Frequently Asked Questions and Answers

2014 MDS 3.0: Nutrition/Dietary and Related Sections

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Introductory comments:

The responses and comments for this document are very specific to the RAI manual and coding directions for the MDS 3.0. In many areas the MDS 3.0 does not provide specific guidance and documentation will be used to support your coding for the resident. In addition, please remember that the terms are specific to MDS 3.0 and other frequently used resources will need to be considered in provision of nutritional care and services. The CMS State Operations Manual is used by surveyors to interpret compliance with LTC regulations and it is imperative that the practitioner understand the process and specific terminology used for all processes. An example would include the difference in the definition of "therapeutic diet" which defined in the State Operations Manual is: *"Therapeutic diet" refers to a diet ordered by a health care practitioner as part of the treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium or potassium), or to provide mechanically altered food when indicated."* This can be compared to the MDS 3.0 definition which is : "*A therapeutic diet is a diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status, to eliminate, decrease, or increase certain substances in the diet (e.g. sodium, potassium) (ADA, 2011)."* It is important to note differences in the definitions when determining appropriate responses.

1. Q: Is a fluid restriction considered a therapeutic diet?

   RESPONSE: The MDS 3.0 has no specific coding guidance for this question.
   Per the RAI manual, Therapeutic diets are not defined by the content of what is provided or when it is served, but why the diet is required. Therapeutic diets provide the corresponding treatment that addresses a particular disease or clinical condition which is manifesting an altered nutritional status by providing the specific nutritional requirements to remedy the alteration. THERAPEUTIC DIET DEFINITION (RAI MANUAL): A therapeutic diet is a diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status, to eliminate, decrease, or increase certain substances in the diet (e.g. sodium, potassium) (ADA, 2011).
2. Q: In addition to coding a TF under K0510 B is it also coded as a therapeutic diet if it is a renal or diabetic product being used?

   RESPONSE: Should only be coded as K0510D, Therapeutic Diet when the enteral formula is altered to manage problematic health conditions, e.g. enteral formulas specific to diabetics. (Or Respiratory conditions such as with Pulmocare etc.)

3. Q: Do you code if both the symptom and the successful intervention occur in the 7 day look back period.

   RESPONSE: Per the RAI Manual, Do not code a swallowing problem when interventions have been successful in treating the problem and therefore the signs/symptoms of the problem (K0100A through K0100D) did not occur during the 7-day look-back period.
   • Code even if the symptom occurred only once in the 7-day look-back period

4. Q: For clarification - chewing is not coded in Section K. Only swallowing- even though the SLP would consider oral phase impairment- a part of the swallow?

   RESPONSE: Chewing problems are coded in section L – Oral/Dental Status. If the resident is experiencing swallowing problems because they have chewing problems, and the documentation reflects this during the look back, you could code in both sections.
5. Q: What if a patient refuses to be weighted and you don't have a current weight for long time period?

   RESPONSE: This needs to be documented as to the refusal to be weighed and then marked as a (-) "unknown". For best practice, other parameters for determining nutrition status should be established such as intake, labs, physical assessments (skin status, etc.). These parameters can be used when assessing overall nutritional status, interventions, etc.
6. Q: For the MDS, if there are multiple weights taken within the 30 days preceding the current weight, do you only look at the weight 30 days ago and disregard the weights between and current weight and 30 days ago?

   RESPONSE: "If the resident's weight was taken more than once during the preceding month, record the most recent weight." However, "weight loss should be monitored on a continuing basis; weight loss should be assessed and care planned at the time of detection and not delayed until the next MDS assessment."
7. Q: What about coding for weight loss for a new admit? Do you use a weight reported by patient to calculate the 5% loss/gain?

   RESPONSE: The RAI manual does state to" ask the resident, family, or significant other about weight loss over the past 30 and 180 days"; however it indicates that you should "consult the resident's physician, review transfer documentation, and compare with admission weight. If the admission weight is less than the previous weight, calculate the percentage of weight loss." The manual does not state to use actual weights reported by the resident/family, but those documented in other health records. Information provided by the resident/family should be incorporated into the assessment/CAA and care planning process.

