



**MYERS AND  
STAUFFER** LC  
CERTIFIED PUBLIC ACCOUNTANTS

# OFFICE OF INSPECTOR GENERAL AND MYERS AND STAUFFER LC PRESENT MDS CODING AND INTERPRETATION



## ■ MDS 3.0 RAI MANUAL V1.11

### ✓ MDS update – effective October 1, 2015

- Version 1.13.1

- Posted July 27, 2015
- Updated legal copyright notice only
- No item changes with this version
- Scheduled to be effective in conjunction with new data specs (v.1.15.0)
- Item sets should be considered final
- Replaces Version 1.13.0
  - Posted January 29, 2015
  - Revised footnote for Item C1300 only



- ✓ <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>

# CHAPTER 1

## RESIDENT ASSESSMENT INSTRUMENT (RAI)



# ■ RESIDENT ASSESSMENT INSTRUMENT

## ✓ Overview

- Offers clear guidance
- Gathering definitive information
- Developing individualized care plans
- Evaluating goal achievement
- Look at residents holistically
- Interdisciplinary process



## ✓ Content of the RAI for Nursing Homes

- Minimum Data Set
- Care Area Assessment Process
- RAI Utilization Guidelines
  - Instructions for when and how to use the RAI

## ■ RESIDENT ASSESSMENT INSTRUMENT

### ✓ **Completion of the RAI**

- **Assessment tool**
- **SNF PPS**
- **State Medicaid reimbursement**
- **Monitoring quality of care**
- **Consumer access – Nursing Home Compare**
- **Multiple regulatory requirements**
  - **42 CFR 483.20 (b)(1)(xviii), (g) and (h)**

## ■ RESIDENT ASSESSMENT INSTRUMENT

### ✓ Problem Identification Using the RAI

- Assessment
- Decision Making
- Identification of Outcomes
- Care Planning
- Implementation
- Evaluation



- ✓ Key to success is understanding structure is designed to enhance resident care
- ✓ Solution oriented and dynamic process

## ■ RESIDENT ASSESSMENT INSTRUMENT

- ✓ **Components of the MDS**
  - **Mandated assessment schedule**
- ✓ **Layout of the RAI Manual**
  - **Divided into 6 chapters**
  - **Appendices A - H**
- ✓ **Protecting the Privacy of the MDS Data**
  - **Privacy Act of 1974**
    - **Residents must be notified**
    - **Consent is not required**



# CHAPTER 2

## ASSESSMENTS FOR THE RESIDENT ASSESSMENT INSTRUMENT (RAI)



## ■ 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)**



## ■ 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 Medicare Part A**



## ■ 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**
    - **Age**
    - **Diagnosis**
  - **Hospice**
  - **Short-term or respite (>14 days)**
  - **Special populations**
  - **Swing beds**

## ■ 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**



## ■ 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).**



## ■ 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



## ■ 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 or discharged return anticipated but does not return in 30 days**
- ✓ **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**



## ■ 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)**

## ■ NURSING HOME RESPONSIBILITIES FOR MAINTAINING ASSESSMENTS



- ✓ **Ensure that proper security measures are implemented via facility policy to ensure the privacy and integrity of the record**
- ✓ **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**

## ■ ASSESSMENT TYPES AND DEFINITIONS

- ✓ **Admission** – the date a person enters the facility and is admitted
- ✓ **Completion of an Admission assessment required:**
  - 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** – 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 Completion** – the date that all information has been collected and recorded and staff have signed and dated that assessment is complete

## ■ ASSESSMENT TYPES AND DEFINITIONS

- ✓ **Assessment Reference Date (ARD)** – the last day of observation (look back period)
  - Must be set within required time frames of the assessment type
- ✓ **Assessment Scheduling** – the period during which assessments are completed, setting the ARD, timing, completion, submission and observation periods
- ✓ **Assessment Submission** – the electronic data in record and file format, conforming to standard layouts and data dictionaries and passing standardized edits

## ■ ASSESSMENT TYPES AND DEFINITIONS

- ✓ **Assessment Timing** – when and how often assessments must be conducted (table pages 2-15,16)
- ✓ **Assessment Transmission** – the electronic submission of files to the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system
- ✓ **Comprehensive Assessment** – assessment that includes the completion of the MDS, CAAs, and care plan
- ✓ **Death in Facility** – resident death in facility or while on LOA; Death in Facility tracking record required

## ■ ASSESSMENT TYPES AND DEFINITIONS

✓ **Discharge** – the date resident leaves facility

- **Two types of discharge:**

- **Return anticipated**
- **Return not anticipated**



- **Discharge assessment required when resident:**

- **Discharged to private residence**
- **Admitted to hospital or other care setting**
- **Hospital observation stay greater than 24 hours**
- **Transferred from a Medicare- and/or Medicaid-certified bed to a non-certified bed**

## ■ ASSESSMENT TYPES AND DEFINITIONS

- ✓ **Discharge Assessment** – required on discharge; included clinical items for quality monitoring as well as discharge tracking information
- ✓ **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 assessment**
  - Admission
  - Annual
  - Significant Change in Status (SCSA)
  - Significant Correction of Prior Comprehensive Assessment (SCPA)
  - May stand alone
  - May be combined with any PPS and/or Discharge assessment
- ✓ **NQ = Quarterly assessment**
  - May stand alone
  - May be combined with any type of PPS and/or Discharge assessment

## ■ ITEM SETS

- ✓ **NP = Scheduled PPS assessment**
  - **5-day**
  - **14-day**
  - **30-day**
  - **60-day**
  - **90-day**
  - **May stand alone**
  - **May be combined with a PPS OMRA and/or a Discharge assessment**
- ✓ **NS = Start of Therapy assessment**
  - **Stand alone OMRA**

## ■ ITEM SETS

- ✓ **NSD = Start of Therapy and Discharge assessment**
  - **Start of therapy OMRA combined with Discharge**
    - **Return anticipated**
    - **Return not anticipated**
- ✓ **NO = OMRA (Other Medicare Required Assessment)**
  - **Stand alone end of therapy**
  - **Change of therapy**
- ✓ **NOD = Discharge assessment**
  - **End of therapy OMRA combined with Discharge**
    - **Return anticipated**
    - **Return not anticipated**

## ■ ITEM SETS

- ✓ **ND = Discharge assessment**
  - **Stand alone**
  - **Return anticipated**
  - **Return not anticipated**
  
- ✓ **NT = Tracking Record**
  - **Entry**
  - **Death in Facility**

## ■ ASSESSMENT TYPES AND DEFINITIONS

- ✓ **Leave of Absence (LOA)** –
  - 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 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

## ■ ASSESSMENT TYPES AND DEFINITIONS

### ✓ Observation (Look-Back) Period –

- 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



### ✓ Reentry – when all 3 of the following occur:

- Resident was previously in facility
- Discharged return anticipated
- Returned within 30 days of discharge

# OBRA REQUIRED ASSESSMENTS AND TRACKING RECORDS



## ■ OBRA REQUIRED ASSESSMENT SUMMARY

### ✓ **Comprehensive Assessments Completion Dates:**

- **MDS Completion Z0500B = ARD + 14 calendar days**
- **CAA(s) V0200B2 = ARD + 14 calendar days**
- **Care Plans V0200C = V0200B + 14 calendar days**
- **Transmission Date V0200C + 14 calendar days**

### ✓ **Non-Comprehensive Assessments Completion Dates:**

- **MDS Completion Z0500B = ARD + 14 calendar days**
- **Transmission Date Z0500B + 14 calendar days**

## ■ OBRA REQUIRED ASSESSMENT SUMMARY

- ✓ **Entry Tracking Record Completion Dates:**
  - **Entry Date + 7 calendar days**
  - **Transmission date = Entry date + 14 calendar days**
- ✓ **Death in Facility Tracking Record Completion Dates:**
  - **Discharge (death) date + 7 calendar days**
  - **Transmission date = Discharge (death) date + 14 calendar days**
- ✓ **Refer to table in Chapter 2, pages 2-15 and 2-16**

## ■ OBRA COMPREHENSIVE ASSESSMENTS

- ✓ **Includes completion of:**
  - **MDS**
  - **CAA process**
  - **Care plan**
- ✓ **Comprehensive assessments:**
  - **Admission**
  - **Annual**
  - **Significant Change in Status Assessment (SCSA)**
  - **Significant Correction to Prior Comprehensive Assessment (SCPA)**
- ✓ **Assessment type determined at A0310A, B, C, F**



## ■ COMPREHENSIVE ASSESSMENT TIPS

- ✓ **If resident discharges to hospital prior to completion of the Admission assessment, then returns, must consider as new Admission**
- ✓ **May not complete SCSA until Admission completed**
- ✓ **If Admission assessment was completed then discharges to the hospital (D=11), returns during an assessment period and most of assessment was completed prior to discharge;**
  - **May continue original assessment but must keep ARD and completion dates the same as originally set**
  - **Set new ARD and complete within 14 days of reentry**
    - **The portion of assessment previously completed must be stored on the resident's record**

## ■ COMPREHENSIVE ASSESSMENTS TIPS

- ✓ **If resident discharges or dies prior to completion deadline of assessment, completion is not required**
  - **Completed portions must be maintained in medical record**
  - **Document reason not completed**
- ✓ **If SCSA is identified in the process of completing any OBRA (except Admission), code and complete SCSA**
- ✓ **May combine comprehensive with Discharge**

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

- ✓ **Completed when:**
  - **Resident's first admission**
  - **Was a previous resident, but discharged return not anticipated**
  - **Was a previous resident, discharged return anticipated, but returned more 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 + 7 days**
- ✓ **Transmission = Care plan completion + 14 days**
- ✓ **Not required if discharged before end of day 14**
- ✓ **Day of admission = Day 1**

## ■ 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 + 366 days AND**
  - **ARD of previous quarterly + 92 days**

## ■ 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 interventions**
  - **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**

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

- ✓ **Must be completed when IDT determines resident meets significant change guidelines**
  - **Document initial identification in clinical record**
- ✓ **Resident's condition not expected to return to baseline within 2 weeks**
- ✓ **SCSA may not be completed prior to the Admission**
- ✓ **ARD = No later than 14th day after determination that significant change occurred**
- ✓ **Hospice:**
  - **Required when enrolls in a hospice program:**
    - **ARD must be within 14 days from effective date of hospice election**

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

### ✓ Hospice:

- **Must be performed regardless of whether an assessment was recently conducted**
- **If admitted on hospice benefit or elects hospice on or prior to the ARD of the Admission Assessment:**
  - **Check Hospice Care (O0100K)**
  - **SCSA is not required**
- **If admitted on hospice benefit but discontinues it prior to the ARD of the Admission Assessment:**
  - **Complete Admission assessment**
  - **Check Hospice Care (O0100K)**
  - **SCSA is not required**

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

### ✓ Hospice:

- **If hospice election occurs after the Admission assessment ARD but prior to completion:**
  - **Adjust ARD to date of hospice election**
  - **Only Admission assessment is required**
  - **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**

## ■ 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 SCSA for one change**
  - **Each situation is unique**
  - **Resident may benefit from SCSA**
  - **Medical record must document rationale for completing SCSA if does not meet criteria**
  - **Decline examples Chapter 2, page 2-23**
  - **Improvement examples Chapter 2, page 2-24**

## ■ WOULD YOU COMPLETE A SIGNIFICANT CHANGE IN STATUS ASSESSMENT?

### Example 1:

- Resident no longer responds to verbal requests to alter his screaming behavior. It now occurs daily and has neither lessened on its own nor responded to treatment. He now resists care daily, pushing staff away as they help with ADLs.
  - ***YES; deterioration in behavioral symptoms to occurring daily and new approaches are needed.***

