

COMMONWEALTH OF KENTUCKY
OFFICE OF INSPECTOR GENERAL AND
MYERS AND STAUFFER LC
PRESENT
MDS CODING AND INTERPRETATION BASICS



■ **MDS 3.0 RAI MANUAL V1.11**

- ✓ Updated – effective October 25, 2013
<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>
- ✓ Updates included grammar, capitalization and very minor item changes
- ✓ Only pages with actual updates have updated footer dates



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■ **OCTOBER 1, 2014 UPDATES**

- ✓ New MDS assessment, version 1.12.0 "Final"
- ✓ A0310B = 06 Readmission/return assessment – Deleted
- ✓ A0410 = Renamed item – Unit Certification or Licensure Designation
 - Response options;
 - 1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State
 - 2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State
 - 3. Unit is Medicare and/or Medicaid certified
- ✓ A0500 = First name – no blanks allowed
- ✓ A1500 = PASRR removed from;
 - Discharge
 - PPS assessments
 - Quarterly

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■ OCTOBER 1, 2014 UPDATES

- ✓ A1510 = Level II PASRR Conditions removed from;
 - Discharge
 - PPS assessments
 - Quarterly
- ✓ A1550 = Conditions related to ID/DD status removed from;
 - Discharge
 - PPS assessments
 - Quarterly
- ✓ A1600-1800 = Grouped these items under the heading "Most Recent Admission/Entry or Reentry into this Facility"
- ✓ A1900 = **NEW item** - Admission date
- ✓ O0250 = Flu season changed to influenza vaccination season
- ✓ O0250A = Influenza season changed to influenza vaccination season

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■ OCTOBER 1, 2014 UPDATES

- ✓ O0250B = Added to Discharge item set
- ✓ O0250C = Verbiage changes to include influenza vaccination season and influenza vaccine
- ✓ X0150-X0700 = Includes associated MDS item on prior assessment;
 - X0150 = Equivalent to A0200 on prior assessment
 - X0200 = Equivalent to A0500 on prior assessment
 - X0300 = Equivalent to A0800 on prior assessment
 - X0400 = Equivalent to A0900 on prior assessment
 - X0500 = Equivalent to A0600A on prior assessment
 - X0600 = Equivalent to A0310 on prior assessment
 - X0600B = Deleted response 06
 - X0700A = Equivalent to A2300 on prior assessment
 - X0700B = Equivalent to A2000 on prior assessment
 - X0700C = Equivalent to A1600 on prior assessment

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CHAPTER 2
ASSESSMENTS FOR THE RESIDENT
ASSESSMENT INSTRUMENT (RAI)
(V1.11)



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■ *INTRODUCTION TO THE REQUIREMENTS FOR THE RAI*

- ✓ The statutory authority for the RAI is found in:
 - Section 1819(f)(6)(A-B) for Medicare
 - 1919(f)(6)(A-B) for Medicaid
 - Social Security Act (SSA)
 - Amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987)



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■ *INTRODUCTION TO THE REQUIREMENTS FOR THE RAI*

- ✓ The OBRA regulations require:
 - Medicare certified, Medicaid certified or both to conduct initial and periodic assessments for all residents
 - RAI process is used as the basis for the accurate assessment of each nursing home resident
 - MDS 3.0 is part of that assessment process and is required by CMS
 - Required for PPS under Part A



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■ *NURSING HOME RESPONSIBILITIES FOR COMPLETING ASSESSMENTS*

- ✓ RAI must be completed for any resident in a Medicare/Medicaid certified LTC facility:
 - All residents regardless of payer
 - Hospice residents
 - Short-term or respite residents (>14 days)
 - Special populations
 - Swing bed residents



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■ **NURSING HOME RESPONSIBILITIES FOR COMPLETING ASSESSMENTS**

- ✓ The RAI process must be used with residents in facilities with different certification situations, including:
 - Newly Certified Nursing Homes
 - Adding Certified Beds
 - Change In Ownership
 - Resident Transfers:
 - Traditional
 - Natural disasters



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■ **NURSING HOME RESPONSIBILITIES FOR MAINTAINING ASSESSMENTS**

- ✓ The Federal regulatory requirement at 42 CFR 483.20(d) requires nursing homes to maintain all resident assessments completed within the previous 15 months in the resident's active clinical record. This requirement applies to all MDS assessment types regardless of the form of storage (i.e., electronic or hard copy).



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■ **NURSING HOME RESPONSIBILITIES FOR MAINTAINING ASSESSMENTS**

- ✓ The 15-month period for maintaining assessment data may not restart with each readmission to the facility:
 - When a resident is *discharged return anticipated* and returns to the facility within 30 days, facility must copy the previous RAI and transfer that copy to the chart
 - When a resident is *discharged return anticipated* and does not return within 30 days or *discharged return not anticipated*, facilities may develop their own policies for copying the previous record or not



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■ **NURSING HOME RESPONSIBILITIES FOR MAINTAINING ASSESSMENTS**

- ✓ After the 15-month period, RAI information may be thinned, provided that it is easily retrievable **except**:
 - Demographic information (A0500-A1600) from the most recent Admission assessment **must** be maintained in the active clinical record until resident discharged return **not** anticipated
- ✓ Nursing homes may use electronic signatures:
 - Written policies must be in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs



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■ **NURSING HOME RESPONSIBILITIES FOR MAINTAINING ASSESSMENTS**

- ✓ NF has the option for a resident's clinical record to be maintained electronically rather than in hard copy
- ✓ In cases where the MDS is maintained electronically without the use of electronic signatures, must maintain in the active record hard copies signed and dated of the:
 - CAA(s) completion (V0200B-C)
 - Correction completion (X1100A-E)
 - Assessment completion (Z0400-Z0500)

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■ **NURSING HOME RESPONSIBILITIES FOR MAINTAINING ASSESSMENTS**

- ✓ **Must ensure that clinical records, regardless of form, are maintained in a centralized location as deemed by facility policy and procedure**
- ✓ Nursing homes that are **not** capable of maintaining MDS electronically must adhere to the current requirement that either a hand written or a computer-generated copy be maintained in the clinical record
- ✓ **Must ensure that proper security measures are implemented via facility policy to ensure the privacy and integrity of the record**



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■ ASSESSMENT TYPES AND DEFINITIONS

- ✓ **Admission** – defined as the date a person enters the facility and is admitted
- ✓ Completion of an Admission assessment required when:
 - Resident never admitted before
 - Was a previous resident, but Admission assessment never completed
 - Was a previous resident, but discharged return not anticipated
 - Was a previous resident, discharged return anticipated, but returned later than 30 days from the discharge date



■ ASSESSMENT TYPES AND DEFINITIONS

- ✓ **Assessment Combination** – defined as the use of one assessment to satisfy both OBRA and PPS required assessments when the time frames coincide:
 - Most stringent requirement applies
 - Avoids unnecessary duplication
 - One assessment may satisfy two OBRA or two PPS, such as:
 - Admission + Discharge
 - 30-day + EOT
- ✓ **Assessment Reference Date (ARD)** – defined as the last day of observation (look back period) that assessment covers
 - Required to be set within required timeframes of assessment type being completed
- ✓ **Assessment Scheduling** – defined as the period during which assessments take place, setting the ARD, timing, completion, submission and observation periods

■ ASSESSMENT TYPES AND DEFINITIONS

- ✓ **Assessment Submission** – defined as the electronic data in record and file format, conforming to standard layouts and data dictionaries and passing standardized edits
- ✓ **Assessment Timing** – defined as when and how often assessments must be conducted (table pg. 15-16)
- ✓ **Assessment Transmission** – defined as the electronic submission of files to the QIES ASAP system
- ✓ **Comprehensive Assessment** – defined as assessment that includes the completion of the MDS, CAAs, and care plan
- ✓ **Death in Facility** – defined as resident death in facility or LOA; Death in Facility tracking record required

■ ASSESSMENT TYPES AND DEFINITIONS

- ✓ **Discharge** – defined as the date resident leaves facility:
 - Two types of discharge:
 - Return anticipated
 - Return not anticipated
 - Discharge assessment required when:
 - Discharged to private residence
 - Admitted to hospital or other care setting
 - Hospital observation stay greater than 24 hours
- ✓ **Entry** – term used for both admission and reentry
- ✓ **Item Set** – defined as MDS items that are active for a particular assessment type; there are 10 different item subsets for nursing homes and 8 for swing bed providers



■ ITEM SETS

- ✓ NC = Comprehensive assessments item set
- ✓ NQ = Quarterly assessments item set
- ✓ NP = Scheduled PPS assessments item set
- ✓ NS = Standalone Start of Therapy OMRA item set
- ✓ NSD = PPS Start of Therapy OMRA combined with a Discharge assessment item set
- ✓ NO = Standalone End of Therapy OMRA and a Change of Therapy OMRA assessment item set
- ✓ NOD = PPS End of Therapy OMRA combined with a Discharge assessment item set
- ✓ ND = Standalone Discharge assessment item set
- ✓ NT = Entry Tracking or Death in Facility Tracking record item set

■ ASSESSMENT TYPES AND DEFINITIONS

- ✓ **Observation (Look-Back) Period** – defined as:
 - Time over which resident's status is captured
 - Defined by counting backwards from ARD
 - Length is specific to each MDS item, but all end at 11:59 p.m. on the ARD
 - Anything occurring before or after observation period is not captured on MDS
- ✓ **Leave of Absence (LOA)** – defined as:
 - Temporary home visit of at least one night
 - Therapeutic leave of at least one night
 - Hospital observation stay less than 24 hours with no admission
 - No assessment completion required, unless change of condition



■ *MDS ASSESSMENT CODES*

✓ Values that correspond to the OBRA, PPS assessments

- A0310A = OBRA
- A0310B = Scheduled PPS
- A0310C = Unscheduled PPS
- A0310F = Discharge and Tracking Forms

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OBRA REQUIRED ASSESSMENTS AND TRACKING RECORDS



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■ *OBRA COMPREHENSIVE ASSESSMENTS*

✓ Includes completion of:

- MDS
- CAA process
- Care plan



✓ Comprehensive assessment types:

- Admission
- Annual
- Significant Change in Status Assessment (SCSA)
- Significant Correction to Prior Comprehensive Assessment (SCPA)

✓ Not required in swing bed facilities

✓ Assessment type determined at A0310A, B, C, F

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■ **COMPREHENSIVE ASSESSMENTS**

- ✓ ARD = last day of observation/look back period
- ✓ If resident goes to hospital prior to completion of Admission, when returns, must consider as new Admission
- ✓ May not complete Sig Change until Admission completed
- ✓ If Admission was completed then goes to hospital (D=11), returns during an assessment period and most of assessment completed prior to hospital;
 - May continue original assessment but must keep ARD and completion dates the same as originally stated
 - Initiate new ARD and complete within 14 days of reentry
 - The portion of assessment previously completed must be stored on the resident's record

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■ **COMPREHENSIVE ASSESSMENTS**

- ✓ If resident discharged prior to completion deadline of assessment, completion is not required
 - Completed portions must be maintained in medical record
- ✓ If resident dies prior to completion deadline of assessment, completion is not required
 - Completed portions must be maintained in medical record
- ✓ If Sig Change is identified in the process of completing any OBRA (except Admission), code and complete Sig Change
- ✓ May combine comprehensive with Discharge
- ✓ MDS completion (Z0500B) and CAAs completion (V0200B2) = ARD plus 14 days
- ✓ Care Plan completion (V0200C2) = CAAs completion plus 7 days
- ✓ Transmission = Care plan completion plus 14 days

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■ **ADMISSION ASSESSMENT (A0310A=01)**

- ✓ Completed when:
 - Resident's first admission
 - Was a previous resident, but discharged prior to completing the Admission assessment
 - Was a previous resident, but discharged return not anticipated
 - Was a previous resident, discharged return anticipated, but returned later than 30 days from the discharge date
- ✓ ARD = No later than 14th day of admission
- ✓ MDS and CAAs completion = No later than 14th day of admission (may be earlier)
- ✓ Care plan completion = CAAs completion plus 7 days
- ✓ Transmission = Care plan completion plus 14 days
- ✓ Not required if discharged before end of day 14

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■ ANNUAL ASSESSMENT (A0310A=03)

- ✓ Must be completed every 366 days unless SCSA or SCPA completed since most recent comprehensive
- ✓ ARD = No later than:
 - ARD of previous comprehensive plus 366 days AND
 - ARD of previous quarterly plus 92 days
- ✓ MDS and CAAs completion = ARD plus 14 days
- ✓ Care plan completion = CAAs completion plus 7 days
- ✓ Transmission = Care plan completion plus 14 days

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■ SIGNIFICANT CHANGE IN STATUS ASSESSMENT (SCSA) (A0310A=04)

- ✓ A decline or improvement in a resident's status that:
 - Will not normally resolve itself without intervention or by implementing standard disease-related clinical intervention
 - Impacts more than one area of resident's health status
 - Requires IDT review and/or revision of care plan
- ✓ If status is unclear, may take up to 14 days to make determination

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■ SIGNIFICANT CHANGE IN STATUS ASSESSMENT (SCSA) (A0310A=04)

- ✓ Must be completed when IDT determines resident meets significant change guidelines
- ✓ Guidelines include decline and improvement in status
- ✓ Resident's condition not expected to return to baseline
- ✓ SCSA may not be completed prior to the Admission
- ✓ ARD = No later than 14th day after determination that significant change occurred
- ✓ MDS and CAAs completion = No later than 14th day from ARD but no later than 14 days after determination
- ✓ Care plan completion = CAAs completion plus 7 days
- ✓ Transmission = Care plan completion plus 14 days

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■ **SIGNIFICANT CHANGE IN STATUS ASSESSMENT (SCSA) (A0310A=04)**

- ✓ **Hospice:**
 - Required when enrolls in a hospice program:
 - ARD must be within 14 days from effective date of hospice election
 - Must be performed regardless of whether an assessment was recently conducted
 - If admitted on hospice benefit, complete Admission assessment checking Hospice Care (O0100K):
 - Completing an Admission assessment followed by SCSA is not required
 - Required when hospice revoked:
 - ARD must be within 14 days of:
 - > Effective date of revocation
 - > Expiration date of certification of terminally ill
 - > Date physician order states no longer terminally ill

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■ **SIGNIFICANT CHANGE IN STATUS ASSESSMENT (SCSA) (A0310A=04)**

- ✓ **Significant Change in Condition guidelines:**
 - Determine if condition is “self-limiting”
 - Determine if there are two or more areas of decline or improvement (includes two areas of ADLs)
 - May decide to complete Sig Change for one change
 - Each situation is unique
 - Resident may benefit from Sig Change
 - Medical record must document rationale for completing Sig Change if does not meet criteria
 - Decline examples page 23
 - Improvement examples page 24

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■ **SIGNIFICANT CHANGE IN STATUS ASSESSMENT (SCSA) (A0310A=04)**

- ✓ **Sig Change for terminally ill:**
 - Determine if change in condition expected
 - New onset of symptoms or condition not part of expected course of deterioration
- ✓ **Referral for PASRR Level II:**
 - Required by law when SCSA is completed for an individual known or suspected to have a mental illness, intellectual disability, or related condition
 - Referral should be made as soon as criteria is met
 - Do not wait until the SCSA is complete

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■ **SIGNIFICANT CORRECTION TO PRIOR COMPREHENSIVE ASSESSMENT (SCPA) (A0310A=05)**

- ✓ Required when uncorrected significant error is identified in a prior comprehensive assessment:
 - Significant error in an assessment where:
 - Resident's overall clinical status is not accurately represented
 - Error has not been corrected via submission of a more recent comprehensive assessment
- ✓ ARD = No later than 14th day after determination
- ✓ MDS and CAAs completion = No later than 14th day after ARD and no later than 14 days after determination
- ✓ Care plan completion = CAAs completion plus 7 days
- ✓ Transmission = Care plan completion plus 14 days

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■ **OBRA NON-COMPREHENSIVE ASSESSMENTS**

- ✓ Includes a select number of MDS items
- ✓ Excludes completion of:
 - CAA process
 - Care plan
- ✓ Non-comprehensive assessment types:
 - Quarterly (not required for swing beds)
 - Significant Correction to Prior Quarterly Assessment (SCQA) (not required for swing beds)
 - Discharge assessment – return not anticipated (required for swing beds)
 - Discharge assessment – return anticipated (required for swing beds)
 - Entry Tracking Record
 - Death in Facility Tracking Record

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■ **NON-COMPREHENSIVE ASSESSMENTS**

- ✓ ARD = last day of observation/look back period
- ✓ If resident goes to hospital (D=11), returns during an assessment period and most of assessment completed prior to hospital;
 - May continue original assessment but must keep ARD and completion dates the same as originally stated, provided does not meet Sig Change criteria
 - Initiate new ARD and complete within 14 days of reentry
 - The portion of assessment previously completed must be stored on the resident's record

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■ *NON-COMPREHENSIVE ASSESSMENTS*

- ✓ If resident discharged prior to completion deadline of assessment, completion is not required
 - Completed portions must be maintained in medical record
- ✓ If resident dies prior to completion deadline of assessment, completion is not required
 - Completed portions must be maintained in medical record
- ✓ If Sig Change is identified in the process of completing any OBRA (except Admission), code and complete Sig Change
- ✓ May combine with Discharge
- ✓ May combine with PPS assessment
- ✓ ARD drives due date (non-comprehensive due within 92 days of prior ARD)
- ✓ CAAs process not required; care plan must be updated if necessary
- ✓ Transmission = MDS completion plus 14 days

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■ *QUARTERLY (A0310A=02)*

- ✓ Must be completed every 92 days following the ARD of the most recent OBRA assessment
- ✓ Used to track resident's status between comprehensive assessments
- ✓ ARD = 92 days from previous OBRA assessment ARD
- ✓ MDS completion = ARD plus 14 days
- ✓ Transmission = MDS completion plus 14 days

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■ *SIGNIFICANT CORRECTION TO PRIOR QUARTERLY ASSESSMENT (SCQA) (A0310A=06)*

- ✓ Required when uncorrected significant error is identified in a prior quarterly assessment:
 - Error in an assessment where:
 - Resident's overall clinical status is not accurately represented
 - Error has not been corrected via submission of a more recent assessment
- ✓ ARD = No later than 14th day after determination
- ✓ MDS Completion = No later than 14th day after ARD and no later than 14 days after determination
- ✓ Transmission = MDS completion plus 14 days

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■ **ENTRY TRACKING RECORD (A0310F=01)**

- ✓ Two types:
 - Admission (A1700=01):
 - Admitted for the first time
 - Readmitted after a discharge prior to completion of Admission assessment
 - Readmitted after a discharge return not anticipated
 - Readmitted after a discharge return anticipated when return was later than 30 days from discharge date
 - Reentry (A1700=02):
 - Previous resident of this facility
 - Admission assessment previously completed
 - Discharged return anticipated
 - Returned within 30 days of discharge date
- ✓ MDS Completion = Entry date plus 7 days
- ✓ Transmission = Entry date plus 14 days



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■ **ENTRY TRACKING RECORD (A0310F=01)**

- ✓ First item set completed for all residents
- ✓ Completed for respite resident upon each entry
- ✓ Stand-alone tracking record
- ✓ Contains administrative and demographic information
- ✓ Required in addition to the Admission assessment or other OBRA or PPS assessments that might be required
- ✓ Cannot be combined with an assessment



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■ **DEATH IN FACILITY TRACKING RECORD (A0310F=12)**

- ✓ Must be completed when:
 - Dies in facility
 - Dies while on leave of absence
 - Discharge assessment not required
- ✓ Consists of demographic and administrative items
- ✓ MDS Completion = Discharge (death) date plus 7 days
- ✓ Transmission = Discharge (death) plus 14 days
- ✓ May not be combined with any type of assessment



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■ DISCHARGE ASSESSMENTS

- ✓ Two types:
 - Discharge return not anticipated (10)
 - Discharge return anticipated (11)
 - OBRA required
- ✓ Must complete Discharge assessment when:
 - Discharged to private residence (not LOA)
 - Discharged and admitted to hospital or other care setting
 - Hospital observation stay of > 24 hours
 - Each time respite resident discharged
 - May be combined with another OBRA
 - May be combined with another PPS
- ✓ Discharge date and ARD must be the same
- ✓ Bed hold status and opening/closing of record not impacted



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■ DISCHARGE RETURN NOT ANTICIPATED (A0310F=10)

- ✓ Discharged and not expected to return within 30 days
- ✓ Consists of demographic, administrative, and clinical items
- ✓ If resident returns, Entry tracking must be coded as Admission entry (A1700=01)
- ✓ MDS Completion = Discharge date plus 14 days
- ✓ Transmission = MDS Completion plus 14 days

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■ DISCHARGE RETURN ANTICIPATED (A0310F=11)

- ✓ Expected to return within 30 days
- ✓ For a respite resident who comes in and out frequently and return is expected
- ✓ Consists of demographic, administrative, and clinical items
- ✓ If resident returns, Entry tracking must be coded as Reentry (A1700=02)
- ✓ If return is NOT by day 30, when returns a new Entry record and new Admission assessment will be required including a new entry date (A1700=01)
- ✓ MDS Completion = Discharge date plus 14 days
- ✓ Transmission = MDS completion plus 14 days
- ✓ If resident does not return, no requirement to inactivate or complete another Discharge



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■ TYPE OF DISCHARGE



- ✓ Two types of discharges (A0310G):
 - Planned
 - Unplanned:
 - Acute-care transfer of the resident to a hospital or an emergency department in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation
 - Resident unexpectedly leaving the facility against medical advice
 - Resident unexpectedly deciding to go home or to another setting
- ✓ MDS Completion = Discharge date plus 14 days
- ✓ Transmission = MDS completion plus 14 days

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SNF MEDICARE PROSPECTIVE
PAYMENT SYSTEM ASSESSMENT
OVERVIEW



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■ SNF PPS ASSESSMENTS

- ✓ Required for reimbursement under Medicare Part A
- ✓ Must also meet OBRA requirements*
- ✓ Two types of PPS Assessments:
 - Scheduled (A0310B):
 - Standard, predetermined time period for ARD
 - Grace days allowed
 - Unscheduled (A0310C):
 - Applicable when certain situations occur

*Swing bed providers must complete entry tracking record, discharge assessments and death in facility tracking record but not other OBRA required assessments

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■ SNF PPS ASSESSMENT WINDOWS

- ✓ Defined days within which the ARD must be set
- ✓ Timeliness of the PPS assessment is defined by selecting an ARD within the prescribed ARD window
- ✓ First day of Medicare Part A coverage for the current stay is considered day 1 for PPS scheduling purposes
- ✓ Grace days allow clinical flexibility in setting ARD:
 - Grace days are not applied to unscheduled PPS assessments

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■ PPS SCHEDULED ASSESSMENTS

- ✓ Medicare-required standard assessments
- ✓ Identified at A0310B as follows:
 - 01 = 5-day
 - 02 = 14-day
 - 03 = 30-day
 - 04 = 60-day
 - 05 = 90-day
 - 06 = Readmission/return assessment
- ✓ PPS scheduled assessment table (pg. 40)

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■ PPS UNSCHEDULED ASSESSMENTS

- ✓ Medicare-required assessments outside the standard schedule
- ✓ Identified at A0310C as follows:
 - 1 = Start of Therapy
 - 2 = End of Therapy
 - 3 = Both Start and End of Therapy
 - 4 = Change of Therapy
- ✓ An unscheduled assessment in a scheduled assessment window cannot be followed by the scheduled assessment in that window:
 - The two assessments must be combined with ARD appropriate to the unscheduled assessment
- ✓ Medicare scheduled and unscheduled MDS assessment reporting schedule (pg. 42-44)
- ✓ Includes SCSA and SCPA

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MDS MEDICARE SCHEDULED ASSESSMENTS FOR SNF



■ *SCHEDULED PPS ASSESSMENT TABLE*

Medicare Scheduled Assessment Type	Reason for Assessment A0310B	ARD	ARD Grace Days	Standard Medicare Payment Days
5-day Readmission/Return	01 06	1-5	6-8	1 through 14
14-day	02	13-14	15-18	15 through 30
30-day	03	27-29	30-33	31 through 60
60-day	04	57-59	60-63	61 through 90
90-day	05	87-89	90-93	91 through 100

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■ *5-DAY PPS SCHEDULED ASSESSMENT (A0310B=01)*

- ✓ **First Medicare-required assessment completed for Part A stay**
- ✓ **Must have at least one 5-day assessment**
- ✓ **ARD = set on days 1 through 5**
- ✓ **ARD may be extended up to day 8**
- ✓ **MDS Completion = ARD plus 14 days**
- ✓ **Transmission = MDS Completion plus 14 days**
- ✓ **Authorizes payment from days 1 through 14**
- ✓ **If resident goes from Medicare Advantage to Medicare Part A, the Medicare PPS schedule must start over with a 5-day, etc.**

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■ 14-DAY PPS SCHEDULED ASSESSMENT
(A0310B=02)

- ✓ ARD = set on days 13 through 14
- ✓ ARD may be extended up to day 18
- ✓ MDS Completion = ARD plus 14 days
- ✓ Transmission = MDS Completion plus 14 days
- ✓ Authorizes payment from days 15 through 30
- ✓ When combined with the OBRA Admission, grace days may not be used

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■ 30-DAY PPS SCHEDULED ASSESSMENT
(A0310B=03)

- ✓ ARD = set on days 27 through 29
- ✓ ARD may be extended up to day 33
- ✓ MDS Completion = ARD plus 14 days
- ✓ Transmission = MDS Completion plus 14 days
- ✓ Authorizes payment from days 31 through 60

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■ 60-DAY PPS SCHEDULED ASSESSMENT
(A0310B=04)

- ✓ ARD = set on days 57 through 59
- ✓ ARD may be extended up to day 63
- ✓ MDS Completion = ARD plus 14 days
- ✓ Transmission = MDS Completion plus 14 days
- ✓ Authorizes payment from days 61 through 90

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■ 90-DAY PPS SCHEDULED ASSESSMENT
(A0310B=05)

- ✓ ARD = set on days 87 through 89
- ✓ ARD may be extended up to day 93
- ✓ MDS Completion = ARD plus 14 days
- ✓ Transmission = MDS Completion plus 14 days
- ✓ Authorizes payment from days 91 through 100

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■ READMISSION/RETURN PPS SCHEDULED ASSESSMENT (A0310B=06)

- ✓ Completed when resident is hospitalized, discharged return anticipated, then returns within 30 days under Part A services
- ✓ Entry tracking is coded as reentry (A1700=2)
- ✓ ARD = set on days 1 through 5
- ✓ ARD may be extended up to day 8
- ✓ MDS Completion = ARD plus 14 days
- ✓ Transmission = MDS Completion plus 14 days
- ✓ Authorizes payment from days 1 through 14

✓ Deleted effective 10/1/2014

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MDS MEDICARE UNSCHEDULED ASSESSMENTS FOR SNF



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■ **START OF THERAPY (SOT) OMRA ASSESSMENT (A0310C=1)**



- ✓ Optional
- ✓ Completed only to classify into a Rehabilitation group
- ✓ Completed only if not already classified into a Rehabilitation group
- ✓ May be combined with scheduled PPS assessment
- ✓ ARD = set on days 5-7 after the start of therapy
- ✓ Date of the earliest therapy eval is counted as day 1 when determining the ARD, regardless if treatment is provided or not on that day
- ✓ MDS Completion = ARD plus 14 days
- ✓ Transmission = MDS Completion plus 14 days

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■ **START OF THERAPY (SOT) OMRA ASSESSMENT (A0310C=1)**

- ✓ SOT OMRA is not necessary if:
 - Rehabilitation services start within the ARD window (including grace days) of the 5-day assessment, since the therapy rate will be paid starting Day 1 of the SNF stay
 - Unless it is a Medicare Short Stay assessment, there is never a need to combine an SOT with a Medicare 5-day or Medicare Readmission/Return assessment



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■ **END OF THERAPY (EOT) OMRA (A0310C=2)**

- ✓ Completed when a resident classified in a Rehabilitation group, continues to need Part A services, and did not receive any therapy services for three consecutive calendar days for any reason
- ✓ May be combined with scheduled PPS assessment
- ✓ Establishes a new non-therapy RUG
- ✓ Last day therapy was provided is day 0
- ✓ Day 1 is first day after last therapy session provided whether therapy was scheduled or not scheduled
- ✓ ARD = set for day 1, 2, or 3 after the date of the last therapy session
- ✓ MDS Completion = ARD plus 14 days
- ✓ Transmission = MDS Completion plus 14 days



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■ END OF THERAPY (EOT) OMRA (A0310C=2)

- ✓ When an EOT is not required:
 - Discharged on or prior to the third consecutive day of missed therapy services
 - When the last day of Part A benefit is prior to the third day of missed therapy services
 - If last day of Part A is on the third consecutive day or after of missed therapy services, then an EOT is required
 - When discharge from Part A is equal to the discharge from facility, and is on or prior to the third consecutive day of missed therapy services

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■ END OF THERAPY (EOT-R) OMRA (A0310C=2)

End of Therapy with Resumption (EOT-R)

- ✓ Resumption of therapy must occur no more than five consecutive days after the last day of therapy provided
- ✓ May be used when the resident will resume therapy services at the same therapy level intensity as prior to the discontinuation of therapy
- ✓ Providers are not required to consider possible ADL changes when determining if a resumption of therapy will occur

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■ END OF THERAPY (EOT-R) OMRA (A0310C=2)

End of Therapy with Resumption Billing

- ✓ The facility should bill the non-therapy RUG on the EOT beginning the day after the patient's last therapy session. The facility would then begin billing the therapy RUG that was in effect prior to the EOT beginning on the day that therapy resumed (O0450B).



