Indiana Title XIX

M E D I C A I D B U L L E T I N

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To: All Indiana Medicaid Nursing Facility Providers

Subject: Supportive Documentation Guidelines Related to Resource Utilization Group (RUG)-III Version 5.01

Overview

The purpose of this bulletin is to remind Medicaid-certified nursing facilities of the requirements for Minimum Data Set (MDS) supportive documentation. Please be advised that supportive documentation for all MDS data elements that are utilized to classify nursing facility residents in accordance with the RUG-III resident classification system must be routinely maintained in each resident's medical chart. Such supportive documentation shall be maintained by the nursing facility for all residents.

Attached are revised Supportive Documentation Guidelines that will assist you in identifying and documenting all MDS data elements that are utilized to classify nursing facility residents in accordance with the RUG-III resident classification system.

*Note: Revisions have been **bolded** for your convenience.*

If you have any questions regarding the information contained in this bulletin, please contact the Myers and Stauffer help desk at (317) 816-4122. For questions about the Supportive Documentation Guidelines and the EDS review process, please contact the EDS Long Term Care Unit at (317) 488-5099.

NOTE: Beginning October 1, 1999, an MDS record will not be considered inaccurate unless the audited MDS values result in a new RUG-III classification for the resident record.

Prepared by the Office of Medicaid Policy and Planning, October 1, 1999 (Version 2)

Table 1.1 – Special Rehabilitation

MDS 2.0 VERSION 5.01			
SPECIAL REHABILITATION			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i Col. A,B and G1h,A **ADL ONLY**	Physical Functioning and Structural Problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provided during all shifts, as functionality may vary.	NN, SSN, SN, CP, NR
K5a ADL ONLY	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 ADL ONLY	**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
P1b a,b,c Col. A,B	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
P3a-i **LOW INTENSITY ONLY**	Nursing Rehab/ Restorative	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 total time that is then converted to days on the MDS.**	NR, NN, SN, CP

Very High Intensity		**High Intensity**		**Medium Intensity**		**Low Intensity**	
450 minutes or more of therapy per week and one type of therapy at least five days a week and two or more therapies delivered.		300 minutes or more of therapy per week and one type of therapy at least five days a week delivered.		150 minutes or more of therapy per week and five days or more of one or a combination of therapy delivered.		45 minutes or more of therapy per week and three days or more of one or a combined therapy and two types or more of nursing restorative, five or more days per week.	
ADL Score	**RUG-III**	**ADL Score**	**RUG-III**	**ADL Score**	**RUG-III**	**ADL Score**	**RUG-III**
14-18	**RVC**	**15-18**	**RHD**	**16-18**	**RMC**	**12-18**	**RLB**
8-13	**RVB**	**12-14**	**RHC**	**8-15**	**RMB**	**4-11**	**RLA**
4-7	**RVA**	**8-11**	**RHB**	**4-7**	**RMA**		
		4-7	**RHA**				

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Table 1.2 – Extensive Services

MDS 2.0 VERSION 5.01			
EXTENSIVE SERVICES			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i Col. A,B and G1h,A **ADL ONLY**	Physical Functioning and Structural Problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provided during all shifts, as functionality may vary.	NN, SSN, SN, CP, NR
K5a*****	Parenteral/IV	Evidence of an IV or heparin lock must be cited in the medical chart.	NN, SN, PO, PPN, CP, Hospital records
K5b **ADL ONLY**	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
P1a,i*****	**Suctioning**	Evidence of nasopharyngeal or tracheal **aspiration** must be cited in the medical chart.	NN, SN, PO, PPN, CP, TN, Hospital records
P1a,j*****	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,l*****	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 considered for audit validation.**	NN, SN, PO, PPN, CP, TN, Hospital records

*At least one of the above treatments must be coded and have an ADL score of 7 or more. If the ADL score is 6 or less, the record will classify in the Clinically Complex group.