### Example 2:

- Resident has well-established, predictable, cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions, such as bipolar disorder.
  - ***NO; depressive symptoms in resident previously diagnosed with bipolar disorder.***

## ■ WOULD YOU COMPLETE A SIGNIFICANT CHANGE IN STATUS ASSESSMENT?

### Example 3:

- Resident has been in the facility for 8 weeks following a lengthy hospitalization. On admission, she was very frail, confused, calling out “momma, momma” all day long. She required extensive assist with toileting, bathing, dressing and eating.
  - Fully oriented
  - Supervision only with eating
  - Limited assist with toileting, bathing, dressing
  - ***YES; initial problems have resolved and she is remaining in facility.***

### Example 4:

- Resident has flu
- Experiences 5% weight loss in 30 days
  - ***NO; short-term illness with expected full recovery.***

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

### ✓ **SCSA 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**

## ■ 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 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**

## ■ OBRA NON-COMPREHENSIVE ASSESSMENTS

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

## ■ 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 SCSA 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**

## ■ NON-COMPREHENSIVE ASSESSMENTS

- ✓ **If resident discharged or dies prior to completion deadline of assessment, completion is not required**
  - **Maintain completed portions in medical record**
- ✓ **If SCSA is identified in the process of completing any OBRA (except Admission), complete SCSA**
- ✓ **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**
- ✓ **Update care plan if necessary**

## ■ SWING BED ASSESSMENT REQUIREMENTS

- ✓ **Assessments not required for residents in swing beds:**
  - **OBRA-required comprehensive assessments**
    - **Admission**
    - **Annual**
    - **Significant Change in Status Assessment**
    - **Significant Correction to Prior Comprehensive Assessment**
  - **OBRA-required non-comprehensive assessments**
    - **Quarterly**
    - **Significant Correction to Prior Quarterly Assessment**

## ■ SWING BED ASSESSMENT REQUIREMENTS

- ✓ **Assessments/Tracking records required for residents in swing beds**
  - **Entry Tracking Record**
  - **Death in Facility Tracking Record**
  - **Discharge Assessment**
    - **Return anticipated**
    - **Return not anticipated**

## ■ 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**
- ✓ **Evaluate appropriateness of care plan**
  - **Modify care plan if appropriate**
- ✓ **ARD = 92 days from previous OBRA assessment ARD**

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

- ✓ **Required when uncorrected significant error is identified in a prior quarterly assessment:**
  - **Document initial identification in clinical record**
  - **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**

## ■ ENTRY TRACKING RECORD (A0310F=01)



### ✓ Two types:

- **Admission (A1700=01):**
  - **Admitted for the first time**
    - **Or after a discharge return not anticipated**
  - **Readmitted after a discharge prior to completion of Admission assessment**
  - **Readmitted after a discharge return anticipated when return was later than 30 days from discharge date**
- **Reentry (A1700=02):**
  - **Is readmitted to the facility**
  - **Discharged return anticipated**
    - **Returned within 30 days of discharge date**

## ■ 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**

## ■ 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**
- ✓ **May not be combined with any type of assessment**
- ✓ **Tracking records and stand alone Discharge assessments do not impact payment**

## ■ DISCHARGE ASSESSMENTS

- ✓ **Two types:**
  - **Discharge return not anticipated (10)**
  - **Discharge return anticipated (11)**
  - **OBRA required**
- ✓ **Must complete 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 or PPS**
- ✓ **Bed hold status and opening/closing of record not impacted**



## ■ 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

## ■ 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
- ✓ If returns within 30 days
  - Entry tracking must be coded as Reentry (A1700=02)
- ✓ If return is NOT by day 30
  - New Entry record
  - Admission assessment will be required including a new entry date (A1700=01)
- ✓ If resident does not return
  - No requirement to inactivate or complete another Discharge



## ■ 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**
      - **Determine if an acute-care admission is required**
    - **Resident unexpectedly leaving the facility against medical advice**
    - **Resident unexpectedly deciding to go home or to another setting**

## ■ TIPS FOR DISCHARGE ASSESSMENTS

- ✓ **ARD is not set prospectively**
- ✓ **Discharge date and ARD must be the same**
  - **May be coded on assessment any time during the assessment completion period**
    - **Discharge date (A2000) + 14 days**
- ✓ **Use of dash (“-”) is appropriate when unable to determine response**
- ✓ **For unplanned discharge, facility should complete to the best of its abilities**

■ THINK BEFORE YOU CHART!!

“Discharge status:  
Alive but against medical advice.”



# SNF MEDICARE PROSPECTIVE PAYMENT SYSTEM ASSESSMENT OVERVIEW



## ■ 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
- ✓ MDS Completion Z0500B = ARD + 14 calendar days
- ✓ Transmission Date Z0500B + 14 calendar days

## ■ SNF PPS ASSESSMENT WINDOWS

- ✓ **Defined days within which the ARD must be set**
  - **Required to set the ARD on the MDS form itself or in the facility software within the appropriate timeline**
- ✓ **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**

# MDS MEDICARE SCHEDULED ASSESSMENTS FOR SNF



## ■ 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**
- ✓ **PPS scheduled assessment table  
(Chapter 2, page 2-41)**

## ■ SCHEDULED PPS ASSESSMENT TABLE

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

## ■ SCHEDULED PPS ASSESSMENTS

### ✓ 5-day = A0310B=01

- First Medicare-required assessment completed for Part A stay
- Must have at least one 5-day assessment
- If resident goes from Medicare Advantage to Medicare Part A, the PPS schedule must start over with a 5-day
- ARD = set on days 1 through 5 (Grace days 6-8)
- Authorizes payment from days 1 through 14

### ✓ 14-day = A0310B=02

- When combined with the OBRA Admission, grace days may not be used
- ARD = set on days 13 through 14 (Grace days 15-18)
- Authorizes payment from days 15 through 30

## ■ SCHEDULED PPS ASSESSMENTS

### ✓ 30-day = A0310B=03

- ARD = set on days 27 through 29 (Grace days 30-33)
- Authorizes payment from days 31 through 60

### ✓ 60-day = A0310B=04

- ARD = set on days 57 through 59 (Grace days 60-63)
- Authorizes payment from days 61 through 90

### ✓ 90-day = A0310B=05

- ARD = set on days 87 through 89 (Grace days 90-93)
- Authorizes payment from days 91 through 100

# MDS MEDICARE UNSCHEDULED ASSESSMENTS FOR SNF



## ■ 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**

## ■ PPS UNSCHEDULED ASSESSMENTS

- ✓ **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 (Chapter 2, pages 2-42,43,44)**
  
- ✓ **Includes SCSA and SCPA**

## ■ 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 evaluation is counted as day 1 when determining the ARD, regardless if treatment is provided or not on that day**

## ■ 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
  - Therapy rate will be paid starting Day 1 of stay
- Unless it is a Medicare Short Stay assessment, there is never a need to combine an SOT with a Medicare 5-day assessment



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

- ✓ **Completed when a resident:**
  - **Classified in a Rehabilitation group**
  - **Continues Part A services**
  - **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**



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

### Example:

- ✓ Resident received therapy on Friday
  - Therapy was not scheduled for Saturday or Sunday
  - Refused therapy on Monday
  - Saturday is counted as Day 1
- ✓ A treatment day is defined the same as in Chapter 3, Section O
  - 15 minutes of therapy a day

## ■ 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
    - 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

## ■ 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



## ■ 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)



## ■ 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**

## ■ 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

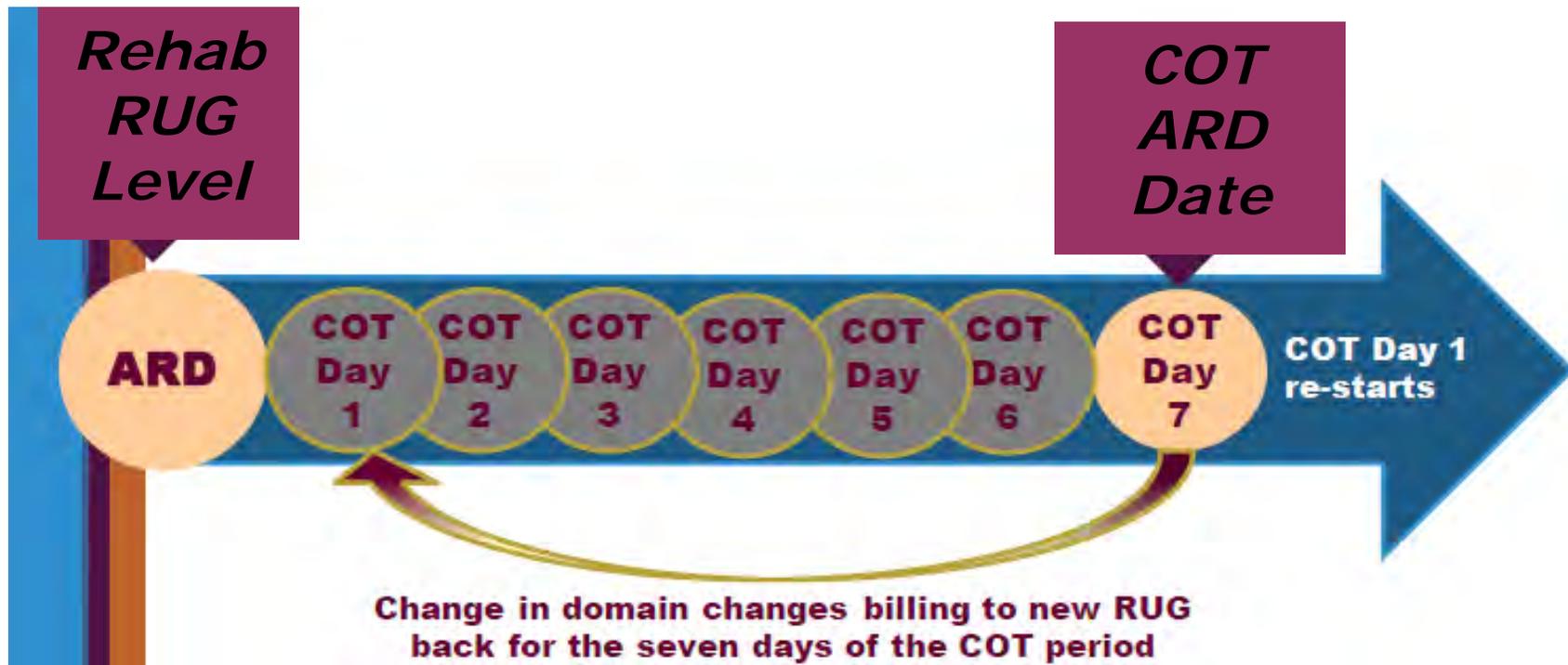
## ■ CHANGE OF THERAPY OMRA (A0310C=4)

- ✓ May be used to classify a patient into a higher or lower RUG category
- ✓ COT ARD may not precede the ARD of the first PPS assessment
- ✓ ARD = Day 7 of COT 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.

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



## ■ 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?

- ✓ Total Reimbursable Therapy Minutes (RTM)



- ✓ Number of Therapy Days

- ✓ Number of Therapy Disciplines

- ✓ Restorative Nursing (for residents in a Rehabilitation Low category)

## ■ 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!**

## ■ 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 required**

## ■ 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		
<b>Subtotals</b>		<b>105</b>	<b>75</b>	<b>120</b>	<b>30</b>	<b>75</b>	<b>75</b>	<b>45</b>
Number of RNP								
						<b>Total RTM</b>		<b>525</b>

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

## ■ 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 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.**

## ■ CHANGE OF THERAPY OMRA AND INDEX MAXIMIZATION

### ✓ Index maximization:

- Resident meets the qualifying criteria for both a therapy and a non-therapy RUG
- The RUG-IV per diem payment rate for the non-therapy RUG may be higher than Therapy RUG
  - 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.*

## ■ 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).

**COT not required because no change to index maximized RUG category**

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).