8. Q: What if a physician starts a resident on dialysis and then has weight loss do you code this as a physician ordered weight loss?

   RESPONSE: RAI DEFINITIONS for PHYSICIAN-PRESCRIBED WEIGHT-LOSS REGIMEN is a weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. May employ a calorie-restricted diet or other weight loss diets and exercise. Also includes planned diuresis. It is important that weight loss is intentional. Your documentation needs to reflect the components as listed in the MDS definition.
9. Q: Can you provide examples of column 1?

   RESPONSE: If you mean column 1 of K0510, While not a resident, this would include all services provided during the look back period prior to admission of the resident to the facility. These might take place in the acute care hospital, Doctors office, etc.
10. Q: If I have weekly weights and weight loss has been >5% but the time frame for these weight is 14 days not 30 days, do I still code the loss on the MDS as this is the closest weight to 30 days?

    RESPONSE: It is best to use weights as close to the 30 and 180 days' time frames as possible. If the resident has not yet been there 30 days (such as when doing a Medicare 14 day assessment), the manual does not require that weight loss in less than 30 days be coded, as it is not within the comparison snap shots. However, you would still need to address the weight loss when detected.
11. Q: If a resident triggers for significant weight loss x28 days, but not x31 days, would I code "no" weight loss since weight on day 31 is closer to 30 days than 28 days?

    RESPONSE: The manual states "Base weight on the most recent measure in the last 30 days." So if you have a weight within the last 30 days, you must use that. If you do not, you weigh the resident again. So, in this case you would base the wt. loss on the weight at 28 days.
12. Q: Since CAA form- not a requirement, can a focused Nutrition assessment by the RD stand if for the CAA?

    RESPONSE: "Written documentation of the CAA findings and decision making process may appear anywhere in a resident's record: for example, in discipline-specific flow sheets, progress notes, the care plan summary notes, a CAA summary narrative etc."
13. Q: Should the ARD period be completed before the MDS can be done? If so, is there a time frame for completing the MDS / CAA once the ARD date has passed? If the RD completing the MDS is not in the facility past day 6 of the ARD for several days, how can the MDS be completed and still reflect the entire 7 days?

RESPONSE: The ARD does not end until 11:59 pm. All information pertinent to the resident up until that time should be included. It is up to the facility to determine how best to accomplish this.

14. Where do you code if vegetarian diet or lactose free diet per resident request but not doctored ordered? Is that considered therapeutic diet?

    RESPONSE: Food elimination diets r/t food allergies can be coded as a therapeutic diet. (pg. K-12 under coding tips) However; if the diet is not related to food allergies, or does not provide the corresponding treatment that addresses a particular disease or clinical condition, it would not meet the RAI definition for therapeutic diet.

15. Is a herb/vitamin, calcium vitamin D considered supplement and do you code that under supplements and therapeutic diet or just house shakes or ensure etc. considered supplements?

    RESPONSE: Supplements (whether given with, in-between, or instead of meals) are only coded in K0510D, Therapeutic Diet, when they are being administered as part of a therapeutic diet to manage problematic health conditions (e.g. supplement for protein-calorie malnutrition). Pg. K-12

    You may refer to the RAI Manual N0410: Medications Received. That includes the following for herbs and alternative medicine products: *Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted as medications (e.g. chamomile, valerian root). Keep in mind that, for clinical purposes, it is important to document a resident's intake of such herbal and alternative medicine products elsewhere in the medical record and to monitor their potential effects as they can interact with medications the resident is currently taking. For more information consult theFDA website*

    http://www.fda.gov/food/dietarysupplements/consumerinformation/ucm110567.htm.

16. Where do you code IV dextrose calories on the MDS? Is that included in the MDS section KO700? What do I include in the amount of fluids and the calories?

    RESPONSE: IV Dextrose would only be coded in K0710 for calories and amount of fluids if it specifically addressed a nutrition or hydration need as supported by documentation in the medical record.