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■ *START & END OF THERAPY (A0310C=3)*

- ✓ SOT/EOT – Both Start and End of Therapy:
 - ARD must be 5-7 days after the start of therapy
 - ARD must be 1-3 days after the last day of therapy
 - Completed to classify into a Rehabilitation Plus Extensive Services or Rehabilitation AND into a non-therapy group when Part A continues after the discontinuation of all therapy
- ✓ If assessment does not classify into a therapy RUG CMS will not accept the assessment

67

■ *CHANGE OF THERAPY OMRA (A0310C=4)*

- ✓ COT Observation Period: A successive 7-day window beginning the day following the ARD of the resident's last rehabilitation PPS assessment used for payment
- ✓ A COT is required if the therapy received during the COT observation period does not reflect the RUG-IV classification level on the patient's most recent PPS assessment used for payment
- ✓ When the last PPS assessment was an EOT-R, the end of the COT observation period is day 7 after the resumption date (O0450B), rather than ARD
 - Resumption date is counted as day 1
- ✓ May be used to classify a patient into a higher or lower RUG category

68

■ *CHANGE OF THERAPY OMRA (A0310C=4)*

- ✓ COT ARD may not precede the ARD of the first PPS assessment
- ✓ ARD = Day 7 of COT observation period
- ✓ MDS Completion = ARD plus 14
- ✓ Transmission = MDS Completion plus 14

69

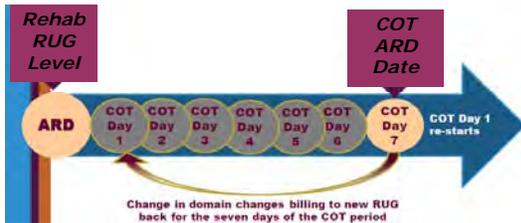
■ ROLLING 7 DAY OBSERVATION PERIOD

Example:

- ✓ ARD of 14-day PPS assessment = Day 13
- ✓ Window for COT observation = Days 14-20
- ✓ Next COT observation window = Days 21-27
- ✓ Next COT observation window = Days 28-34, etc.

70

■ DETERMINE IF THERE IS A CHANGE IN THE RTM/RUG LEVEL



71

■ CHANGE OF THERAPY OMRA (A0310C=4)

- ✓ In order to determine if a COT is required, providers should perform an informal evaluation that considers the intensity of the therapy the resident received during the COT observation period

But what must a facility actually consider?



72

■ CHANGE OF THERAPY OMRA (A0310C=4)

- ✓ A COT is required in cases where the therapy intensity received during the COT observation period would cause the resident to be classified into a different RUG category
- ✓ ADL changes are excluded from this determination

RUG Category Shortcut = Second character in RUG code

RUC: Ultra-High Rehab RHL: High Rehab
 RVX: Very-High Rehab RMA: Medium Rehab

As long as the second character does not change, no COT OMRA is required!

73

■ IS A COT OMRA REQUIRED?

Patient Current Classification: RUB (Ultra High) (827 RTM)

		Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
PT	Individual	60		60			60	45
	Concurrent (/2)		30				30	
	Group (/4)					60		
OT	Individual							
	Concurrent (/2)							
	Group (/4)							
SLP	Individual	45	45	60		45		
	Concurrent (/2)				60			
	Group (/4)		60			60		
Subtotals		105	75	120	30	75	75	45
Number of RNP								
							Total RTM	525

Total RTM: 525 (Very-High); COT OMRA ????????????

74

■ IS A COT OMRA REQUIRED?

Patient Current Classification: RHC (High) (365 RTM)

		Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
PT	Individual	60		60			60	45
	Concurrent (/2)		30				30	
	Group (/4)					60		
OT	Individual							
	Concurrent (/2)							
	Group (/4)							
SLP	Individual	45	45	60		45		
	Concurrent (/2)				60			
	Group (/4)		60			60		
Subtotals		105	75	120	30	75	75	45
Number of RNP								
							Total RTM	525

Total RTM: 525 (Very-High); COT OMRA ???????

75

■ CHANGE OF THERAPY OMRA AND SNF BILLING

- ✓ The COT retroactively establishes a new RUG beginning Day 1 of the COT observation period and continues until the next scheduled or unscheduled PPS assessment
- ✓ **Example:** A resident's 30-day assessment ARD set for Day 30. Based on the 30-day assessment ARD, the therapy services provided to this resident are evaluated on Day 37. If a COT is required, then payment would be set back to Day 31.

76

■ CHANGE OF THERAPY OMRA AND INDEX MAXIMIZATION

- ✓ **Index maximization:** In some situations a resident may simultaneously meet the qualifying criteria for both a therapy and a non-therapy RUG. For some of these cases the RUG-IV per diem payment rate for the non-therapy RUG will be higher; therefore, although the resident is receiving therapy services, the index maximized RUG is a non-therapy RUG.
- ✓ *A facility is required to evaluate change of therapy for all residents receiving any amount of skilled therapy services, including those who have index maximized into a non-therapy RUG group*

77

■ CHANGE OF THERAPY OMRA AND INDEX MAXIMIZATION EXAMPLE

- ✓ A COT is only required for residents in such cases that the therapy services received during the COT observation period are no longer reflective of the RUG-IV category after considering index maximization. **For example:**

Resident qualifies for RMB (\$344.47) but index maximizes into HC2 (\$401.48). During the COT observation period, resident receives only enough therapy to qualify for RLB (\$356.78) and HC2 (\$401.48).

Resident qualifies for RMB (\$344.47) but index maximizes into HC2 (\$401.48). During the COT observation period, resident receives enough therapy to qualify for RUB (\$558.79) and HC2 (\$401.48).

78

■ CHANGE OF THERAPY OMRA (A0310C=4)

- ✓ COT and Day of Discharge:
 - If discharged on or before Day 7 of the COT observation period, then a COT OMRA would **not** be required
- ✓ COT and Scheduled PPS Assessments:
 - If the ARD of a scheduled PPS assessment is set for on or prior to Day 7 of the COT observation period, then **no** COT OMRA would be required. **This resets the COT observation period.**
 - May choose to combine assessments

79

■ CHANGE OF THERAPY OMRA (A0310C=4)
PROPOSED RULE CHANGES FOR 2015

COT Technical Change Proposed

- ✓ May complete COT OMRA for a resident **not** currently classified into a Rehab group, or receiving a level of therapy sufficient for classification into a Rehab group
 - **ONLY** in the rare case where:
 - The resident **had** qualified for a Rehab group on a **prior** assessment during the current Part A stay
 - And **no** discontinuation of therapy between day 1 of the COT observation period for the COT that classified the current non-therapy group and the ARD of the COT that classified into the therapy group

80

■ CHANGE OF THERAPY OMRA (A0310C=4)
PROPOSED RULE CHANGES FOR 2015

“Under the proposed policy, while a COT OMRA may be used to **reclassify** a resident into a therapy RUG in the circumstances described, it may **not** be used to **initially** classify a resident into a therapy RUG”

81

■ SIGNIFICANT CHANGE IN STATUS
ASSESSMENT IMPACT

- ✓ May establish new RUG classification
- ✓ When SCSA is not combined with a PPS assessment, RUG classification and payment begin on ARD
- ✓ When SCSA is combined with a scheduled PPS assessment and grace days are not used, RUG classification and payment begin on ARD
- ✓ When SCSA is combined with a scheduled PPS assessment and grace days are used, RUG classification and payment begin on the first day of the standard payment period

82

■ UNSCHEDULED "STANDALONE"
PPS ASSESSMENT INTERVIEW ITEMS

- ✓ Includes SOT, EOT, COT
 - Interview items may be coded using the responses provided by the resident on a previous assessment
 - Only if the DATE of the interview responses from the previous assessment (as documented in Z0400) were obtained no more than 14 days prior to the DATE of completion for the interview items on the unscheduled assessment (as documented in Z0400) for which those responses will be used

Note: In limited circumstances, providers may conduct interview portions of the assessment up to two calendar days after the ARD

83

■ UNSCHEDULED "STANDALONE"
PPS ASSESSMENT ARD

- ✓ Includes SOT, EOT, COT
 - Set the ARD for a day within the allowable ARD window, but may only do so no more than 2 days after the window has passed
 - **Example:** If a resident misses therapy on July 2-4, then the facility must complete an EOT OMRA for this resident and the ARD must be set for either July 2nd, 3rd, or 4th. However, the decision for which of those days should be used for the ARD on the EOT OMRA may be made after July 4th, the last day of the ARD window but NO later than July 6.

84

COMBINING PPS SCHEDULED AND UNSCHEDULED ASSESSMENTS



■ *PPS SNF ASSESSMENT COMBINATIONS*

- ✓ Can **NEVER** combine 2 PPS scheduled assessments
- ✓ May combine scheduled PPS assessment with unscheduled PPS assessment
- ✓ May combine any PPS assessment with any OBRA assessment
- ✓ When combining assessments use the more stringent requirements



■ *COMBINING SCHEDULED AND UNSCHEDULED PPS ASSESSMENTS*

- ✓ If an unscheduled PPS assessment is required in the assessment window of the scheduled assessment, the scheduled assessment **MUST** be combined with the unscheduled assessment setting the ARD for the unscheduled assessment
- ✓ A scheduled PPS assessment cannot occur after an unscheduled assessment in the assessment window--the scheduled assessment must be combined with the unscheduled assessment using the ARD for the unscheduled assessment
- ✓ When the facility fails to combine a scheduled and unscheduled PPS assessment required by policy, the payment is controlled by the unscheduled assessment

■ *COMBINING SCHEDULED AND UNSCHEDULED PPS ASSESSMENTS*

- ✓ **Example:** If the ARD for an EOT is Day 14 and an ARD of the 14-day scheduled PPS assessment is set for Day 15, this would violate the combined assessment policy if not combined. Consequently, the EOT would control the payment.
- ✓ The EOT would begin payment on Day 12, and continue paying until the next scheduled or unscheduled assessment



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■ *COMBINING SCHEDULED AND UNSCHEDULED PPS ASSESSMENTS*

- ✓ An assessment is considered to be “used for payment” in that it controls the payment for a given period or with scheduled assessment may set the basis for payment for a given period
- ✓ Assessment combination details pg. 54-70

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■ *FACTORS IMPACTING THE SNF MEDICARE ASSESSMENT SCHEDULE*

- ✓ Resident expires before or on the eighth day of stay:
 - Provider should complete a PPS required assessment and submit as required
 - If there is not a PPS assessment in the system, provider must bill default rate for any Medicare days
 - The short stay may apply
 - Must complete Death in Facility tracking record



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■ FACTORS IMPACTING THE SNF MEDICARE ASSESSMENT SCHEDULE

- ✓ Resident transfers to another pay source or discharges before or on the eighth day of stay:
 - Provider should complete a PPS required assessment and submit as required
 - If there is not a PPS assessment in the system, provider must bill default rate for any Medicare days
 - The short stay may apply
 - Must complete Discharge assessment
- ✓ Short stay:
 - If resident dies, discharges from SNF, or discharges from Part A before or on the eighth day of stay, may be a candidate for short stay assessment

91

■ FACTORS IMPACTING THE SNF MEDICARE ASSESSMENT SCHEDULE

- ✓ Resident is admitted to acute care facility and returns:
 - To resume Part A coverage, the Medicare cycle is restarted (even if acute stay is less than 24 hours and not overnight)
 - Entry Tracking record determines whether a 5-day or readmission/return assessment is completed
 - When reason is reentry (A1700=2), readmission/return assessment is completed (A0310B=6)
 - When reason is admission (A1700=1), 5-day assessment is completed (A0310B=7)

92

■ FACTORS IMPACTING THE SNF MEDICARE ASSESSMENT SCHEDULE

- ✓ Resident is sent to acute care facility, not in SNF overnight, and not admitted to acute care facility:
 - Medicare cycle is not restarted
 - Payment implications:
 - Day preceding midnight is not a covered Part A day (midnight rule)
 - Medicare assessment schedule is adjusted
 - Day preceding midnight is skipped when scheduling the next Medicare assessment

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■ FACTORS IMPACTING THE SNF MEDICARE ASSESSMENT SCHEDULE

✓ Leave of Absence:

- Scheduled PPS assessment: the Medicare schedule is adjusted to exclude the LOA when determining the ARD
- Unscheduled PPS assessment: the ARD is not affected by the LOA



- ✓ **COT Example:** If the ARD for a resident's 30-day assessment were set for November 7 and the resident went to the emergency room at 11:00pm on November 9, returning at 2:00pm on November 10, Day 7 of the COT observation period would remain November 14

NOTE: The COT evaluation process and payment implications remain unchanged

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■ FACTORS IMPACTING THE SNF MEDICARE ASSESSMENT SCHEDULE

✓ Resident leaves facility and returns during observation period

- ARD is not altered for a temporary LOA

✓ Resident discharges from Part A and returns to Part A services:

- When resident discharges from Part A (remains in facility in certified bed) with another payer source, the OBRA schedule continues from the original admission date
- If Part A resumes, Medicare schedule starts with 5-day assessment, etc.

95

■ FACTORS IMPACTING THE SNF MEDICARE ASSESSMENT SCHEDULE

✓ Early PPS Assessment:

- If an assessment is performed earlier than the schedule indicates (ARD is not in the defined window), the facility will be paid at the default rate for the total number of days the assessment is out of compliance

• **Example:**

- Medicare 14-day with ARD on day 12 (1 day early) would be paid at the default rate for the first day of the payment period that begins on day 15

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■ FACTORS IMPACTING THE SNF MEDICARE ASSESSMENT SCHEDULE

✓ Early COT PPS Assessment:

• **Example:**

- 30-day assessment ARD is Day 30:
- Day 7 of the COT observation period is Day 37
- COT ARD set for Day 35 (2 days out of compliance)
- Facility would be paid the default rate for Days 29 and 30
- Facility would then be paid the RUG from the early COT beginning on Day 31 until the next scheduled or unscheduled assessment used for payment
- The early COT resets the COT calendar, so the next COT check in this scenario would be Day 42 (day 35+7)

97

■ FACTORS IMPACTING THE SNF MEDICARE ASSESSMENT SCHEDULE

✓ Late PPS Assessment:

- If the SNF fails to set the ARD within the defined ARD window for a Medicare-required assessment, including grace days, and the resident is still on Part A, the facility must complete a late assessment
- The ARD can be no earlier than the day the error was identified
- The total number of days the assessment is out of compliance, including the late ARD, must be billed at default beginning on the day that the assessment would have controlled payment

98

■ FACTORS IMPACTING THE SNF MEDICARE ASSESSMENT SCHEDULE

✓ Late EOT PPS Assessment:

• **Example:**

- Resident last received therapy on Day 33
- EOT ARD set for Day 39 (3 days out of compliance)
- Facility would bill the default rate for Days 34 through 36 (3 days out of compliance).
- Facility would then bill RUG from late EOT from Day 37 until next scheduled or unscheduled assessment used for payment.

99

■ FACTORS IMPACTING THE SNF MEDICARE ASSESSMENT SCHEDULE

✓ Late COT PPS Assessment:

- **Example:**
 - 30-day assessment ARD is Day 30:
 - Day 7 of the COT observation period is Day 37
 - COT ARD set for Day 40 (3 days out of compliance)
 - Facility would bill the default rate for Days 31 through 33.
 - Facility would then bill RUG from late COT from Day 34 until next scheduled or unscheduled assessment used for payment.
 - Late COT resets COT ARD calendar. Next COT ARD would be Day 47 (day 41-47)

100

■ FACTORS IMPACTING THE SNF MEDICARE ASSESSMENT SCHEDULE

✓ Missed PPS Assessment:

- If the SNF fails to set the ARD for a *scheduled* PPS assessment prior to the end of the last day of the ARD window for that assessment, and the resident has been discharged from Part A, the assessment cannot be completed
- All days which would have been paid by the missed assessment, had it been completed timely, are considered provider-liable and may not be billed

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■ FACTORS IMPACTING THE SNF MEDICARE ASSESSMENT SCHEDULE

✓ Missed PPS Assessment:

- If the SNF fails to set the ARD for an *unscheduled* PPS assessment within the defined ARD window for that assessment, and the resident has been discharged from Part A, the assessment cannot be completed
- All days which would have been paid by the missed assessment, had it been completed timely, are considered provider-liable and may not be billed
- Provider liability period lasts until an intervening assessment controls the payment

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■ FACTORS IMPACTING THE SNF MEDICARE ASSESSMENT SCHEDULE

✓ Missed COT PPS Assessment:

• **Example:**

- 30-day assessment ARD is Day 30:
 - Day 7 of the COT observation period is Day 37
- COT is missed
- Resident is discharged from Part A on Day 40
- Facility may not bill any of the days between Days 31 and 40

103

■ FACTORS IMPACTING THE SNF MEDICARE ASSESSMENT SCHEDULE

✓ Missed COT PPS Assessment:

• **Example:**

- 30-day assessment ARD is Day 30:
 - Day 7 of the COT observation period is Day 37
- COT is not completed
- EOT completed timely with ARD set for Day 42:
 - Resident last received therapy on Day 39
- Resident discharged from Part A on Day 45
- Facility may not bill any days from Days 31 through 39
- Facility would then bill RUG from EOT beginning on Day 40 and continue until discharge

104

■ EXPECTED ORDER OF MDS RECORDS

✓ MDS records are expected to occur in a specific order:

- Sequence order for new admission:
 1. Entry Tracking record (A1700= 1, Admission)
 2. Admission assessment, 5-day Medicare, Discharge, Death in Facility

✓ The target date is used to determine the order of records:

- A2300 for assessments
- A1600 for entry records
- A2000 for discharges or death in facility

✓ Out of order records will generate a warning on the CMS validation report

✓ Expected order of records table on page 2-76

105

■ DETERMINING THE ITEM SET FOR AN MDS RECORD

- ✓ Item set is determined by the reason for assessment:
 - A0310A (OBRA)
 - A0310B (Scheduled PPS)
 - A0310C (Unscheduled PPS)
 - A0310F (Tracking records, Discharges)
- ✓ Nursing home item set code (ISC) reference table on page 2-77
- ✓ An inactivation request indicated by A0050 = 3 will display an ISC of XX

106

■ DETERMINING THE ITEM SET FOR AN MDS RECORD

- ✓ **Examples:**
 - A0310A=01, A0310B=99, A0310C=0, A0310F=99
 - Standalone Admission assessment (**NC**)
 - A0310A=99, A0310B=99, A0310C=0, A0310F=12
 - Death in Facility record (**NT**)
 - A0310A=99, A0310B=99, A0310C=0, A0310F=99
 - No such record combination exists
 - Fatal error (rejected record)

107

CHAPTER 3
MDS 3.0 ITEM BY ITEM



SECTION A:
IDENTIFICATION INFORMATION

■ TYPE OF RECORD (A0050)

✓ Coding instructions:

- **Code 1** = Add new record:
 - A new record not previously submitted
 - Continue to A0100
- **Code 2** = Modify existing record:
 - Already submitted and accepted
 - Continue to A0100
 - Refer to Chapter 5
- **Code 3** = Inactivate existing record:
 - Already submitted and accepted
 - Skip to X0150, Type of Provider
 - Refer to Chapter 5



■ FACILITY PROVIDER NUMBERS (A0100)
TYPE OF PROVIDER (A0200)

✓ A0100 = Facility Provider Numbers:

- A = National Provider Identifier (NPI)
- B = CMS Certification Number (CCN)
- C = State Provider Number
(CMS optional – but Medicaid number necessary for KY)

✓ A0200 = Type of Provider:

- **Code 1** = Nursing home (SNF/NF)
- **Code 2** = Swing bed

■ TYPE OF ASSESSMENT (A0310)

- ✓ A0310A = Federal OBRA Reason for Assessment:
 - Code 01 = Admission assessment (required by day 14)
 - Code 02 = Quarterly review assessment
 - Code 03 = Annual assessment
 - Code 04 = Significant change in status assessment
 - Code 05 = Significant correction to prior comprehensive assessment
 - Code 06 = Significant correction to prior quarterly assessment
 - Code 99 = None of the above

112

■ PPS ASSESSMENT (A0310B)

- ✓ PPS Scheduled Assessments for a Medicare Part A Stay:
 - Code 01 = 5-day scheduled assessment
 - Code 02 = 14-day scheduled assessment
 - Code 03 = 30-day scheduled assessment
 - Code 04 = 60-day scheduled assessment
 - Code 05 = 90-day scheduled assessment
 - Code 06 = Readmission/return assessment
- ✓ PPS Unscheduled Assessments for a Medicare Part A Stay:
 - Code 07 = Unscheduled assessments used for PPS
 - Includes SCSA and SCPA
- ✓ Not PPS Assessment:
 - Code 99 = None of above

113

■ PPS OTHER MEDICARE REQUIRED ASSESSMENT — OMRA (A0310C)

- ✓ PPS Other Medicare Required Assessment - OMRA:
- ✓ Unscheduled PPS assessments
 - Code 0 = No
 - Code 1 = Start of therapy assessment (optional)
 - Code 2 = End of therapy assessment
 - Code 3 = Both Start and End of therapy assessment
 - Code 4 = Change of therapy assessment

114

■ IS THIS A SWING BED CLINICAL CHANGE ASSESSMENT? (A0310D)
IS THIS ASSESSMENT THE FIRST ASSESSMENT SINCE THE MOST RECENT ADMISSION/ENTRY OR REENTRY? (A0310E)

✓ A0310D = Indicate whether this is a swing bed clinical change assessment:

- Complete only if A0200=2:
 - Code 0 = No
 - Code 1 = Yes

✓ A0310E = Indicates whether this is the first OBRA, Scheduled PPS, or Discharge assessment since the most recent admission/entry or reentry:

- Code 0 = No
- Code 1 = Yes

Note: Code "0" for any tracking record; tracking records are not considered an assessment

115

■ ENTRY/DISCHARGE REPORTING (A0310F)

✓ Indicates reason for Federal OBRA & PPS entry/discharge reporting:

- Code 01 = Entry tracking record
- Code 10 = Discharge assessment-return not anticipated
- Code 11 = Discharge assessment-return anticipated
- Code 12 = Death in facility tracking record
- Code 99 = None of the above

116

■ TYPE OF DISCHARGE (A0310 G)

✓ Two types of discharges:

- Code 1 = Planned
- Code 2 = Unplanned:
 - Acute-care transfer of the resident to a hospital or an emergency department in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation
 - Resident unexpectedly leaving the facility against medical advice
 - Resident unexpectedly deciding to go home or to another setting



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■ SUBMISSION REQUIREMENT (A0410)

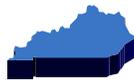
- ✓ Designates the submission authority for the resident assessment
- ✓ All Medicare and Medicaid certified beds must submit with code "3"
- ✓ Including HMO, Medicare Advantage, etc. if in a certified bed

A0410. Submission Requirement	
Enter Code	<ol style="list-style-type: none"> 1. Neither federal nor state required submission 2. State but not federal required submission (FOR NURSING HOMES ONLY) 3. Federal required submission

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■ UNIT CERTIFICATION OR LICENSURE DESIGNATION DRAFT 10/1/2014 (A0410)

- ✓ Enter code:
 1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State
 2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State
 3. Unit is Medicare and/or Medicaid certified



119

■ LEGAL NAME OF RESIDENT (A0500)*

- ✓ Enter the resident's name as it appears on the resident's Medicare card
- ✓ If not in program, check Medicaid card or other government issued document
- ✓ Used to identify resident and match records
- ✓ No blanks



A0500. Legal Name of Resident			
A. First name:	<input type="text"/>	B. Middle initial:	<input type="text"/>
C. Last name:	<input type="text"/>	D. Suffix:	<input type="text"/>

*CMS Identifier

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■ SECTION A (A0600A-A1300)

- ✓ A0600A = Social Security Number*
- ✓ A0600B = Medicare Number
- ✓ A0700 = Medicaid Number (resident):
 - “+” if pending
 - “N” if not a Medicaid recipient
- ✓ A0800 = Gender*
- ✓ A0900 = Birth Date*
- ✓ A1000 = Race/Ethnicity – *check all that apply*
- ✓ A1100 = Language
- ✓ A1200 = Marital Status
- ✓ A1300 = Optional Resident Items:
 - Optional but very useful in NH



*CMS Identifier

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■ *CMS IDENTIFIERS

- ✓ State ID
 - ✓ Facility Internal ID
- MDS Items
- ✓ Legal Name (A0500)
 - ✓ SSN (A0600A)
 - ✓ Gender (A0800)
 - ✓ Birth Date (A0900)



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■ PREAMISSION SCREENING AND RESIDENT REVIEW (PASRR) OVERVIEW

- ✓ All admissions to a Medicaid certified facility must have a Level I PASRR completed
- ✓ Individuals who have or are suspected of MI or ID/DD or related conditions may not be admitted without Level II approval
- ✓ Resident Review (RR) required of residents with MI or ID/DD when a physical or mental significant change occurs (SCSA):
 - Consult your State Medicaid Agency for PASRR procedures
- ✓ Ensures that individuals with serious mental illness or intellectual disability or related condition are not placed in a NF inappropriately

123

■ *PREADMISSION SCREENING AND RESIDENT REVIEW (A1500)*

- ✓ Complete only if comprehensive assessment
- ✓ Is the resident currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?
 - Code 0 = No, skip to A1550
 - Code 1 = Yes, continue to A1510
 - Code 9 = Not a Medicaid-certified unit, skip to A1550

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■ *LEVEL II PASRR CONDITIONS (A1510)*

- ✓ Complete only if comprehensive assessment
- ✓ Check all that apply:
 - A = Serious mental illness
 - B = Intellectual Disability
 - C = Other related conditions

125

■ *CONDITIONS RELATED TO ID/DD STATUS (A1550)*

- ✓ Documents conditions associated with intellectual disability or developmental disabilities
- ✓ If resident is 22 years or older as of ARD date:
 - Complete only if Admission assessment (A0310A = 01)
- ✓ If resident is 21 years or younger as of ARD date:
 - Complete only if a comprehensive assessment
- ✓ Check all conditions related to ID/DD status present before age 22
- ✓ When age of onset is not specified, assume that the condition meets this criterion AND is likely to continue indefinitely

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■ **CONDITIONS RELATED TO ID/DD STATUS (A1550)**

- ✓ Complete only if comprehensive assessment
- ✓ Check all that apply:
- ✓ ID/DD With Organic Condition:
 - A = Down syndrome
 - B = Autism
 - C = Epilepsy
 - D = Other organic condition related to ID/DD
- ✓ ID/DD Without Organic Condition:
 - E = ID/DD condition with no specific conditions listed
- ✓ No ID/DD:
 - Z = None of the above

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■ **PASRR RESOURCES**

- ✓ Your SMA is overall responsible for PASRR and should direct you to agencies or vendors:
 - National Association of PASRR Professionals www.PASRR.org
 - The PASRR Technical Assistance Center (PTAC) is for state agencies, but website is informative: www.PASRRassist.org
 - Kentucky PASRR documents may be downloaded at: www.chfs.ky.gov/dms/mnfs.htm

128

■ **ENTRY DATE (A1600)
TYPE OF ENTRY (A1700)**

- ✓ A1600 = Entry Date:
 - Initial date of admission to the facility
 - Date resident most recently returned to facility after being discharged
- ✓ A1700 = Type of Entry:
 - Code 1 = Admission
 - Code 2 = Reentry
- ✓ When considering a return after a D=11; the day of discharge from the facility is not counted in the 30 days
- ✓ Swing bed facilities always code resident's entry as an admission (A1700=1)