**COT is required because of change to index maximized RUG category**

## ■ CHANGE OF THERAPY OMRA (A0310C=4)

### ✓ COT and Day of Discharge:

- If Day 7 of the COT observation period is also on or before the day of discharge, 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

## ■ CHANGE OF THERAPY OMRA (A0310C=4)

- ✓ **May complete COT OMRA when a resident is not currently classified into a RUG-IV therapy group, but only if *both of the following conditions are met*:**
  - **Resident classified into a RUG-IV therapy group on a prior assessment during the current Part A stay**
  - **No discontinuation of therapy services (planned or unplanned of all therapies for 3 or more consecutive days) occurred between Day 1 of the COT observation period for the COT OMRA that classified the resident into current non-therapy group and the ARD of the COT OMRA that reclassified resident into a therapy group**

## ■ CHANGE OF THERAPY OMRA (A0310C=4)

***“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.”***

## ■ 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**

## ■ UNSCHEDULED STAND ALONE 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, interview portions of the assessment may be conducted up to two calendar days after the ARD.***

## ■ UNSCHEDULED STAND ALONE 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:

- Resident misses therapy on July 2-4
- Must complete an EOT OMRA
- ARD must be set for either July 2nd, 3rd, or 4<sup>th</sup>
- The decision for which of those days should be used for the ARD may be made after July 4th, but NO later than July 6

# 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 window of the scheduled assessment:**
  - **The scheduled MUST be combined with the unscheduled setting the ARD for the unscheduled assessment**
- ✓ **A scheduled PPS assessment cannot occur after an unscheduled assessment in the assessment window:**
  - **The scheduled MUST be combined with the unscheduled 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 the ARD of a 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.



## ■ 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 in Chapter 2, pages 2-56 through 2-73**

## ■ 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**



## ■ 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

## ■ 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)
  - Medicare-required 5-day assessment (A0310B=01) is always the first Medicare assessment if:
    - Resident is eligible for Part A
    - Days remain in the benefit period
    - Includes Swing Bed providers

## ■ 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

## ■ 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:

### EXAMPLE:

- Resident goes to ER at 10 pm Wednesday, day 22 of Part A stay
- Returns at 3 am the next day (Thursday)
- Wednesday is not billable to Part A
- Day of return, Thursday, becomes day 22 of Part A stay

## ■ FACTORS IMPACTING THE SNF MEDICARE ASSESSMENT SCHEDULE

### ✓ Leave of Absence:

- Scheduled PPS assessment
- 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.*

## ■ FACTORS IMPACTING THE SNF MEDICARE ASSESSMENT SCHEDULE

- ✓ **Resident leaves facility and returns during observation period**
  - **ARD is not altered for a temporary LOA**
  - **May include services furnished when permitted under MDS coding guidelines**
- ✓ **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.**

## ■ 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

## ■ 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 paid the default rate for Days 29 and 30
- Facility paid the RUG from the early COT beginning on Day 31 until the next assessment used for payment
- The early COT resets the COT calendar
  - Next COT check in this scenario would be Day 42 (day 35 + 7)

## ■ 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**

## ■ 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

## ■ 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)

## ■ 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, may **not** be billed

## ■ 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

## ■ 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



## ■ 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

## ■ 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, or Death in Facility**
- ✓ **The target date determines 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**
  - **RAI Manual Chapter 2, page 2-80**

## ■ 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 2-81**
- ✓ **An inactivation request indicated by A0050 = 3 will display an ISC of XX**

## ■ DETERMINING THE ITEM SET FOR AN MDS RECORD

### Examples:

- **A0310A=01, A0310B=99, A0310C=0, A0310F=99**
  - **Stand alone 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)**

RAI Manual Chapter 2, pages 2-81 and 2-83

## ■ POST TEST #1

- ✓ **What does RAI stand for?**
  - **Resident Assessment Instrument**
- ✓ **Name the types of Comprehensive assessments.**
  - **Admission, Annual, SCSA, SCPA**
- ✓ **What are the two types of Discharges?**
  - **Return anticipated and return not anticipated**
- ✓ **Name the scheduled PPS assessments.**
  - **5, 14, 30, 60 and 90 days**
- ✓ **Can two scheduled PPS assessments be combined?**
  - **Never**
- ✓ **What are the two types of Tracking records?**
  - **Entry and Death in Facility**
- ✓ **When is a SCSA completed?**
  - **Decline or improvement that: will not resolve itself without intervention, impacts more than one area of health status, requires IDT review and/or care plan revision; enrolls in hospice**

# 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
  - **Code 03** = Annual
  - **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

## ■ PPS ASSESSMENT (A0310B)

- ✓ **PPS Scheduled Assessments for a Medicare Part A Stay:**
  - **Code 01** = 5-day
  - **Code 02** = 14-day
  - **Code 03** = 30-day
  - **Code 04** = 60-day
  - **Code 05** = 90-day
- ✓ **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

## ■ PPS OTHER MEDICARE REQUIRED ASSESSMENT — OMRA (A0310C)

✓ **PPS Other Medicare Required Assessment - OMRA:**

✓ **Unscheduled PPS assessments**

- **Code 0 = No**
- **Code 1 = Start of therapy (optional)**
- **Code 2 = End of therapy**
- **Code 3 = Both Start and End of therapy**
- **Code 4 = Change of therapy**

■ 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 assessments.**

## ■ 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

## ■ 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**



## ■ UNIT CERTIFICATION OR LICENSURE DESIGNATION (A0410)

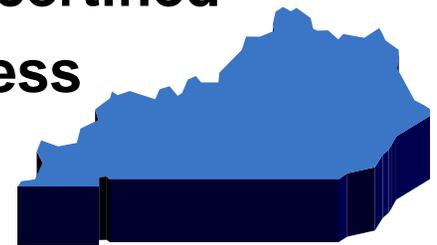
- ✓ **Designates the submission authority for the resident assessment**
- ✓ **All Medicare and Medicaid certified beds must submit with code “3”**
- ✓ **Including HMO, Medicare Advantage, etc. if in a certified bed**
- ✓ **Payer source does not determine coding of item**

A0410. Unit Certification or Licensure Designation	
Enter Code <input type="checkbox"/>	<ol style="list-style-type: none"><li>1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State</li><li>2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State</li><li>3. Unit is Medicare and/or Medicaid certified</li></ol>

## ■ UNIT CERTIFICATION OR LICENSURE DESIGNATION (A0410)

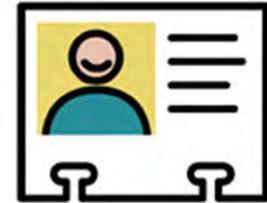
### ✓ Enter code:

- **Code 1 = Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State**
  - MDS records may not be submitted
  - Rejected by QIES ASAP system
- **Code 2 = Unit is neither Medicare nor Medicaid certified but MDS data is required by the State**
  - MDS records should be submitted per State's requirements
- **Code 3 = Unit is Medicare and/or Medicaid certified**
  - MDS records must be submitted regardless of payer source
  - *See Chapter 5 for more information*



## ■ 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:	B. Middle initial:
<input type="text"/>	<input type="text"/>
C. Last name:	D. Suffix:
<input type="text"/>	<input type="text"/>

**\*CMS Identifier**

## ■ 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**

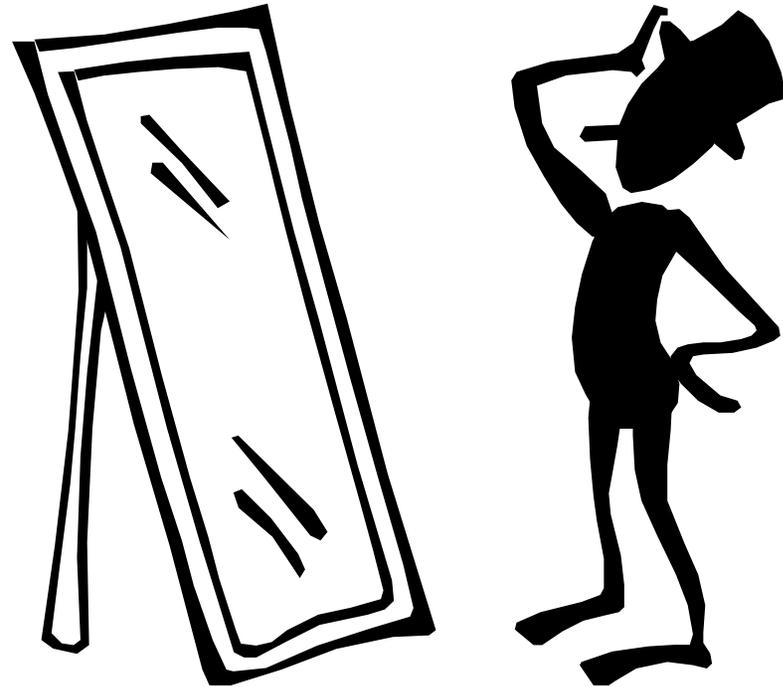


## ■ \*CMS IDENTIFIERS

- ✓ **State ID**
- ✓ **Facility Internal ID**

### MDS Items

- ✓ **Legal Name (A0500)**
- ✓ **SSN (A0600A)**
- ✓ **Gender (A0800)**
- ✓ **Birth Date (A0900)**



## ■ PREADMISSION 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**

## ■ 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**

## ■ 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**

## ■ 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:**
  - **Complete only if Admission assessment (A0310A = 01)**
- ✓ **If resident is 21 years or younger as of ARD:**
  - **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**

## ■ 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**

## ■ 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](http://www.PASRR.org)
  - **The PASRR Technical Assistance Center (PTAC) is for state agencies, but website is informative:**  
[www.PASRRassist.org](http://www.PASRRassist.org)
  - **Kentucky PASRR documents may be downloaded at:** [www.chfs.ky.gov/dms/mnfs.htm](http://www.chfs.ky.gov/dms/mnfs.htm)

## ■ ENTRY DATE (A1600)

### ✓ A1600 = Entry Date:

- Initial date of admission to the facility OR
- Date resident most recently returned to facility after being discharged
- Format Month-Day-Year
  - 09-10-2015

## ■ TYPE OF ENTRY (A1700)

### ✓ A1700 = Type of Entry:

- **Code 1 = Admission**

- **Never been admitted**
- **Was in facility but discharged return not anticipated**
- **Was in facility previously, was discharged return anticipated but did not return within 30 days**
  - **When considering a return after a D=11, the day of discharge from the facility is not counted in the 30 days**
- **Swing beds always code as admission**

## ■ TYPE OF ENTRY (A1700)

✓ **A1700 = Type of Entry:**

- **Code 2 = Reentry**

- **All of the following apply:**

- **Resident was admitted to the facility**

- **Discharged return anticipated**

- **Returned to facility within 30 days of discharge**



## ■ ENTERED FROM (A1800)

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

- **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.**

## ■ ADMISSION DATE (A1900)

- ✓ **Date this episode of care began**
- ✓ **Must be the same as the Entry Date (A1600) when entry reason equals Admission (A1700=1)**
- ✓ **When the type of entry is Reentry (A1700=2)**
  - **Admission Date (A1900) remains the same**
  - **Entry Date (A1600) must be later than the A1900**
- ✓ **Included on all record types**
- ✓ **Definitions:**
  - **Stay**-set of contiguous days in the facility
  - **Episode**-a series of one or more stays that may be separated by brief interruptions in the facility

## ■ ADMISSION DATE (A1900)

- ✓ **Episode**-a series of one or more stays that may be separated by brief interruptions in the facility
- ✓ An episode continues until one of the following three events occur:
  1. Resident is discharged return not anticipated
  2. Resident is discharged return anticipated but is out of facility greater than 30 days
  3. Resident dies

