MDS Coding Tips: Incontinence

Always refer to your MDS RAI manual for coding examples and clarification. CNA documentation is very important for MDS coding accuracy.

How many times is resident incontinent in 7 days?

- ≥ 7 times for bladder / ≥ 2 times for bowel
- < 7 times for bladder / < 2 times for bowel — **Yes** → Excluded from numerator

Is the resident comatose? — **No**

Is the resident totally dependent with either: Bed mobility, Transfers or Locomotion on unit? — **No** → *Excluded from QM completely

What is resident's BIMS score?
(for residents who need staff interview for BIMS - if resident is coded as having short term memory problems AND severely impaired cognitive skills for daily decision making, this resident is also excluded) — **≤7** → *Excluded from QM completely

>7

Does the resident have an indwelling catheter for any reason? Does the resident have an ostomy? — **Yes** → *Excluded from QM completely

No

Resident is flagging appropriately for QM of low risk residents who lose control of bowel or bladder

*Excluded = Resident should not flag on resident level QM report for low risk residents who lose control of bowel or bladder and MDS should be evaluated