129

■ ENTERED FROM (A1800)

✓ Enter the two-digit code that corresponds to the location or program the resident was admitted from for this admission:

- Code 01 = Community
- Code 02 = Another nursing home or swing bed
- Code 03 = Acute hospital
- Code 04 = Psychiatric hospital
- Code 05 = Inpatient rehabilitation facility
- Code 06 = ID/DD facility
- Code 07 = Hospice
- Code 09 = Long Term Care Hospital (LTCH)
- Code 99 = Other



NOTE: If resident was enrolled in a home-based hospice program, enter 07, not 01

130

■ ADMISSION DATE (A1900)

- ✓ Included on all record types
- ✓ Clarification to follow

131

■ DISCHARGE DATE (A2000)

- ✓ Complete only if A0310F = 10, 11 or 12
- ✓ Enter the date the resident leaves the facility
- ✓ Discharge date and ARD (A2300) must be the same for discharge assessments
- ✓ If resident was receiving services under Part A, the discharge date may be later than the end of Medicare stay date (A2400C)
- ✓ Do not include leaves of absence or hospital stays less than 24 hours unless admitted

132

■ **MEDICARE STAY (A2400)**

- ✓ Identifies when a resident is receiving services under the scheduled PPS
- ✓ Identifies when a resident's Medicare Part A stay begins and ends
- ✓ The end date is used to determine if the resident's stay qualifies for the short stay assessment

- ✓ **A = Has the resident had a Medicare-covered stay since the most recent entry?**
 - **Code 0 = No, skip to B0100**
 - **Code 1 = Yes, continue to A2400B**

136

■ **MEDICARE STAY START DATE (A2400B)**
MEDICARE STAY END DATE (A2400C)

- ✓ If A2400A is coded 1 (Yes):
 - **B = Enter start date of most recent Medicare stay**
 - **C = Enter end date of most recent Medicare stay**
 - Enter dashes (-) if stay is on-going

B. Start date of most recent Medicare stay:
[] - [] - []
Month Day Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:
[] - [] - []
Month Day Year

137

■ **MEDICARE STAY END DATE (A2400C)**

- ✓ The end of Medicare date is coded as follows, whichever occurs first:
 - Date SNF benefit exhausts
 - Date of last day covered as recorded on the effective date from the Generic Notice
 - The last paid day of Medicare A when payer source changes (regardless if the resident was moved to another bed or not)
 - Date resident was discharged from facility
- ✓ When resident returns from LOA or hospital <24 hours, not a new Part A stay (continued stay)
- ✓ End of Part A stay may be earlier than the discharge date
- ✓ Medicare Stay End Date Algorithm (pg. 28)

138

**SECTION B:
HEARING, SPEECH AND VISION**

■ **COMATOSE (B0100) (34-66)**

- ✓ **Must be documented by physician**
- ✓ **Persistent vegetative state/no discernible consciousness:**
 - **Code 0** = No, continue to B0200, Hearing
 - **Code 1** = Yes, skip to G0110, ADL

■ **HEARING (B0200)**

- ✓ **Code the response option that best reflects the resident's hearing ability (with hearing aid or hearing appliance if normally used):**
 - **Code 0** = Adequate, no difficulty in normal conversation, listening to TV
 - **Code 1** = Minimal difficulty, difficulty in some environments (person speaks softly, setting noisy)
 - **Code 2** = Moderate difficulty, speaker has to increase volume and speak distinctly
 - **Code 3** = Highly impaired, absence of useful hearing

■ HEARING AID (B0300)
SPEECH CLARITY (B0600)



- ✓ B0300 – Aid or device used in completing B0200:
 - Code 0 = No
 - Code 1 = Yes
- ✓ B0600 – Select best description of speech pattern:
 - Code 0 = Clear speech – distinct intelligible words
 - Code 1 = Unclear speech – slurred or mumbled words
 - Code 2 = No speech – absence of spoken words

NOTE: Determine the quality of resident's speech, not the content or appropriateness – just words spoken

142

■ MAKES SELF UNDERSTOOD (B0700) (34-66)

- ✓ Ability to express ideas and wants, consider both verbal and non-verbal expression:
 - Code 0 = Understood
 - Code 1 = Usually understood
 - Code 2 = Sometimes understood
 - Code 3 = Rarely/never understood
- ✓ Interact with the resident
- ✓ Offer alternative means of communication
- ✓ Consult with primary nurse assistant over all shifts, resident's family and speech-language pathologist



143

■ ABILITY TO UNDERSTAND OTHERS (B0800)

- ✓ Enter the code that best reflects the resident's ability to understand verbal content however able (with hearing aid or device if used):
 - Code 0 = Understands
 - Code 1 = Usually understands
 - Code 2 = Sometimes understands
 - Code 3 = Rarely/never understands



144

■ *VISION (B1000)*

- ✓ If the resident is unable to read English, ask the resident to read numbers or name items in a small picture
- ✓ If the resident is unable to communicate or follow directions, observe eye movements
 - If follows eye movement – code 3, Highly impaired
- ✓ Enter the code that best reflects the resident's ability to see in adequate light (with glasses or other visual appliances):
 - Code 0 = Adequate
 - Code 1 = Impaired
 - Code 2 = Moderately impaired
 - Code 3 = Highly impaired
 - Code 4 = Severely impaired

145

■ *CORRECTIVE LENSES (B1200)*

- ✓ Visual aids do not include surgical lens implant
- ✓ Code if resident uses corrective lenses (contacts, glasses or magnifying glass) used in B1000:
 - Code 0 = No
 - Code 1 = Yes



146

*SECTION C:
COGNITIVE PATTERNS*



147

■ *COGNITIVE PATTERNS*

- ✓ Determine resident's:
 - Attention
 - Orientation
 - Ability to register and recall new information
- ✓ Crucial factors for care planning decisions



148

■ *BRIEF INTERVIEW FOR MENTAL STATUS (BIMS)*

- ✓ The BIMS is a brief screener that aids in detecting cognitive impairment
- ✓ Most residents are able to attempt the BIMS
- ✓ It does not assess all possible aspects of cognitive impairment
- ✓ A diagnosis of dementia should only be made after a careful assessment for other reasons for impaired cognitive performance
- ✓ The final determination of the level of impairment should be made by the resident's physician or mental health care specialist

149

■ *SHOULD RESIDENT INTERVIEW FOR MENTAL STATUS BE CONDUCTED (C0100)*

- ✓ Should Brief Interview for Mental Status be Conducted?
 - Code 0 = No, skip to C0700
 - Code 1 = Yes, continue to C0200

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?
Attempt to conduct interview with all residents.



NOTE: Includes residents who use American Sign Language (ASL)

150

■ **CONDUCTING THE BIMS INTERVIEW (C0200 - C0400) (34-66)**



- ✓ C0200 = Repetition of Three Words
- ✓ C0300A-C = Temporal Orientation
- ✓ C0400A-C = Recall
- ✓ Interview is considered complete if resident attempted and provided relevant answers to at least four (4) of the questions in C0200-C0400
- ✓ Nonsensical responses should be coded as zero
- ✓ Refer to Appendix D for effective interviewing techniques
- ✓ When primary method of communication is writing; BIMS can be administered in writing
 - Refer to Appendix E for details on administering the BIMS in writing (should be limited)

151

■ **STOPPING THE INTERVIEW**

- ✓ Stop the interview after C0300C "Day of the Week" if:
 - All responses have been nonsensical
 - There has been no verbal or written response to any items up to that point
 - There has been no verbal or written response to some items and nonsensical responses to the other questions
- If interview stopped:
 - Code -, dash in C0400A-C
 - Code 99 in C0500
 - Code 1, yes in C0600
 - Complete staff assessment



152

■ **BIMS SUMMARY SCORE (C0500)**

- ✓ The total score is calculated by adding values for all questions from C0200-C0400:
 - Ranges from 00 – 15 and 99
 - Allows comparison with future and past performance
 - Decreases chance of incorrect labeling of dementia
 - Improves detection of delirium
 - Provides more reliable estimate of resident function
 - Score <= 9 – cognitively impaired for RUG purposes
 - Code 99 if:
 - Resident chooses not to participate or gave nonsensical responses
 - 4 or more items were coded 0 because the resident chose not to answer or gave nonsensical responses
 - Any BIMS items is coded with a dash (-)



153

■ SHOULD THE STAFF ASSESSMENT BE CONDUCTED (C0600)

- ✓ Staff assessment completed when resident unable or unwilling to participate in the resident interview
- ✓ Should the staff assessment for mental status (C0700-1000) be conducted?
 - Code 0 = No, skip to C1300
 - Code 1 = Yes, continue to C0700



154

■ STAFF ASSESSMENT OF MENTAL STATUS (C0700 - C0800) (34-66)

- ✓ C0700 = Short-term Memory OK:
 - Code 0 = Memory OK
 - Code 1 = Memory problem
 - If the test cannot be conducted (resident uncooperative or non-responsive, etc.) and staff were unable to make a determination based on observation, code -, dash to indicate that the information is not available because it could not be assessed
- ✓ C0800 = Long-term Memory OK:
 - Code 0 = Memory OK
 - Code 1 = Memory problem
 - If the test cannot be conducted (resident uncooperative or non-responsive, etc.) and staff were unable to make a determination based on observation, code -, dash to indicate that the information is not available because it could not be assessed

155

■ STAFF ASSESSMENT OF MENTAL STATUS (C0900 - C1000) (34-66)

- ✓ C0900 = Memory/Recall Ability: (check all that apply)
 - A. Current season
 - B. Location of own room
 - C. Staff names and faces
 - D. That he or she is in a nursing home
 - Z. None of above were recalled
- ✓ C1000 = Cognitive Skills for Daily Decision Making:
 - Code 0 = Independent
 - Code 1 = Modified independence
 - Code 2 = Moderately impaired
 - Code 3 = Severely impaired
 - If resident "rarely or never" made a decision, despite opportunities and cues, Code C1000=3
 - If resident makes decision, although poorly, C1000=2
 - A resident's cognitive decision to exercise his/her right to decline treatment should not be captured as impaired decision making in C1000



158

■ DELIRIUM

- ✓ Mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness or hallucinations
- ✓ Associated with:
 - Increased mortality
 - Functional decline
 - Development or worsening of incontinence
 - Behavior problems
 - Withdrawal from activities
 - Re-hospitalizations and increased length of stay



157

■ DELIRIUM

- ✓ Delirium can be misdiagnosed as dementia
- ✓ A recent deterioration in cognitive function
- ✓ May be reversible if detected and treated timely
- ✓ Planning for care:
 - May be symptom of acute, treatable illness
 - Infection or reaction to medications
 - Prompt detection essential

158

■ ASSESSMENT OF DELIRIUM (C1300)

- ✓ While completing the BIMS:
 - Observe resident behavior for signs and symptoms of delirium
- ✓ If conducting a staff assessment:
 - Ask staff members who conducted the assessment about observations of signs and symptoms of delirium
- ✓ Review medical record
- ✓ Interview staff, family, etc.
- ✓ Additional guidelines in Appendix C



159

■ **SIGNS AND SYMPTOMS OF DELIRIUM (C1300)**

✓ **Standardized instrument developed to facilitate detection of delirium**

✓ **Consists of 4 components:**

- **A = Inattention**
- **B = Disorganized thinking**
- **C = Altered level of consciousness**
- **D = Psychomotor retardation**

C1300. Signs and Symptoms of Delirium (from CAMc)

Code after completing Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

160

■ **SIGNS AND SYMPTOMS OF DELIRIUM (C1300)
ACUTE ONSET MENTAL STATUS CHANGE (C1600)**

✓ **Enter code in boxes for C1300A-D:**

- **Code 0 = Behavior not present**
- **Code 1 = Behavior continuously present, does not fluctuate**
- **Code 2 = Behavior presents, fluctuates (comes and goes, changes in severity)**

✓ **C1600--Is there evidence of an acute change in mental status from the resident's baseline?**

- **Code 0 = No**
- **Code 1 = Yes**

161

**SECTION D:
MOOD**



162

■ *SHOULD RESIDENT MOOD INTERVIEW BE CONDUCTED ? (D0100)*

- ✓ Identify the presence or absence of clinical mood indicators, not to diagnose depression or a mood disorder
- ✓ Determination is made by either a resident interview (PHQ-9©) or by staff assessment (PHQ-9-OV©)
- ✓ Attempt to conduct interview with all residents

- ✓ D0100 – Should resident mood interview be conducted?
 - Code 0 = No, skip to D0500
 - Code 1 = Yes, continue to D0200

163

■ *RESIDENT MOOD INTERVIEW PHQ-9© (D0200)*

- ✓ Patient Health Questionnaire (PHQ-9©)
- ✓ PHQ-9© is a 9-item validated interview that screens for symptoms of depression
- ✓ A standardized severity score and rating for evidence of depressive disorder
- ✓ Look-back period is 14 days
- ✓ There are two parts for each item:
 - Symptom presence (column 1)
 - Symptom frequency (column 2)
- ✓ Conduct interview preferably day before or day of ARD



164

■ *RESIDENT MOOD INTERVIEW PHQ-9© (D0200A-I) (34-66)*

- ✓ Symptom Presence (column 1):
 - Code 0 = No
 - Code 1 = Yes
 - Code 9 = No response, leave column 2 blank
- ✓ Symptom Frequency (column 2):
 - Code 0 = Never or 1 day
 - Code 1 = 2-6 days
 - Code 2 = 7-11 days
 - Code 3 = 12-14 days
 - If resident has difficulty selecting between two frequency responses, code for the higher frequency

165

■ **TOTAL SEVERITY SCORE (D0300)**

- ✓ A summary of the frequency scores that indicates the extent of potential depression symptoms
- ✓ The score does not diagnose a mood disorder
- ✓ The interview is considered successfully completed if resident answered frequency response on 7 or more items
- ✓ If symptom frequency is blank for 3 or more items, interview is not complete, the Total Severity Score is coded 99 and the Staff Assessment of Mood should be done
- ✓ Add the numeric scores across all frequency responses from Column 2
- ✓ Total Severity Score range (00-27 and 99):
 - Score >= 10 – depressed for RUG purposes

166

■ **SAFETY NOTIFICATION (D0350)**

- ✓ Complete only if D0200I, (Thoughts you would be better off dead or of hurting yourself in some way), is coded as a 1 (symptom present)
- ✓ May indicate the possibility of resident self-harm
- ✓ Was responsible staff or provider informed that there is a potential for resident self harm?
 - Code 0 = No
 - Code 1 = Yes

167

■ **STAFF ASSESSMENT OF RESIDENT MOOD (PHQ-9-OV®) (D0500)**

- ✓ Alternate means of assessing mood for residents who cannot communicate, or refuse or are unable to participate in PHQ-9® interview
- ✓ Look-back period is 14 days
- ✓ Use same interview techniques with staff as in PHQ-9® interviews
- ✓ The staff assessment has one additional item (J)

168

■ **STAFF ASSESSMENT OF RESIDENT MOOD**
(PHQ-9-OV®) (D0500A-J) (34-66)

- ✓ **Symptom Presence (column 1):**
 - **Code 0** = No
 - **Code 1** = Yes
- ✓ **Symptom Frequency (column 2):**
 - **Code 0** = Never or 1 day
 - **Code 1** = 2-6 days
 - **Code 2** = 7-11 days
 - **Code 3** = 12-14 days
 - If a longer item is separated into its components, select the highest frequency reported
 - If it is difficult to select between two frequencies, select the higher frequency

169

■ **TOTAL SEVERITY SCORE (D0600)**

- ✓ The interview is successfully completed if staff members were able to answer the frequency responses of at least 8 or more items
- ✓ Add the numeric scores across all frequency responses from Column 2
- ✓ **Total Severity Score range (00-30):**
 - **Score >= 10** – depressed for RUG purposes

170

■ **SAFETY NOTIFICATION (D0650)**

- ✓ Complete only if D0500I, (States that Life isn't Worth Living, Wishes for Death, or Attempts to Harm Self), is coded as a 1 (symptom present)
- ✓ May indicate the possibility of resident self-harm
- ✓ Was responsible staff or provider informed that there is a potential for resident self harm?
 - **Code 0** = No
 - **Code 1** = Yes



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SECTION E:
BEHAVIOR



■ BEHAVIORS

- ✓ Identify behavioral symptoms in the last 7 days that:
 - May cause distress to the resident
 - Are distressing or disruptive to facility residents, staff members or the care environment
- ✓ Behaviors may:
 - Place resident at risk for injury, isolation, inactivity
 - May indicate unrecognized needs, preferences, illness
- ✓ Emphasis is on identifying behaviors
- ✓ Do not take resident's intent into account when coding
- ✓ Staff may have become used to resident's behavior:
 - May under-report or minimize



■ POTENTIAL INDICATORS OF PSYCHOSIS (E0100) (34-66)

- ✓ When resident expresses a belief that is plausible but alleged by others to be false, try to verify the facts:
 - Determine whether there is reason to believe that it happened, or
 - Whether it is likely that the belief is false
- ✓ When resident expresses a clear false belief:
 - Determine if it can be readily corrected by a simple explanation of the facts, or
 - Demonstration of evidence to the contrary
 - Do not challenge the resident
- ✓ The resident's responses to the offering of a potential alternative explanation is often helpful in determining whether the false belief is held strongly enough to be considered fixed

■ **POTENTIAL INDICATORS OF PSYCHOSIS (E0100)**

✓ **Check all that apply:**

✓ **E0100A = Hallucinations:**

- Perception of something being present that is **not** actually there
- May be auditory or visual or involve smells, tastes or touch

✓ **E0100B = Delusions:**

- Fixed false belief **not** shared by others that the resident holds **even** in the face of evidence to the contrary

✓ **E0100Z = None of the above**

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■ **POTENTIAL INDICATORS OF PSYCHOSIS (E0100)**

✓ **Coding Tips for Delusion:**

- If a belief cannot be objectively shown to be false, or it is **not** possible to determine whether it is false, do **not** code it as a delusion
- If a resident expresses a false belief but easily accepts a reasonable alternative explanation, do **not** code it as a delusion
- If the resident continues to insist that the belief is correct despite an explanation or direct evidence to the contrary, code as a delusion

176

■ **BEHAVIORAL SYMPTOM (E0200) (34-66)**

✓ **New onset of behavioral symptoms warrants:**

- Prompt evaluation
- Assurance of resident safety
- Relief of distressing symptoms
- Caring response to the resident



✓ **Prompt identification and treatment of reversible and treatable causes**

✓ **Development of management strategies to minimize the amount of disability and distress**

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■ BEHAVIORAL SYMPTOM (E0200)

- ✓ Code based on whether the symptoms occurred and not based on an interpretation of the behavior's meaning
- ✓ Code as present even if staff have become used to the behavior or view it as typical or tolerable
- ✓ Behaviors in these categories should be coded as present or not present, whether or not they might represent a rejection of care



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■ BEHAVIORAL SYMPTOM PRESENCE & FREQUENCY (E0200)

- ✓ To identify the presence and frequency of 3 types of behaviors:
 - A = Physical behavioral symptoms directed towards others
 - B = Verbal behavioral symptoms directed toward others
 - C = Other behavioral symptoms not directed toward others
 - E0200C does not include wandering
- ✓ Goal - to develop interventions to improve symptoms or reduce their impact
- ✓ Observe resident, interview staff and review resident record

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■ BEHAVIORAL SYMPTOM PRESENCE & FREQUENCY (E0200)

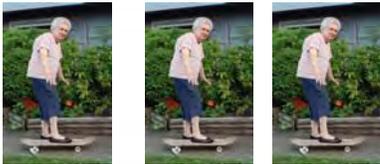
- ✓ For each behavior symptom note presence of symptoms and their frequency:
 - Code 0 = Behavior not exhibited
 - Code 1 = Behavior of this type occurred 1 to 3 days
 - Code 2 = Behavior of this type occurred 4 to 6 days
 - Code 3 = Behavior of this type occurred daily

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■ OVERALL PRESENCE OF BEHAVIORAL SYMPTOMS (E0300)

✓ Were any behavioral symptoms in questions E0200 coded 1, 2 or 3?

- Code 0 = No, skip to E0800
- Code 1 = Yes, proceed to E0500



181

■ IMPACT ON RESIDENT (E0500)

✓ Identify behaviors that may require treatment planning and intervention

✓ Consider all behavioral symptoms coded in E0200

✓ Behaviors that impact the resident's risk for significant injury, interfere with care or their participation in activities or social interactions

✓ Did any of the identified symptom(s):

- A = Put the resident at significant risk for physical illness or injury?
 - Code 0 = No
 - Code 1 = Yes
 - Code based on whether risk for physical injury/illness is known to commonly occur under similar circumstances

182

■ IMPACT ON RESIDENT (E0500)



✓ Did any of the identified symptom(s) (continued):

- B = Significantly interfere with the resident's care?
 - Code 0 = No
 - Code 1 = Yes
 - Code if care delivery is impeded to such an extent that necessary or essential care cannot be received safely, completely or timely
- C = Significantly interfere with the resident's participation in activities or social interactions?
 - Code 0 = No
 - Code 1 = Yes
 - Code if behaviors keep resident from participating in solitary or group activities, or having positive social encounters with visitors, other residents or staff

183

■ **IMPACT ON OTHERS (E0600)**

- ✓ Identify behaviors in E0200 that may require treatment planning and intervention
- ✓ Behaviors that put others at risk for significant injury, intrude on their privacy or activities and/or disrupt their care or living environment
- ✓ Did any of the identified symptom(s):
 - A = Put others at significant risk for physical injury?
 - B = Significantly intrude on the privacy or activity of others?
 - C = Significantly disrupt care or living environment?
 - Code for all 3 impacts:
 - Code 0 = No
 - Code 1 = Yes



■ **REJECTION OF CARE PRESENCE & FREQUENCY (E0800) (34-66)**

- ✓ Resident's preferences do **not** have to appear logical or rational to the clinician
- ✓ It is really a matter of resident choice; education is provided and resident's choices become part of the care plan
- ✓ On future assessments, this behavior would **not** be coded in this item
- ✓ Care might conflict with resident's preferences and goals; in such cases, rejection of care is **not** considered a problem
- ✓ Rejection of care might be caused by underlying neuropsychiatric, medical, or dental problems

185

■ **REJECTION OF CARE PRESENCE & FREQUENCY (E0800)**

- ✓ Identify potential behavioral problems, **not** situations where care is rejected based on a choice that is consistent with the resident's preferences or goals for health and well-being or a choice made by the resident's family or proxy decision maker
- ✓ Rejection of care may appear as:
 - Verbally declining or making statements of refusal
 - Physical behaviors that avoid or interfere with care
- ✓ Did the resident reject evaluation or care that is necessary to achieve the resident's goals for health and well-being?
 - Code 0 = Behavior **not** exhibited
 - Code 1 = Behavior of this type occurred 1 to 3 days
 - Code 2 = Behavior of this type occurred 4 to 6 days
 - Code 3 = Behavior of this type occurred daily



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■ **WANDERING**
PRESENCE & FREQUENCY (E0900) (34-66)

- ✓ Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction
- ✓ Wandering may or may not be aimless
- ✓ The wandering resident may be oblivious to his or her physical or safety needs
- ✓ The resident may have a purpose such as searching to find something, but he or she persists without knowing the exact direction or location of the object, person or place
- ✓ The behavior may or may not be driven by confused thoughts or delusional ideas (e.g., when a resident believes she must find her mother, who staff know is deceased)

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■ **WANDERING**
PRESENCE & FREQUENCY (E0900)

- ✓ Has the resident wandered?
 - Code 0 = Behavior not exhibited, skip to E1100
 - Code 1 = Behavior of this type occurred 1 to 3 days
 - Code 2 = Behavior of this type occurred 4 to 6 days
 - Code 3 = Behavior of this type occurred daily
- Pacing within a constrained space is not included in wandering
- Traveling via a planned course is not considered wandering



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■ **WANDERING - IMPACT (E1000)**

- ✓ Answer only if E0900, Wandering, was coded 1, 2 or 3
- ✓ A – Does the wandering place the resident at significant risk of getting to a potentially dangerous place?
 - Code 0 = No
 - Code 1 = Yes
- ✓ B - Does the wandering significantly intrude on the privacy or activities of others?
 - Code 0 = No
 - Code 1 = Yes
- ✓ Not all wandering is harmful



189

■ CHANGE IN BEHAVIOR OR OTHER SYMPTOMS (E1100)

- ✓ Consider all responses in E0100 thru E1000
- ✓ Compare with responses on prior MDS assessments
- ✓ How does resident's current behavior status, care rejection, or wandering compare to prior assessment (OBRA or Scheduled PPS)?
 - Code 0 = Same
 - Code 1 = Improved
 - Code 2 = Worse
 - Code 3 = N/A because no prior MDS assessment



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SECTION F:
PREFERENCE FOR CUSTOMARY
ROUTINE & ACTIVITIES



191

■ SHOULD INTERVIEW FOR DAILY & ACTIVITY PREFERENCES BE CONDUCTED (F0300)

- ✓ Attempt to interview residents able to communicate. If resident is unable to complete, attempt to complete interview with family member or significant other.
- ✓ Should interview for daily and activity preferences be conducted?
 - Code 0 = No, resident is rarely/never understood and family/significant other not available
 - Skip to F0800
 - Code 1 = Yes, continue to F0400



192

■ INTERVIEW FOR DAILY PREFERENCES (F0400)
INTERVIEW FOR ACTIVITY PREFERENCES (F0500)

- ✓ Explain interview response choices, showing resident a written list, such as a cue card
- ✓ Show resident the coding responses and say “While you are in this home...”
- ✓ Resident may respond verbally, by pointing to or by writing response
- ✓ No look-back period is provided to resident; he/she is being asked about current preferences but is not limited to a 7 day look-back period
- ✓ However, facility must still complete the assessment within the 7 day look-back period



193

■ INTERVIEW FOR DAILY PREFERENCES (F0400)
INTERVIEW FOR ACTIVITY PREFERENCES (F0500)

Eight (8) items in F0400 and 8 items in F0500 will be evaluated using the same coding scale:

- Code 1 = Very important
- Code 2 = Somewhat important
- Code 3 = Not very important
- Code 4 = Not important at all
- Code 5 = Important, but can't do or no choice
- Code 9 = No response or non-responsive (incoherent, nonsensical answer not corresponding to question)



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■ INTERVIEW FOR DAILY PREFERENCES (F0400)
INTERVIEW FOR ACTIVITY PREFERENCES (F0500)

- ✓ Interview is considered incomplete if resident gives nonsensical responses or fails to respond to 3 or more of the 16 items in F0400 and F0500
- ✓ If interview is stopped because incomplete, fill remaining items with a “9” and proceed to F0600



195

■ DAILY AND ACTIVITY PREFERENCES
PRIMARY RESPONDENT (F0600)

✓ Indicate primary respondent for F0400 and F0500:

- Code 1 = Resident
- Code 2 = Family or significant other
- Code 9 = Interview could not be completed



196

■ SHOULD THE STAFF ASSESSMENT OF DAILY &
ACTIVITY PREFERENCES BE CONDUCTED? (F0700)

- Code 0 = No
 - F0400 and F0500 was completed by resident or family/significant other
 - Skip to G0110
- Code 1 = Yes
 - 3 or more items in F0400 or F0500 were not completed by resident or family/significant other
 - Continue to F0800

NOTE: *If the total number of unanswered questions in F0400 - F0500 is equal to 3 or more, the interview is considered incomplete*

197

■ STAFF ASSESSMENT OF DAILY & ACTIVITY
PREFERENCES (F0800)

- ✓ Conduct only if resident/family interview was not completed
- ✓ Assessment is done by observing the resident when care, routines and activities specified in these items are made available to the resident
- ✓ Observations are made by staff across all shifts and departments during the look-back period
- ✓ Check all items A-T, Z for which the resident appears content or happy during the activity:
 - Resident is involved, pays attention or smiles, etc.