## ■ 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**

## ■ DISCHARGE STATUS (A2100)

- ✓ **Complete only if A0310F = 10, 11 or 12:**
  - **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 08 = Deceased**
  - **Code 09 = Long Term Care Hospital (LTCH)**
  - **Code 99 = Other**

## ■ PREVIOUS ARD FOR SIGNIFICANT CORRECTION (A2200)

- ✓ Required only for a significant correction to a prior comprehensive or quarterly assessment (A0310A = 05 or 06)
- ✓ Enter the ARD of the prior assessment for which a significant error has been identified and a correction is required

<b>A2200. Previous Assessment Reference Date for Significant Correction</b>											
Complete only if A0310A = 05 or 06											
		<input type="text"/>		-		<input type="text"/>		-		<input type="text"/>	
		Month				Day				Year	

## ■ ASSESSMENT REFERENCE DATE (ARD) (A2300)

- ✓ Designates end of look-back period
- ✓ Look-back period includes observations and behaviors through the end of the day (11:59 pm) of the ARD
- ✓ Team members should consider the following when selecting the ARD:
  - Reason for the assessment
  - Compliance with timing and scheduling requirements
- ✓ **MUST** adjust ARD to equal the discharge date if resident dies or is discharged prior to end of the look-back period
- ✓ All sections have to use the same ARD; it cannot be changed after the assessment is completed



## ■ 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**

■ 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:**

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

**C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:**

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month			Day			Year			

## ■ 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 (Chapter 3, page A-33)**

# SECTION B: HEARING, SPEECH AND VISION



## ■ COMATOSE (B0100)

- ✓ **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 Assistance

B0100. Comatose	
Enter Code <input type="checkbox"/>	<b>Persistent vegetative state/no discernible consciousness</b> 0. No → Continue to B0200, Hearing 1. Yes → Skip to G0110, Activities of Daily Living (ADL) Assistance

0	<b>No</b>
1	<b>Yes</b>

## ■ 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:**

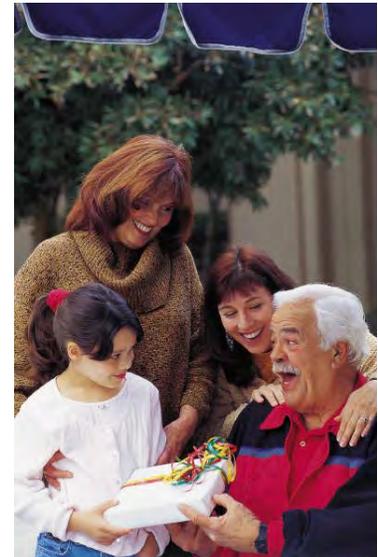
- **Code 0 = Clear speech – distinct intelligible words**
- **Code 1 = Unclear speech – slurred or mumbled words**
- **Code 2 = No speech – absence of spoken words**



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

## ■ MAKES SELF UNDERSTOOD (B0700)

- ✓ **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**



## ■ 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



**SENIOR TEXTING CODE**  
**TLCH = Talk Louder, Can't Hear.**

## ■ 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

## ■ 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



# SECTION C: COGNITIVE PATTERNS



## ■ COGNITIVE PATTERNS

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



## ■ 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**

## ■ 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

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

Enter Code

0. **No** (resident is rarely/never understood) → Skip to and complete C0700-C1000, Staff Assessment for Mental Status
1. **Yes** → Continue to C0200, Repetition of Three Words

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

## ■ CONDUCTING THE BIMS INTERVIEW (C0200 - C0400)



- ✓ **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 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)**

## ■ 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**



## ■ 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  $\leq 9$  – cognitively impaired for RUG purposes**



## ■ BIMS SUMMARY SCORE (C0500)

- **Code 99 if:**
  - **Resident chooses not to participate or gave nonsensical responses**
  - **4 or more items were coded 0 because**
    - **Resident chose not to answer**
    - **Gave nonsensical responses**
  - **Any BIMS items is coded with a dash (“-”)**



## ■ 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

**“Daily confusional forgetfulness.”  
Did I really write that??**



## ■ STAFF ASSESSMENT OF MENTAL STATUS (C0700 - C0800)

- ✓ **C0700 = Short-term Memory OK:**
  - **Code 0 = Memory OK**
  - **Code 1 = Memory problem**
- ✓ **C0800 = Long-term Memory OK:**
  - **Code 0 = Memory OK**
  - **Code 1 = Memory problem**
- ✓ **If neither test can be conducted**
  - **Resident uncooperative or non-responsive**
  - **Staff unable to make a determination based on observation**
  - **Code dash (“-”) to indicate that the information is not available because it could not be assessed**

## ■ STAFF ASSESSMENT OF MENTAL STATUS (C0900- C1000)

- ✓ **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
    - Makes poor decisions
  - **Code 3** = Severely impaired
    - Rarely or never makes a decision, despite opportunities and cues
  - A resident's cognitive decision to exercise his/her right to decline treatment should not be captured as impaired decision making



## ■ 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**



## ■ 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**

## ■ 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**



## ■ 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 CAM©)**

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

■ 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

# SECTION D: MOOD



## ■ 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

## ■ 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**



## ■ RESIDENT MOOD INTERVIEW PHQ-9© (D0200A-I)

### ✓ 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

## ■ 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
  - Total Severity Score is coded 99
  - 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  $\geq 10$  – depressed for RUG purposes

## ■ 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**

## ■ 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)**

## ■ STAFF ASSESSMENT OF RESIDENT MOOD (PHQ-9-OV©) (D0500A-J)

### ✓ 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**

## ■ 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  $\geq$  10 – depressed for RUG purposes**

## ■ 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**



# 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)

- ✓ **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**

## ■ 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

## ■ BEHAVIORAL SYMPTOM (E0200)

### ✓ **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**

## ■ 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**



## ■ 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**
    - **This item does not include wandering**
- ✓ **Goal - to develop interventions to improve symptoms or reduce their impact**
- ✓ **Observe resident, interview staff and review resident record**

## ■ 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

## ■ 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**



## ■ 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**

## ■ 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**

## ■ 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)

- ✓ 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 PRESENCE & FREQUENCY (E0800)

- ✓ **Rejection of care might be caused by underlying neuropsychiatric, medical, or dental problems**
- ✓ **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 PRESENCE & FREQUENCY (E0800)

- ✓ **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**

## ■ WANDERING PRESENCE & FREQUENCY (E0900)

- ✓ **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)**

## ■ 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



## ■ 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



## ■ 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**



# SECTION F: PREFERENCE FOR CUSTOMARY ROUTINE & ACTIVITIES



## ■ 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 and F0500



■ 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



■ 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)**



- 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



## ■ 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**



■ 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.***

## ■ 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.**



## ■ POST TEST #2

- ✓ **What is the definition of an episode of stay?**
  - **A series of one or more stays that may be separated by brief interruptions in the facility**
- ✓ **Does the BIMS interview assess all possible aspects of cognitive impairment?**
  - **No; it is a brief screener to aid in detecting cognitive impairment**
- ✓ **Is the presence of clinical mood indicators on the PHQ-9© sufficient to diagnose depression or a mood disorder?**
  - **No; indication of extent of potential depression symptoms**
- ✓ **Should behavioral symptoms be coded if present all the time or the resident's usual behavior?**
  - **Yes**
- ✓ **What is the look-back period for the resident responding to the activity preferences interview?**
  - **No look-back period is provided to the resident, being asked about current preferences but not limited to 7 days**
  - **But assessment must be completed within the 7 day look-back**

# 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)

- ✓ **Code based on level of assistance when using special adaptive devices**
- ✓ **Do not include assistance provided by individuals hired (compensated or not) outside of the facility's management/ administration**
  - **Hospice staff**
  - **Nursing/CNA students**
  - **Family members**
- ✓ **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

## ■ 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

## ■ 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
  - For more explanation please watch:
    - **CMS youtube video for Section G:**  
<http://youtu.be/t-6e5NV4j6k>

# ACTIVITIES OF DAILY LIVING RULE OF 3



## ■ 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**

## ■ 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**

## ■ 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).

## ■ INSTRUCTIONS FOR THE RULE OF 3

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

- ✓ **\*This box in the algorithm 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**

# ADL SAMPLE EXERCISES



## ■ EXAMPLE #1

HOW WOULD YOU CODE SELF-PERFORMANCE?

0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	3	3	0	2	2	0

**Code of 1**

### Applicable Rule of 3

#1. Applies because the activity occurred 3 times as Independent but “0” is an exception so can’t be used

#2. Does not apply

#3. Does not apply because the activity DID occur at least 3 times at “0”  
SO... If none of the above are met, code Supervision (1)

## ■ EXAMPLE #2

HOW WOULD YOU CODE SELF-PERFORMANCE?

4		1		0		2
2					0	
	1			3		

**Code of 2**

### Applicable Rule of 3

- #3. When an activity occurs 3 or more times and at multiple levels, but not 3 times at any one level, apply the following:**
- 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)**

## ■ EXAMPLE #3

HOW WOULD YOU CODE SELF-PERFORMANCE?

4	8	4	4	8	8	4
0	0	0	0	0	0	0
2	2	2	0	3	2	0

### Code of 3

#### Applicable Rule of 3

#2. When an activity occurs 3 or more times at multiple levels, code the most dependent level that occurred 3 or more times

NOTE: Instructions for coding “Extensive Assistance” (3) from RAI Manual Chapter 3, page G-5: if resident performed part of the activity over the last 7 days and help of the following type was provided three or more times:

Weight-bearing support OR Full staff performance of activity three or more times during part but not all of the last 7 days

## ■ EXAMPLE #4

HOW WOULD YOU CODE SELF-PERFORMANCE?

3	0	1	2	0	0	2
0	4	0	0	1	0	4
0	0	0	0	3	0	0

**Code of 1**

### Applicable Rule of 3

#1. Applies because the activity occurred 3 times as Independent but “0” is an exception so can’t be used

#2. Does not apply

#3. Does not apply because the activity DID occur at least 3 times at “0”  
SO... If none of the above are met, code Supervision (1)

## ■ EXAMPLE #5

HOW WOULD YOU CODE SELF-PERFORMANCE?

8	8	8	8	8	8	8
8	4	8	8	8	8	8
8	8	8	8	8	8	8

**Code of 7**

### Exceptions for the Rule of 3:

- **Code 7 – as this code only applies if the activity occurred only 1 or 2 times**

## ■ EXAMPLE #6

HOW WOULD YOU CODE SELF-PERFORMANCE?

0	4	2	2	0	2	2
1	3	4	1	1	3	1
1	2	0	1	2	0	0

**Code of 2**

### Applicable Rule of 3

**#2. When an activity occurs 3 or more times at multiple levels, code the most dependent level**

## ■ EXAMPLE #7

HOW WOULD YOU CODE SELF-PERFORMANCE?

4	8	8	2	8	8	8
8	3	2	0	1	0	4
8	8	3	8	8	1	8

### Code of 3

#### Applicable Rule of 3

- #3. When an activity occurs 3 or more times and at multiple levels, but not 3 times at any one level, apply the following:**
- b. When there is a combination of full staff performance and weight-bearing assistance that total 3 or more times – code extensive assist (3)**

## ■ EXAMPLE #8

HOW WOULD YOU CODE SELF-PERFORMANCE?

3	0	0	0	0	0	2
0	0	8	0	2	0	0
8	8	8	8	8	8	8

**Code of 1**

### Applicable Rule of 3

#1. Applies because the activity occurred 3 times as Independent but “0” is an exception so can’t be used

#2. Does not apply

#3. Does not apply because the activity DID occur at least 3 times at “0”  
SO... If none of the above are met, code Supervision (1)

## ■ EXAMPLE #9

HOW WOULD YOU CODE SELF-PERFORMANCE?

