELINES**	**POSSIBLE CHART LOCATION**
P8 (page 3-161)	Physician orders	Evidence includes the **number of days** (NOT NUMBER OF ORDERS) in the last 14 days a physician changed the resident's orders. Includes written, telephone, fax, or consultation orders for new or altered treatment. Does *not* include admission orders, return admission orders, or renewal orders without changes. A licensed psychologist may not be included for an order.	PO, PPN

Table 1.3 – Key for Possible Chart Location

Abbreviation	Definition	Abbreviation	Definition
CP	Care Plan	PO	Physician Orders
DN	Dietary Notes	PPN	Physician Progress Note
LAB	Laboratory	SN	Summary Notes (nursing)
MAR	Medicine Administration Record	SSN	Social Service Notes
CNAN	Certified Nursing Assistant Notes	NR	Nursing Restorative
NN	Nurses Notes	TN	Therapy Notes
TAR	Treatment Administration Record		

Special Notes About Documentation

- The history and physical (H&P) may be an excellent source of supportive documentation for any of the RUG-III elements.
- Any response(s) on the MDS 2.0 that reflects the resident's hospital stay prior to admission must be supported by hospital supportive documentation and placed in the resident's medical chart.
- Supportive documentation in the medical chart must be dated during the assessment reference period to support the MDS 2.0 responses. The assessment reference period is established by identifying the assessment reference date (A3a) and the previous six days. (Note that on certain MDS questions the reference period may be greater than or less than seven days).
- Responses on the MDS 2.0 must be from observations taken by all shifts during the specified assessment reference period.
- Old unrelated diagnosis or diagnoses that do not meet the definition on the MDS 2.0 for Section I1 should not be coded on the MDS.
- Nursing rehabilitation/restorative care (P3) includes nursing intervention that assists or promotes the resident's ability to attain his or her maximum functional potential. It does not include procedures under the direction and delivery of qualified, licensed therapists. Nursing Restorative criteria must be met as defined on page 3-154 of the RAI manual.
- In order to qualify as a restorative nursing program (P3) for MDS purposes, staff must document the nature of the deficit, the specific deficit and treatment goals, and the expected frequency and duration of the treatment. Once the purpose and objectives of the treatment have been established, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative program.
- ADL documentation must reflect the assessment period.
- Information contained in the clinical record must be consistent and cannot be in conflict with the MDS.
- Therapy minutes provided simultaneously by two or more therapists must be split accurately between disciplines (section P1b,a-c)

- Group therapy is limited to four residents per session and only 25 percent of the total therapy minutes per discipline may be contributed to group therapy (section P1b,a-c).
- **The time it takes to perform an initial evaluation and develop the treatment goals and the plan of care for the patient cannot be counted as minutes of therapy received by the patient. Re-evaluations, once therapy is underway, may be counted.**
- **Do not code services that were provided solely in conjunction with a surgical procedure such as IV, medications or ventilators.**
- **Each page or individual document in the medical record should contain the resident identification information. At a minimum, all charting entries should include the resident name, medical record number, and a complete date (MM/DD/YY).**
- **Signatures are required to authenticate all medical records. At a minimum, the signature should include the first initial, last name, and title/credential.**
- **Any time a facility chooses to use initials in any part of the record for authentication of an entry there has to be corresponding full identification of the initials on the same form or on a signature legend. Initials should never be used where a signature is required by law (for example, on the MDS).**