TREATMENTS	RUG-III
3 or more	SE3
2	SE2
1	SE1

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Table 1.3 – Special Care

MDS 2.0 VERSION 5.01			
SPECIAL CARE			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i Col. A,B and G1h,A **ADL ONLY**	Physical Functioning and Structural Problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provided during all shifts, as functionality may vary.	NN, SSN, SN, CP, NR
I1w*****	Multiple Sclerosis	An **active** physician diagnosis must be present in the medical chart.	PO, PPN, NN, CP, SN, NR
I1z*****	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.	PO, PPN ,NN, CP, SN, NR
I2g*****	Septicemia	An **active** physician diagnosis must be present in the medical chart. Septicemia is a morbid condition associated with bacterial growth in the blood. **Urosepsis is not considered for audit validation.**	PO, PPN, NN, LAB, SN
K5a **ADL ONLY**	Parenteral/IV	Evidence of an IV or heparin lock must be cited in the medical chart.	NN, SN, PO, PPN, CP, Hospital records
K5b*****	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
M2a*****	Pressure Ulcer (stage 3 or 4)	All pressure ulcers must be described and staged as they appear during the observation period on the MDS. This may require the stage to be increased or decreased from the previous MDS.	NN, SN, PO, PPN, CP, DN, TN, Wound record
M4b*****	Burns	All second and third degree burns must be documented in the medical chart.	NN, SN, PO, PPN, CP, DN, TN, Skin sheet
P1a,c*****	IV Medications	Documentation must be present in the medical chart.	NN, MAR, PO, CP, Hospital records

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MDS 2.0 VERSION 5.01			
SPECIAL CARE			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
P1a,h*****	Radiation	Includes radiation therapy or a radiation implant. Documentation must be available in the medical chart.	NN, SN, PO, PPN, SSN, DNCP, Hospital records
B1**	Comatose	Must have a documented neurological diagnosis of coma or persistent vegetative state from physician.	PO, PPN, NN, CP, SN
N1d******	Time Awake (None of Above)	Evidence of time awake or nap frequency should be cited in the medical chart to validate the response.	NN, SN, PPN, CP, SSN, NR, CNAN
J1h**	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
I2e**	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, NN, SN, X-RAY
J1c**	Dehydration; output exceeds input	Supportive 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
J1o**	Vomiting	Evidence must be cited in the medical chart.	NN, SN, SSN, PPN
K3a**	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

****Special combination considerations:** When B1=coma, all ADL self-performance (G1a,b,h,i) are coded with a 4 or 8 and time awake (N1d-None of Above) is checked.

When J1h, fever is checked, one of the following must also be checked; I2e, pneumonia; J1c, dehydration; J1o, vomiting; K3a, weight loss.

*At least one of the above conditions must be coded and have an ADL score of 7 or more. If the ADL score is 6 or less, the record will classify in the Clinically Complex group.

ADL Score	**RUG-III**
17-18	**SSC**
14-16	**SSB**
7-13	**SSA**

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Table 1.4 – Clinically Complex

MDS 2.0 VERSION 5.01			
CLINICALLY COMPLEX			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i Col. A,B and G1h,A **ADL ONLY**	Physical Functioning and Structural Problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provided during all shifts, as functionality may vary.	NN, SSN, SN, CP, NR
I1r*****	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.	NN, SSN, SN, CP, PPN, PO
I1s*****	Cerebral Palsy	An **active** physician diagnosis must be present in the medical chart. Paralysis related to developmental brain defects or birth trauma.	PO, PPN, NN, CP, SN
I1v*****	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, NN, CP, SN, NR
I2e*****	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, NN, SN, X-RAY
I2j*****	Urinary Tract Infection	Includes chronic and acute symptomatic infection(s) in the last 30 days. There must be current supportive documentation. Significant laboratory findings in the medical chart **are not required for audit validation.**	PO, PPN, NN, LAB, SN
J1c*****	Dehydration; output exceeds input	Supportive documentation might include intake/output records and thorough nurses' documentation describing the resident's symptoms and/or fluid loss which exceeds intake.	PO, PPN, NN, CP, SN, LAB
J1j*****	Internal Bleeding	Clinical evidence must be cited in the medical chart such as: black, tarry stools; vomiting "coffee grounds"; hematuria; hemoptysis; or severe epistaxis.	NN, SN, PO, PPN