4	3	2	2	1	1	0

**Code of 2**

### Applicable Rule of 3

**#3. When an activity occurs 3 or more times and at multiple levels, but not 3 times at any one level, apply the following:**

**c. When there is a combination of full staff performance/ weight-bearing assistance, and/or non-weight-bearing assistance that total three or more times, code limited assistance (2)**

## ■ EXAMPLE #10

HOW WOULD YOU CODE SELF-PERFORMANCE?

8	8	8	8	8	8	8
0	0	0	0	0	0	0
8	0	2	4	2	0	8

**Code of 1**

### Applicable Rule of 3

- #1. Applies because the activity occurred 3 times as Independent but “0” is an exception so can’t be used
  - #2. Does not apply
  - #3. Does not apply because the activity DID occur at least 3 times at “0”
- SO... If none of the above are met, code Supervision (1)

## ■ ADL SUPPORT PROVIDED GUIDELINES (G0110 COLUMN 2)

- ✓ Code the most support provided over all shifts, regardless of self-performance code
- ✓ Document the most support provided even if it occurred only once

### 2. ADL Support Provided

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

#### 1. ADL Self-Performance

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

#### 2. ADL Support Provided

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

## ■ 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

## ■ THE ADL SONG WRITTEN BY SUE SALYER

**Have you heard the story of the ADLs? The A is for awesome, the D is for delivery and the L is for the letter of the law.**

**SO...When you are worrying with them, please use the Algorithm Chart and Rule of 3 to do them.**

**SO...The story is one of history and also full of mystery.**

**SO... Start at the top of the Algorithm Chart and Rule of 3 and go down as far as you need to, to find the ADL score that is due you.**

**SO...This is not the end of the story, but the continuing glory of the GREAT, MAGNIFICENT AND AWESOME ADLS!!!**

## ■ 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**

## ■ 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**

## ■ 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)**



## ■ BALANCE DURING TRANSITIONS AND WALKING (G0300)

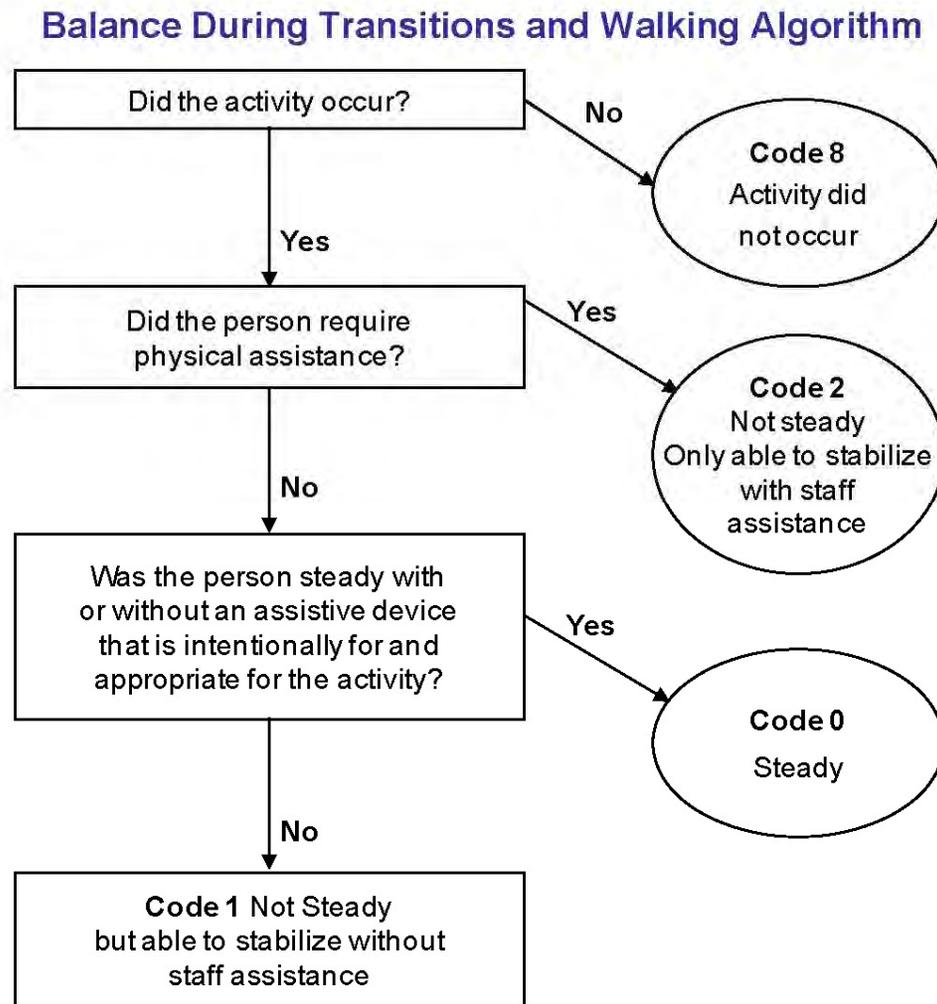


### f) Ask resident to:

- 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 resident who uses a wheelchair for mobility to transfer from a seated position in the wheelchair to a seated position on the bed (rate G0300E now)

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



## ■ 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



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

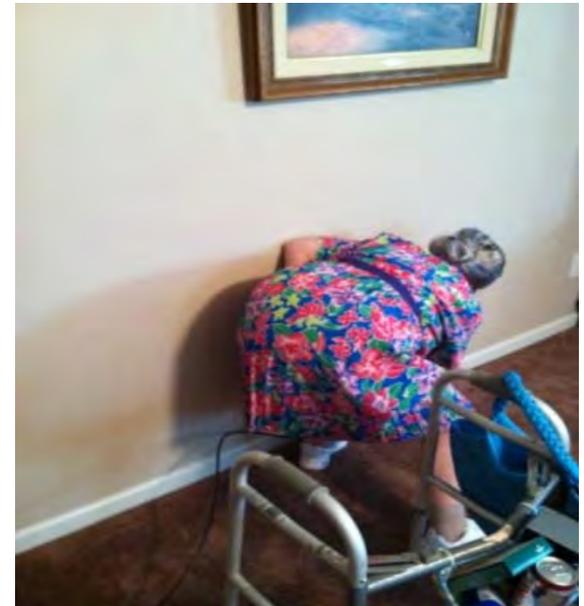
- ✓ **Test the upper and lower extremity for limitations that interfere with daily functioning or place the resident at risk of injury**
- ✓ **Assess ROM bilaterally at the shoulder, elbow, wrist, hand, hip, knee, ankle, foot and other joints unless contraindicated**
- ✓ **Ask resident to follow verbal directions for each movement**
- ✓ **Demonstrate each movement**
- ✓ **Actively assist the resident with ROM exercises by supporting the 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



## ■ 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**



## ■ 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**

# SECTION H: BLADDER & BOWEL



## ■ 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**

# *Did You Know?*

***Ancient Egyptians used metal tubes for catheters as early as 3000BC?***

***And that other objects used as catheters included:***

- ***Straw***
- ***Rolled up palm leaves***
- ***Gold, silver, brass, copper, lead tubes***



## ■ 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



## ■ URINARY TOILETING PROGRAM TRIAL (H0200A)

- ✓ **Look for evidence of a trial individualized toileting program including 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**

## ■ 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**

## ■ CURRENT TOILETING PROGRAM OR TRIAL (H0200C)

- ✓ **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

## ■ 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

## ■ 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***

## ■ BOWEL TOILETING PROGRAM (H0500)

- ✓ **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**

## ■ 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

■ THINK BEFORE YOU CHART!!



**“She stated that she had been constipated for most of her life, until she got a divorce.”**



# SECTION I: ACTIVE DIAGNOSIS



## ■ 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**



## ■ 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)**

## ■ 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
  - Do not drive the resident’s plan of care during the 7-day look-back period

## ■ 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**
- ***Seen in transcribed progress note:***
  - ***“Foul-smelling your run”***

## ■ ACTIVE DIAGNOSES (I0100-I8000)

- ✓ **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**

## ■ ACTIVE DIAGNOSES (I0100-I8000)

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



# SECTION J: HEALTH CONDITIONS



## ■ PAIN MANAGEMENT (J0100)

- ✓ At any time in the last 5 days has the resident received:
  - A = Scheduled pain medication regimen?
    - Defined dose
    - Specific time interval
  - B = PRN pain medications OR was offered and declined?
    - Specified dose
    - Indicates may be given as needed
    - Includes time interval



## ■ PAIN MANAGEMENT (J0100)

- **C = Non-medication intervention for pain?**
  - **Scheduled and implemented interventions**
    - **Bio-feedback**
    - **Heat/cold**
    - **Acupuncture**
    - **Massage**
    - **Physical therapy**
    - **Electrical stimulation (E-stim)**
    - **Herbal or alternative medicine products are not included in this category**



## ■ PAIN MANAGEMENT (J0100)

### ✓ Coding for all of the above:

- **Code 0 = No**
  - A and C, the medical record does not contain documentation that a pain medication was received
  - B, also includes was received or offered
- **Code 1 = Yes**
- A, the medical record contains documentation that a pain medication was received
- B, also includes offered, but declined
- 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**

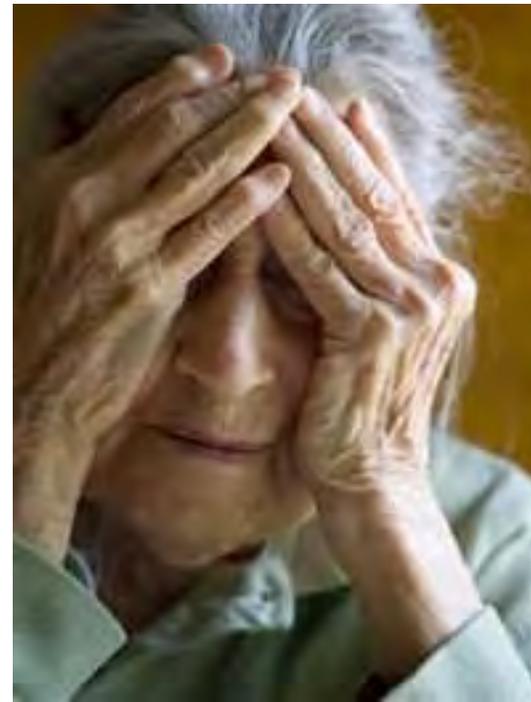


## ■ PAIN PRESENCE (J0300)

- ✓ 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

## ■ 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



## ■ 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



## ■ 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

## ■ 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

## ■ 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**

## ■ 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, winces)**
  - **D = Protective body movements or postures (bracing, guarding, rubbing body part/area)**
  - **Z = None of these signs observed or documented, skip to J1100**

## ■ 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



## ■ SHORTNESS OF BREATH (DYSPNEA) (J1100)

✓ Resident may have any combination

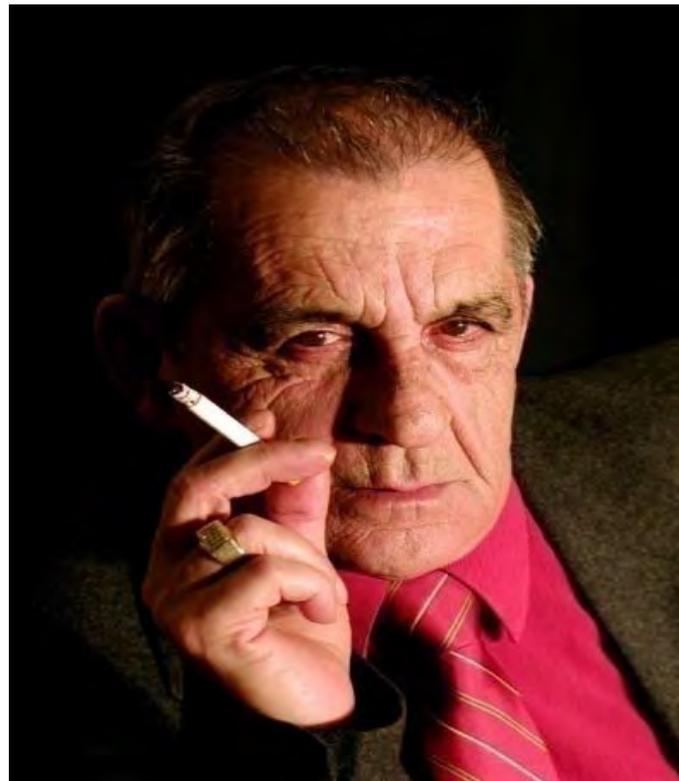
✓ *Check all that apply:*

- 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

## ■ CURRENT TOBACCO USE (J1300)

✓ Includes tobacco used in any form:

