MDS Forms: Where Does the Information Come from and How to Use It

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One of the most beneficial tools for a practitioner seeking justice for the victims of nursing home neglect and abuse is the government mandated Minimum Data Set (MDS). In addition to being the most comprehensive document for assessing the needs of each long-term care resident, it is one of the few documents in a nursing home case that is signed by facility staff under the penalty of perjury.

On October 1, 2010, CMS implemented MDS 3.0, which was intended to improve the reliability and accuracy of the standardized assessment. The MDS is one of three parts of the Resident Assessment Instrument (RAI) and must be completed regardless of whether that particular patient is self-pay or a Medicare or Medicaid beneficiary, as long as that facility accepts Medicare or Medicaid funds. The purpose of the MDS is to assess the physical and mental status of a resident and to establish acuity. The information gathered is then submitted to the federal government and used to establish a patient's Resource Utilization Group (RUG) which dictates the payment amount that a facility receives from Medicare or Medicaid for the treatment and care of that resident. The idea being that a quadriplegic resident needs a great deal more care than an individual who is merely in the facility recovering from hip surgery. Facilities receive a higher level of payment to reimburse them for the additional staff time required to care for a resident requiring a higher level of care.

More importantly, 42 C.F.R. 483.20(j) provides that, "MDS information serves as the clinical basis for care planning and delivery." Thus, since the MDS establishes the level of care that the facility claims the resident requires, the facility must then care plan for the needs assessed and deliver that care.

Completing the MDS

MDS forms are generally completed by an MDS coordinator, sometimes also referred to as a Nurse Assessment Coordinator. This individual is responsible for using the RAI to gather information from the resident, their families, doctors, and staff to complete the instrument and the MDS. The MDS coordinator must ensure the accuracy of the information inputted into the MDS. Oftentimes, MDS coordinators are RNs or LPNs because the government requires a staff person of at least that level to sign off on the MDS.

When utilizing an MDS in your case, it is important to understand the context and the timing of each MDS you are working with. First, establish the type of assessment the MDS represents. In all, there are a total of 15 different circumstances under which a new MDS form needs to be completed for a resident. Following admission, a new MDS form must be completed for each resident within 14 days of admission into a long-term care facility. After admission, each resident must then be reassessed no less than annually but may be assessed for other reasons on a more frequent basis. For instance, a resident must be reassessed when there is a significant change in status, such as following a fall resulting in injury.

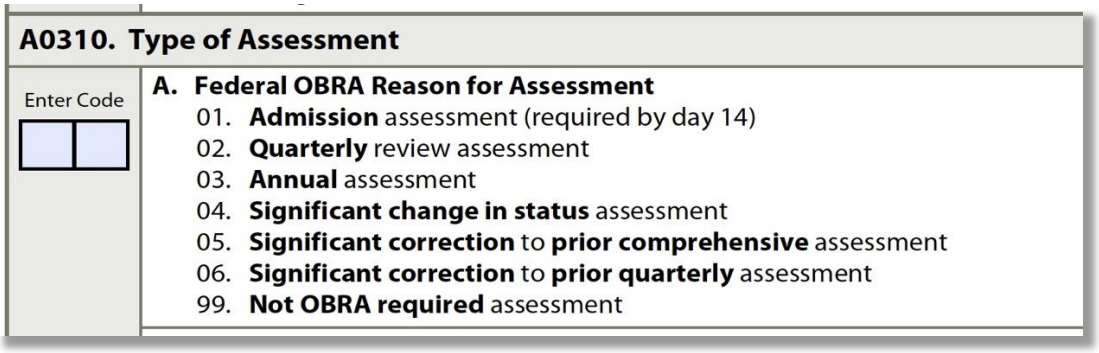


Fig. 1 – Section A0310 of the MDS setting forth the type of assessment.

Next, determine the assessment reference date which is listed in Section A2300. This will provide you with a frame of reference regarding your client's health at that point in time and is the date on which the look-back period ends. A look-back period is the time frame that the MDS coordinator, or staff completing the MDS form, must look at to determine the resident's functional status. For example, when completing Section G0110 Functional Status, the staff must determine the amount of support an individual required over the seven days preceding the reference date. If a resident requires extensive assistance in turning and repositioning during the entire look-back period, the staff cannot code the resident as being totally dependent upon staff for turning and reposition.