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MDS 2.0 VERSION 5.01			
CLINICALLY COMPLEX			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
J1k*****	Recurrent Lung Aspirations	Clinical indicators required in the medical chart might include: productive cough, shortness of breath or wheezing.	NN, SN, PO, PPN, CP, X-RAY, TN
J5c*****	End-stage Disease	A physician **terminal** diagnosis of a deteriorating clinical course is required in the medical chart.	PO, PPN, NN, SN, CP, SSN, Hospice notes
K5a***** **ADL ONLY**	Parenteral/IV	Evidence of an IV or heparin lock must be cited in the medical chart	NN, SN, PO, PPN, CP, Hospital records
K5b **ADL ONLY**	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
M2b*****	Stasis Ulcer (stage 1, 2, 3, or 4)	All stasis ulcers must be described and staged as they appear during the observation period on the MDS. This may require the stage to be increased or decreased from the previous MDS.	NN, SN, PO, PPN, CP, DN, TN, Wound record
P1a,a*****	Chemotherapy	Includes any type of chemotherapy (anticancer drug) given by any route. Evidence must be cited in the medical chart.	NN, SN, PO, PPN, CP, DN, SSN, MAR, Hospital records
P1a,b*****	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,g*****	Oxygen Therapy	Oxygen therapy shall be defined as the administration of oxygen continuous or intermittent via mask, cannula, etc. Evidence must be cited on the medical chart.	NN, SN, PO, PPN, CP, SSN, TN, Hospital records
P1a,k*****	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
P1b,d A*****	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

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MDS 2.0 VERSION 5.01			
CLINICALLY COMPLEX			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
P8*****	Physician Orders (4 or more)	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.	PO, PPN
M4c******	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, Skin sheet
M4f******	Skin Tears or Cuts	A skin tear or cut is any traumatic break in the skin penetrating to subcutaneous tissue. Documentation might include appearance, measurement, treatment, color, odor, etc.	NN, SN, PO, PPN, CP, DN, TN, Skin sheet
M5i******	Other preventative or protective skin care (other than to feet)	Includes application of creams or bath soaks to prevent dryness, scaling; application of protective elbow pads, etc. Evidence of preventive or protective care must be documented in the medical chart.	NN, SN, PO, PPN, CP, TN, NR, Skin sheet, Treatment sheet
M6f**	Applications of Dressings (feet)	Evidence of dressing changes to the feet must be documented in the medical chart.	NN, SN, PO, PPN, CP, TN, Skin sheet, Treatment sheet
M4g**	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.	NN, SN, PO, PPN, CP, DN, TN, Skin sheet
M5f**	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, Skin sheet
**Special combination considerations: M4c, open lesions must also include coding for M5i, other skin care or M6f, foot dressings. M4f, skin tears/cuts must also include coding for M5i, other skin care or M6f, foot dressings.			
*The resident must qualify for one of the above conditions. The resident who met criteria for Extensive Services or Special Care but the ADL score was below 7 would classify as Clinically Complex. Once classified in Clinically Complex, next the resident is evaluated for Depression using the items in Table 1.5			

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MDS 2.0 VERSION 5.01			
CLINICALLY COMPLEX - DEPRESSION ELEMENTS			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
E2	Mood Persistence (1 or 2)	Of the indicators described in E1, the medical chart must cite the results of attempts to alter the indicator(s)	NN, SSN, SN, NR, CP
E1a,g,j,n,o,p	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. See MDS (E1) for specific **details.**	NN, SSN, SN, NR, CP
E4e Col.A	Behavioral Symptoms (1, 2, or 3)	Acknowledgment and **examples** of the resident's behavior symptom patterns must be provided in the medical chart. The record must reflect **daily** behavioral symptoms manifested by the resident.	NN, SSN, SN, NR, CP
N1d	Time Awake (None of Above)	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
N1a,b,c	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
B1	Comatose (equal 0)	Must have a documented neurological diagnosis of coma or persistent vegetative state from physician.	PO, PPN, NN, CP, SN
K3a	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
I1ee	Depression	An **active** physician diagnosis must be present in the medical chart.	PO, PPN, NN, CP, SN, SSN
I1ff	Manic Depression (bipolar disease)	An **active** physician diagnosis must be present in the medical chart.	PO, PPN, NN, CP, SN, SSN