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



## ■ 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

## ■ *PROBLEM CONDITIONS (J1550)*

### ✓ *Check all that apply:*

- **A = Fever**
  - **Must be 2.4 degrees F above baseline**
  - **Temperature of 100.4 on admission**
- **B = Vomiting**
- **C = Dehydrated**
  - **Must have 2 of the 3 criteria to code**
    - **Takes in less than 1500 cc fluids daily**
    - **One or more potential clinical signs of dehydration such as dry mucous membranes, dark urine, abnormal labs values**
    - **Fluid loss exceeds fluid intake**
- **D = Internal bleeding**
  - **Frank**
  - **Occult**
- **Z = None of the above**



## ■ 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



## ■ 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

■ 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

■ 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**

■ 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**



## ■ 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.



# SECTION K: SWALLOWING/NUTRITIONAL STATUS



## ■ 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 signs/symptoms are present.***

## ■ HEIGHT AND WEIGHT (K0200)

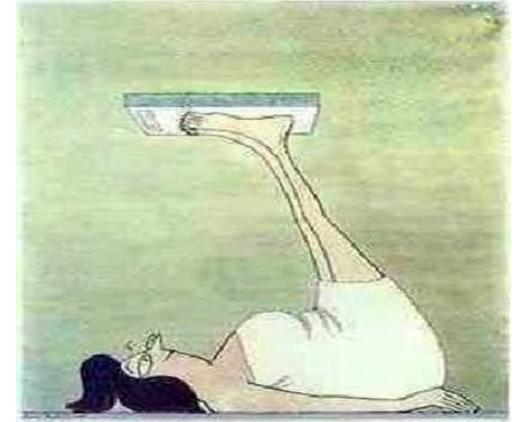
- ✓ Record a current height and weight in order to monitor nutrition and hydration over time
- ✓ A = Height (in inches):
  - On admission, measure and record height in inches to the nearest whole inch
  - Use mathematical rounding  
(.1 to .4 inches round down, .5 or greater round up)
  - Re-measure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



## ■ 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 (.1 to .4# round down, .5# or more round up)**
- **Weigh consistently**
- **If unable to weigh, code with a dash ("-") and document reason in medical record**



## ■ WEIGHT LOSS (K0300)

- ✓ **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**

## ■ 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.***

## ■ NUTRITIONAL APPROACHES (K0510)

✓ 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
  - *Seen in nurses note: “Ate 75% of tray at lunch”. Wonder if that is considered a therapeutic diet??*
- Z = None of the above



## ■ PERCENT INTAKE BY ARTIFICIAL ROUTE (K0710)

- ✓ **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**

■ K0710A CALCULATE PROPORTION EXAMPLE  
WHILE A RESIDENT DURING ENTIRE 7 DAYS

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

## ■ K0710A CALCULATE PROPORTION EXAMPLE WHILE A RESIDENT DURING ENTIRE 7 DAYS

- ✓ **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**
  - **$15,000 \div 17,450 = 0.859$**
  - **$0.859 \times 100 = 85.9\%$**

## ■ K0710A CALCULATE PROPORTION EXAMPLE WHILE RESIDENT DURING ENTIRE 7 DAYS

**Coding:**      **K0710A1 = 1, 25% or less**  
                         **K0710A2 = 3, 51% or more**  
                         **K0710A3 = 3, 51% or more**

**Rationale:**    **For K0710A1**  
                         **>Resident during entire 7 days, therefore code 1, 25% or less**

**For K0710A2**  
**>Proportion of total calories received while a resident is 86%, therefore code 3, 51% or more**

**For K0710A3**  
**>Proportion of total calories received is 86%, therefore code 3, 51% or more**

Example from RAI Manual, Chapter 3, pages K-14 and 15

## ■ PERCENT INTAKE BY ARTIFICIAL ROUTE (K0710)

- ✓ **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**

## ■ K0710B CALCULATE AVERAGE FLUIDS EXAMPLE

**Mr. K. has been able to take some fluids orally, however, due to his progressing multiple sclerosis, his dysphagia is not allowing him to remain hydrated enough. Therefore, he received the following fluid amounts over the last 7 days via supplemental tube feedings while in the hospital and after he was admitted to the nursing home.**

## ■ K0710B CALCULATE AVERAGE FLUIDS EXAMPLE

While in the Hospital		While in the Nursing Home	
<b>Monday</b>	<b>400 cc</b>	<b>Monday</b>	<b>510 cc</b>
<b>Tuesday</b>	<b>520 cc</b>	<b>Tuesday</b>	<b>520 cc</b>
<b>Wednesday</b>	<b>500 cc</b>	<b>Wednesday</b>	<b>490 cc</b>
<b>Thursday</b>	<b>480 cc</b>		
<b>Total</b>	<b>1,900 cc</b>	<b>Total</b>	<b>1,520 cc</b>

## ■ K0710B CALCULATE AVERAGE FLUIDS EXAMPLE

**Coding:**      K0710B1 = 1, 500 cc/day or less  
                      K0710B2 = 2, 501 cc/day or more  
                      K0710B3 = 1, 500 cc/day or less

**Rationale:**    For K0710B1

>The total fluid intake within the last 7 days while Mr. K. was not a resident was 1,900 cc (400 cc + 520 cc + 500 cc + 480 cc = 1,900 cc).

>Average fluid intake while not a resident totaled 475 cc (1,900 cc divided by 4 days).

>475 cc is less than 500 cc, therefore code 1,500 cc/day or less is correct for K0710B1, While NOT a Resident.

## ■ K0710B CALCULATE AVERAGE FLUIDS EXAMPLE

### **Rationale: For K0710B2**

**>The total fluid intake within the last 7 days while Mr. K. was a resident of the nursing home was 1,520 cc (510 cc + 520 cc + 490 cc = 1,520 cc).**

**>Average fluid intake while a resident totaled 507 cc (1,520 cc divided by 3 days).**

**>507 cc is greater than 500 cc, therefore code 2, 501 cc/day or more is correct for K0710B2, While a Resident.**

## ■ K0710B CALCULATE AVERAGE FLUIDS EXAMPLE

### **Rationale: For K0710B3**

**>The total fluid intake within the last 7 days (includes fluid intake while Mr. K. was in the hospital AND while Mr. K. was a resident of the nursing home) was 3,420 cc (1,900 cc + 1,520 cc).**

**>Average fluid intake during the entire 7 days was 489 cc (3,420 cc divided by 7 days).**

**>489 cc is less than 500 cc, therefore code 1, 500 cc/day or less is correct for K0710B3, During Entire 7 Days.**

Example from RAI Manual, Chapter 3, pages K-16 and 17

# 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
    - *Oral mucosal ulcers caused by pressure should be coded here (L0200C) and not in Section M*



## ■ DENTAL (L0200)

### ✓ *Check all that apply:*

- **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**



## ■ POST TEST #3

- ✓ If resident has multiple injuries in a single fall, do you code for all the levels of injury?
  - **No; code for the highest level of injury**
- ✓ If a resident is found on the floor or ground without knowledge of how they got there, is that considered a fall?
  - **Yes**
- ✓ Is a swallowing problem coded a when interventions have been successful in treating the problem and no signs/symptoms are present?
  - **No**
- ✓ Is an oral mucosal ulcer caused by pressure coded in Section M as a pressure ulcer?
  - **No; it is coded at L0200C**

# SECTION M: SKIN CONDITIONS



## ■ **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.**

## ■ 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**

## ■ 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

## ■ UNHEALED PRESSURE ULCER(S) (M0210)

- ✓ If an ulcer arises from a combination of factors which are primarily caused by pressure
  - Code as a pressure ulcer
- ✓ If a pressure ulcer is surgically closed with a flap or graft
  - Code as a surgical wound and not as a pressure ulcer
  - If the flap or graft fails, code as a surgical wound until healed
- ✓ If a pressure ulcer on the last assessment is now healed, complete Healed Pressure Ulcers item (M0900)

## ■ 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

## ■ 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**

## ■ 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**
    - **If a pressure ulcer healed during the look-back period, and was not present on prior assessment, code 0**
  - **Code 1 = Yes, continue to M0300**

# WARNING...

- ✓ **THIS NEXT SECTION IS RATED “M” FOR MATURE MEDICAL AUDIENCES**
- ✓ **THE PICTURES YOU ARE ABOUT TO SEE CONTAIN GRAPHIC IMAGES AND MAY BE DISTURBING TO SOME NON-MEDICAL INDIVIDUALS**

## ■ 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”



## ■ 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**

## ■ 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 – anatomical 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**

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

- ✓ **If the pressure ulcer was present on admission/entry or reentry**
  - **Increased in numerical stage during the stay**
  - **Code at the higher stage**
  - **The higher stage should not be considered as present on admission**
- ✓ **If the pressure ulcer was unstageable on admission/entry or reentry**
  - **Becomes numerically stageable later**
  - **Code at the numerical stage**
  - **Considered as present on admission**
  - **Increases in numerical stage**
  - **The higher stage is not considered present on admission**

## ■ STEP 3: DETERMINE “PRESENT ON ADMISSION, ENTRY OR REENTRY”

- ✓ Resident who has a pressure ulcer is hospitalized
  - Returns with that pressure ulcer at the same numerical stage
  - The pressure ulcer should not be considered present on admission
- ✓ If a current pressure ulcer increases in numerical stage during a hospitalization
  - Code at the higher stage
  - Considered as present on admission

## ■ 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**

## ■ NUMBER OF STAGE 1 PRESSURE ULCERS (M0300A)

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



## ■ DEFINITION OF STAGE 2 PRESSURE

- ✓ **Partial thickness loss of dermis**
  - **Presents as a shallow open ulcer**
    - **Red-pink wound bed**
    - **Without slough**
- ✓ **Presents as a shiny or dry shallow ulcer**
  - **Without slough or bruising**
- ✓ **May appear as an intact or open/ruptured blister**
- ✓ **Do not include:**
  - **Skin tears**
  - **Tape burns**
  - **Moisture associated skin damage**
  - **Excoriation**

## ■ DEFINITION OF STAGE 2 PRESSURE

- ✓ **When a pressure ulcer 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)**
- ✓ **If pressure ulcer fails to show some evidence of healing in 14 days**
  - **Reassess potential complications**
  - **Reassess overall clinical condition**

## ■ STAGE 2 PRESSURE ULCER(S) (M0300B)

### ✓ 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



## ■ 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)**

## ■ STAGE 3 PRESSURE ULCER(S) (M0300C)

### ✓ 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



## ■ 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**

## ■ STAGE 4 PRESSURE ULCER(S) (M0300D)

✓ **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**



## ■ 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**

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

### ✓ 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
- Hard or soft in texture
- Usually black, brown, or tan in color
- May appear scab-like