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SECTION G:
FUNCTIONAL STATUS



■ **ACTIVITIES OF DAILY LIVING (ADL)**

- ✓ **ADL** – Tasks related to personal care
- ✓ **ADL Self-Performance** – Measures what the resident actually did (not what he/she might be capable of doing) according to a performance-based scale
- ✓ **ADL Support Provided** – Measures the most support provided by staff, even if that level of support only occurred once
- ✓ **ADL Aspects** – Components of an ADL activity
- ✓ Since each section uses its own scale, it is recommended that Self-Performance column be completed in its entirety followed by the Support Provided column

■ **ACTIVITIES OF DAILY LIVING (ADL) ASSISTANCE (G0110) (34-66)**

- ✓ Code based on level of assistance when using special adaptive devices
- ✓ Do not include assistance provided by individuals hired (compensated or not) by individuals outside facility's management/ administration, hospice staff, nursing/CNA students
- ✓ Self-performance and support provided may vary day to day, shift to shift, within shifts, 24 hours a day

■ ADL SELF-PERFORMANCE CODING
(G0110 COLUMN 1)

✓ Activity Occurred 3 or More Times:

- Code 0 = Independent, no help or staff oversight at any time
- Code 1 = Supervision, oversight, encouragement, or cueing
- Code 2 = Limited assistance:
 - Resident highly involved in activity
 - Staff provide guided maneuvering of limbs or other non-weight-bearing assistance:
 - Guided maneuvering vs. weight-bearing is determined by who is supporting the weight of the resident's extremity or body

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■ ADL SELF-PERFORMANCE CODING
(G0110 COLUMN 1)

✓ Activity Occurred 3 or More Times:

- Code 3 = Extensive assistance:
 - Resident involved in part of activity
 - Staff provide weight-bearing support, OR
 - Full staff performance part but not all of the time
- Code 4 = Total dependence:
 - Full staff performance every time during entire 7-day period
 - No participation by resident for any aspect of ADL activity



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■ ADL SELF-PERFORMANCE CODING
(G0110 COLUMN 1)

✓ Activity Occurred 2 or Fewer Times:

- Code 7 = Activity occurred only once or twice
- Code 8 = Activity did not occur:
 - Activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

204

■ ACTIVITIES OF DAILY LIVING RULE OF 3



205

■ INSTRUCTIONS FOR THE RULE OF 3

- ✓ The Rule of 3 is a method that was developed to help determine the appropriate code to document ADL Self-Performance on the MDS
- ✓ It is very important that staff fully understand the components of each ADL, the ADL Self-Performance coding level definitions and the Rule of 3
- ✓ To properly apply the Rule of 3, the facility must note which activities occurred, how many times, what type and what level of support was required over the 7-day observation period
- ✓ The Rule of 3 steps must be used in sequential order
- ✓ Use the first instruction encountered that meets the coding scenario

206

■ INSTRUCTIONS FOR THE RULE OF 3

Exceptions for the Rule of 3:

- ✓ Code 0, Code 4, and Code 8 – as the definition for these coding levels are finite and cannot be entered on the MDS unless it is the level that occurred every time the ADL occurred
- ✓ Code 7 – as this code only applies if the activity occurred only 1 or 2 times

207

■ INSTRUCTIONS FOR THE RULE OF 3

Rule of 3:

1. When activity occurs 3 times at any one level, code that level.
2. When an activity occurs 3 or more times at multiple levels, code the most dependent level.
3. When an activity occurs 3 or more times and at multiple levels, but not 3 times at any one level, apply the following:
 - a) Convert episodes of full staff performance to weight-bearing assistance.
 - b) When there are 3 or more episodes of a combination of full staff performance, and weight-bearing assistance – code extensive assistance (3).
Do not proceed to "c" below if "b" applies.
 - c) When there are 3 or more episodes of a combination of full staff performance, weight-bearing assistance, and/or non-weight-bearing assistance, code limited assistance (2).

208

■ INSTRUCTIONS FOR THE RULE OF 3

If none of the above are met, code Supervision (1):

- ✓ This box corresponds to a, b, and c under the third Rule above
- ✓ The instruction in this box only applies when the third Rule applies, i.e., an activity occurs 3 times and at multiple levels, but not 3 times at any one level (e.g., 2 times non-weight bearing, 2 times weight bearing)
- ✓ If the coding scenario does not meet the third Rule, do not apply a, b, and c of the third Rule. Code (1) Supervision

209

ADL SAMPLE EXERCISES



■ **ADL SUPPORT PROVIDED CODING (G0110 COLUMN 2)**

- ✓ Code regardless of self-performance codes:
 - Code 0 = No setup or physical help from staff
 - Code 1 = Setup help only
 - Code 2 = One person physical assist
 - Code 3 = Two+ persons physical assist
 - Code 8 = ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

232

■ **BATHING (G0120)**

- ✓ Code how resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower
- ✓ Code for the most dependent in self-performance and support provided
- ✓ G0120A=Self-Performance:
 - Code 0 = Independent
 - Code 1 = Supervision
 - Code 2 = Physical help limited to transfer only
 - Code 3 = Physical help in parts of bathing activity
 - Code 4 = Total dependence
 - Code 8 = Activity did not occur
- ✓ G0120B=Support Provided:
 - Use the same codes as G0110 Column 2



NOTE: excludes washing of back and hair

233

■ **BALANCE DURING TRANSITIONS AND WALKING (G0300)**

- ✓ Conducting the assessment:
 - Can be done through observations of the resident during the entire 7-day look-back period
 - During transitions from sitting to standing, walking, turning, transfers on and off toilet, and transfer from wheelchair to bed and bed to wheelchair
 - Must have documentation that reflects the resident's stability in these activities at least once during the look-back period, otherwise the following assessment must be done

234

■ **BALANCE DURING TRANSITIONS AND WALKING (G0300)**

- a) Have assistive devices the resident normally uses available
- b) Start with resident sitting on the edge of the bed, in a chair or in a wheelchair
- c) Ask the resident to stand up and stay still for 3-5 seconds (rate G0300A now)
- d) Ask resident to walk approximately 15 feet using his/her usual assistive device (rate G0300B now)
- e) Ask resident to turn around (rate G0300C now)



235

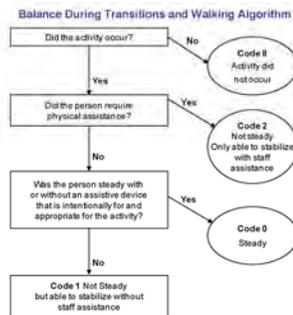
■ **BALANCE DURING TRANSITIONS AND WALKING (G0300)**

- f) Ask resident to:
 - Walk or wheel from a starting point in his/her room into the bathroom
 - Prepare for toileting as normally do (including taking down pants or other clothing, but leaving undergarments on)
 - Sit down on the toilet (rate G0300D now)
- g) Ask residents who use a wheelchair for mobility to transfer from a seated position in the wheelchair to a seated position on the bed (rate G0300E now)



236

■ **BALANCE DURING TRANSITIONS AND WALKING ALGORITHM (G-26)**



237

■ **BALANCE DURING TRANSITIONS AND WALKING (G0300)**

✓ Code the following walking and transition items for most dependent:

- A = Moving from seated to standing position
- B = Walking
- C = Turning around
- D = Moving on and off toilet
- E = Surface-to-surface transfer
 - Code 0 = Steady at all times
 - Code 1 = Not steady, but able to stabilize with help
 - Code 2 = Not steady, only able to stabilize with help
 - Code 8 = Activity did not occur



238

■ **FUNCTIONAL LIMITATION IN RANGE OF MOTION (G0400)**

- ✓ Test the upper and lower extremity for limitations that interfere with daily functioning or place the resident at risk of injury
- ✓ Assess ROM bilaterally at the shoulder, elbow, wrist, hand, hip, knee, ankle, foot and other joints unless contraindicated
- ✓ Ask resident to follow verbal directions for each movement
- ✓ Demonstrate each movement
- ✓ Actively assist the resident with ROM exercises by supporting h/h extremity and guiding
- ✓ A = Upper extremity
- ✓ B = Lower extremity:
 - Code 0 = No impairment
 - Code 1 = Impairment on one side
 - Code 2 = Impairment on both sides



239

■ **MOBILITY DEVICES (G0600)**

✓ Check all that were normally used:

- A = Cane/crutch
- B = Walker
- C = Wheelchair
- D = Limb prosthesis
- Z = None of the above were used



240

■ **FUNCTIONAL REHABILITATION POTENTIAL (G0900)**

✓ **Complete only on OBRA Admission (A0310A = 01)**

✓ **A = Resident believes he or she is capable of increased independence in at least some ADLs:**

- **Code 0 = No**
- **Code 1 = Yes**
- **Code 9 = Unable to determine**



✓ **B = Direct care staff believe resident is capable of increased independence in at least some ADLs:**

- **Code 0 = No**
- **Code 1 = Yes**

241

**SECTION H:
BLADDER & BOWEL**



242

■ **APPLIANCES (H0100)**

✓ **Check all that apply:**

- **A = Indwelling catheter**
 - Including suprapubic catheters and nephrostomy tubes
- **B = External catheter**
- **C = Ostomy**
 - Any type of surgically created opening of the GI or genitourinary tract for discharge of body waste including:
 - > Urostomy
 - > Ileostomy
 - > Colostomy
- **D = Intermittent catheterization**
- **Z = None of the above**

243

■ URINARY TOILETING PROGRAM (H0200)

- ✓ An individualized, resident-centered toileting program
- ✓ A toileting program or trial toileting program refers to a specific approach that is organized, planned, documented, monitored, and evaluated
- ✓ Urinary Toileting Program has 3 components:
 - A. Trial
 - B. Program response
 - C. Current program or trial
- ✓ It does not refer to:
 - Simply tracking continence status
 - Changing pads or wet clothing
 - Random assistance with toileting or hygiene



244

■ URINARY TOILETING PROGRAM TRIAL (H0200A)

- ✓ Look for evidence of a trial individualized toileting program that includes at least 3 days of toileting patterns with prompts to void recorded in a bladder record or voiding diary
- ✓ Simply tracking continence status or check and change is not a trial
 - A = Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/entry or reentry or since the urinary incontinence was noted in this facility?
 - Code 0 = No, skip to H0300
 - Code 1 = Yes, continue to H0200B
 - Code 9 = Unable to determine, skip to H0200C

245

■ URINARY TOILETING PROGRAM RESPONSE (H0200B)

- ✓ B = What was the resident's response to the trial program?
 - Code 0 = No improvement
 - Code 1 = Decreased wetness
 - Code 2 = Completely dry (continent)
 - Code 3 = Unable to determine, or trial in progress

246

■ CURRENT TOILETING PROGRAM OR TRIAL (H0200C)
(34-66)

- ✓ C = Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?
 - Code 0 = No:
 - Individualized program used less than 4 of the 7 day look-back period
 - Code 1 = Yes:
 - Some kind of systematic toileting program was used 4 or more days of the 7 day look-back period
- ✓ Look for documentation in the clinical record that the following 3 requirements are met:
 - Program was implemented
 - Program was communicated to the resident and staff
 - Resident's response to the toileting program and subsequent re-evaluations

247

■ URINARY CONTINENCE (H0300)

- ✓ **Continence** – any void into a commode, urinal or bedpan that occurs voluntarily or as the result of prompted toileting, assisted toileting or scheduled toileting
- ✓ **Incontinence** – the involuntary loss of urine
- ✓ Urinary continence:
 - Code 0 = Always continent
 - Code 1 = Occasionally incontinent (less than 7 episodes)
 - Code 2 = Frequently incontinent (7 or more episodes with 1 or more episode of continent voiding)
 - Code 3 = Always incontinent (no continent voiding)
 - Code 9 = Not rated

248

■ BOWEL CONTINENCE (H0400)

- ✓ Bowel continence:
 - Code 0 = Always continent
 - Code 1 = Occasionally incontinent (1 episode of incontinence)
 - Code 2 = Frequently incontinent (2 or more episodes of incontinence, but at least 1 continent bowel movement)
 - Code 3 = Always incontinent (no episodes of continent bowel movements)
 - Code 9 = Not rated

NOTE: Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinence

249

■ **BOWEL TOILETING PROGRAM (H0500)**
(34-66)

- ✓ Look for documentation in the clinical record that the following 3 requirements are met:
 - Program was implemented
 - Program was communicated to the resident and staff
 - Resident's response to the toileting program and subsequent re-evaluations
- ✓ Is a toileting program currently being used to manage the resident's bowel continence?
 - Code 0 = No
 - Code 1 = Yes

250

■ **BOWEL PATTERNS (H0600)**

- ✓ **Constipation**- 2 or fewer bowel movements during the 7-day look-back period or if most stool is hard and difficult to pass (regardless of frequency)
- ✓ **Fecal Impaction**:
 - Fecal impaction is caused by chronic constipation
 - Fecal impaction is not synonymous with constipation
- ✓ Constipation present?
 - Code 0 = No
 - Code 1 = Yes

251

SECTION I:
ACTIVE DIAGNOSIS



252

■ ACTIVE DIAGNOSES

- ✓ Code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death
- ✓ Disease processes can have a significant adverse affect on the individual's health status and quality of life
- ✓ This section identifies active diseases and infections that drive the current plan of care



253

■ ACTIVE DIAGNOSES

- ✓ 2 look back periods:
 - Step 1 = Diagnosis identification 60-day window
 - Must have physician documented diagnosis (or by NP, PA, or CNS) in the last 60 days
 - Step 2 = Diagnosis Status: Active or Inactive 7-day window (except UTI)

254

■ ACTIVE DIAGNOSES

- ✓ Coding Tips:
 - If disease/condition not specifically listed, check "Other" box (I8000); write in ICD code and name of diagnosis
 - If diagnosis is a V-code, another diagnosis for the related primary medical condition should be checked or entered in I8000
 - Do not include conditions that have been resolved, do not affect the resident's current status or do not drive the resident's plan of care during the 7-day look-back period

255

■ ACTIVE DIAGNOSES

✓ Coding Tips, continued:

- When there is no specific documentation that a disease is “active”, may confirm this using other indicators; tests, procedures, positive study, etc.
- Special criteria for UTI:
 - Physician diagnosis of UTI in last 30 days
 - Signs and symptoms attributed to UTI
 - Positive test, study or procedure
 - Current medication or treatment for UTI in last 30 days



256

■ ACTIVE DIAGNOSES (I0100-I8000) (34-66)

- ✓ I0100 = Cancer
- ✓ I0200-I0900 = Heart/Circulation
- ✓ I1100-I1300 = Gastrointestinal
- ✓ I1400-I1650 = Genitourinary
- ✓ I1700-I2500 = Infections
- ✓ I2900-I3400 = Metabolic
- ✓ I3700-I4000 = Musculoskeletal
- ✓ I4200-I5500 = Neurological
- ✓ I5600 = Nutritional
- ✓ I5700-I6100 = Psychiatric/Mood Disorder
- ✓ I6200-I6300 = Pulmonary
- ✓ I6500 = Vision
- ✓ I7900 = None of Above
- ✓ I8000 = Other

257

■ ACTIVE DIAGNOSES (I0100-I8000) (34-66)

- ✓ I2000 = Pneumonia (34-66)
- ✓ I2100 = Septicemia (34-66)
- ✓ I2900 = Diabetes Mellitus (34-66)
- ✓ I4300 = Aphasia (34)
- ✓ I4400 = Cerebral Palsy (34-66)
- ✓ I4900 = Hemiplegia (34-66)
- ✓ I5100 = Quadriplegia (34-66)
- ✓ I5200 = Multiple Sclerosis (34-66)
- ✓ I5300 = Parkinson's Disease (66)
- ✓ I6200 = COPD (66)
- ✓ I6300 = Respiratory Failure (66)

258

SECTION J:
HEALTH CONDITIONS



■ PAIN MANAGEMENT (J0100) 

✓ At any time in the last **5 days** has the resident received:

- A = Scheduled pain medication regimen?
- B = PRN pain medications OR was offered and declined?
- C = Non-medication intervention for pain?

✓ Coding for all of the above:

- **Code 0** = No, for A and C, the medical record does not contain documentation that a pain medication was received.
For item B also include was received or offered
- **Code 1** = Yes, for A, the medical record contains documentation that a pain medication was received.
For item B also include offered, but declined.
For item C, the efficacy must be documented.

■ SHOULD PAIN ASSESSMENT INTERVIEW BE CONDUCTED? (J0200)

✓ Attempt to conduct the interview if the resident is at least sometimes understood and an interpreter is present (or not required):

- **Code 0** = No, resident is rarely/never understood, skip to J0800
- **Code 1** = Yes, continue to J0300

■ PAIN ASSESSMENT INTERVIEW
(J0300 - J0600)

- ✓ Assessment should be conducted on the day before or the day of the ARD date
- ✓ The look back period is 5 days
- ✓ Directly ask the resident each item in J0300 thru J0600 in the order provided
- ✓ Use resident's terminology for pain – such as hurting, aching, burning



262

■ PAIN PRESENCE (J0300)

- ✓ Ask resident: *“Have you had pain or hurting at any time in the last 5 days?”*
- ✓ Code for the presence or absence of pain regardless of pain management efforts:
 - Code 0 = No, resident says there was no pain even if the reason for no pain was due to receipt of pain management interventions, skip to J1100
 - Code 1 = Yes, continue to J0400
 - Code 9 = Unable to answer, does not respond, or gives nonsensical response, skip to J0800

263

■ PAIN FREQUENCY (J0400)

- ✓ Ask resident: *“How much of the time have you experienced pain or hurting over the last 5 days?”*
 - Code 1 = Almost constantly
 - Code 2 = Frequently
 - Code 3 = Occasionally
 - Code 4 = Rarely
 - Code 9 = Unable to answer



264

■ PAIN EFFECT ON FUNCTION (J0500)

- ✓ A = Ask resident: "Over the past 5 days, has pain made it hard for you to sleep at night?"
- ✓ B = Ask resident: "Over the past 5 days, have you limited your day-to-day activities because of pain?"
- ✓ Coding for all of the above:
 - Code 0 = No, pain did not interfere
 - Code 1 = Yes, pain interfered with sleep or activities
 - Code 9 = Unable to answer



265

■ PAIN INTENSITY (J0600)

- ✓ Administer **ONLY ONE** of the Pain Intensity questions (A or B)
- ✓ For each resident try to use the same scale consistently
- ✓ Leave the unused scale blank

- ✓ A = Numeric Rating Scale (00-10)
 - Ask resident: "Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine":
 - Code 00-10 = Record resident two-digit response
 - Code 99 = Unable to answer

266

■ PAIN INTENSITY (J0600)

- ✓ B = Verbal Descriptor Scale
 - Ask resident: "Please rate the intensity of your worst pain over the last 5 days":
 - Code 1 = Mild
 - Code 2 = Moderate
 - Code 3 = Severe
 - Code 4 = Very severe, horrible
 - Code 9 = Unable to answer
 - Use this if resident either unable, chooses not to respond, or gives a nonsensical response

267

■ SHOULD THE STAFF ASSESSMENT FOR PAIN BE CONDUCTED (J0700)

- ✓ Closes the pain interview and determines if the resident interview was complete or incomplete:
 - The pain interview is successfully completed if:
 - The resident reported no pain (J0300 = No)
 - The resident reported pain (J0300 = Yes) and the follow-up question J0400 is answered
- ✓ Should the Staff Assessment for Pain be conducted?
 - Code 0 = No (J0400 = 1 thru 4), skip to J1100
 - Code 1 = Yes (J0400 = 9), continue to J0800

268

■ INDICATORS OF PAIN (J0800)

- ✓ Complete only if Pain Assessment Interview was not completed
- ✓ Check all indicators that apply:
 - A = Non-verbal sounds (crying, whining, moaning)
 - B = Vocal complaints of pain (that hurts, ouch)
 - C = Facial expressions (grimaces, wincing)
 - D = Protective body movements or postures (bracing, guarding, rubbing body part/area)
 - Z = None of these signs observed or documented, skip to J1100

269

■ FREQUENCY OF INDICATOR OF PAIN OR POSSIBLE PAIN (J0850)

- ✓ Frequency with which resident complains or shows evidence of pain or possible pain:
 - Code 1 = Indicators of pain or possible pain observed 1 to 2 days
 - Code 2 = Indicators of pain or possible pain observed 3 to 4 days
 - Code 3 = Indicators of pain or possible pain observed daily



270

■ **SHORTNESS OF BREATH (DYSPNEA) (J1100)**
(66)

- ✓ Resident may have any combination
- ✓ **Check all that apply:**
 - Resident has shortness of breath or trouble breathing:
 - A = With exertion
 - B = When sitting at rest
 - C = When lying flat
 - Z = None of the above

271

■ **CURRENT TOBACCO USE (J1300)**

- ✓ Includes tobacco used in any form:
 - Code 0 = No
 - Code 1 = Yes



272

■ **PROGNOSIS (J1400)**

- ✓ Resident has less than 6 months to live
- ✓ Resident has a terminal illness
- ✓ Physician documentation must be in the medical record to substantiate coding this item
- ✓ Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?
 - Code 0 = No, medical record has no physician documentation to support this and is not receiving hospice services
 - Code 1 = Yes, medical record documentation by the physician supports this or resident is receiving hospice services

273

■ **PROBLEM CONDITIONS (J1550) (34-66)**

✓ **Check all that apply:**

- **A = Fever (34-66)**
 - Must be 2.4 degrees F above baseline
 - Temperature of 100.4 on admission
- **B = Vomiting (34-66)**
- **C = Dehydrated (34)**
 - Must have 2 of the 3 criteria to code
- **D = Internal bleeding (34)**
 - Frank
 - Occult
- **Z = None of the above**



274

■ **FALL HISTORY ON ADMISSION/ENTRY OR REENTRY (J1700)**

✓ **Fall Definition:**

- Unintentional change in position coming to rest on the ground, floor or onto the next lower surface
- Includes any fall, no matter where it occurs
- Falls are not the result of an overwhelming external force
- An intercepted fall is still considered a fall
- A resident found on the floor or ground without knowledge of how they got there, is a fall
- Fall may be witnessed or reported by resident or observer



275

■ **FALL HISTORY ON ADMISSION/ENTRY OR REENTRY (J1700)**

- ✓ **Complete only if Admission assessment**
- ✓ **Ask resident and family or significant other about falls in the past month and prior 6 months before admission (A1600 entry date)**
- ✓ **A = a fall any time in the last month**
- ✓ **B = a fall any time in last 2-6 months**
- ✓ **C = any fracture related to a fall in the 6 months**
- ✓ **Coding for all of the above:**
 - **Code 0** = No, no falls or fractures in time frame
 - **Code 1** = Yes, a fall (A-B) or fracture (C) occurred in the time frame
 - **Code 9** = Unable to determine



276

■ ANY FALLS SINCE ADMISSION/ENTRY OR REENTRY OR PRIOR ASSESSMENT (OBRA OR SCHEDULED PPS) (J1800)

- ✓ If this is the first assessment since the most recent admission/entry or reentry
- ✓ If yes, review the record for the time period from admission date to ARD
- ✓ If this is not the first assessment, review the record for the time period from the day after the ARD of last MDS to the ARD of current MDS:
 - Code 0 = No, skip to K0100
 - Code 1 = Yes, continue to J1900

277

■ NUMBER OF FALLS SINCE ADMISSION/ENTRY OR REENTRY OR PRIOR ASSESSMENT (OBRA OR SCHEDULED PPS) (J1900)

- ✓ If this is the first assessment since the most recent admission/entry or reentry
- ✓ If yes, review the record for the time period from admission date to ARD
- ✓ If this is not the first assessment, review the record for the time period from the day after the ARD of last MDS to the ARD of current MDS

278

■ NUMBER OF FALLS SINCE ADMISSION/ENTRY OR REENTRY OR PRIOR ASSESSMENT (OBRA OR SCHEDULED PPS) (J1900)

- A = No injury
- B = Injury (except major)
- C = Major injury
- Coding for all of the above:
 - Code 0 = None
 - Code 1 = One fall with or without injury
 - Code 2 = Two or more falls with or without injury



279

■ CODING TIPS AND EXAMPLE (J1900)

✓ If resident has multiple injuries in a single fall, code for the highest level of injury

✓ Code each fall only once

Example:

- The resident fell and lacerated his head. The head CT scan showed a subdural hematoma.
- J1900C would be coded as a "1". The resident had a major injury from a fall.



280

SECTION K:
SWALLOWING/NUTRITIONAL STATUS



281

■ SWALLOWING DISORDER (K0100)

✓ Signs and symptoms of possible swallowing disorder even if occurred only once

✓ Check all that apply:

- A = Loss of liquids/solids from mouth when eating or drinking
- B = Holding food in mouth/cheeks or residual food in mouth after meals
- C = Coughing or choking during meals or when swallowing medications
- D = Complaints of difficulty or pain with swallowing
- Z = None of the above

NOTE: Do **not** code a problem when interventions have been successful in treating the problem and no S&S are present

282



■ HEIGHT AND WEIGHT (K0200)



- ✓ Record a current height and weight in order to monitor nutrition and hydration over time
- ✓ A = Height (in inches):
 - On admission, measure and record height in inches – to the nearest whole inch
 - Use mathematical rounding (.1 to .4 inches round down, .5 or greater round up)
 - Re-measure if last height was over a year ago
 - Measure consistently

283

■ HEIGHT AND WEIGHT (K0200)



- ✓ B = Weight (in pounds):
 - Base weight on most recent measure in last 30 days
 - On subsequent assessments, enter weight taken within 30 days of ARD
 - If multiple weights in preceding month, record most recent one
 - Use mathematical rounding (if weight is .5# or more round up; if weight is .1 to .4#, round down)
 - Weigh consistently
 - If unable to weigh, code with a dash (-), no information available code, and document reason in medical record

284

■ WEIGHT LOSS (K0300) (34-66)

- ✓ Compares resident's current weight to the weight from two distinct points in time only
- ✓ Mathematically round weights
- ✓ Look first at whether the resident lost 5% or more weight in the last 30 days or 10% or more in last 180 days:
 - Code 0 = No or unknown
 - Code 1 = Yes, on physician-prescribed weight-loss regimen
 - Code 2 = Yes, not on physician-prescribed weight-loss regimen
- Physician-prescribed weight-loss regimen is a weight reduction plan ordered by the physician. Includes planned diuresis; it is important that weight loss is intentional

NOTE: A weight variance between snapshots is not captured on MDS

285

■ WEIGHT GAIN (K0310)

- ✓ Compares resident's current weight to the weight from two distinct points in time only
- ✓ Mathematically round weights
- ✓ Determine if there was a gain of 5% or more in the last 30 days or gain of 10% or more in last 180 days:
 - Code 0 = No or unknown
 - Code 1 = Yes, on physician-prescribed weight-gain regimen
 - Code 2 = Yes, not on physician-prescribed weight-gain regimen



NOTE: A weight variance between snapshots is not captured on MDS

286

■ NUTRITIONAL APPROACHES (K0510) (34-66)

- ✓ Identify nutritional approaches that vary from the normal or that rely on alternative methods while not a resident or while a resident
- ✓ Check all that apply:
 - A = Parenteral/IV feeding administered for nutrition or hydration
 - B = Feeding tube
 - C = Mechanically altered diet
 - D = Therapeutic diet
 - Not defined by the content of what is provided or when it is served, but why the diet is required
 - Z = None of the above

287

■ PERCENT INTAKE BY ARTIFICIAL ROUTE (K0710) (34-66)

- ✓ Complete only if K0510A and/or K0510B are checked
- ✓ K0710A = Proportion of total calories the resident received through parenteral or tube feeding is completed for three conditions:
 1. While NOT a resident
 2. While a resident
 3. During entire 7 days
 - Review intake record for actual intake received:
 - Code 1 = 25% or less
 - Code 2 = 26-50%
 - Code 3 = 51% or more

288

■ **K0710A CALCULATE PROPORTION EXAMPLE**

✓ Dietician report of total calories:

	<u>Oral</u>	<u>Tube</u>
Sunday	500	2,000
Monday	250	2,250
Tuesday	250	2,250
Wednesday	350	2,250
Thursday	500	2,000
Friday	250	2,250
Saturday	50	2,000
Total	2,450	15,000

289

■ **K0710A CALCULATE PROPORTION**

- ✓ Total oral intake = 2,450 calories
- ✓ Total tube intake = 15,000 calories
- ✓ Total calories = 2,450 + 15,000 = 17,450
- ✓ Percentage of calories by tube feeding
 - $15,000 \div 17,450 = 0.859$
 - $0.859 \times 100 = 85.9\%$

290

■ **PERCENT INTAKE BY ARTIFICIAL ROUTE (K0710) (34-66)**

- ✓ Complete only if K0510A and/or K0510B are checked
- ✓ K0710B = Average fluid intake per day by IV or tube feeding is completed for three conditions:
 1. While NOT a resident
 2. While a resident
 3. During entire 7 days
 - Code for the average number of cc per day of fluids
 - Review intake record for actual intake received:
 - Code 1 = 500 cc/day or less
 - Code 2 = 501 cc/day or more

291

■ **K0710B CALCULATE AVERAGE FLUIDS EXAMPLE**

✓ **Dietician report of total calories:**

	IV Fluid Intake
Sunday	1250 cc
Monday	775 cc
Tuesday	925 cc
Wednesday	1200 cc
Thursday	1200 cc
Friday	500 cc
Saturday	450 cc
Total	6300 cc

292

■ **K0710B CALCULATE AVERAGE FLUIDS EXAMPLE**

- ✓ **Total fluid intake = 6300 cc**
- ✓ **6300 cc divided by 7 days = 900 cc/day**
- ✓ **900 cc is greater than 500 cc, therefore code 2; 501 cc/day or more**

293

**SECTION L:
ORAL/DENTAL STATUS**



■ **DENTAL (L0200)**

- ✓ To identify any dental problems
- ✓ Conduct oral exam of lips and oral cavity
- ✓ Mouth or facial pain coded here should also be coded in Section J, where appropriate



✓ **Check all that apply:**

- A = Broken or loosely fitting full or partial dentures
- B = No natural teeth or tooth fragment(s)
- C = Abnormal mouth tissue
- D = Obvious or likely cavity or broken natural teeth
- E = Inflamed or bleeding gums or loose natural teeth
- F = Mouth or facial pain, discomfort or difficulty with chewing
- G = Unable to examine
- Z = None of the above were present

295

**SECTION M:
SKIN CONDITIONS**



296

■ **PRESSURE ULCER RISK FACTORS**

- ✓ Immobility and decreased functional ability
- ✓ Co-morbid conditions (ESRD, thyroid, diabetes)
- ✓ Drugs such as steroids
- ✓ Impaired diffuse or localized blood flow
- ✓ Resident refusal of care and treatment
- ✓ Cognitive impairment
- ✓ Exposure of skin to urinary and fecal incontinence
- ✓ Under-nutrition, malnutrition, and hydration deficits
- ✓ Healed pressure ulcer
- ✓ Common risk tools include the Braden Scale for Predicting Pressure Sore Risk, etc.