17. Section K areas to code for now regarding Percent Intake by Artificial Route - While NOT a Resident, While a Resident, and During Entire 7 Days. Do we only code in the "During Entire 7 Days" column if the resident was receiving artificial nutrition for all 7 days during the 7 day look back period?

    RESPONSE: Yes.

    Or do we still code in the "During Entire 7 Days" column regardless because it is possible to code two different percentages for While NOT a Resident and While a Resident, and they are looking for a total here?

    RESPONSE: No See examples on pages K-14 thru K-15.

18. My understanding is that with many of the computerized charting such as PCC, for the charting you do to "push" to the MDS the charting must be done prior to the ARD date. We have moved our ARD by one day to accommodate our consultants. Otherwise it appears that the charting is being done late and it will NOT push into the MDS which is exactly what you want it to do to save time and money. Is this accurate?

    RESPONSE: We cannot speak for individual software, but the MDS questions must be answered utilizing information collected during the specified look back periods leading up to 11:59 pm on the ARD.

19. I just came across MDS Alert. It indicates that ' *Don't be tempted to code dietary supplements as KO510D Therapeutic diet. Although residents may take supplements to support calorie or Protein Malnutrition, or for a host of other reasons, you can't code Therapeutic diet if the supplements aren't treating a specific disease or condition.'" Alone supplements do not constitute a therapeutic diet; they must be administered as part of a therapeutic diet to manage problematic health conditions."* So my question is if we use supplements for weight loss Is this not therapeutic? Is malnutrition not enough to code therapeutic if supplements are used to correct it?

RESPONSE: Remember that weight loss is an important indicator and needs to be monitored and assessed for any change in the resident's health status or environment. At times the weight loss may be beneficial with no intervention needed. If the weight loss is also associated with a particular disease or clinical condition that manifests an altering of nutrient(s) then a dietary supplement may be a part of the overall treatment and intervention to treat that disease or clinical condition. It is not the supplement alone that is a therapeutic diet but when it is a part of the treatment.

20. I am not clear- in comfort care residents would you input a dash or would you check unable to determine

    RESPONSE: We am not sure what section of the MDS is being referred to here, but if it is section K0200B, Weight, if the resident cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code (-) and document rationale on the resident's medical record.

21. When does MDS Section K need to be completed? 5 day, 14 day, 30 day, end of therapy, continuation of therapy, discharge, quarterly, annual, etc. And should the completion dates correspond to the care plan calendar?

    RESPONSE: Section K is included with all PPS and OBRA assessments. The care plan must be completed within 7 days of completion of a comprehensive assessment. Also by regulation, the care plan must be periodically reviewed/revised by a team of qualified persons after each assessment.

22. Section K0300-Wt gain and K0310-Wt gain.

    For the MDS Item: *Yes on physician prescribed weight loss or wt. gain* regimen-does this mean the diet order or supplement orders can justify if the weight change noted was desired and/or planned? Ex. Most diet orders would not be physician prescribed wt. gain/loss unless orders include give double portions or no seconds or doubles as an example. Is this correct? Or does diet/supplement order need to include why ordered to justify wt. change noted?

    RESPONSE: To be "physician prescribed" the wt. loss or gain must be planned and pursuant to a physician's order.

23. -How would you treat weights done more frequently than monthly in regards to the 30, 90 and 180 day triggers? Ex weekly weights may trigger based on another weekly wt. but when you are looking at monthly weights, there is no trigger. Does it depend on when you are doing the assessment or go with the monthly weights for triggers?

    RESPONSE: If the resident's weight was taken more than once during the preceding month, record the most recent weight. Wt. loss and wt. gain are based on comparison of weights at the 30 day and 180 day time frames, not week to week.

24. How are these multiple weights addressed when doing 5, 14 and 30 day MDS assessments? Ex if you have a wt. loss noted at a 14 day review that may be significant since admit, do you count as 5% wt. loss in the last month or do you wait to mark until resident has been in facility 30 days then document at 30 day review?

    RESPONSE: If you have no data to compare (i.e. no weight to compare 30 days ago), then the wt. loss or wt. gain sections could be coded as dash filled (information not available) because you do not have the weight information for those snapshots in time to compare.