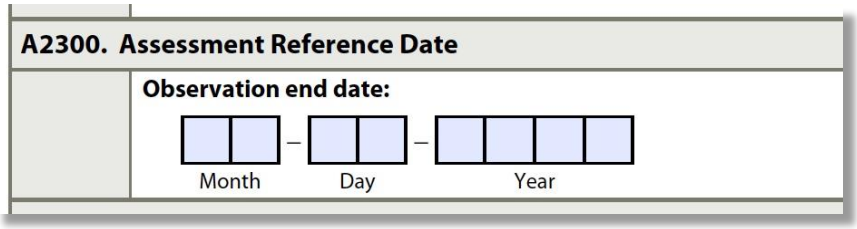
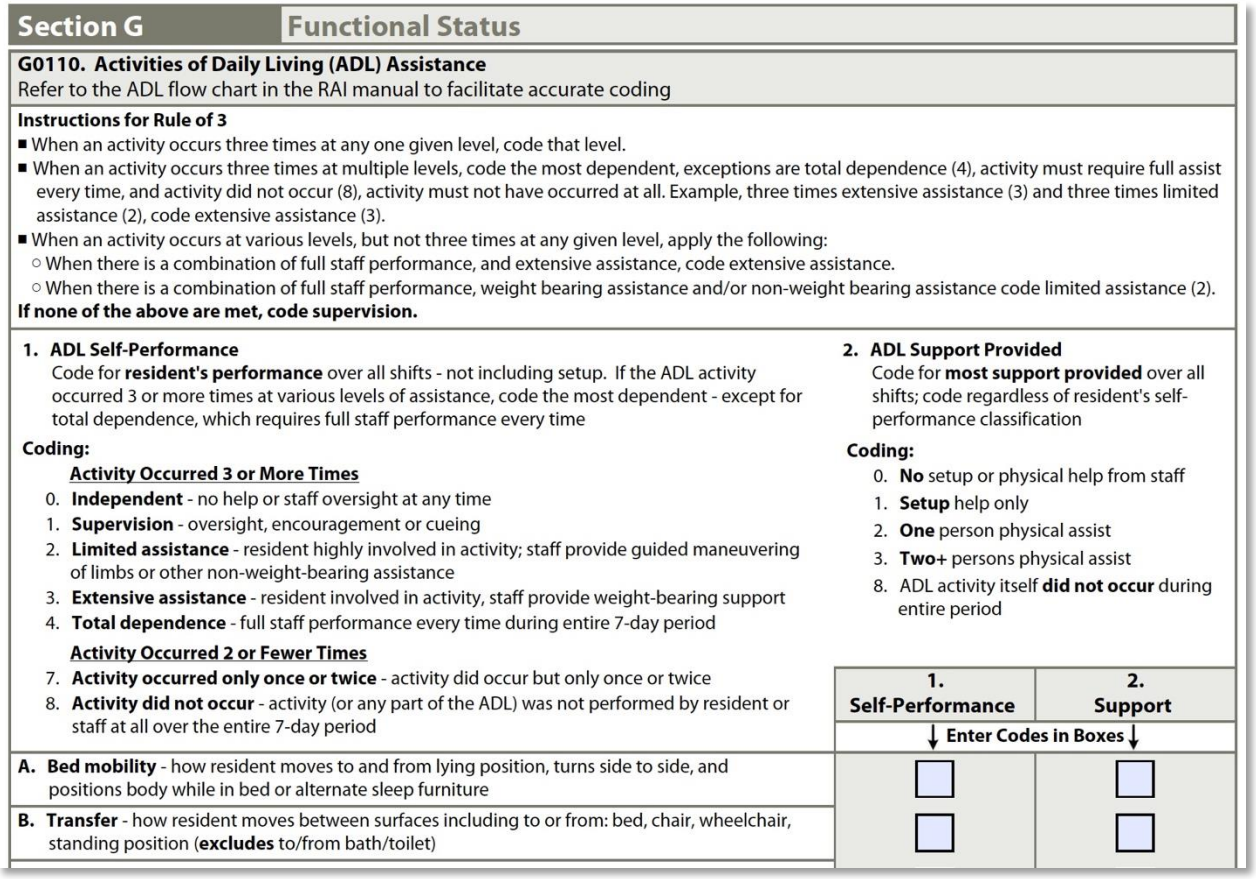


Fig. 2 – Section 2300 showing the Assessment Reference Date field in the MDS.

Where You See Issues

In nursing home cases, incidents of up-coding are prevalent. Up-coding occurs when a facility codes a resident as requiring more care than the facility actually provided in an effort to boost revenue. Thus, a resident who has some bed mobility is coded on the MDS as totally dependent upon staff for turning and repositioning. Then, when reviewing the nursing notes or in

deposition testimony, staff will attempt to defend their conduct by claiming that the resident had more functional abilities than what was listed in the MDS form.



Section G **Functional Status**

G0110. Activities of Daily Living (ADL) Assistance
Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

Instructions for Rule of 3
- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.