297

■ DETERMINATION OF PRESSURE ULCER RISK (M0100)

✓ Check all that apply:

- A = Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device:
 - Pressure ulcer description/staging
 - Non-removable dressing, cast, brace
- B = Formal assessment instrument/tool has been used:
 - Braden Scale
 - Norton Scale
- C = Clinical assessment:
 - Head-to-toe assessment
 - Medical record review
 - Identify risk factors
- Z = None of the above

298

■ RISK OF PRESSURE ULCERS (M0150)

✓ Based on items reviewed for M0100

✓ Is this resident at risk of developing pressure ulcers?

- Code 0 = No, resident is not at risk for developing pressure ulcers
- Code 1 = Yes, resident is at risk for developing pressure ulcers

299

■ UNHEALED PRESSURE ULCER(S) (M0210)

- ✓ If an ulcer arises from a combination of factors which are primarily caused by pressure, then the ulcer should be included in this section as a pressure ulcer
- ✓ Oral mucosal ulcers caused by pressure should not be coded here (code at L0200C)
- ✓ If a pressure ulcer is surgically closed with a flap or graft, it should be coded as a surgical wound and not as a pressure ulcer (If the flap or graft fails, continue to code it as a surgical wound until healed)
- ✓ If a pressure ulcer on the last assessment is now healed, complete Healed Pressure Ulcers item (M0900)
- ✓ If a pressure ulcer healed during the look-back period, and was not present on prior assessment, code 0

300

■ UNHEALED PRESSURE ULCER(S) (M0210)

- ✓ Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether the diabetic has an ulcer that is caused by pressure or other factors:
 - If a resident with DM has a heel ulcer from pressure, code 1 and proceed to code items M0300–M0900 as appropriate for the pressure ulcer
 - If a resident with DM has an ulcer on the plantar (bottom) surface of the foot closer to the metatarsal, code 0 and proceed to M1040 to code the ulcer as a diabetic foot ulcer
- ✓ Scab and eschar are different both physically and chemically

301

■ UNHEALED PRESSURE ULCER(S) (M0210)

- ✓ Pressure ulcer definitions in RAI are adapted from the National Pressure Ulcer Advisory Panel (NPUAP)
- ✓ Numeric staging or DTI should be coded as assessed
- ✓ Facilities may adopt the NPUAP guidelines
 - In clinical practice
 - Nursing documentation
 - But not for coding the MDS
- ✓ The RAI staging definitions do not perfectly correlate with the NPUAP staging definitions
- ✓ MDS must be coded according to the instructions in the RAI manual!!
- ✓ Pressure ulcer staging is an assessment system that provides a description and classification based on anatomic depth of soft tissue damage:
 - Tissue damage can be visible or palpable in the ulcer bed
 - Pressure ulcer staging also informs expectations for healing time

302

■ UNHEALED PRESSURE ULCER(S) (M0210)

- ✓ Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?
- ✓ Code based on presence of any pressure ulcer, regardless of stage, in past 7 days:
 - Code 0 = No, skip to M0900
 - Code 1 = Yes, continue to M0300

303

■ **CURRENT NUMBER OF UNHEALED PRESSURE ULCERS AT EACH STAGE (M0300)**

- ✓ Staging is based on the deepest anatomical soft tissue damage that is visible or palpable
- ✓ Identify unstageable pressure ulcers
- ✓ Determine “present on admission”



304

■ **STEP 1: DEEPEST ANATOMICAL STAGE**

- ✓ Ulcer staging should be based on the deepest anatomic soft tissue damage that is visible or palpable
- ✓ If ulcer tissue is obscured, consider it to be unstageable
- ✓ Review ulcer history and maintain in medical record
- ✓ Once the initial staging is identified, the pressure ulcer remains that stage until the ulcer heals, worsens or becomes unstageable
- ✓ As pressure ulcers heal they are NEVER reverse staged

305

■ **STEP 2: IDENTIFYING UNSTAGEABLE PRESSURE ULCER**

- ✓ Must visualize wound bed
- ✓ Pressure ulcers that have eschar or slough – anatomic depth cannot be visualized or palpated – should be classified as unstageable
- ✓ If wound bed is partially covered by eschar or slough – anatomic depth can be visualized or palpated – stage the ulcer
- ✓ A pressure ulcer with intact skin that is a suspected tissue injury (sDTI) should be coded as unstageable
- ✓ Pressure ulcers covered by a non-removeable dressing/device should be coded unstageable

306

■ **STEP 3: DETERMINE "PRESENT ON ADMISSION, ENTRY OR REENTRY"**

- ✓ If the PU was present on admission/entry or reentry and subsequently increased in numerical stage during the stay, the PU is coded at that higher stage, and that higher stage should **not** be considered as "PoA"
- ✓ If the PU was unstageable on admission/entry or reentry, but becomes numerically stageable later, the PU is coded at the numerical stage and should be considered as "PoA". If it subsequently increases in numerical stage, that higher stage is **not** considered "PoA"
- ✓ If a resident who has a PU is hospitalized and returns with that PU at the same numerical stage, the PU should **not** be considered "PoA"
- ✓ If a current PU increases in numerical stage during a hospitalization, it is coded at the higher stage and should be considered as "PoA"

307

■ **DEFINITION OF STAGE 1 PRESSURE ULCER**

- ✓ **Observable, pressure-related alteration of intact skin, as compared to adjacent or opposite area on the body**
- ✓ **May include changes in one or more parameters:**
 - Redness of tissue that does **not** turn white or pale when pressure is applied (non-blanchable)
 - Skin may include changes in temperature, tissue consistency, sensation or coloration
 - Darkly pigmented skin may **not** have visible blanching
 - Color may differ from the surrounding area
 - Does **not** include deep tissue injury

308

■ **NUMBER OF STAGE 1 PRESSURE ULCERS (M0300A) (34)**

- ✓ **A = Number of Stage 1 pressure ulcers:**
 - **Code = 0-9**



309

■ DEFINITION OF STAGE 2 PRESSURE

- ✓ Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough
- ✓ Presents as a shiny or dry shallow ulcer (without slough or bruising)
- ✓ May also appear as an intact or open/ruptured blister
- ✓ Do not include skin tears, tape burns, moisture associated skin damage, or excoriation here
- ✓ When a PU presents as an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury is determined, do not code as a Stage 2
- ✓ Most stage 2 pressure ulcers should heal in a reasonable time frame (60 days) or reassess

310

■ STAGE 2 PRESSURE ULCER(S) (M0300B) (34-66)

- ✓ B = Stage 2:
 - 1 = Number of Stage 2 pressure ulcers
 - 2 = Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry
 - 3 = Date of oldest Stage 2 pressure ulcer



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■ DEFINITION OF STAGE 3 PRESSURE ULCER

- ✓ Full thickness tissue loss
- ✓ Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed
- ✓ Slough may be present but does not obscure depth
- ✓ May include undermining or tunneling
- ✓ May be shallow in areas that do not have subcutaneous tissue (bridge of nose, ear, occiput, malleolus)

312

■ **STAGE 3 PRESSURE ULCER(S) (M0300C)**
(34-66)

✓ **C = Stage 3:**

- **1 = Number of Stage 3 pressure ulcers**
- **2 = Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry**



313

■ **DEFINITION OF STAGE 4 PRESSURE ULCER**

- ✓ Full thickness tissue loss with exposed bone, tendon or muscle is visible or directly palpable
- ✓ At risk for osteomyelitis
- ✓ Cartilage serves the same anatomical function as bone
- ✓ Slough or eschar may be present on some parts of the wound bed
- ✓ Often includes undermining and tunneling:
 - **Tunneling** - a passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound
 - **Undermining** - the destruction of tissue or ulceration extending under the skin edges so that the pressure ulcer is larger at its base than at the skin surface

314

■ **STAGE 4 PRESSURE ULCER(S) (M0300D)**
(34-66)

✓ **D = Stage 4:**

- **1 = Number of Stage 4 pressure ulcers**
- **2 = Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry**



315

■ UNSTAGEABLE PRESSURE ULCER RELATED TO NON-REMOVABLE DRESSING/DEVICE (M0300E)

- ✓ Examples include, a primary surgical dressing that cannot be removed, an orthopedic device, or cast
- ✓ Unstageable – non-removable dressing/device:
 - 1 = Number of unstageable pressure ulcers due to non-removable dressing/device



- 2 = Number of these unstageable pressure ulcers that were present upon admission/entry or reentry

316

■ UNSTAGEABLE PRESSURE ULCERS RELATED TO SLOUGH/ESCHAR (M0300F) (34-66)

- ✓ **Slough tissue** – non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture
- ✓ **Eschar tissue** – dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color; may appear scab-like
- ✓ True depth cannot be determined
- ✓ Unstageable-slough/eschar:
 - 1 = Number of unstageable pressure ulcers due to coverage of wound bed by slough/eschar
 - 2 = Number of these unstageable pressure ulcers that were present upon admission/entry or reentry

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■ UNSTAGEABLE PRESSURE ULCERS RELATED TO SLOUGH/ ESCHAR (M0300F)



318

■ *UNSTAGEABLE PRESSURE ULCER RELATED TO SUSPECTED DEEP TISSUE INJURY (M0300G)*

- ✓ Purple or maroon area of discolored intact skin due to damage of underlying soft tissue
- ✓ Area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue
- ✓ If suspected deep tissue injury opens to an ulcer, reclassify the ulcer into appropriate stage
- ✓ In dark skin tones, area is probably not purple/maroon, rather darker than surrounding tissue
- ✓ Unstageable – Deep tissue:
 - 1 = Number of unstageable pressure ulcers with suspected deep tissue injury evolution
 - 2 = Number of these unstageable pressure ulcers that were present upon admission/entry or reentry

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■ *UNSTAGEABLE PRESSURE ULCER RELATED TO SUSPECTED DEEP TISSUE INJURY (M0300G)*



320

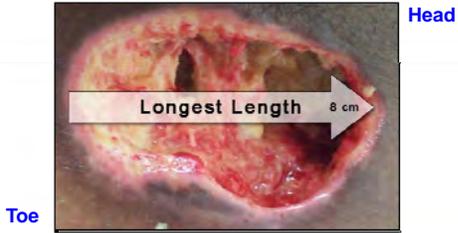
■ *DIMENSIONS OF UNHEALED STAGE 3 OR 4 PRESSURE ULCERS OR UNSTAGEABLE ULCERS (M0610)*

- ✓ Identify pressure ulcer with the largest surface (length X width) area from the following:
 - Unhealed Stage 3 or 4
 - Unstageable pressure ulcer due to slough or eschar
- ✓ Measure after dressing and exudate has been removed
- ✓ Record in centimeters to one decimal:
 - A = Pressure ulcer length
 - B = Pressure ulcer width
 - C = Pressure ulcer depth

321

■ *PRESSURE ULCER LENGTH (M0610A)*

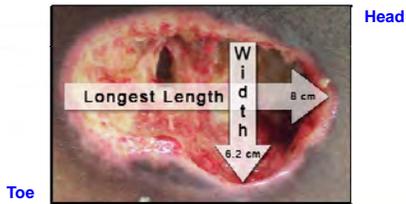
- ✓ Measure the longest length from head to toe using a disposable device



322

■ *PRESSURE ULCER WIDTH (M0610B)*

- ✓ Measure widest width of the same pressure ulcer side to side perpendicular (90° angle) to length



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■ *PRESSURE ULCER DEPTH (M0610C)*

- ✓ Moisten a cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water
- ✓ Place applicator tip in deepest aspect of the wound and measure distance to the skin level



324

■ *MOST SEVERE TISSUE TYPE FOR ANY PRESSURE ULCER (M0700)*

- ✓ Examine the wound bed of the most severe type of tissue present in any pressure ulcer bed
- ✓ Code for the most severe type of tissue:
 - Code 1 = Epithelial tissue
 - Code 2 = Granulation tissue
 - Code 3 = Slough (any amount, but no eschar)
 - Code 4 = Eschar
 - Code 9 = None of the above
- ✓ If wound bed is covered with a mix of different types of tissue, code for the most severe type
- ✓ Stage 2 pressure ulcer should be coded as a 1

325

■ *WORSENING IN PRESSURE ULCER STATUS SINCE PRIOR ASSESSMENT (M0800)*

- ✓ Look-back period is back to the ARD of prior assessment
- ✓ If there is no prior assessment, do not complete, skip to M1030
- ✓ If PU unstageable on prior assessment, do not consider it worsened on next assessment that is able to be staged; however if the PU subsequently increases in numerical staging, should be considered worsened
- ✓ If a previously staged pressure ulcer becomes unstageable due to slough or eschar, do not include in worsening pressure ulcers
- ✓ If a previously staged pressure ulcer becomes unstageable, is then debrided and staged, if the stage has increased, code as a worsening pressure ulcer

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■ *WORSENING IN PRESSURE ULCER STATUS SINCE PRIOR ASSESSMENT (M0800)*

- ✓ If two pressure ulcers merge, do not code as worsened unless there is an increase in the numerical stage
- ✓ PU acquired during hospital admission; code "present on admission/entry or reentry", do not include in count of worsening pressure ulcers
- ✓ If PU increases in numerical stage during hospital admission, it's stage should be coded on admission and considered present on admission, but not included here

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■ *WORSENING IN PRESSURE ULCER STATUS SINCE PRIOR ASSESSMENT (M0800)*

- ✓ Complete only if A0310E = 0
- ✓ Indicate the number of current ulcers that were not present or were at a lesser stage on a prior assessment (OBRA or scheduled PPS) or last entry
- ✓ Enter 0 if no current pressure ulcers at a given stage:
 - A = Stage 2
 - B = Stage 3
 - C = Stage 4

328

■ *HEALED PRESSURE ULCERS (M0900)*

- ✓ Complete only if A0310E = 0
- ✓ Healed pressure ulcer – completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, even if the area continues to have some surface discoloration:
 - A = Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)?
 - > Code 0 = No, skip to M1030
 - > Code 1 = Yes, continue to M0900B
 - B = Enter the number of healed Stage 2 ulcers
 - C = Enter the number of healed Stage 3 ulcers
 - D = Enter the number of healed Stage 4 ulcers:
 - If no healed pressure ulcer at a given stage since the prior OBRA or scheduled PPS, enter 0

329

■ *NUMBER OF VENOUS AND ARTERIAL ULCERS (M1030) (34-66)*

- ✓ Do not code pressure ulcers in this item
- ✓ These wounds are typically not found over bony prominences and pressure forces play virtually no role in the development of the ulcers
- ✓ Enter the total number of venous and arterial ulcers present

330

■ DEFINITION OF VENOUS ULCERS

- ✓ Caused by peripheral venous disease
- ✓ Commonly occur proximal to medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of leg
- ✓ Wound may start due to minor trauma
- ✓ Characterized by:
 - Irregular wound edges
 - Leg edema
 - Possible pain
 - Red granular wound bed
 - Yellow fibrinous material
 - Exudate



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■ DEFINITION OF ARTERIAL ULCERS

- ✓ Caused by peripheral arterial disease
- ✓ Wound may start due to minor trauma
- ✓ Common location:
 - Top of toes
 - Top of foot
 - Distal to medial malleolus



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■ DEFINITION OF ARTERIAL ULCERS

- ✓ Ischemia is major etiology
- ✓ Characterized by:
 - Necrotic tissue or pale pink wound bed
 - Lower extremity and foot pulses may be diminished or absent
 - Often painful
 - Minimal exudate
 - Minimal bleeding
 - Trophic skin changes:
 - Dry skin
 - Loss of hair growth
 - Muscle atrophy
 - Brittle nails



333

■ OTHER ULCERS, WOUNDS, AND SKIN PROBLEMS (M1040) (34-66)

✓ Check all that apply:

- Foot Problems
 - A = Infection of the foot
 - B = Diabetic foot ulcer(s)
 - C = Other open lesion(s) on the foot
- Other Problems
 - E = Surgical wound(s)
 - F = Burn(s)
 - G = Skin tear(s)
 - H = Moisture Associated Skin Damage (MASD)
- None of the Above
 - Z = None of the above were present



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■ SKIN AND ULCER TREATMENTS (M1200) (34-66)

✓ Document any specific or general skin treatment that the resident received in the past 7 days

✓ Check all that apply:

- A = Pressure reducing device for chair
- B = Pressure reducing device for bed
- C = Turning/repositioning program
- D = Nutrition or hydration intervention
- E = Pressure ulcer care
- F = Surgical wound care

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■ SKIN AND ULCER TREATMENTS (M1200)

- G = Application of non-surgical dressings (with or without topical medications) other than to feet
- H = Application of ointments/medications other than to feet
- I = Application of dressings to feet (with or without topical medications)
 - Includes interventions to treat any foot wound or ulcer other than a pressure ulcer
- Z = None of the above were provided



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SECTION N:
MEDICATIONS



■ INJECTIONS (N0300) (34)

- ✓ Record the number of days that injections of any type were received during the last 7 days or since admission/entry or reentry if less than 7 days
- ✓ Insulin injections are counted in N0300 as well as in N0350
- ✓ For subcutaneous pumps, code only number of days pump restarted
- ✓ If 0, skip to N0410



■ INSULIN (N0350) (66)

- ✓ A = Insulin injections - Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days
- ✓ B = Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders during the last 7 days or since admission/entry or reentry if less than 7 days



■ **MEDICATIONS RECEIVED (N0410)**

- ✓ Medication categories should only be checked according to the medication's therapeutic category or pharmacological classification
 - **Example:** Oxazepam may be used as a hypnotic, but it is classified as an anti-anxiety medication. It would be coded as an anti-anxiety medication.
- ✓ Include meds by any route in any setting
- ✓ Code if med given only once
- ✓ Code long-acting med only when given
- ✓ Combination meds should be coded in all categories
- ✓ OTC sleeping meds not coded



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■ **MEDICATIONS RECEIVED (N0410)**

- ✓ Enter the number of days medication was received in the last 7 days by any route:
 - A = Antipsychotic
 - B = Antianxiety
 - C = Antidepressant
 - D = Hypnotic
 - E = Anticoagulant
 - F = Antibiotic
 - G = Diuretic
- ✓ Check the manual for information on Adverse Drug Reactions, Gradual Dose Reduction and other Care Planning considerations



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**SECTION O:
SPECIAL TREATMENTS,
PROCEDURES AND PROGRAMS**



342

■ SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS (00100) (34-66)



- ✓ Look-back period is the last 14 days
- ✓ Code even if resident performs procedure themselves or after set up
- ✓ Do not code if service was provided solely in conjunction with a surgical procedure (including routine pre-and post-operative procedures) or diagnostic procedure
- ✓ Two columns to record information:
 - Column 1 – While not a resident
 - Column 2 – While a resident

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■ SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS (00100)

- ✓ Cancer Treatments:
 - A = Chemotherapy (34-66):
 - Antineoplastic given by any route
 - Only drugs actually used for cancer treatment - evaluate reason for medication use
 - IV, IV med, blood transfusions during chemo are not coded
 - B = Radiation (34-66):
 - Intermittent therapy
 - Radiation implant
- ✓ Respiratory Treatments:
 - C = Oxygen therapy (34-66):
 - Continuous or intermittent to relieve hypoxia
 - Code when used in BiPAP/CPAP
 - Hyperbaric oxygen for wound therapy not coded

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■ SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS (00100)

- ✓ Respiratory Treatments:
 - D = Suctioning (34):
 - Tracheal or nasopharyngeal only
 - Oral suctioning not included
 - E = Tracheostomy care (34-66):
 - Cleansing of trach or cannula
 - F = Ventilator or respirator (34-66):
 - Any electric or pneumatic closed-system that ensures ventilation
 - G = BiPAP/CPAP:
 - Any type that prevents airways from closing
 - If ventilator or respirator is used as a substitute for BiPAP or CPAP may code here not O0100F

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■ SPECIAL TREATMENTS, PROGRAMS AND PROCEDURES (O0100)

✓ Other:

- H = IV Medications (34-66):
 - Do not code flushes to keep IV patent
 - Do not code subcutaneous pumps
 - Do not code Dextrose 50% or Lactated Ringers
 - Do not code IV meds administered during dialysis or chemo
 - Does include epidural, intrathecal, and baclofen pumps
- I = Transfusions (34-66):
 - Any blood or blood products (platelets, synthetic blood products), administered directly into the bloodstream
 - Do not code when administered during dialysis or chemo
- J = Dialysis (34-66):
 - Peritoneal or renal dialysis
 - IV, IV med, blood transfusions during dialysis are not coded



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■ SPECIAL TREATMENTS, PROGRAMS AND PROCEDURES (O0100)

✓ Other:

- K = Hospice Care:
 - Hospice must be licensed by the state or certified under Medicare program as a provider
- L = Respite Care:
 - Short-term stay
- M = Isolation or quarantine for active infectious disease (66):
 - Does not include standard precautions
 - Code only when transmission-based precautions required
 - Code only when a single room isolation is required because of active infection with highly transmissible or epidemiologically significant pathogens acquired by physical contact or airborne or droplet transmission
 - Do not code for history of infectious disease (MRSA)
- Z = None of the above

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■ DEFINITION FOR "SINGLE ROOM ISOLATION"

1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission
2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.
4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).



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■ INFLUENZA VACCINE (O0250)

- ✓ A = Did the resident receive Influenza vaccine in this facility for this year's **Influenza season**?
 - Code 0 = No, skip to O0250C
 - Code 1 = Yes, continue to O0250B
- ✓ B = Date vaccine received:
 - MM-DD-YYYY (if month/day a single digit, fill first box with "0")
 - If date is unknown or not available, a (-) is entered in the first box
 - **Added to Discharge item set 10/1/2014**
- ✓ If vaccinated status cannot be determined, administer vaccine according to standards of clinical practice



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■ INFLUENZA VACCINE (O0250)

- ✓ C = If **Influenza vaccine not** received, state reason:
 - Code 1 = Resident not in facility during flu season
 - Code 2 = Received outside of this facility
 - Code 3 = Not eligible (medical contraindication)
 - Code 4 = Offered and declined
 - Code 5 = Not offered
 - Code 6 = Inability to obtain vaccin
 - Code 9 = None of the above
- ✓ Influenza season ends when influenza is no longer active in area
- ✓ O0250C value carries forward until new season begins



350

■ PNEUMOCOCCAL VACCINE (O0300)

- ✓ A = Is the resident's Pneumococcal vaccination up to date?
 - Code 0 = No, continue to O0300B
 - Code 1 = Yes, skip to O0400
- ✓ B = If Pneumococcal vaccination not received, state reason:
 - Code 1 = Not eligible (medical contradiction)
 - Code 2 = Offered and declined
 - Code 3 = Not offered

See RAI manual, pages O 9-13 for complete vaccine details

351

■ THERAPIES (O0400) (34-66)

- ✓ Code only medically necessary therapies that occurred after admission/readmission
- ✓ Therapy can occur inside or outside facility
- ✓ All Therapies must be:
 - Ordered by a physician (or approved extender)
 - Based on a qualified therapist's assessment and treatment plan
 - Documented in the resident's medical record
 - Care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective



352

■ MINUTES FOR ST, OT AND PT (O0400)

- ✓ 1 = Individual Minutes:
 - Total number of minutes of therapy provided by one therapist or assistant to one resident at a time
- ✓ 2 = Concurrent Minutes:
 - Medicare Part A – total number of minutes while treating 2 residents at the same time, NOT performing the same or similar activities, both within line-of-sight of treating therapist or assistant
 - Medicare Part B - residents cannot be treated concurrently
 - All other payers follow Medicare Part A instructions



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■ MINUTES FOR ST, OT AND PT (O0400)

- ✓ 3 = Group Minutes:
 - Total number of minutes of therapy provided in a group setting
 - Medicare Part A – treatment of 4 residents performing same or similar activities and supervised by a therapist or assistant who is not supervising anyone else
 - Medicare Part B - treatment of 2 or more residents at the same time
 - All other payers follow Medicare Part A instructions



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■ *DAYS AND DATES FOR ST, OT, AND PT (00400)*

- ✓ 3A = Co-treatment Minutes:
 - Total number of minutes each discipline administered to the resident in co-treatment session
- ✓ 4 = Days:
 - Number of days therapy services were provided in the last 7 days (a day = skilled treatment for 15 minutes or more)
 - Use total minutes of therapy (individual+concurrent+group) to determine if the day is counted

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■ *THERAPY- FOR ST, OT, AND PT (00400)*

- ✓ 5 = Therapy Start Date:
 - Record the date the most recent therapy regimen (since the most recent entry/reentry) started
 - If more than one therapy; enter the most recent date
 - The date the initial therapy evaluation is conducted regardless if treatment was rendered or not
 - Date of resumption if EOT OMRA
- ✓ 6 = Therapy End Date:
 - Record the date the most recent therapy regimen (since the most recent entry/reentry) ended
 - Last date resident received skilled therapy
 - If therapy is ongoing, enter dashes

356

■ *RESPIRATORY THERAPY (00400D) (34-66)*

- ✓ Services provided by a qualified professional (respiratory therapist, respiratory nurse)
- ✓ Services include coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds and mechanical ventilation, etc.
- ✓ A respiratory nurse must be proficient in the modalities either through formal nursing or specific training and may provide these modalities as allowed under the state Nurse Practice Act and applicable laws



357

■ *PSYCHOLOGICAL THERAPY (O0400E)*
RECREATIONAL THERAPY (O0400F)

✓ **Psychological Therapy:**

- Provided by a psychiatrist, psychologist, clinical social worker, clinical nurse specialist in mental health (allowable under state laws)



✓ **Recreational Therapy:**

- Services provided or directly supervised by a qualified recreational therapist
- Includes treatment and activities using a variety of techniques; including arts and crafts, animals, games, etc.