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

- ✓ **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**

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



## ■ 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**

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

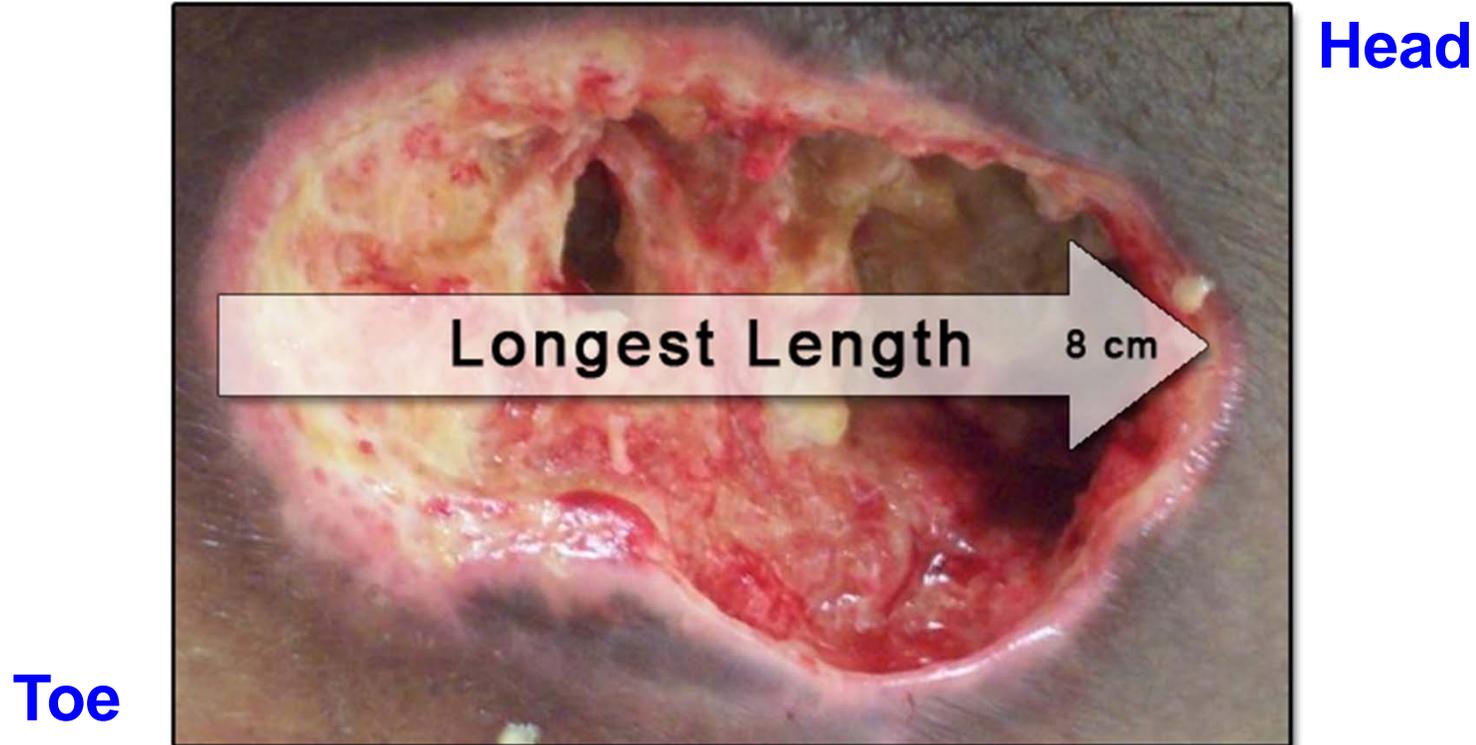


## ■ DIMENSIONS OF UNHEALED STAGE 3 OR 4 PRESSURE ULCERS OR UNSTAGEABLE ULCERS (M0610)

- ✓ **Identify pressure ulcer with the largest surface (length X width) area from only the following:**
  - **Unhealed Stage 3 or 4**
  - **Unstageable pressure ulcer due to slough or eschar**
- ✓ **Measure after dressing and exudate have been removed**
- ✓ **Record in centimeters to one decimal:**
  - **A = Pressure ulcer length**
  - **B = Pressure ulcer width**
  - **C = Pressure ulcer depth**
    - **If depth cannot be assessed due to slough and or eschar, enter dashes (“-”) in M0610C**

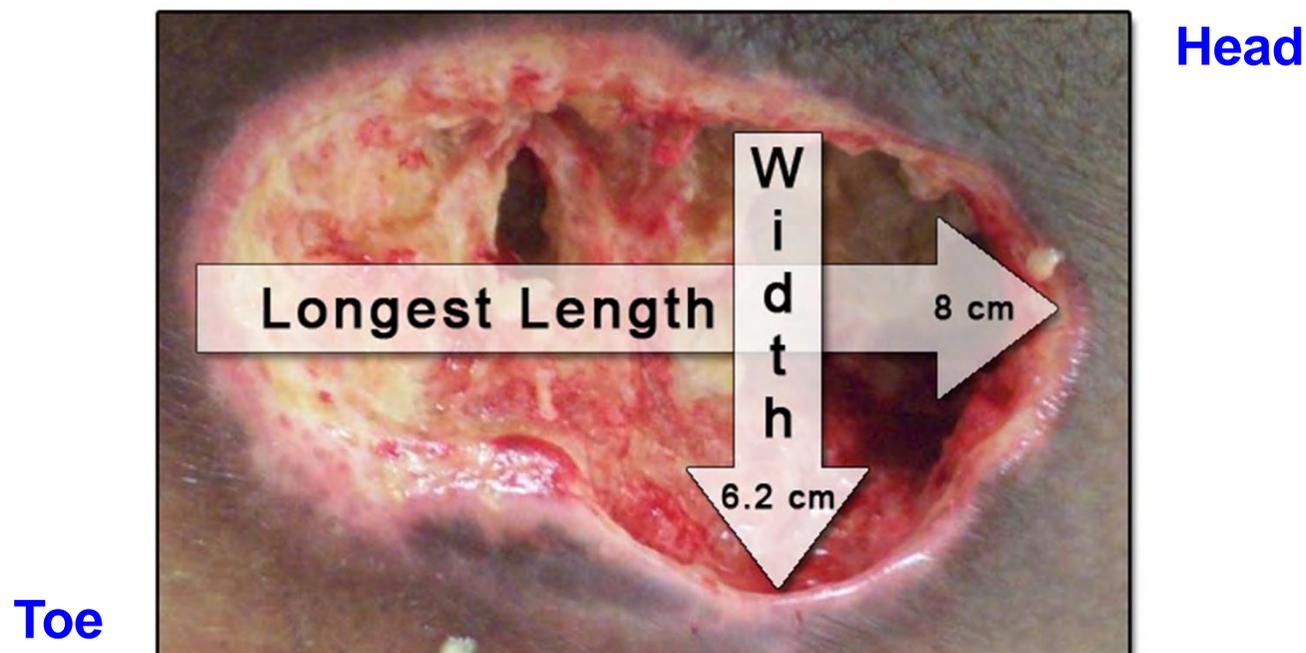
## ■ PRESSURE ULCER LENGTH (M0610A)

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



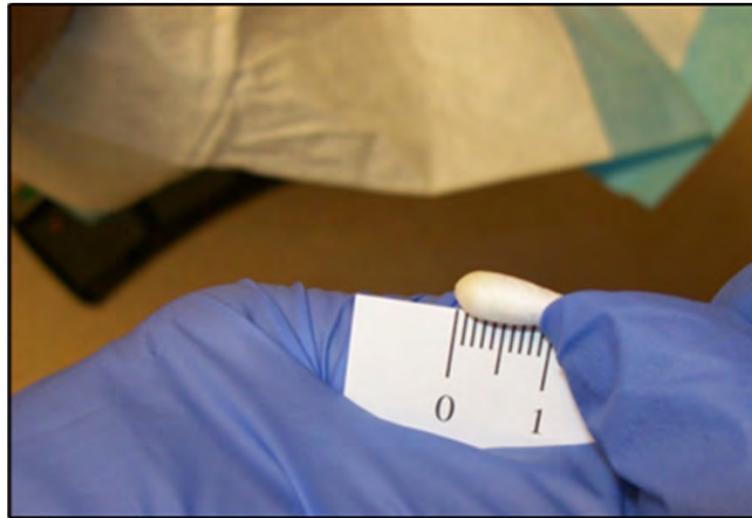
## ■ PRESSURE ULCER WIDTH (M0610B)

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



## ■ 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**



## ■ 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**

## ■ 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 skip to M1030**
- ✓ **If pressure ulcer is unstageable on admission/entry or reentry**
  - **Do not consider it worsened on first assessment that is able to be numerically staged**
  - **If the pressure ulcer subsequently increases in numerical staging after that assessment**
    - **Should be considered worsened**

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

- ✓ **If a previously staged pressure ulcer becomes unstageable due to slough or eschar, do not include in worsening pressure ulcers**
  - **Only way to determine if worsened is to remove enough slough or eschar to visualize wound bed**
  - **Once able to visualize wound bed, the determination can be made**
- ✓ **If a previously staged pressure ulcer becomes unstageable**
  - **Is debrided and staged**
  - **Compare numerical stage before and after**
  - **If the stage has increased**
    - **Code as a worsening pressure ulcer**

## ■ 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**
- ✓ **If a pressure ulcer is acquired during hospital admission**
  - **Code the stage on admission**
  - **Do not include in count of worsening pressure ulcers**
- ✓ **If pressure ulcer increases in numerical stage during hospital admission**
  - **Stage should be coded on admission**
  - **Considered present on admission**
    - **Pressure ulcer is not included here**

## ■ 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**

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

### Example 1:

**A resident has a pressure ulcer on the right ischial tuberosity that was Stage 2 on the previous MDS assessment and has now increased to a Stage 3 pressure ulcer.**

**Code: M0800A = 0   M0800B = 1   M0800C = 0**

**Rationale: The pressure ulcer was at a lesser numerical stage on the prior assessment.**

RAI Manual, Chapter 3, page M-27

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

### Example 2:

**A resident is admitted with an unstageable pressure ulcer on the sacrum, which is debrided and reclassified as a Stage 4 pressure ulcer 3 weeks later. The initial MDS assessment listed the pressure ulcer as unstageable.**

**Code: M0800A = 0 M0800B = 0 M0800C = 0**

**Rationale: The unstageable pressure ulcer was present on the initial MDS assessment. After debridement it was numerically staged as a Stage 4 pressure ulcer. This is the first numerical staging since debridement and therefore, should not be considered or coded as worsening on the MDS assessment.**

## ■ HEALED PRESSURE ULCERS (M0900)

- ✓ **Complete only if A0310E = 0 (not the first assessment)**
- ✓ **Healed pressure ulcer is:**
  - **Completely closed**
  - **Fully epithelialized**
  - **Covered completely with epithelial tissue**
  - **Or resurfaced with new skin,**
  - **Even if the area continues to have some surface discoloration**

## ■ HEALED PRESSURE ULCERS (M0900)

- ✓ **Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage**
- ✓ **If the prior assessment documents that a pressure ulcer healed between MDS assessments, but another pressure ulcer occurred at the same anatomical location**
  - **Do not consider this pressure ulcer as healed**
  - **The re-opened pressure ulcer should be staged at its highest numerical stage until fully healed**
- ✓ **For care planning purposes this healed pressure ulcer would:**
  - **Remain at increased risk for future breakdown or injury**
  - **Require continued monitoring**
  - **Require preventative care**

## ■ HEALED PRESSURE ULCERS (M0900)

- **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**

## ■ NUMBER OF VENOUS AND ARTERIAL ULCERS (M1030)

- ✓ 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

## ■ 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**



## ■ 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**



## ■ 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**



## ■ OTHER ULCERS, WOUNDS, AND SKIN PROBLEMS (M1040)

### ✓ *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**



## ■ SKIN AND ULCER TREATMENTS (M1200)

- ✓ **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**

## ■ 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 (does not include band-aids)**
- **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**