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MDS 2.0 VERSION 5.01

CLINICALLY COMPLEX - DEPRESSION ELEMENTS

DEPRESSION EVALUATION

The resident is considered depressed if he/she meets either a combination of group **A** or group **B** of the following criteria:

GROUP A

E2 Persistent sad mood (1 or 2) and two other symptoms (only one symptom can be counted from groups 2 and 3):

1. E1a – Negative statements (1 or 2)
2. E1n – Repetitive movements (1 or 2)
   E1o – Withdrawal (1 or 2)
   E1p – Reduced interaction (1 or 2)
   E4eA – Resists care (1,2, or 3)
3. E1j – Unpleasant AM mood (1 or 2)
   N1d – Time awake (checked)
   N1a,b,c – Awake only morning, afternoon, or evening (total checked = 0 or 1) and B1=0
4. E1g – Terrible future (1 or 2)
5. K3a – Weight loss

OR

GROUP B

(I1ee) Depression and one symptom from the items above **or** (I1ff) Bipolar disease and one symptom from the items above.

ADL Score	**Depressed**	**RUG-III**
17-18	**YES**	**CD2**
17-18	**NO**	**CD1**
11-16	**YES**	**CC2**
11-16	**NO**	**CC1**
6-10	**YES**	**CB2**
6-10	**NO**	**CB1**
4-5	**YES**	**CA2**
4-5	**NO**	**CA1**

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Table 1.5 - Impaired Cognition

MDS 2.0 VERSION 5.01			
IMPAIRED COGNITION			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i Col. A,B and G1h,A **ADL ONLY**	Physical Functioning and Structural Problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provided during all shifts, as functionality may vary.	NN, SSN, SN, CP, NR
B2a*****	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.**	NN, SSN, SN, NR, CP
B3a-d*****	Memory/ Recall Ability	Examples of the resident's memory/recall performance within the enviroment or circumstances must be found in the medical chart. (E.g., ask the resident "what is the current season, what is the name of this place or what kind of place this is.")	NN, SSN, SN, NR, CP
B4*****	Cognitive Skills for Daily Decision Making	Citations or examples 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
H3a **NURSING RESTORE SCORE ONLY**	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
P3a-i **NURSING RESTORE SCORE ONLY**	Nursing Rehab/ Restorative	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

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MDS 2.0 VERSION 5.01		
IMPAIRED COGNITION		
Nursing Restorative care (P3) counts as a score of 1 for each item (P3 a,b,c,e,g,h,i) with an entry of five or more days of activity. P3d and/or P3f may be counted as a score of 1, but do not count both. Additionally, if any toileting plan (H3a) is checked, add a score of 1 to the Nursing Restorative Score.		
Total ADL score must be 10 or less. The following criteria combination must be met: *B2a Short term memory = 1 and B3a-d Memory/Recall (any **not** checked) and B4 Decision making (1, 2, or 3)		
ADL Score	**Nursing Restorative Score**	**RUG-III**
6-10	**2 or more**	**IB2**
6-10	**0 or 1**	**IB1**
4-5	**2 or more**	**IA2**
4-5	**0 or 1**	**IA1**

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Table 1.6 – Behavior Problems