358

■ *MINUTES OF THERAPY (O0400)*

- ✓ Include only therapies provided after resident admitted to the nursing home
- ✓ If a resident returns from a hospital stay, an initial evaluation must be done again after entry and only those therapies that occurred since reentry can be coded on the MDS
- ✓ Do not count initial evaluation or documentation time
- ✓ Can count subsequent re-evaluation time if part of the treatment process

359

■ *MINUTES OF THERAPY (O0400)*

- ✓ Resident's treatment time starts when they begin the first treatment activity or task, and ends when resident finishes the last task or last apparatus
- ✓ Only skilled therapy time shall be coded in the MDS
- ✓ Time required to adjust equipment or prepare for individualized therapy is set-up time and can be included in the count of minutes
- ✓ COTA and PTA services for OT and PT only count as long as they function under the direction of the licensed therapist
- ✓ Do not round up minutes
- ✓ Record actual minutes, not units

360

■ CO-TREATMENT (00400)

- ✓ Medicare Part A:
 - Two clinicians (therapists or therapy assistant), each from a different discipline, treat one resident at the same time with different treatments
 - Both disciplines may code the treatment in full
- ✓ Medicare Part B:
 - Therapists or therapy assistants, working together as a “team” to treat one or more residents cannot each bill separately for the same or different service provided at the same time

361

■ THERAPY AIDES AND STUDENTS

- ✓ Therapy Aides:
 - May not provide skilled services
 - Only time spent on set-up preceding skilled therapy may be coded
 - Must be under direct supervision of the therapist or assistant
- ✓ Therapy Students:
 - Medicare Part A:
 - Therapy students are not required to be in line-of-sight
 - Medicare Part B:
 - Qualified professional must be present the entire session
 - Practitioner not engaged in another resident or tasks at the same time
 - Qualified professional is responsible for services and documentation
 - PT and OT assistants may serve as instructors for therapy assistant students within scope of work and under the direction/supervision of a licensed therapist



362

■ DISTINCT CALENDAR DAYS OF THERAPY (00420) (66)

- ✓ Record the number of calendar days the resident received therapy for at least 15 minutes in the past 7 days
- ✓ When resident receives more than one therapy discipline on a given calendar day, counts for one calendar day

363

■ RESUMPTION OF THERAPY (O0450)

- ✓ Complete only if A0310C = 2 or 3 and A0310F = 99
- ✓ Therapy resumes after the EOT OMRA is performed
- ✓ Resumption of therapy is no more than 5 consecutive calendar days after the last day of therapy provided
- ✓ Therapy services have resumed at the same RUG-IV classification level that had been in effect prior to EOT
- ✓ The EOT-R reduces the number of assessments to be completed:
 - A = Has a previous rehab therapy regimen ended and now resumed at exactly the same level for each discipline?
 - Code 0 = No, skip to O0500
 - Code 1 = Yes
 - B = Date on which therapy resumed:
 - MM-DD-YYYY

364

■ RESTORATIVE NURSING PROGRAMS (O0500) (34-66)

- Nursing interventions that promote resident's ability to adapt and adjust to living as independently and safely as possible
- Focus is to achieve and maintain optimal physical, mental and psychosocial functioning



365

■ RESTORATIVE NURSING PROGRAMS (O0500)

- ✓ Must meet specific criteria prior to coding:
 - Measurable objectives and interventions documented in care plan and medical record
 - Evaluation by licensed nurse in medical record dated within the observation period
 - Nursing assistants/aides must be trained in the techniques that promote resident involvement
 - An RN or LPN must supervise the activities in a nursing restorative program
 - Groups no larger than 4 residents per supervising helper or caregiver



366

■ RESTORATIVE NURSING PROGRAMS (O0500)

✓ Techniques provided by restorative nursing staff:

- A = Range of Motion (Passive)
- B = Range of Motion (Active)
- C = Splint or Brace Assistance

✓ Training and Skill Practice in:

- D = Bed Mobility
- E = Transfer
- F = Walking
- G = Dressing and/or Grooming
- H = Eating and/or Swallowing
- I = Amputation/Prosthesis Care
- J = Communication



367

■ RESTORATIVE NURSING PROGRAMS (O0500)

- ✓ Record the number of days that each of the restorative nursing programs were performed for at least 15 minutes/day in the last 7 days
- ✓ Enter 0 if none or programs were less than 15 minutes daily
- ✓ The time provided for each program must be coded separately
- ✓ Cannot claim techniques that therapists claim under O0400A, B or C
- ✓ Does not require a physician order

368

■ PHYSICIAN EXAMINATIONS (O0600) (34)

- ✓ Enter number of days in the last 14 days that the physician examined the resident
- ✓ Includes MDs, DOs, Podiatrists, Dentists and authorized Physician Assistants, Nurse Practitioners or Clinical Nurse Specialists working in collaboration with the physician as allowable by state law
- ✓ Examination (full or partial) can occur in facility or in physician's office
- ✓ Telehealth included per requirements
- ✓ Does not include exams prior to admission or readmission, in ER, while in hospital observation stay or by a Medicine Man
- ✓ Does include off-site exam (dialysis or radiation therapy) with documentation



Podiatry

369

■ *PHYSICIAN ORDERS (00700) (34)*

- ✓ Enter number of days in last 14 days that the physician changed the orders
- ✓ Includes written, telephone, fax or consultation orders for new or altered treatment
- ✓ Excludes standard admit orders, return admit orders, renewal orders, clarification orders without changes
- ✓ Orders on day of admission as a result of an unexpected change/deterioration or injury are considered new or altered orders and do count
- ✓ Orders written to increase RUG classification and facility payment are not acceptable



370

■ *PHYSICIAN ORDERS (00700)*

- ✓ Sliding scale dosage schedule to cover dosages depending on lab values does not count as an order change when a dose is given
- ✓ PRN orders already on file and notification of the physician to activate order does not count as **new** order
- ✓ Medicare cert/recert does not count
- ✓ Order for a consultant may count but must be reasonable (for a new or altered treatment)
- ✓ Order on the last day of OP for a consult planned 3-6 months in the future should be reviewed carefully
- ✓ Order to transfer care to another physician is not counted
- ✓ Order written by a pharmacist does not count

371

*SECTION P:
RESTRAINTS*



372

■ PHYSICAL RESTRAINTS

- ✓ Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body
- ✓ "Resident has the right to be free from physical and chemical restraints imposed for the purpose of discipline or convenience and not required to treat the medical symptoms"
- ✓ Research shows that restraints have many negative side effects and risks that far outweigh the benefit
- ✓ Prior to use, a resident assessment must be completed
- ✓ Use of restraints should be the exception, not the rule

373

■ PHYSICAL RESTRAINTS (P0100)

- ✓ Assess resident to determine need for the restraint, then evaluate the effect the device has on the resident not the type of device, intent, or reason for use
- ✓ Evaluate whether the resident can easily and voluntarily remove any manual method or physical or mechanical device, material or equipment attached or adjacent to the body:
 - Can the resident easily and intentionally remove the device
 - Does the device restrict freedom of movement

374

■ PHYSICAL RESTRAINTS (P0100) REQUIREMENTS

- ✓ Any manual method or physical or mechanical device, material, or equipment that meets the definition must have:
 - Physician documentation of medical symptom to support device
 - Physician order for the type of restraint and parameters of use
 - Care plan and process in place for systematic and gradual restraint reduction, as appropriate



375

■ PHYSICAL RESTRAINTS

- ✓ **Removes easily:**
 - Resident can intentionally remove restraint, in the same manner as it was applied by staff
- ✓ **Freedom of movement:**
 - Any change in place or position for the body or any part of the body that the person is able to control or access
- ✓ **Medical symptoms/diagnoses:**
 - Must have clear link between restraint use and how it benefits the resident by addressing the specific medical symptom
 - Resident's subjective symptoms are not the sole basis for using a restraint

376

■ PHYSICAL RESTRAINTS

- ✓ NH must perform due diligence and document to ensure that alternative measures have been exhausted
- ✓ Physical restraints as an intervention do not treat the underlying causes of medical symptoms
- ✓ Physical restraints may be used as a symptomatic intervention when they are immediately necessary to prevent a resident from injuring h/h or others and/or to prevent the resident from interfering with life-sustaining tx.
- ✓ A clear link must exist between the restraint use and how it benefits the resident
- ✓ A physician's order alone is not sufficient to employ restrain use
- ✓ Document, document, document, document
- ✓ CMS will hold NH accountable for decision

377

■ PHYSICAL RESTRAINTS (P0100)

- ✓ Record the frequency that the resident was restrained by any of the listed devices at any time, day or night, over the last 7 days
- Used in Bed**
- ✓ **A = Bed rail:**
 - Any combination of partial or full rails
 - Bed rails used for positioning but meet the definition of a restraint
 - Immobile residents who cannot voluntarily get out of bed may not meet the definition of restraint
 - ✓ **B = Trunk Restraint:**
 - Resident cannot easily remove
 - Examples include, but not limited to, vest or waist restraints, belts used in wheelchairs

378

■ PHYSICAL RESTRAINTS (P0100)

Used in Bed

- ✓ C = Limb Restraint:
 - Resident cannot easily remove
 - Restricts movement of any part of an upper or lower extremity; including mittens
- ✓ D = Other:
 - Any device that does not fit into the listed categories but meets the definition of a restraint and has not been excluded from this section

379

■ PHYSICAL RESTRAINTS (P0100)

Used in Chair or Out of Bed

- ✓ E = Trunk Restraint:
 - Examples include, but not limited to, vest or waist restraints, belts used in wheelchairs
- ✓ F = Limb Restraint:
 - Restrict movement of any part of an upper or lower extremity; including mittens
- ✓ G = Chair Prevents Rising:
 - Chair with locked lap board
 - Chair that places the resident in a recumbent position that restricts rising
 - Chair that is soft and low to the floor
 - Chair that has a cushion placed in the seat that prohibit the resident from rising
 - Geriatric chairs
 - Enclosed-frame wheeled walkers



380

■ PHYSICAL RESTRAINTS (P0100)

Used in Chair or Out of Bed

- ✓ H = Other:
 - Any device that does not fit into the listed categories but meets the definition of a restraint and has not been excluded from this section
- ✓ Record the frequency that the resident was restrained by any of the listed devices at any time, day or night, over the last 7 days
- ✓ Coding for all P0100 items:
 - Code 0 = Not used
 - Code 1 = Used less than daily
 - Code 2 = Used daily

381

*SECTION Q:
PARTICIPATION IN ASSESSMENT
AND GOAL SETTING*



■ *PARTICIPATION IN ASSESSMENT (Q0100)*

- ✓ **A more person-centered approach**
- ✓ **Places resident/family at center of decision-making**
- ✓ **Gives individual residents a voice and a choice while being sensitive to those who may be upset by the assessment process**
- ✓ **Is more targeted about who gets queried**

■ *DISCHARGE PLANNING COLLABORATION (Q0100)*

- ✓ **Meaningfully engages residents in their discharge planning goals**
- ✓ **Directly asks the resident if they want information about long-term care community options**
- ✓ **Promotes linkages and information exchange between nursing homes, local contact agencies, and community based long-term providers**
- ✓ **Promotes discharge planning collaboration between nursing home and local contact agencies for residents who may require medical and supportive services to return to the community**

■ DISCHARGE PLANNING COLLABORATION (Q0100)

- ✓ **Nursing home staff** expected to contact Local Contact Agencies for those residents who express a desire to learn about possible transition back to the community and what care options and supports are available
- ✓ **Local Contact Agencies** expected to respond to nursing home staff referrals by providing information to residents about available community-based long term supports and services
- ✓ Nursing home staff and Local Contact Agencies expected to meaningfully engage the resident in their discharge and transition plan and collaboratively work to arrange for all of the necessary community-based long term services

385

■ PARTICIPATION IN ASSESSMENT (Q0100)

- ✓ The resident actively engages in interviews and conversations to meaningfully contribute to the completion of the MDS 3.0.
- ✓ Interdisciplinary team should engage the resident during assessment in order to determine the resident's expectations and perspective.
- ✓ A = Resident participated in assessment:
 - Code 0 = No
 - Code 1 = Yes

386

■ PARTICIPATION IN ASSESSMENT (Q0100)

- ✓ B = Family or significant other participated in assessment:
 - Spousal, kinship (e.g., sibling, child, parent, nephew) or in-law relationship
 - Partner, housemate, primary community caregiver or close friend
 - Does not include nursing home staff:
 - Code 0 = No, did not participate
 - Code 1 = Yes, did participate
 - Code 9 = No family or significant other available
- ✓ C = Guardian or legally authorized representative participated in assessment:
 - Authorized to make decisions for the resident
 - Includes giving and withholding consent for medical treatment:
 - Code 0 = No, did not participate
 - Code 1 = Yes, did participate
 - Code 9 = No guardian or legally authorized representative available



387

■ LEGALLY AUTHORIZED REPRESENTATIVE OR GUARDIAN

- ✓ Guardian
 - Individual appointed by the court
 - Authorized to make decisions instead of the resident
 - Includes giving and withholding consent for medical treatment
- ✓ Legally Authorized Representative
 - Designated by the resident under state law
 - Makes decisions on the resident's behalf when resident is not able
 - Includes a medical power of attorney

388

■ RESIDENT'S OVERALL EXPECTATION (Q0300)

- ✓ Complete only when A0310E=1
- ✓ Ask resident about overall expectations & goals:
 - Expectations about returning to community
- ✓ Ask resident if has considered:
 - Current health status
 - Social supports
 - Services and support in community
- ✓ If resident unable to express goals or gives consent to involve family, significant other, legal representative or guardian



389

■ RESIDENT'S OVERALL EXPECTATION (Q0300)

- ✓ A = Select one for resident's overall goal established during assessment process:
 - Code 1 = Expects to be discharged to the community
 - Code 2 = Expects to remain in this facility
 - Code 3 = Expects to be discharged to another facility/institution
 - Code 9 = Unknown or uncertain
- ✓ B = Indicate information source for Q0300A:
 - Code 1 = Resident
 - Code 2 = If not resident, then family or significant other
 - Code 3 = If not resident, family, or significant other, then guardian or legally authorized representative
 - Code 9 = Unknown or uncertain

390

■ DISCHARGE PLAN (Q0400)

✓ Is active discharge planning already occurring for resident to return to community?

- Code 0 = No
- Code 1 = Yes, skip to Q0600



391

■ RESIDENT'S PREFERENCE TO AVOID BEING ASKED Q0500B (Q0490)

✓ Complete only if A0310A = 02, 06, 99

✓ Does resident's clinical record document a request that this question be asked only on comprehensive assessments?

- Code 0 = No
- Code 1 = Yes, skip to Q0600
- Code 8 = Information not available

✓ Do not skip if this is a comprehensive assessment

✓ Documentation must be in medical record

392

■ RETURN TO COMMUNITY (Q0500)

✓ Ask if would like to talk to someone about returning to the community:

- Yes, does not commit resident to moving
- Yes, does not guarantee ability to move to community
- No does not mean permanent commitment
- Explore possibility of different ways of receiving ongoing care



✓ If unable to communicate preference; contact family, significant other, guardian or legal representative

393

■ RETURN TO COMMUNITY (Q0500B)

- ✓ Ask the resident: "Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"
 - Code 0 = No, resident, family, et al states does not want to talk to someone about possibility of returning to community
 - Code 1 = Yes, resident, family, et al states that he or she does want to talk to someone about possibility of returning to community
 - Code 9 = Unknown or uncertain, resident cannot understand or respond and the family or significant other, or guardian or legally authorized representative is not available or has not been appointed by court

394

■ RETURN TO COMMUNITY (Q0500B)

- ✓ A "yes" will trigger follow-up care planning and contact with the LCA within 10 business days
- ✓ Follow-up is expected in a "reasonable" amount of time and 10 business days is recommended (not required)
- ✓ SNF/NF should not assume the resident cannot transition out of facility due to their level of care needs

395

■ RESIDENT'S PREFERENCE TO AVOID BEING ASKED QUESTION Q0500B AGAIN (Q0550)

- ✓ A = Does the resident want to be asked about returning to the community on all assessments:
 - Code 0 = No - document in resident's clinical record and ask again only on the next comprehensive assessment
 - Code 1 = Yes
 - Code 8 = Information not available
- ✓ B = Indicate information source for Q0550A:
 - Code 1 = Resident
 - Code 2 = If not resident, then family or significant other
 - Code 3 = If not resident, family or significant other, then guardian or legally authorized representative
 - Code 8 = No information source available

396

■ REFERRAL (Q0600)

- ✓ Make a referral for resident to local contact transition agency when individual says yes they would like to talk to someone about available long-term care community options and supports
- ✓ Has a referral been made to the Local Contact Agency?
 - Code 0 = No, referral not needed
 - Code 1 = No, referral is or may be needed
 - Code 2 = Yes, referral made
- ✓ Document reasons in resident's clinical record
- ✓ Assessments will be rejected if not completed

397

SECTION V:
CARE AREA ASSESSMENT SUMMARY



398

■ CARE AREA ASSESSMENT SUMMARY

- ✓ MDS does not constitute a comprehensive assessment
- ✓ MDS is a preliminary assessment to identify potential problems, strengths, preferences
- ✓ CAAs indicate the need for additional assessment based on problem identification which forms a link between the MDS and care planning
- ✓ 20 Care Areas
- ✓ Important to obtain input from resident, family, significant other, guardian, legal representative
- ✓ Guides staff to look for causal or confounding factors
- ✓ Care plan then addresses these factors;
 - Promoting highest practicable level of function
 - Improve where possible
 - Maintain and prevent avoidable declines

399

■ *ITEMS FROM THE MOST RECENT PRIOR OBRA OR SCHEDULED PPS ASSESSMENT (V0100)*

- ✓ Complete only if A0310E=0 and the prior assessment is A0310A=01-06 or A0310B=01-06
- ✓ The items in V0100 are used to determine whether to trigger several of the CAAs that compare a resident's current status to prior status
- ✓ These values are derived from a prior OBRA or scheduled PPS assessment performed since the most recent admission of any kind (entry/reentry) if available
- ✓ Complete only if prior assessment has been completed since the most recent admission of any kind
- ✓ Copy values in V0100A, B, C, D, E and F from the prior assessment to current assessment

400

■ *ITEMS FROM THE MOST RECENT PRIOR OBRA OR SCHEDULED PPS ASSESSMENT (V0100)*

- ✓ A = Prior Assessment Federal OBRA Reason for Assessment (A0310A):
 - Must be value of 01 through 06 or 99
- ✓ B = Prior Assessment PPS Reason for Assessment (A0310B):
 - Must be value of 01 through 07 or 99
 - V0100A and V0100B cannot both be 99
- ✓ C = Prior Assessment Reference Date (A2300):
 - MM-DD-YYYY
- ✓ D = Prior Assessment BIMS Summary Score (C0500)
- ✓ E = Prior Assessment Resident Mood Interview (PHQ-9©) Total Severity Score (D0300)
- ✓ F = Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV©) Total Severity Score (D0600)

401

■ *CAAS AND CARE PLANNING (V0200)*

- ✓ 20 Care Areas:
 - Identify triggered areas require further assessment
 - Decision as to whether or not area is care planned
 - Identify location and date of the CAA documentation
 - CAA summary documents IDT's, resident's, family or representative's final decision(s) on which triggered areas will be care planned
- ✓ AA = Care Area Triggered:
 - Identifies all triggered care areas
- ✓ AB = Care Planning Decision:
 - Identifies new or revised care plan, or continuation of current care plan
 - For each triggered care area, complete the "Location and Date of CAA Documentation" column

402

■ CAAS AND CARE PLANNING (V0200)

- ✓ **B = Signature of RN Coordinator for CAA Process and Date Signed:**
 - 1 = RN Signature
 - 2 = Date RN coordinating CAA process certifies that the CAAs have been completed
 - MM-DD-YYYY
 - Must be completed within 14 days of an admission for an Admission assessment or within 14 days of ARD (A2300) for other comprehensive assessment
 - This date is considered the completion date for the RAI

403

■ CAAS AND CARE PLANNING (V0200)

- ✓ **C = Signature of Person Completing Care Plan Decision and Date Signed:**
 - 1 = Signature of staff member facilitating care planning decision-making (not required to be same person as signing in V0200B):
 - Does not have to be an RN
 - 2 = Date staff member completes Care Plan Decisions
 - Date on which staff member completes the care planning decision column, which is done after care plan is completed
 - Must be completed within 7 days of completion of comprehensive assessment (MDS and CAAs) as indicated by date in V0200B2
 - Assessment must be transmitted within 14 days of date in V0200C2

404

■ CAAS AND CARE PLANNING (V0200)

- ✓ **Guidelines for completing a comprehensive assessment that is in progress when a resident is discharged:**
 - Complete all required MDS items Sections A through Z; indicate date of completion in Z0500B
 - Check all triggered care areas in V0200A
 - Sign and date the CAAs were completed at V0200B1 and 2
 - Dash fill all "Care Planning Decision" items in V0200AB, indicating decisions unknown
 - Sign and date care planning decisions were completed in V0200C1 and 2, using same date as V0200B2
 - Transmit the assessment

405

SECTION X:
CORRECTION REQUEST



■ MODIFICATION PROCESS

- ✓ Complete only if A0050 = 2
- ✓ Must reproduce information exactly as it appeared on erroneous record
- ✓ Modification used to correct:
 - Transcription errors
 - Data entry errors
 - Software product errors
 - Item coding errors
 - Other error requiring modification
- ✓ Corrected record replaces prior erroneous record
- ✓ Moves erroneous record from the active file to an archive file (history file)



■ INACTIVATION PROCESS

- ✓ Complete only if A0050 = 3
- ✓ Used when the event did not occur
- ✓ Only includes item A0050 and Section X items
- ✓ All other MDS sections are skipped
- ✓ Moves inactivated record from the active file to an archive file (history file)
- ✓ Manual deletion request; Chapter 5
- ✓ Type of Provider (X0150):
 - Code 1 = Nursing home (SNF/NF)
 - Code 2 = Swing Bed

■ **NAME, GENDER, BIRTH DATE, AND SSN (X0200-X0500)**

- ✓ Identifies an existing record to be modified/inactivated
- ✓ Must reflect the information **EXACTLY** as it appears on the erroneous record:
 - **X0200A, C** – Name of resident (A0500A, C)
 - **X0300** – Gender (A0800)
 - **X0400** – Birth date (A0900)
 - **X0500** – Social Security Number (A0600)
- ✓ These items do not have to match the current values

409

■ **TYPE OF ASSESSMENT (X0600)**

- ✓ Identifies an existing record to be modified/inactivated
- ✓ Must reflect the information **EXACTLY** as it appears on the erroneous record:
 - **X0600** – Type of assessment (from erroneous record):
 - A = Federal OBRA Reason for Assessment (A0310A)
 - B = PPS Assessment (A0310B)
 - C = PPS Other Medicare Required Assessment-OMRA (A0310C)
 - D = Is this a Swing Bed clinical change assessment? (A0310D)
 - F = Entry/discharge reporting (A0310F)

410

■ **DATE ON EXISTING RECORD TO BE MOD/INACT. (X0700) CORRECTION ATTESTATION SECTION (X0800)**

- ✓ Complete only one date in X0700
- ✓ **X0700** – Date on existing record to be modified/inactivated:
 - A = Assessment Reference Date, complete only if X0600F=99
 - B = Discharge Date, complete only if X0600F=10, 11, or 12
 - C = Entry date, complete only if X0600F=01
- ✓ **X0800** – Correction Number:
 - Enter number of correction request to modify/inactivate existing record, including the present one

411

■ REASONS FOR MODIFICATION (X0900)

- ✓ X0900 – Reasons for Modification
 - Completed only when A0050 = 2
 - Skipped when A0050 = 3

✓ Check all that apply:

- A = Transcription error
- B = Data entry error
- C = Software product error
- D = Item coding error
- E = End of therapy – resumption date
- Z = Other error requiring modification

412

■ REASONS FOR INACTIVATION (X1050)
RN ASSESSMENT COORDINATOR ATTESTATION
OF COMPLETION (X1100)

- ✓ X1050 – Complete only if A0050 = 3:
 - Check all that apply:
 - A = Event did not occur
 - Z = Other error requiring inactivation

- ✓ X1100 – RN Assessment Coordinator Attestation of Completion:
 - A = Attesting individual's first name
 - B = Attesting individual's last name
 - C = Attesting individual's title
 - D = Signature
 - E = Attestation date

413

SECTION Z:
ASSESSMENT ADMINISTRATION



■ **MEDICARE PART A BILLING (Z0100)**

- ✓ Medicare Part A Billing:
 - A = Medicare Part A HIPPS code:
 - Health Insurance Prospective Payment System (HIPPS) code is comprised of the RUG category followed by an indicator of the type of assessment completed
 - A five position code; RUG (3) + assessment type (2)
 - HIPPS details in Chapter 6 of RAI manual
 - Does not include stays billable to Medicare Advantage HMO plans
 - B = RUG version code:
 - RUG-IV Medicare 66 grouper
 - C = Is this a Medicare Short Stay assessment:
 - Code 0 = No
 - Code 1 = Yes
 - Short stay details in Chapter 6 of RAI Manual

415

■ **MEDICARE PART A NON-THERAPY BILLING (Z0150)**

- ✓ Medicare Part A Non-Therapy Billing:
 - A = Medicare Part A Non-therapy HIPPS code
 - B = RUG version code
- ✓ Typically the software data entry product will calculate these values
- ✓ RUG-IV classification ignoring all rehabilitation therapy

416

■ **STATE MEDICAID BILLING (Z0200)**
ALTERNATE STATE MEDICAID BILLING (Z0250)

- ✓ Z0200 – State Medicaid Billing:
 - A = RUG Case Mix group
 - B = RUG version code
 - If the state has selected a standard RUG model, these items will usually be populated automatically by the software data entry product
- ✓ Z0250 – Alternate State Medicaid Billing:
 - A = RUG Case Mix group
 - B = RUG version code
 - States may want to capture a second payment group for Medicaid purposes to allow evaluation of the fiscal impact of changing to a new payment model

417

■ **INSURANCE BILLING (Z0300)**

- ✓ Allows providers and vendors to capture case-mix codes required by other payers (e.g. private insurance or the Department of Veterans Affairs)
- ✓ Insurance Billing:
 - A = RUG billing code:
 - This code is for use by other payment systems such as private insurance or the Department of Veterans Affairs
 - B = RUG billing version:
 - This is the billing version appropriate to the billing code in Item Z0300A

418

■ **SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT OR ENTRY/DEATH REPORTING (Z0400)**

- ✓ Signatures of Persons Completing Assessment or Entry/Death Reporting (Z0400):
 - Signature/title
 - Section(s)
 - Date Section(s) completed
- ✓ All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed
- ✓ If a staff member cannot sign Z0400 on the same day that he or she completed a section or portion of a section, when the staff member signs, use the date the item originally was completed
- ✓ *Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response*

419

■ **SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT OR ENTRY/DEATH REPORTING**

- ✓ The importance of accurately completing and submitting the MDS cannot be over-emphasized. The MDS is the basis for the development of:
 - An individualized care plan
 - The Medicare Prospective Payment System
 - Medicaid reimbursement programs
 - Quality monitoring activities
 - The data-driven survey and certification process
 - The quality measures used for public reporting
 - Research and policy development



420

■ SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT OR ENTRY/DEATH REPORTING

- ✓ **Read the Attestation Statement carefully:**
 - You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident's status
 - Penalties may be applied for submitting false information



421

■ SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT OR ENTRY/DEATH REPORTING

- ✓ **Two or more staff members can complete items within the same section of the MDS:**
 - Any staff member who has completed a sub-set of items within a section should identify which item(s) he/she completed within that section
- ✓ **May use electronic signatures:**
 - When permitted to do so by state and local law
 - When authorized by the nursing home's policy
 - Must have written policies in place that meet any and all state and federal privacy and security requirements to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs

422

■ SIGNATURE OF RN ASSESSMENT COORDINATOR VERIFYING ASSESSMENT COMPLETION (Z0500)

- ✓ **Signature of RN Assessment Coordinator Verifying Assessment Completion:**
 - Verify that all items on this assessment or tracking record are complete
 - Verify that Item Z0400 (Signature of Persons Completing the Assessment) contains attestation for all MDS sections
 - Signature certifies completion of assessment
 - When copy of MDS is printed and dates are automatically encoded, be sure to note that it is a "copy" document and not the original
 - A = Signature
 - B = Date (MM-DD-YYYY)

423

■ SIGNATURE OF RN ASSESSMENT COORDINATOR VERIFYING ASSESSMENT COMPLETION (Z0500)

Coding Instructions:

- ✓ For Z0500B, use the actual date that the MDS was completed, reviewed, and signed as complete by the RN assessment coordinator
- ✓ This date will generally be later than the date(s) at Z0400
- ✓ If for some reason the MDS cannot be signed by the RN assessment coordinator on the date it is completed, the RN assessment coordinator should use the actual date that it is signed
- ✓ The RN assessment coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals

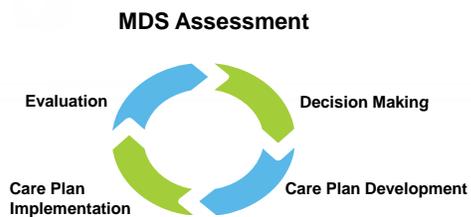
424

CHAPTER 4
CARE AREA ASSESSMENT (CAA)
PROCESS AND CARE PLANNING



425

■ OVERVIEW OF THE RAI AND CARE AREA ASSESSMENTS (CAAs)