## ■ POST TEST #4

- ✓ **Name 3 pressure ulcer risk factors.**
  - **Immobility, co-morbid conditions, cognitive impairment, healed pressure ulcer, malnutrition**
- ✓ **Are a scab and eschar the same?**
  - **No; they are different both physically and chemically**
- ✓ **If a resident with diabetes has a pressure ulcer on the heel, is that coded as both a pressure ulcer and a diabetic foot ulcer?**
  - **No; it is coded as a pressure ulcer**
- ✓ **How is a pressure ulcer that has been surgically closed with a flap or graft coded?**
  - **Code as a surgical wound and not a pressure ulcer**
- ✓ **In what time frame should a Stage 2 pressure ulcer heal?**
  - **Most should heal in a “reasonable time frame” of 60 days**

# SECTION N: MEDICATIONS



## ■ INJECTIONS (N0300)

- ✓ 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)

- ✓ **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 is classified and 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



## ■ MEDICATIONS RECEIVED (N0410)

- ✓ **Herbal and alternative medicine products are considered to be dietary supplements**
  - **Not regulated by FDA**
  - **Composition is not standardized**
  - **They should not be counted as medications**
  - **Use should be documented in the medical record**
  - **Should be monitored for potential effects**
    - **Interaction with other medications taken**

## ■ MEDICATIONS RECEIVED (N0410)

### EXAMPLE:

The Medication Administration Record (MAR) for resident reflects the following:

- ✓ Risperidone 0.5 mg PO BID PRN: Received once a day on Monday, Wednesday and Thursday
- ✓ Lorazepam 1 mg PO QAM: Received every day
- ✓ Temazepam 15 mg PO QHS PRN: Received at bedtime on Tuesday and Wednesday

### Code:

- A. Antipsychotic = 3; Risperadone
- B. Antianxiety = 7; Lorazepam
- D. Hypnotic = 2; Temazepam

RAI Manual, Chapter 3, page N-8

## ■ MEDICATIONS RECEIVED (N0410)

### **PLEASE NOTE:**

**If a resident is receiving medications in all three categories simultaneously there must be a clear clinical indication for the use of these medications.**

**Administration of these types of medications, particularly in this combination, could be interpreted as chemically restraining the resident.**

**Adequate documentation is essential in justifying their use.**

**RAI Manual, Chapter 3, page N-8**

## ■ 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



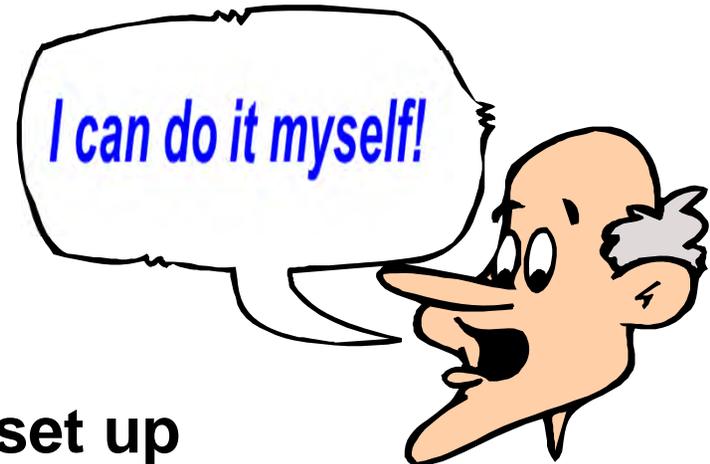
✓ Check the manual for information on Adverse Drug Reactions, Gradual Dose Reduction and other Care Planning considerations

# SECTION O: SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS



## ■ SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS (O0100)

- ✓ **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**



## ■ SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS (O0100)

### ✓ Cancer Treatments:

- **A = Chemotherapy:**
  - 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:**
  - Intermittent therapy
  - Radiation implant

### ✓ Respiratory Treatments:

- **C = Oxygen therapy:**
  - Continuous or intermittent to relieve hypoxia
  - Code when used in BiPAP/CPAP
  - Hyperbaric oxygen for wound therapy not coded

## ■ SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS (O0100)

### ✓ Respiratory Treatments:

- **D = Suctioning:**
  - Tracheal or nasopharyngeal only
  - Oral suctioning not included
- **E = Tracheostomy care:**
  - Cleansing of trach or cannula
- **F = Ventilator or respirator:**
  - Any electric or pneumatic closed-system that ensures ventilation
    - Includes residents receiving ventilation via an endotracheal tube (nasally or orally intubated)
    - Residents with a tracheostomy

## ■ SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS (O0100)

### ✓ Respiratory Treatments:

- **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

### ✓ Other:

- **H = IV Medications:**

- 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

## ■ SPECIAL TREATMENTS, PROGRAMS AND PROCEDURES (O0100)

### ✓ Other:

- **I = Transfusions:**
  - 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:**
  - Peritoneal or renal dialysis
  - Do not code IV, IV med, blood transfusions during dialysis
- **K = Hospice Care:**
  - Hospice must be licensed by the state or certified under Medicare program as a provider
- **L = Respite Care:**
  - Short-term stay

## ■ SPECIAL TREATMENTS, PROGRAMS AND PROCEDURES (O0100)

### ✓ Other:

- **M = Isolation or quarantine for active infectious disease:**
  - **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**

## ■ 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; all services must be brought to the resident (e.g. rehabilitation, activities, dining, etc.).



I can't come out of my room; I'm highly contagious.

## ■ 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 dash ("-") is entered in the first box
- ✓ **If vaccinated status cannot be determined, administer vaccine according to standards of clinical practice**



See RAI Manual, Chapter 3, pages O5 – O9 for complete Influenza Vaccine details

## ■ 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 vaccine due to a declared shortage**
  - **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**

## ■ 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, Chapter 3, pages O 10-14 for complete vaccine details

## ■ THERAPIES (O0400)

- ✓ **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**



## ■ 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



## ■ 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



## ■ DAYS AND DATES FOR ST, OT, AND PT (O0400)

### ✓ **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**

## ■ 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
- The date the initial therapy evaluation is conducted regardless if treatment was rendered or not

### ✓ 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

**If only we had spell check.....**

“I saw your patient today, who  
is still under our car for  
physical therapy.”



## ■ RESPIRATORY THERAPY (O0400D)

- ✓ **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**



## ■ 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.

## ■ 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**
- ✓ **Family education when resident is present and must be documented**

## ■ 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

## ■ CO-TREATMENT (O0400)

### ✓ 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**

## ■ 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

## ■ DISTINCT CALENDAR DAYS OF THERAPY (O0420)

- ✓ **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**

## ■ RESUMPTION OF THERAPY (00450)

- ✓ **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**

## ■ RESUMPTION OF THERAPY (O0450)

- ✓ **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**

## ■ RESTORATIVE NURSING PROGRAMS (O0500)

- **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**



## ■ 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**
  - **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**



## ■ 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**



## ■ RESTORATIVE “DANCING” PROGRAM



## ■ 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

## ■ PHYSICIAN EXAMINATIONS (00600)

- ✓ Enter number of days in the last 14 days that the physician examined the resident
- ✓ Includes MDs, DOs, Podiatrists, Dentists and PAs, NPs or CNSs 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
- ✓ *Seen in nurses note: "Went to appt with Dr. Jones, accompanied by daughter. Returned from appt with Dr. Jones."*



**Podiatry**

## ■ PHYSICIAN ORDERS (00700)

- ✓ 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



## ■ 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 certification/recertification 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 observation period 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**

# SECTION P: RESTRAINTS



## ■ 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

## ■ 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**

## ■ 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**



## ■ PHYSICAL RESTRAINTS

### ✓ *Remove 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 physically 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

## ■ 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 self or others and/or to prevent the resident from interfering with life-sustaining treatment**
- ✓ **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 restraint use**
- ✓ **Document, document, document, document**
- ✓ **CMS will hold NH accountable for decision**

## ■ 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

## ■ 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

### Used in Chair or Out of Bed

- ✓ **E = Trunk Restraint:**
  - Examples include, but not limited to, vest or waist restraints, belts used in wheelchairs

## ■ PHYSICAL RESTRAINTS (P0100)

### Used in Chair or Out of Bed

- ✓ **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**

## ■ 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

## ■ POST TEST #5

- ✓ Are insulin injections counted in both N0300 (injections) as well as in N0350 (insulin injections)?
  - Yes
- ✓ Are herbal and alternative medicine products included in the count of medications?
  - No
- ✓ What types of suctioning are allowed to be coded?
  - Tracheal and nasopharyngeal only
- ✓ Does a sliding scale dosage schedule to cover dosages depending on lab values count as an order change when a dose is given?
  - No
- ✓ Should a facility apply a restraint based on family request?
  - No

# 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 resident in 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 LCAs 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**

## ■ 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**



## ■ 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**

## ■ PARTICIPATION IN ASSESSMENT (Q0100)

- ✓ **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**



## ■ 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**

## ■ 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**



## ■ 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**

## ■ DISCHARGE PLAN (Q0400)

- ✓ **Is active discharge planning already occurring for resident to return to community?**
  - **Code 0 = No**
  - **Code 1 = Yes, skip to Q0600**

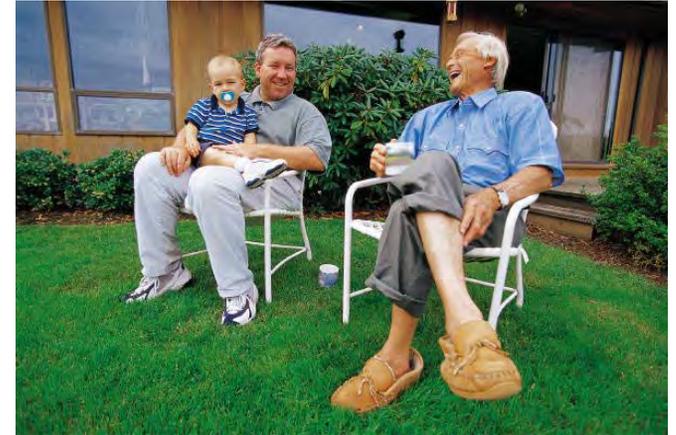


## ■ RESIDENT'S PREFERENCE TO AVOID BEING ASKED Q0500B (Q0490)

- ✓ **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**

## ■ 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**



## ■ 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

## ■ RETURN TO COMMUNITY (Q0500B)

- ✓ **A “yes” will trigger follow-up care planning and contact with the Local Contact Agency 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**

## ■ 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**

## ■ 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**

## ■ POINT OF CONTACT LIST FOR LOCAL CONTACT AGENCIES

- ✓ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html>

# SECTION V: CARE AREA ASSESSMENT SUMMARY



## ■ 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**

## ■ 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**

## ■ 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)**

## ■ 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

## ■ 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**

## ■ 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**

## ■ 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 V0200B2**
  - **Dash fill all “Care Planning Decision” items in V0200A and V0200B, indicating decisions unknown**
  - **Sign and date care planning decisions were completed in V0200C1 and V0200C2, using same date as V0200B2**
  - **Transmit the assessment**

# 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**
  
- ✓ **X0150 – Type of Provider (A0200 on existing record to be modified):**
  - **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

## ■ 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)

■ 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, (A2300) complete only if X0600F=99**
  - **B = Discharge Date, (A2000) complete only if X0600F=10, 11, or 12**
  - **C = Entry date, (1600) complete only if X0600F=01**
- ✓ **X0800 – Correction Number:**
  - **Enter number of correction request to modify/inactivate existing record, including the present one**

## ■ 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



## ■ 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**

# 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**

## ■ 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**

■ **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**

## ■ 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**

## ■ 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.***

## ■ 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**



## ■ 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**



## ■ 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**

## ■ 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)**

## ■ 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**