MDS 2.0 VERSION 5.01			
BEHAVIOR PROBLEMS			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i Col. A,B and G1h,A **ADL ONLY**	Physical Functioning and Structural Problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provided during all shifts, as functionality may vary.	NN, SSN, SN, CP, NR
E4a,b,c,d***** Col.A	Behavioral Symptoms	Acknowledgment and **examples** of the resident's behavior symptom patterns must be provided in the medical chart. The record must reflect **daily** behavioral symptoms manifested by the resident.	NN, SSN, SN, NR, CP
H3a **NURSING RESTORE SCORE ONLY**	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
J1e*****	Delusions	Evidence in the medical chart must describe examples of residents fixed, false beliefs not shared by others even when there is obvious proof or evidence to the contrary.	PO, PPN, NN, SN, CP, SSN
J1i*****	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
P3a-i **NURSING RESTORE ONLY SCORE**	Nursing Rehab/ Restorative	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 is then converted to days on the MDS.	NR, NN, SN, CP
Nursing Restorative care (P3) counts as a score of 1 for each item (P3 a,b,c,e,g,h,i) with an entry of five or more days of activity. P3d and/or P3f may be counted as a score of 1, but do not count both. Additionally, if any toileting plan (H3a) is checked, add a score of 1 to the Nursing Restorative Score.			

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MDS 2.0 VERSION 5.01		
BEHAVIOR PROBLEMS		
Total ADL score must be 10 or less.		
*One of the above must be coded.		
ADL Score	**Nursing Restorative Score**	**RUG-III**
6-10	**2 or more**	**BB2**
6-10	**0 or 1**	**BB1**
4-5	**2 or more**	**BA2**
4-5	**0 or 1**	**BA1**

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Table 1.7 – Reduced Physical Function

MDS 2.O VERSION 5.01			
REDUCED PHYSICIAL FUNCTION			
MDS 2.0 Location	**Field Description**	**Charting Guidelines**	**Possible Chart Location**
G1a,b,i Col. A,B and G1h,A **ADL ONLY**	Physical Functioning and Structural Problems ADLs	Four ADLs must be addressed in the medical chart for purposes of validating the MDS responses. These ADLs include bed mobility, transfer, toileting, and eating. Consider the resident's self-performance and support provide during all shifts, as functionality may vary.	NN, SSN, SN, CP, NR
H3a **NURSING RESTORE ONLY SCORE**	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
P3a-i **NURSING RESTORE ONLY SCORE**	Nursing Rehab/Restorative	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 which is then converted to days on the MDS.	NR, NN, SN, CP
Nursing Restorative care (P3) counts as a score of 1 for each item (P3 a,b,c,e,g,h,i) with an entry of 5 or more days of activity. P3d and/or P3f may be counted as a score of 1, but do not count both. Additionally, if any toileting plan (H3a) is checked, add a score of 1 to the Nursing Restorative Score.			

ADL Score	**Nursing Restorative Score**	**RUG-III**
16-18	**2 or more**	**PE2**
16-18	**0 or 1**	**PE1**
11-15	**2 or more**	**PD2**
11-15	**0 or 1**	**PD1**
9-10	**2 or more**	**PC2**
9-10	**0 or 1**	**PC1**
6-8	**2 or more**	**PB2**
6-8	**0 or 1**	**PB1**
4-5	**2 or more**	**PA2**
4-5	**0 or 1**	**PA1**

NOTE: Beginning October 1, 1999, an MDS record will not be considered inaccurate unless the audited MDS values result in a new RUG-III classification for the resident record.

Prepared by the Office of Medicaid Policy and Planning, October 1, 1999 (Version 2)

Table 1.8 – Key for possible chart locations in the medical record

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

Special Notes About Documentation

- Supportive documentation must occur during the assessment period.
- The history and physical (H&P) may also 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 (validate) 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). You may or may not use prior admission observation.
- 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.
- Facilities will be required to complete a new assessment after the cessation of all therapies when the preceding assessment is in the Rehabilitation category (Rule *405 IAC 1-15-6*).
- Rehabilitation/restorative care 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.
- **Beginning October 1, 1999, ADL documentation must represent all shifts during the assessment period.**

NOTE: Beginning October 1, 1999, an MDS record will not be considered inaccurate unless the audited MDS values result in a new RUG-III classification for the resident record.