426

■ CAA PROCESS FRAMEWORK

- ✓ Guides review of triggered areas
- ✓ Clarifies functional status and related causes of impairments
- ✓ Assessment of causes and contributing factors provides IDT additional information
- ✓ Should help staff:
 - Consider each resident as a whole
 - Identify areas of concern
 - Develop to extent possible, interventions to help improve, stabilize, or prevent declines
 - Address need and desire for other considerations such as palliative care



427

■ WHAT ARE THE CARE AREA ASSESSMENTS (CAAs)

- ✓ The MDS information and the CAA process provide the foundation upon which the individualized care plan is formulated
- ✓ No specific tool mandated
- ✓ No specific guidance on how to understand or interpret triggered areas
- ✓ Facilities are to identify and use tools that are current and grounded in current clinical standards of practice
- ✓ Use sound clinical problem solving and decision making skills
- ✓ Only required for OBRA comprehensive assessments (admission, annual, significant change, significant correction of full)

428

■ WHAT ARE THE CARE AREA ASSESSMENTS (CAAs)

- ✓ Triggered responses to items on there MDS specific to a resident's problems, needs, or strengths
- ✓ CAAs reflect conditions, symptoms, other concern common in nursing home residents
- ✓ Commonly identified or suggested by MDS findings
- ✓ CAAs are not required for Medicare PPS assessments
- ✓ When a PPS is combined with a OBRA comprehensive; the CAA process must be completed

429

■ CARE AREA ASSESSMENTS 1 - 10

- 1 - Delirium
- 2 - Cognitive Loss/Dementia
- 3 - Visual Function
- 4 - Communication
- 5 - ADL Functional/Rehabilitation Potential
- 6 - Urinary Incontinence and Indwelling Catheter
- 7 - Psychosocial Well-Being
- 8 - Mood State
- 9 - Behavioral Symptoms
- 10 - Activities

430

■ CARE AREA ASSESSMENTS 11 - 20

- 11 - Falls
- 12 - Nutritional Status
- 13 - Feeding Tube
- 14 - Dehydration/Fluid Maintenance
- 15 - Dental Care
- 16 - Pressure Ulcer
- 17 - Psychotropic Drug Use
- 18 - Physical Restraints
- 19 - Pain
- 20 - Return to Community Referral



431

■ WHAT THE CAA PROCESS INVOLVES

- ✓ CAA process refers to identifying and clarifying areas of concern that are triggered based on specific MDS item responses
- ✓ Focuses on evaluating these triggered care areas
- ✓ Does not provide exact detail on how to select pertinent interventions for care planning
- ✓ Interventions must be individualized and based on effective problem solving and decision making approaches

432

■ WHAT THE CAA PROCESS INVOLVES

✓ Care Area Triggers (CATs):

- Identify conditions that may require further evaluation
- Each triggered item must be assessed through the CAA process but may or may not be addressed in care plan
- Provides a “flag” for IDT, indicating need for assessment prior to care plan decision
- May identify causes, risk factors and complications associated with the care area condition
- Care plan then addresses these factors with goal of promoting resident’s highest practicable level of functioning



433

■ WHAT THE CAA PROCESS INVOLVES

✓ A risk factor increases chance of a negative outcome or complication:

- **Example:**
 - Impaired bed mobility may increase risk of a pressure ulcer:
 - Impaired bed mobility is the risk factor
 - Unrelieved pressure is the effect
 - Potential pressure ulcer is the complication

434

■ WHAT THE CAA PROCESS INVOLVES

✓ A care area issue/condition (e.g., falls) may result from:

- A single underlying cause (new medication that causes dizziness)
- A combination of factors (new medication, forgot walker, bed too high or too low)



✓ There may be a single cause of multiple triggers and impairments:

✓ **Example:**

- Hypothyroidism is a common, potentially reversible medical condition that can have physical, functional and psychosocial complications:
 - It may trigger as many as 15 CAAs

435

■ WHAT THE CAA PROCESS INVOLVES

- ✓ Recognizing connection among symptoms and treating underlying cause(s) to extent possible:
 - Can help address complications
 - Can improve outcome
- ✓ Failing to recognize links and instead trying to address the triggers in isolation may have little if any benefit for the resident with hypothyroidism or other complex or mixed causes of impaired behavior, cognition or mood

436

■ WHAT THE CAA PROCESS INVOLVES

- ✓ The RAI is not intended to:
 - Provide diagnostic advice
 - Specify which triggered areas may be related to one another
 - How those problems relate to underlying causes
- ✓ The IDT, including resident's MD, should determine these connections and underlying causes as they assess the triggered care areas
- ✓ Not all triggers identify deficits or problems
- ✓ Some triggers indicate areas of strengths

437

■ WHAT THE CAA PROCESS INVOLVES

- ✓ The CAA process may help the IDT to:
 - Identify and address associated causes and effects
 - Determine whether and how multiple triggered conditions are related
 - Identify need to obtain additional information
 - Identify whether and how a triggered condition actually affects resident's function and quality of life or if resident is at risk
 - Review resident's condition with health care practitioner to identify links and pertinent tests, consultations or interventions
 - Determine if resident could potentially benefit from rehabilitation interventions
 - Develop individualized care plan

438

■ *OTHER CONSIDERATIONS REGARDING USE OF THE CAAs*

- ✓ **Assigning responsibility for completing the MDS and CAAs:**
 - Per OBRA statute, the resident assessment must be conducted or coordinated by a RN
 - Appropriate participation of health professionals
 - Common practice for a facility to assign specific MDS items and CAAs associated with those items to various disciplines
 - More than one discipline may need to be involved
 - Facility's responsibility to obtain input needed for clinical decision making consistent with relevant clinical standards of practice

439

■ *OTHER CONSIDERATIONS REGARDING USE OF THE CAAs*

- ✓ **Identifying policies and practices related to the assessment and care planning processes:**
 - Per OBRA, medical director is responsible for overseeing "implementation of resident care policies" and "coordination of medical care in the facility"
 - IDT members should collaborate with the medical director
 - Identify current evidence-based or expert-endorsed resources and standards of practice
 - Be ready to provide state surveyors resources used in CAA process

440

■ *OTHER CONSIDERATIONS REGARDING USE OF THE CAAs*

- ✓ **CAA documentation:**
 - Relevant documentation for each triggered CAA describes causes and contributing factors
 - Nature of issue or condition; what exactly is the issue/problem for resident and why is it a problem
 - Complications affecting or caused by the care area
 - Risk factors that affect decision to proceed to care planning
 - Factors to be considered in developing individualized care plan interventions:
 - To care plan or not to care plan

441

■ OTHER CONSIDERATIONS REGARDING USE OF THE CAAs

✓ CAA documentation:

- Need for additional evaluation by other health professionals
- Resources or assessment tools used for decision making
- Conclusions from performing the CAA
- Completion of Section V (CAA Summary) of the MDS



442

■ OTHER CONSIDERATIONS REGARDING USE OF THE CAAs

✓ CAA documentation:

- Written documentation of CAA findings and decision making process may appear anywhere in the resident's record:
 - Discipline-specific flow sheets
 - Progress notes
 - Care plan summary notes
 - CAA summary narrative
- Use the "Location and Date of CAA Documentation" column on CAA Summary (Section V of MDS)
- Indicate in "Care Planning Decision" if triggered area is addressed in care plan



443

■ WHEN IS THE RAI NOT ENOUGH?

✓ Limitations of the RAI-related instruments:

- MDS may not trigger every relevant issue
- Not all triggers are clinically significant
- MDS is not a diagnostic tool or treatment selection guide
- MDS does not identify causation or history of problems
- Facilities are responsible for assessing and addressing all relevant care issues, whether or not covered by the RAI, including monitoring condition and appropriate interventions

444

■ THE RAI AND CARE PLANNING

- ✓ Per 42 CFR 483.25, the comprehensive care plan:
 - Is an interdisciplinary communication tool
 - Must include measurable objectives and time frames
 - Must describe services to be furnished to attain or maintain resident's highest practicable physical, mental and psychosocial well-being
 - Must be reviewed and revised periodically
 - Services provided or arranged must be consistent with written plan of care
 - Must maintain assessments completed in the previous 15 months in the active record

445

■ THE RAI AND CARE PLANNING

- ✓ A well-developed and executed assessment care plan:
 - Looks at resident as a whole human being with unique characteristics and strengths
 - Views the resident in distinct functional areas (MDS)
 - Gives the IDT a common understanding of the resident
 - Re-groups the information gathered to identify possible issues and/or conditions that the resident may have (i.e., triggers)
 - Provides additional clarity of potential issues and/or conditions (CAA process)
 - Develops and implements an interdisciplinary care plan with necessary monitoring and follow-up
 - Reflects the resident/resident representative input and goals for health care

446

■ THE RAI AND CARE PLANNING

- ✓ A well-developed and executed assessment and care plan:
 - Provides information regarding how the causes and risks associated with issues and/or conditions can be addressed to provide for a resident's highest practicable level of well-being (care planning)
 - Re-evaluates the resident's status at prescribed intervals (i.e., quarterly, annually, or if a significant change in status occurs) using RAI and then modifies the individualized care plan as appropriate and necessary
 - Communicate with resident/family/representative regarding resident's care plan and wishes

447

■ THE OVERALL CARE PLAN

- ✓ The overall care plan should be oriented towards:
 - Preventing avoidable declines in functioning if possible
 - Managing risk factors to the extent possible
 - Addressing ways to try to preserve and build upon resident strengths
 - Assessing and planning for care to meet medical, nursing, mental and psychosocial needs
 - Applying current standards of practice
 - Evaluating treatment for measurable objectives, timetables and outcomes of care

448

■ THE OVERALL CARE PLAN

- ✓ The overall care plan should be oriented towards:
 - Respecting the resident's right to decline treatment
 - Offering alternative treatments, as applicable
 - Using an appropriate interdisciplinary approach to improve the resident's functional abilities
 - Involving resident, resident's family/representatives as appropriate
 - Involving direct care staff
 - Addressing additional relevant care planning areas

449

■ CAA TIPS AND CLARIFICATIONS

- ✓ Care planning has several key steps that may occur at the same time or in sequence
- ✓ Goals should be measurable:
 - Lead to outcome objectives
 - Have a time frame for completion or evaluation
- ✓ Goal statements should include:
 - Subject (first or third person)
 - Verb
 - Modifiers
 - Time frame
 - Goals



450

■ CAA TIPS AND CLARIFICATIONS

- ✓ Clinical problem solving and decision making process, steps and objectives:
 - Recognition/Assessment
 - Problem definition
 - Diagnosis/Cause and effect analysis
 - Identify goals and objectives of care
 - Select interventions/planning care
 - Monitor progress
 - Modify goals and approaches as needed

451

■ CAA TIPS AND CLARIFICATIONS

- ✓ A separate care plan is not necessarily required for each triggered area:
 - A single trigger may have multiple causes and contributing factors
 - Multiple items may have a common cause or related factors
 - May be more appropriate to address multiple issues in one care plan

452

■ USING THE CAA RESOURCES

- ✓ Step 1 - Identification of triggered CAAs:
 - Automated software
 - Manually
- ✓ Step 2 - Analysis of triggered CAAs:
 - Review items that caused this CAA to be triggered
 - In-depth, resident-specific assessment of potential need for care plan interventions
 - Consider any issues and/or conditions that may contribute but are not captured in MDS data
 - Identify areas of concern
 - Use this information to make a clear issue or problem statement that clearly identifies the situation
 - Determine extent of problem

453

■ USING THE CAA RESOURCES

- ✓ Step 2 - Analysis of triggered CAAs (continued):
 - Identify links among triggers and their causes
 - Detailed history is essential
 - Refer to sources as needed to help with clinical decision making that is consistent with professional standards of practice
 - May need to involve physician
- ✓ Step 3 - Decision making:
 - Resident, family or resident's representative should be integral part of process
 - Staff who have participated in the assessment and provided pertinent information should be part of IDT that develops care plan

454

■ USING THE CAA RESOURCES

- ✓ Step 4 - CAA documentation:
 - Information from assessment that led to care plan decision should be clearly documented
 - Refer to CAT Logic tables within each CAA description (Chapter 4, section 4.10) and Appendix C in RAI Manual for detailed information on triggers
- ✓ Twenty Care Areas detail:
 - Pages 16-41

455

*"PSYCHOSOCIAL WELL-BEING"
CARE PLAN EXERCISE*



456

■ PSYCHOSOCIAL WELL-BEING CAA

- ✓ This CAA is triggered when a resident exhibits minimal interest in social involvement
- ✓ Involvement in social relationships is vital
- ✓ Decreases in social relationships may affect:
 - Psychological well-being
 - Mood or behavior
 - Physical activity
- ✓ Declines in physical functioning, cognition, new onset or worsening of pain or other health issues may affect both social relationships and mood
- ✓ Psychosocial well-being may be negatively impacted by significant life changes, such as death of a loved one

457

■ PSYCHOSOCIAL WELL-BEING CAT LOGIC TABLE TRIGGERING CONDITIONS (ANY OF THE FOLLOWING):

1. Resident mood interview indicates the presence of little interest or pleasure in doing things as indicated by:
D0200A1 = 1
2. Staff assessment of resident mood indicates the presence of little interest or pleasure in doing things as indicated by:
D0500A1 = 1
3. Interview for activity preference item "How important is it to you to do your favorite activities?" has a value of 3 (not very important) or 4 (not important at all) as indicated by:
F0500F = 3 or F0500F = 4

458

■ PSYCHOSOCIAL WELL-BEING CAT LOGIC TABLE TRIGGERING CONDITIONS (ANY OF THE FOLLOWING):

4. Staff assessment of daily and activity preferences did not indicate that resident prefers participating in favorite activities as indicated by:
F0800Q = not checked
5. Physical behavioral symptoms directed toward others has a value of 1 through 3 and neither dementia nor Alzheimer's disease is present as indicated by:
E0200A >= 1 and E0200A <= 3) AND
(I4800 = 0 OR I4800 = -) AND
(I4200 = 0 OR I4200 = -)

459

■ *PSYCHOSOCIAL WELL-BEING CAT LOGIC TABLE TRIGGERING CONDITIONS (ANY OF THE FOLLOWING):*

6. Verbal behavioral symptoms directed toward others has a value of 1 through 3 and neither dementia nor Alzheimer's disease is present as indicated by:

(E0200B >= 1 and E0200B <= 3) AND
(I4800 = 0 OR I4800 = -) AND
(I4200 = 0 OR I4200 = -)

7. Any six items for interview for activity preferences has the value of 4 (not important at all) and resident is primary respondent for daily and activity preferences as indicated by:

(Any 6 of F0500A through F0500H = 4) AND
(F0600 = 1)

460

■ *CARE PLAN EXERCISE PSYCHOSOCIAL WELL-BEING*

✓ Step 1 – Identification of Triggered CAA

✓ Step 2 – Analysis of triggered Psychosocial Well-Being CAA

- MDS items that caused this CAA to be triggered
- Issues/conditions not captured in MDS data
- Areas of concern
- Links to other CAAs

461

■ *CARE PLAN EXERCISE PSYCHOSOCIAL WELL-BEING*

✓ Step 3 – Decision Making:

- Proceed to Psychosocial well-Being Care Plan
 - YES _____ NO _____

✓ Care Plan Development:

- Problem Statement:
- Goal Statement:
- Interventions:
- Responsible Discipline(s):

462

■ OFFICE OF INSPECTOR GENERAL

"SKILLED NURSING FACILITIES OFTEN FAIL TO MEET CARE PLANNING AND DISCHARGE PLANNING REQUIREMENTS"

FEBRUARY 2013 REPORT

463

■ OFFICE OF INSPECTOR GENERAL

✓ **Facilities often fail to meet care planning and discharge planning requirements**

✓ **Studies found deficiencies in:**

- Quality of care
- Did not develop appropriate care plans
- Failed to provide adequate care

✓ **Findings:**

- 37% of stays did not develop care plans that met requirements or did not provide services in accordance with care plan
- 31% of stays did not meet discharge planning requirements
- Medicare paid approx. \$5.1 billion for stays that did not meet these quality of life requirements
- Reviewers found examples of poor care related to wound care, medication management and therapy

464

■ OFFICE OF INSPECTOR GENERAL

✓ **First OIG study found that from 2006-2008, SNFs increasingly billed for higher paying categories, even though beneficiary characteristics remained largely unchanged**

✓ **Another study found SNFs billed one-quarter of claims in error in 2009, resulting in \$1.5 billion in inappropriate Medicare payments**

- Found 47% of claims misreported information which is used to create care plans

✓ **Upcoming study will review the quality of care and safety of Medicare beneficiaries transferred from hospitals to SNFs**

465

■ OFFICE OF INSPECTOR GENERAL

Medicare Coverage Requirements for Part A SNF Stays

- ✓ Medicare covers up to 100 days during any spell of illness
- ✓ 3 Consecutive hospital days and stay must have occurred within 30-days of admission to the SNF
- ✓ Beneficiary must need skilled services daily in an inpatient setting
- ✓ Must require the skills of a technical or professional personnel
- ✓ Services must be ordered by a physician for the same condition that the beneficiary was treated in the hospital

466

■ OFFICE OF INSPECTOR GENERAL

Medicare Requirements Related to Quality of Care

- ✓ Required to develop a care plan and provide services in accordance with care plan
- ✓ Requires SNFs to provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with care plan
- ✓ Ensure a safe transition to the next care setting
 - Required to plan for discharge when facilities anticipate discharge
- ✓ Monitored by State Surveyors (2011)
 - 22% did not meet care planning requirements
 - 14% did not provide services according to care plan
 - 1% did not meet discharge planning requirements

467

■ OFFICE OF INSPECTOR GENERAL

Recommendations

- ✓ Strengthen the regulations on care planning and discharge planning
- ✓ Provide guidance to SNFs to improve care planning and discharge planning
- ✓ Increase surveyor efforts to identify SNFs that do not meet care planning and discharge planning requirements and to hold these SNFs accountable
- ✓ Link payments to meeting Quality-of-Care requirements
- ✓ Follow up on the SNFs that failed to meet care planning and discharge planning requirements or that provided poor quality care
- ✓ **CMS concurred with all five recommendations!!**

468

CHAPTER 5
SUBMISSION AND CORRECTION OF
THE MDS ASSESSMENT



■ TRANSMITTING MDS DATA

- ✓ All Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system
- ✓ Required MDS records are those assessments and tracking records that are mandated under OBRA and SNF PPS
- ✓ Assessments completed for purposes other than OBRA and SNF PPS reasons AND are not in a certified bed are not to be submitted, e.g., private insurance, including but not limited to Medicare Advantage plans

■ TRANSMITTING MDS DATA

- ✓ Facilities must be certain they are submitting assessments under the appropriate authority
- ✓ There must be a federal and/or state authority to submit assessments to the QIES ASAP
- ✓ Provider indicates the submission authority in item A0410:
 - Value = 1 Neither federal nor state authority
 - Value = 2 State but not federal authority
 - Value = 3 Federal required authority

■ **COMPLETION TIMING**

- ✓ All non-comprehensive OBRA, and PPS assessments:
 - Completion Date (Z0500B) must be no later than 14 days from ARD (A2300)
- ✓ Admission assessment:
 - Completion Date (Z0500B) must be no later than 13 days after Entry date (A1600)
 - CAA Completion Date (V0200B2) must be no more than 13 days after Entry Date (A1600)
- ✓ Annual assessments:
 - CAA Completion Date (V0200B2) must be no later than 14 days from ARD (A2300)



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■ **COMPLETION TIMING**

- ✓ Significant Change and Significant Correction Comprehensive assessments:
 - CAA Completion Date (V0200B2) must be no later than 14 days from ARD (A2300) AND
 - CAA Completion Date (V0200B2) must be no later than 14 days from determination date
- ✓ Tracking records (entry/death in facility):
 - Must be completed (Z0500B) within 7 days of Event Date:
 - A1600 for entry record
 - A2000 for death in facility record

473

■ **ENCODING DATA TIMING**

- ✓ Comprehensive assessments:
 - Within 7 days after Care Plan Completion Date (V0200C2)
- ✓ Quarterly, discharge or PPS assessment:
 - Within 7 days after MDS Completion Date (Z0500B)
- ✓ Tracking records:
 - Must be completed within 7 days of Event Date:
 - A1600 for entry record
 - A2000 for death in facility record

474

■ SUBMISSION TIMING

- ✓ Comprehensive Assessments:
 - Care Plan completion date (V0200C2) plus 14 days
- ✓ Non-Comprehensive Assessments:
 - Completion date (Z0500B) plus 14 days
- ✓ Tracking Records:
 - Entry date (A1600)/death date (A2000) plus 14 days
- ✓ PPS Assessments:
 - Completion date (Z0500B) plus 14 days
- ✓ Discharge Assessments:
 - Completion date (Z0500B) plus 14 days
- ✓ Modification/Inactivation:
 - RN Attestation date (X1100E) plus 14 days

475

■ VALIDATION EDITS

- ✓ QIES ASAP system has validation edits designed to monitor the timeliness and accuracy of MDS record submissions
- ✓ Initial Submission Feedback: 
 - Confirms file was received
 - Assigns file submission number
 - Assigns date & time file was received for processing
 - Displays submission file name

476

■ VALIDATION EDITS

- ✓ QIES ASAP system performs three types of validation:
 - Fatal file errors:
 - Fatal files are rejected and must be corrected and resubmitted
 - Fatal record errors:
 - Include “out of range” responses or inconsistent relationships between items
 - Fatal records are rejected and must be corrected and resubmitted
 - Non-fatal errors (warnings):  ERROR
 - Include missing or non-critical questionable data
 - Must evaluate non-fatal errors to identify the need for corrective actions

477

■ *ADDITIONAL MEDICARE SUBMISSION REQUIREMENTS THAT IMPACT BILLING UNDER THE SNF PPS*

- ✓ SNFs must submit assessments according to a standard schedule

HIPPS Codes

- ✓ Health Insurance Prospective Payment System (HIPPS) codes are billing codes used when submitting Medicare Part A SNF payment claims to the Part A/Part B Medicare Administrative Contractor (A/B MAC)
- ✓ The HIPPS code consists of five positions:
 - The first three positions represent the Resource Utilization Group-IV (RUG-IV) case mix code for the SNF resident
 - The last two positions are an Assessment Indicator (AI) code indicating which type of assessment was completed
 - The standard grouper logic uses MDS 3.0 items to determine both the RUG-IV group and the AI code

478

■ *ADDITIONAL MEDICARE SUBMISSION REQUIREMENTS THAT IMPACT BILLING UNDER THE SNF PPS*

- ✓ The HIPPS codes used for Medicare Part A SNF claims are included on the MDS. There are two different HIPPS codes:
 1. The Medicare Part A HIPPS code (Item Z0100A) is most often used on the claim. The RUG version code in Item Z0100B documents which version of RUG-IV was used to determine the RUG-IV group in the Medicare Part A HIPPS code.
 2. The Medicare non-therapy Part A HIPPS code (Item Z0150A) is used when the provider is required to bill the non-therapy HIPPS
- ✓ There is also a Medicare Short Stay indicator (Z0100C) on the MDS

479

■ *ADDITIONAL MEDICARE SUBMISSION REQUIREMENTS THAT IMPACT BILLING UNDER THE SNF PPS*

- ✓ The Medicare Part A SNF claim cannot be submitted until the corresponding MDS Medicare PPS assessment has been accepted in the QIES ASAP system
- ✓ The claim must include the correct HIPPS code for the assessment
- ✓ If the HIPPS code on the assessment was in error, then the correct HIPPS code from the Final Validation report must be used on the claim (warning error message -3616a)

480

■ MDS CORRECTION POLICY

- ✓ Once completed, edited, and accepted into the QIES ASAP system, providers may not change a previously completed MDS assessment as the resident's status changes during the course of the resident's stay - the MDS must be accurate as of the ARD
- ✓ Minor changes in resident's status should be noted in resident's record (e.g., in progress notes)
- ✓ Significant change in status warrants a new comprehensive assessment



481

■ MDS CORRECTION POLICY

- ✓ Electronic record submitted to and accepted into QIES ASAP system is the legal assessment
- ✓ Corrections made to electronic record after data transmission, or to paper copy maintained in medical record are not recognized as proper corrections
- ✓ It is the responsibility of the provider to ensure that any corrections made are submitted to the QIES ASAP system in accordance with the MDS Correction Policy



482

■ MDS CORRECTION POLICY

- ✓ Software used by provider to encode MDS must run all CMS standard edits as defined in data specifications
- ✓ Enhanced record rejection standards have been implemented in QIES ASAP system:
 - Out of range responses or inconsistent responses cause record rejection
 - Records with inaccurate data (fatal errors) are not stored in QIES ASAP database
- ✓ Once assessment is accepted in the QIES ASAP system, corrections must be processed using the modification or inactivation procedures

483

■ *MDS CORRECTION POLICY*

- ✓ Clinical corrections must assure accuracy
- ✓ Resident is accurately assessed
- ✓ Care plan is accurate
- ✓ Resident is receiving necessary care
- ✓ May need to perform a:
 - Significant Change in Status assessment
 - Significant Correction of Prior assessment
 - Corrections to record in the QIES ASAP system by sending in modification or inactivation record



484

■ *ERRORS IDENTIFIED DURING ENCODING PERIOD*

- ✓ Correcting errors that have not yet been accepted in the QIES ASAP system
- ✓ Encoding period is up to 7 days after the MDS completion and before submission
- ✓ Changes may be made for any item during encoding and editing period, but must reflect the observation period
- ✓ Provider is responsible for running encoded MDS assessment data against CMS edits that software vendors are responsible for building into computer systems
- ✓ Only assessments that meet all of the required edits are considered complete



485

■ *ERRORS IDENTIFIED AFTER ENCODING PERIOD BEFORE SUBMISSION*

- ✓ **Significant error(s)** - error(s) that inaccurately reflect resident's clinical status and/or result in inappropriate plan of care:
 - Correct errors in original OBRA assessment
 - Submit corrected assessment to QIES ASAP
 - Perform new Significant Change in Status or Significant Correction to Prior assessment with current ARD and update care plan, as necessary
- ✓ If Medicare only or Discharge, no SCSA or SCPA is required
- ✓ **Minor Error(s)** - all errors (not significant) related to coding of MDS items:
 - Correct errors in original OBRA assessment
 - Submit corrected assessment to QIES ASAP



486

■ CORRECTING ERRORS AFTER SUBMISSION AND ACCEPTANCE INTO THE QIES ASAP SYSTEM

- ✓ Errors must be corrected within 14 days after being identified
- ✓ Modification:
 - Moves the inaccurate record into a history file
 - Replaces with the corrected active record
 - Requires MDS correction request items in Section X
- ✓ Inactivation:
 - Moves inaccurate record into history file
 - Does not replace it with new record
 - Requires MDS correction request items in Section X:
- ✓ Section X contains the minimum amount of information necessary to enable location of erroneous MDS record

487

■ CORRECTING ERRORS AFTER SUBMISSION AND ACCEPTANCE INTO THE QIES ASAP SYSTEM

- ✓ Modification may be used for clinical or demographic errors in the following items:
 - A0310: Type of Assessment; *where there is no Item Set Code (ISC) change*
 - A1600: Entry Date (all assessment types)
 - A2000: Discharge Date (all assessment types)
 - A2300: Assessment Reference Date (ARD); *only if error is data entry/typographical error*
 - Clinical Items (B0100 – V0200C)

488

■ CORRECTING ERRORS AFTER SUBMISSION AND ACCEPTANCE INTO THE QIES ASAP SYSTEM

- ✓ Error is discovered in a Entry tracking, Death in facility, Discharge, or PPS (that is not an OBRA):
 1. Create a corrected record with all items included
 2. Complete Section X (correction request) with new record:
 - A0050 = 2
 3. Submit modified record
- ✓ Minor error is discovered in a OBRA only assessment:
 1. Create a corrected record with all items included
 2. Complete Section X (correction request) with new record:
 - A0050 = 2
 3. Submit modified record

489

■ CORRECTING ERRORS AFTER SUBMISSION AND ACCEPTANCE INTO THE QIES ASAP SYSTEM

- **Significant error** is discovered in a OBRA only assessment:
 1. Create a corrected record with **all** items included
 2. Complete Section X (correction request) with new record:
 - A0050 = 2
 3. Submit modified record
 4. Perform a new Significant Correction to Prior Assessment or Significant Change in Status Assessment and update care plan:
 - A SCSA is required only if correction revealed resident met SCSA criteria
 - If criteria for SCSA is not met, a SCPA is required

490

■ CORRECTING ERRORS AFTER SUBMISSION AND ACCEPTANCE INTO THE QIES ASAP SYSTEM

- ✓ When errors in an OBRA assessment in the QIES ASAP system has been corrected in a more current OBRA assessment, the facility is **not** required to perform a new additional assessment (SCSA or SCPA)
- ✓ In this situation, the facility has already updated the resident's status and care plan
- ✓ The facility must use the modification process to assure that the erroneous data is corrected in the system

491

■ EXAMPLE 1:
ITEM SET CODE AND A0310 MODIFICATIONS

- ✓ A modification of a typographical error in the Reason for Assessment (RFA) (A0310A – D,F) may be performed if the change does not result in a change to the ISC used for the assessment:

A0310A = 99	None of the above
A0310B = 03	30-day scheduled assessment
A0310C = 04	Change of Therapy OMRA (COT)

Q: If A0310C should have been coded as "00" (standalone 30-day assessment), can this assessment be corrected through modification?