1. ADL Self-Performance
Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times
0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times
7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity (or any part of the ADL) was not performed by resident or staff at all over the entire 7-day period

2. ADL Support Provided
Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:
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 period

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
A. **Bed mobility** - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture		
B. **Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)		

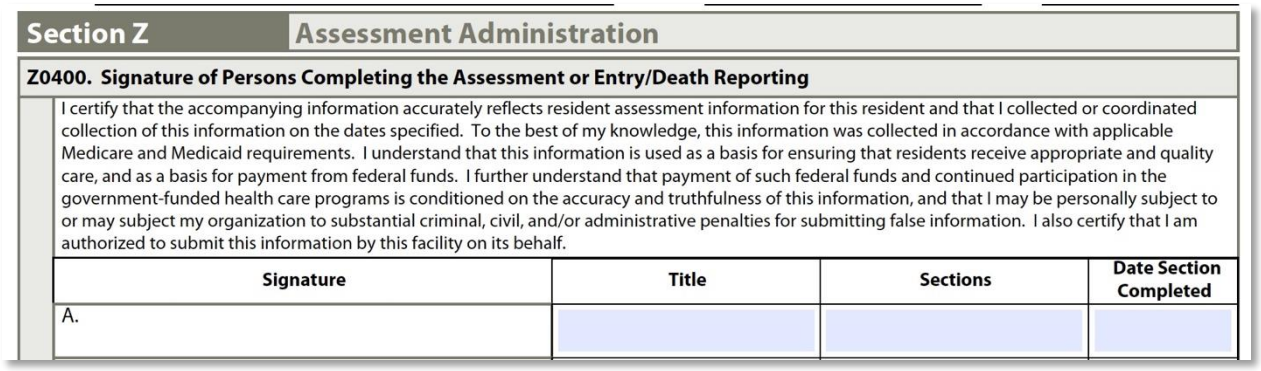
Fig. 3 – Section G of the MDS 3.0 form.

In one case litigated by the author, the defendant nursing home submitted an MDS stating that a resident was totally dependent upon staff for any movement in bed whatsoever. But when the resident was injured in a fall, the staff testified in depositions that the resident was able to move and attempted to get herself out of bed. If that were true, it would have been the first time in three years that this particular resident was able to move herself in bed. A 30(b)(6) deposition of the MDS coordinator was used to show that the staff was either lying about the incident or that the MDS form, which is submitted to the federal government under the penalty of perjury, was false for three years running.

Also, look for the failure of a facility to complete a new MDS form when your client suffers a fall or skin breakdown. The MDS information reported to the government is sometimes used to determine which facilities need a deeper review during annual surveys. By underreporting falls and facility-acquired pressure sores, the facilities are attempting to avoid the ire of inspectors.

As a practitioner, you can use the information submitted in an MDS to hold the provider responsible for providing the level of care that they tell the federal government the resident requires. All MDS forms must be signed by any employee completing any section of the MDS.

And, because the form drives the government's payments to the facility, the forms are signed under the penalty of perjury. Section Z, pictured here, asks each signatory to acknowledge that they complied with Medicare and Medicaid requirements for gathering the information and that the information is true to the best of their ability.



Section Z Assessment Administration

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects resident assessment 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	Title	Sections	Date Section Completed
A.			

Fig. 4 – Section Z of MDS 3.0.

Discovery Tools

At a minimum, you should have received your client's completed MDS forms with the medical records produced before litigation. Be sure that the MDS forms include Section Z, which is often left off in the initial production. In your document requests, also ask the defendant to provide copies of the completed MDS forms for residents of the facility that were on the same wing or section as your client for the time period that your client was on the floor. If you suspect up-coding on those forms, ask the defendant to produce the documents that provided the basis for the MDS information for each resident.

As you might expect, defendants always object to producing such voluminous information. Thus, you will need to set the stage in depositions before asking for the documents. Establish through the director of nursing, or the staffing director, that acuity drives staffing and that the facility was providing all of the care that each patient required. Then, establish through the witness that the best way to determine each resident's physical and mental status is the medical records and MDS for each resident. When the defendant then files a motion for a protective order claiming that these documents are confidential, irrelevant, or too voluminous, you can quote from their own employees to show that these documents are necessary to show the level of care required of each resident and to determine whether the facility had enough staff to provide for each resident's needs.

To head off an objection on the confidentiality of other resident's records, be sure to state in your request, "Pursuant to 45 C.F.R. § 164.512(e), please redact all identifying information of residents other than plaintiff (including names, race, gender, birth dates, dates of death, Social Security Numbers, medical record numbers, numeric identifiers, health plan/Medicare/Medicaid beneficiary numbers, and account numbers)."

In discovery, also consider serving a 30(b)(6) deposition notice on the defendant with the areas of inquiry limited to the completed MDS forms for the client, the facility's understanding of the

federal regulations pertaining to the completion of the MDS form, and the supporting documentation for the completion of each form. Depending upon the facts of the case, additional, more specific topics in the MDS may be identified. Used early in litigation, this deposition locks the defendant into their position on the physical and mental needs of the resident during the entirety of the resident's stay. Then, it is possible to draw contradictory testimony regarding the level of care being provided during the depositions of specific RNs and CNAs who provided care to the resident.

CONCLUSION

When litigating most nursing home cases, the MDS form can be a valuable tool to hold the facility accountable for its failure to provide an appropriate level of care. The MDS is the nursing home's own reporting of the resident's needs and is the basis on which the facility must provide care. Take advantage of the facility's admissions and ensure that they are providing at least the minimum level of care that the facility is being paid to provide.