A:

492

■ **EXAMPLE 2:**
ITEM SET CODE AND A0310 MODIFICATIONS

✓ A modification of a typographical error in the Reason for Assessment (RFA) (A0310A – D,F) may be performed if the change does not result in a change to the ISC used for the assessment:

- A0310A = 99 None of the above
- A0310B = 07 Unscheduled assessment used for PPS
- A0310C = 04 COT

Q: If A0310B should have been coded as "03" (30-day/COT combined), can this assessment be corrected through modification?

A:

493

■ **CORRECTING ERRORS AFTER SUBMISSION AND ACCEPTANCE INTO THE QIES ASAP SYSTEM**

- ✓ An Inactivation Request is required for errors in the following items:
- A0200: Type of Provider
 - A0310: Type of Assessment; *where there is an ISC change*
 - A1600: Entry Date on Entry record (A0310F=1) *when the look back period and/or clinical assessment would change had the MDS been modified*
 - A2000: Discharge Date on a Discharge/Death in facility record (A0310F=10, 11, 12) *when the look back period and/or clinical assessment would change had the MDS been modified*
 - A2300: ARD on an OBRA or PPS assessment *when the look back period and/or clinical assessment would change had the MDS been modified*

494

■ **INACTIVATION**

- ✓ Inactivations should be rare and are appropriate only under narrow circumstances
- ✓ In such cases:
- A new ARD must be established
 - ARD must equal the date the error was determined
 - May be later
 - Not earlier
 - New assessment must include new signatures and dates based on the new look back period
- ✓ Required to submit only Section X items and A0050=2
- All that is needed to locate the record

495

■ *SPECIAL MANUAL CORRECTION REQUEST*

- ✓ **Errors requiring manual corrections request:**
 - Incorrect value in A0410
 - Wrong facility ID in control item FAC_ID
 - Test record inadvertently submitted as production
- ✓ **Facility must notify State Agency of issue:**
 - State sends facility Correction/Deletion request form
 - Facility completes form and must submit to its State Agency via certified mail USPS
 - State Agency must approve, sign and send form to QIES Help Desk via certified mail USPS
- ✓ **Completely removes record from data base**
- ✓ **Data Correction Algorithm on page 15**

496

*CHAPTER 6
MEDICARE SKILLED NURSING
FACILITY PROSPECTIVE PAYMENT
SYSTEM (SNF PPS)*



497

■ *MEDICARE SNF PROSPECTIVE PAYMENT SYSTEM*

- ✓ **RUG classification system uses information from the MDS to classify residents**
- ✓ **2005 – CMS initiated STRIVE time study:**
 - First nationwide time study since 1997
 - Data collected used to update payment systems
 - Based on analysis, CMS developed RUG-IV model
- ✓ **Over half of State Medicaid programs use the MDS for payment systems:**
 - Choice to use RUG-III or RUG-IV
 - Kentucky uses RUG-III

498

■ **RELATIONSHIP BETWEEN THE ASSESSMENT AND THE CLAIM**

- ✓ SNF PPS establishes a schedule of Medicare assessments
- ✓ These scheduled assessments establish per diem payment rates for associated standard payment periods
- ✓ Unscheduled off-cycle assessments may impact the per diem rates
- ✓ Responsibility of the facility to ensure claims are accurate and meet all Medicare requirements
- ✓ RUG assignment is not an indication that Part A requirements have been met
- ✓ Two data items must be included in Medicare claim:
 - Assessment Reference Date (ARD) to link assessment with billing records
 - Health Insurance Prospective Payment System (HIPPS) Code

499

■ **SNF PPS ELIGIBILITY CRITERIA**

- ✓ Beneficiaries must meet the established eligibility requirements for Part A
- ✓ Refer to *Medicare General Information, Eligibility, and Entitlement Manual*; Chapter 1 and
- ✓ *Medicare Benefit Policy Manual*; Chapter 8
- ✓ Summary of four Part A requirements:
 - Technical Eligibility
 - Clinical Eligibility
 - Physician Certification
 - Refer to Medicare Benefit Policy Manual, Chapter 8

500

■ **TECHNICAL ELIGIBILITY REQUIREMENTS**

- ✓ Beneficiary is enrolled in Part A and has days available
- ✓ 3-day prior qualifying hospital stay:
 - 3 consecutive midnights in inpatient status
- ✓ Admission for SNF services is within 30 days of discharge from acute care stay or within 30 days of discharge from SNF level of care

501

■ **CLINICAL ELIGIBILITY REQUIREMENTS**



- ✓ **Beneficiary needs and receives:**
 - Medically necessary skilled care
 - On a daily basis
 - Provided by or under the direct supervision of skilled nursing or skilled rehabilitation professional
- ✓ **Skilled services can only be provided in SNF**
- ✓ **The services must be for a condition:**
 - Which resident was treated during qualifying hospital stay, OR
 - Arose while in SNF for treatment of condition related to hospital stay

502

■ **PHYSICIAN CERTIFICATION**



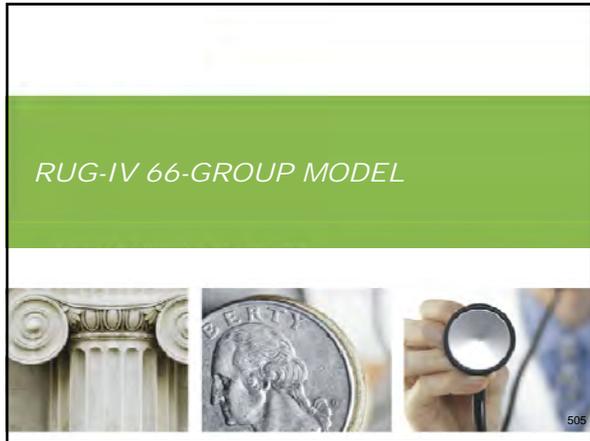
- ✓ **Must certify and then periodically recertify the need for extended care**
- ✓ **Certifications are required at the time of admission or as soon thereafter as is reasonable and practicable (42 CFR 424.20). The initial certification:**
 - Affirms that the resident meets the existing SNF level of care definition, OR
 - Validates via written statement that the beneficiary's assignment to one of the upper RUG-IV (Top 52) groups is correct

503

■ **PHYSICIAN CERTIFICATION**

- ✓ **Re-certifications are used to document the continued need for skilled extended care services:**
 - The first re-certification is required no later than the 14th day
 - Subsequent re-certifications are required at no later than 30 days intervals after the date of the first re-certification
 - The initial certification and first re-certification may be signed at the same time

504



■ *RUG-IV 66-CLASSIFICATION SYSTEM*

- ✓ Reimbursement levels differ based on the resource needs of residents
- ✓ Resource intensity of resident measured by MDS items
- ✓ Residents are classified into one of 66 Resource Utilization Groups (RUGs)
- ✓ Each major category is further divided into levels and then into final classification
- ✓ ADLs, depression, restorative nursing help to determine final RUG, depending on the category

506

■ *RUG-IV CLASSIFICATION SYSTEM*

- ✓ **Hierarchical Classification:**
 - Starting at the top and working down
 - First group for which the resident qualifies
- ✓ **Index Maximizing Classification:**
 - Classifies in the group with the highest Case Mix Index (CMI)
- ✓ **Non-Therapy Classification:**
 - Some instances a non-therapy classification is required
 - A non-therapy RUG uses all the RUG items except the rehabilitation items (O0400A-C)

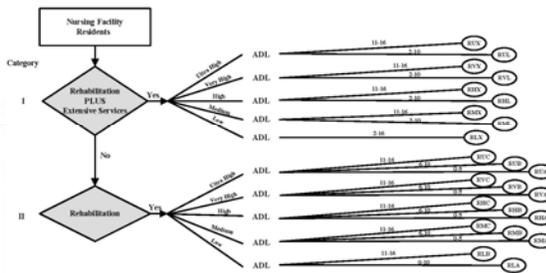
507

**RUG-IV
HIERARCHICAL
GROUPING:
8 MAJOR
CATEGORIES**



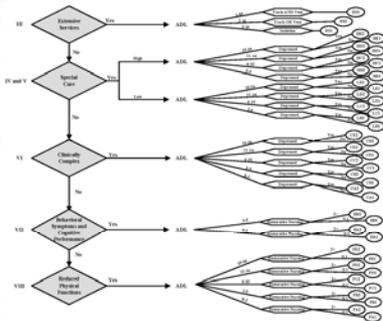
508

**RUG-IV REHABILITATION CATEGORIES
66-GROUP CLASSIFICATION MODEL SCHEMATIC**



509

**RUG-IV CLINICAL CATEGORIES 66-GROUP
CLASSIFICATION MODEL SCHEMATIC**



510

■ STEPS IN DETERMINING RUG-IV CATEGORY

- ✓ Calculation of ADL score
- ✓ Calculation of total Rehabilitation therapy minutes
- ✓ Medicare Short Stay Assessment determination
- ✓ Identification of RUG-IV category



511

■ STEPS IN DETERMINING RUG-IV CATEGORY

✓ Calculation of ADL score:

- Late-Loss ADLs:
 - Bed Mobility
 - Transfer
 - Toileting
 - Eating



512

■ CALCULATION OF ADL SCORE

✓ Bed Mobility, Transfer, Toileting

Self-Performance Column 1 =		Support Column 2 =	ADL Score =	SCORE
-, 0, 1, 7, or 8	and	(any number)	0	G0110A =
2	and	(any number)	1	G0110B =
3	and	-, 0, 1, or 2	2	G0110I =
4	and	-, 0, 1, or 2	3	
3 or 4	and	3	4	

513

■ CALCULATION OF ADL SCORE



✓ Eating

Self-Performance Column 1 (G0110H) =		Support Column 2 =	ADL Score =	SCORE
- 0, 1, 2, 7, or 8	and	- 0, 1, or 8	0	G0110H =
- 0, 1, 2, 7, or 8	and	2 or 3	2	
3 or 4	and	- 0, or 1	2	
3	and	2 or 3	3	
4	and	2 or 3	4	

- Total ADL score = sum of the 4 late-loss ADLs
- Total ADL score range 0 to 16:
 - 0 represents most independent
 - 16 represents most dependent

514

■ THERAPY MINUTES

- ✓ Unallocated Minutes:
 - For each therapy discipline, actual minutes the resident spent in treatments are entered on the MDS for each of the three modes of therapy
- ✓ Allocated Minutes:
 - Used for RUG-IV classification
 - Calculated by grouper software:
 - Individual minutes = 100%
 - Concurrent minutes = 50%
 - Group minutes = 25%
 - Part A – limitation that group minimum cannot exceed 25% of the total minutes:
 - If group minutes exceed 25% of total, minutes are adjusted
 - Limitation is applied after allocation of group minutes

515

■ GROUP THERAPY MINUTES ALLOCATION

Adjustment of Group Therapy Minutes
Example

Four residents participate in a group session for a total of 60 minutes



516

■ **ST MINUTES CALCULATION**
EXAMPLE A

- ✓ Speech-language Pathology Services:
 - Individual Minutes = 110
 - Concurrent Minutes = 99
 - Group Minutes = 100
 - Calculate total SLP minutes = $110 + 99/2 + 100/4 = 184.5$ (retain the decimal)
 - Check group proportion (after group allocation) = $(100/4)/184.5 = 0.136$
 - Do not adjust SLP minutes for Medicare Part A since group proportion is not greater than .25
 - Use unadjusted total SLP minutes

Total Speech-Language Pathology Services Minutes = **184.5**
(retain the decimal)

517

■ **OT MINUTES CALCULATION**
EXAMPLE B

- ✓ Occupational Therapy:
 - Individual Minutes = 78
 - Concurrent Minutes = 79
 - Group Minutes = 320
 - Calculate total OT minutes = $78 + 79/2 + 320/4 = 197.5$ (retain the decimal)
 - Check group proportion (after group allocation) = $(320/4)/197.5 = 0.405$
 - Adjust OT minutes for Medicare Part A since group proportion is greater than .25

Adjusted Occupational Therapy Minutes = $[(78 + 79/2) \times 4/3] =$
156.6666 (retain the decimal)

518

■ **PT MINUTES CALCULATION**
EXAMPLE C

- ✓ Physical Therapy:
 - Individual minutes = 92
 - Concurrent minutes = 93
 - Group minutes = 376
 - Calculate total PT minutes = $92 + 93/2 + 376/4 = 232.5$ (retain the decimal)
 - Check group proportion = $(376/4)/232.5 = 0.404$
 - Adjust PT minutes for Medicare Part A since group proportion is greater than .25

Adjusted Physical Therapy Minutes = $[(92 + 93/2) \times 4/3] =$
184.6666 (retain the decimal)

519

■ TOTAL ADJUSTED THERAPY MINUTES
EXAMPLE A, B, C

Sum SLP, OT and PT minutes after any adjustment =
 $184.5 + 156.6666 + 184.6666 = 525.8332$

Drop decimals = 525 minutes
(this is the total therapy minutes value
for RUG-IV classification)

520

■ MEDICARE SHORT STAY ASSESSMENT
CONDITIONS

- ✓ RUG-IV uses an alternative rehabilitation therapy classification when an assessment is a Medicare Short Stay assessment
- ✓ To be considered a Medicare Short Stay assessment, all eight of the following conditions must be met:
 1. The assessment must be a Start of Therapy (SOT) (A0310C = 1)
 2. A PPS 5-day (A0310B = 01) or readmission/return assessment (A0310B = 06) has been completed
 3. The ARD of the SOT must be on or before the 8th day of the Part A Medicare covered stay
 4. The ARD of the SOT must be the last day of the Medicare Part A stay (A2400C)

521

■ MEDICARE SHORT STAY ASSESSMENT
CONDITIONS "CONTINUED"

5. The ARD of the SOT may not be more than 3 days after the start of therapy date (O0400A5, O0400B5, or O0400C5, whichever is earliest) not including the start of therapy date
6. Rehabilitation therapy (ST, OT, PT) started during the last 4 days of the Medicare Part A stay
7. At least one therapy discipline continued through the last day of the Medicare Part A stay
8. The RUG group assigned to the SOT must be Rehabilitation Plus Extensive Services or a Rehabilitation group

522

■ **MEDICARE SHORT STAY ASSESSMENT CONDITIONS "CONTINUED"**

In addition to the preceding 8 Rules, there are two more rules to know:

- 9. Z0100C must equal 1 (Yes)
- 10. Therapy minutes must average at least 15 minutes a day

523

■ **MEDICARE SHORT STAY AVERAGE THERAPY MINUTES CALCULATION**

- ✓ Total Therapy Minutes divided by the number of days from the start of therapy through the assessment reference date
- ✓ **Example:** if therapy started on August 1 and the assessment reference date is August 3, the average minutes is calculated by dividing by 3 days
- ✓ Discard all numbers after the decimal point and record the result

524

■ **MEDICARE SHORT STAY RUG-IV CATEGORIES**

- ✓ If all eight conditions are met, the resulting RUG-IV group is recorded in MDS Item Z0100A:
 - 1. 15-29 average daily therapy minutes ▶ Rehabilitation Low category (RLx)
 - 2. 30-64 average daily therapy minutes ▶ Rehabilitation Medium category (RMx)
 - 3. 65-99 average daily therapy minutes ▶ Rehabilitation High category (RHx)
 - 4. 100-143 average daily therapy minutes ▶ Rehabilitation Very High category (RVx)
 - 5. 144 or greater average daily therapy minutes ▶ Rehabilitation Ultra High category (RUx)

525

CATEGORY I:
REHABILITATION PLUS EXTENSIVE SERVICES

- 1) ADL 2-16
- 2) Extensive Services:
 - Tracheostomy care while a resident
 - Ventilator/Respirator while a resident
 - Infection isolation while a resident
- 3) Rehabilitation Therapy:
 - Ultra High Intensity (RUX, RUL)
 - Very High Intensity (RVX, RVL)
 - High Intensity (RHX, RHL)
 - Medium Intensity (RMX, RML)
 - Low Intensity (RLX)

OR Medicare Short Stay
Average Therapy
Minutes
Calculation



526

CATEGORY II:
REHABILITATION ULTRA HIGH INTENSITY CRITERIA

- 1) 720 minutes or more
AND
One discipline for at least 5 days
AND
Second discipline for at least 3 days
- OR -
- 2) Medicare Short Stay Indicator = Yes
Average minutes 144 or more



ADL Score	RUG Class
11 - 16	RUC
6 - 10	RUB
0 - 5	RUA

527

CATEGORY II:
REHABILITATION VERY HIGH INTENSITY CRITERIA

- 1) 500 minutes or more
AND
One discipline for at least 5 days
- OR -
- 2) Medicare Short Stay Indicator = Yes
Average minutes 100-143

ADL Score	RUG Class
11 - 16	RVC
6 - 10	RVB
0 - 5	RVA

528

■ **CATEGORY II:**
REHABILITATION HIGH INTENSITY CRITERIA

- 1) 325 minutes or more
AND
 One discipline for at least 5 days
 – OR –
- 2) Medicare Short Stay Indicator = Yes
 Average minutes 65-99

ADL Score	RUG Class
11 - 16	RHC
6 - 10	RHB
0 - 5	RHA

529

■ **CATEGORY II:**
REHABILITATION MEDIUM INTENSITY CRITERIA

- 1) 150 minutes or more
AND
 5 distinct days of any combination of the 3 disciplines
 – OR –
- 2) Medicare Short Stay Indicator = Yes
 Average minutes 30-64

ADL Score	RUG Class
11 - 16	RMC
6 - 10	RMB
0 - 5	RMA

530

■ **CATEGORY II:**
REHABILITATION LOW INTENSITY CRITERIA

- 1) 45 minutes or more
AND
 3 distinct days of any combination of the 3 disciplines
AND
 2 or more Restorative Nursing Services for 6 or more days
 – OR –
- 2) Medicare Short Stay Indicator = Yes
 Average minutes 15-29

ADL Score	RUG Class
11 - 16	RLB
0 - 10	RLA

531

■ RESTORATIVE NURSING SERVICES

- ✓ Urinary toileting program**
- ✓ Bowel toileting program**
- ✓ Passive ROM**
- ✓ Active ROM**
- ✓ Splint or brace assistance
- ✓ Bed mobility**
- ✓ Walking training**
- ✓ Transfer training
- ✓ Dressing and/or grooming training
- ✓ Eating and/or swallowing training
- ✓ Amputation/Prosthesis care
- ✓ Communication training



**Count as one service even if both provided

532

■ CATEGORY III: EXTENSIVE SERVICES

- ✓ ADL 2-16
- ✓ ADL 0 or 1 classifies as Clinically Complex

Extensive Service Conditions	RUG Class
Tracheostomy care* AND Ventilator/respirator*	ES3
Tracheostomy care* OR Ventilator/respirator*	ES2
Infection isolation* without tracheostomy care* without ventilator/respirator*	ES1

*while a resident

533

■ CATEGORY IV: SPECIAL CARE HIGH

- ✓ ADL 2-16
- ✓ ADL 0 or 1 classifies as Clinically Complex:
 - Comatose & ADL dependent, or ADL did not occur
 - Septicemia
 - Diabetes with insulin injections (7 days) and insulin order changes (2 or more days)
 - Quadriplegia with ADL ≥ 5
 - COPD and SOB when lying flat
 - Fever and one of the following:
 - Pneumonia
 - Vomiting
 - Weight loss
 - Feeding tube*
 - Parenteral IV
 - Respiratory therapy (7 days)



*Tube feeding intake $\geq 51\%$ calories or 26-50% calories and 501cc fluid or more per day

534

■ CATEGORY IV: SPECIAL CARE HIGH

✓ Depression Evaluation:

- Resident Mood Interview (PHQ-9©):
 - D0200A-I
 - Total Severity Score ≥ 10 but not 99
- Staff Assessment Resident Mood (PHQ-9-OV©):
 - D0500A-J
 - Total Severity Score ≥ 10



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■ CATEGORY IV: SPECIAL CARE HIGH

ADL Score	Depressed	RUG Class
15 – 16	Yes	HE2
15 – 16	No	HE1
11 – 14	Yes	HD2
11 – 14	No	HD1
6 – 10	Yes	HC2
6 – 10	No	HC1
2 – 5	Yes	HB2
2 – 5	No	HB1

536

■ CATEGORY V: SPECIAL CARE LOW

- ✓ ADL 2-16
- ✓ ADL 0 or 1 classifies as Clinically Complex:
 - Cerebral Palsy with ADL ≥ 5
 - Multiple Sclerosis with ADL ≥ 5
 - Parkinson's Disease with ADL ≥ 5
 - Respiratory failure and oxygen while a resident
 - Feeding tube with intake requirement
 - 2+ Stage 2 pressure ulcers with 2+ skin treatments**
 - Stage 3 or 4 pressure ulcer with 2+ skin treatments**

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■ CATEGORY V: SPECIAL CARE LOW "CONT."

- 2+ venous/arterial ulcers with 2+ skin treatments**
- 1 Stage 2 pressure ulcer and 1 venous/arterial ulcer with 2+ skin treatments**
- Foot infection, diabetic foot ulcer or other open lesion of foot with dressings to feet
- Radiation treatment while a resident
- Dialysis treatment while a resident

538

■ CATEGORY V: SPECIAL CARE LOW "CONT."

✓ **Skin treatments:

- Pressure reducing chair*
- Pressure reducing bed*
- Turning/repositioning program
- Nutrition or hydration intervention
- Pressure ulcer care
- Dressings (not to feet)
- Ointments (not to feet)



*Count as one treatment even if both provided

539

■ CATEGORY V: SPECIAL CARE LOW

✓ Depression Evaluation:

- Resident Mood Interview (PHQ-9©):
 - D0200A-I
 - Total Severity Score ≥ 10 but not 99
- Staff Assessment Resident Mood (PHQ-9-OV©):
 - D0500A-J
 - Total Severity Score ≥ 10



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■ CATEGORY V: SPECIAL CARE LOW

ADL Score	Depressed	RUG Class
15 – 16	Yes	LE2
15 – 16	No	LE1
11 – 14	Yes	LD2
11 – 14	No	LD1
6 – 10	Yes	LC2
6 – 10	No	LC1
2 – 5	Yes	LB2
2 – 5	No	LB1

541

■ CATEGORY VI: CLINICALLY COMPLEX

- ✓ Extensive Services with ADL of 0 or 1
- ✓ Special Care High or Low with ADL of 0 or 1
- ✓ ADL 0-16:
 - Pneumonia
 - Hemiplegia/hemiparesis with ADL >=5
 - Surgical wounds or open lesions with skin treatment:*
 - *Surgical wound care
 - *Dressings (not to feet)
 - *Ointments (not to feet)
 - Burns
 - Chemotherapy while a resident
 - Oxygen while a resident
 - IV medications while a resident
 - Transfusions while a resident

542

■ CATEGORY VI: CLINICALLY COMPLEX

- ✓ Depression Evaluation:
 - Resident Mood Interview (PHQ-9©):
 - D0200A-I
 - Total Severity Score >=10 but not 99
 - Staff Assessment Resident Mood (PHQ-9-OV©):
 - D0500A-J
 - Total Severity Score >=10

543

■ **CATEGORY VI: CLINICALLY COMPLEX**

ADL Score	Depressed	RUG Class
15 – 16	Yes	CE2
15 – 16	No	CE1
11 – 14	Yes	CD2
11 – 14	No	CD1
6 – 10	Yes	CC2
6 – 10	No	CC1
2 – 5	Yes	CB2
2 – 5	No	CB1
0 – 1	Yes	CA2
0 – 1	No	CA1

544

■ **CATEGORY VII: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE**

- ✓ **ADL 0-5:**
 - If 6 or more, classifies into Reduced Physical Function
- ✓ **Cognitive Performance determined by:**
 - Brief Interview for Mental Status (BIMS) if interview was completed
 - Cognitive Performance Scale (CPS) items if the BIMS interview was not completed
- ✓ **If resident doesn't qualify via Cognitive Performance, then evaluate Behavioral Symptoms items**

545

■ **CATEGORY VII: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE**

1. **Brief Interview for Mental Status (BIMS):**

- **Resident Interview:**
 - Repetition of 3 words
 - Temporal orientation
 - Recall
- **Score range 0-15:**
 - 15 – best cognitive performance
 - 0 - worst
- **Qualify with BIMS Score <=9**
- **If score is >9 but not 99, evaluate Behavioral Symptoms**



546

■ CATEGORY VII: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

2. If not able to interview; cognitively impaired if 1 of the 3 following conditions is met:

- a) Coma and ADL dependent, or ADL did not occur
- b) Severely impaired cognitive skills
- c) 2 or more of these impairment indicators:
 - Problem being understood >0
 - Short-term memory problem = yes (1)
 - Cognitive skills problem >0

AND

- 1 or more severe impairment indicators:
 - Severe problem being understood >=2
 - Severe cognitive skills problem >=2

547

■ CATEGORY VII: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

✓ If criteria for Cognitive Impairment not met, evaluate the following Behavioral Symptoms:

- Hallucinations
- Delusions
- Physical behavioral symptom directed toward others*
- Verbal behavioral symptoms directed toward others*
- Other behavioral symptoms not directed toward others*
- Rejection of care*
- Wandering*



*Code 2 or 3 = behavior occurred 4-6 days or daily

548

■ CATEGORY VII: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

✓ If meets criteria via Cognitive Impairment or Behavioral symptoms, determine Restorative Nursing Count:

- Urinary toileting program**
- Bowel toileting program**
- Passive ROM**
- Active ROM**
- Splint or brace assistance
- Bed mobility**
- Walking training**
- Transfer training
- Dressing and/or grooming training
- Eating and/or swallowing training
- Amputation/Prosthesis care
- Communication training

**Count as one service even if both provided

549

■ **CATEGORY VII: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE**

ADL Score	Restorative Nursing	RUG Class
2 – 5	2 or more	BB2
2 – 5	0 or 1	BB1
0 – 1	2 or more	BA2
0 – 1	0 or 1	BA1

550

■ **CATEGORY VIII: REDUCED PHYSICAL FUNCTION**

- ✓ Residents who do not meet criteria in other categories
- ✓ Residents met criteria for the Behavioral Symptoms and Cognitive Performance category with ADL >5
- ✓ Determine Restorative Nursing Count:
 - Urinary Toileting program*
 - Bowel toileting program*
 - Passive ROM*
 - Active ROM*
 - Splint or brace assistance
 - Bed mobility*
 - Walking training*
 - Transfer training
 - Dressing or grooming training
 - Eating or swallowing training
 - Amputation/Prosthesis care
 - Communication training

*Count as one service even if both provided

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■ **CATEGORY VIII: REDUCED PHYSICAL FUNCTION**

ADL Score	Restorative Nursing	RUG Class
15 – 16	2 or more	PE2
15 – 16	0 or 1	PE1
11 – 14	2 or more	PD2
11 – 14	0 or 1	PD1
6 – 10	2 or more	PC2
6 – 10	0 or 1	PC1
2 – 5	2 or more	PB2
2 – 5	0 or 1	PB1
0 – 1	2 or more	PA2
0 – 1	0 or 1	PA1

552

■ *RAI MANUAL APPENDICES*

- ✓ **A = Glossary and Common Acronyms**
- ✓ **B = State Agency and CMS Regional Office RAI/MDS Contacts**
- ✓ **C = Care Area Assessment (CAA) Resources**
- ✓ **D = Interviewing to Increase Resident Choice in MDS Assessments**
- ✓ **E = PHQ-9© Scoring Rules and Instructions for BIMS**
- ✓ **F = MDS Item Matrix**
- ✓ **G = References**
- ✓ **H = MDS 3.0 Forms**

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EVALUATION



THANK YOU FOR COMING!!