Commonwealth of Kentucky
Department for Medicaid Services
Division of Policy and Operations
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Frankfort, Kentucky 40621

Documentation Guidelines Related To RUG-III, Version 5.12, 34-Group

Revised October 2017
Effective Date: January 2018

Kentucky
UNBRIDLED SPIRIT

Asterisk (*) Indicates a Previous RUG Task Group Decision
Revised October 2017 to reflect the CMS Revisions to the Long Term Care Facility Resident Assessment Instrument User's Manual Effective January 2018

ADDENDUM ITEMS

- Hospital documentation present in the clinical record shall validate response(s) where appropriate on the MDS 3.0 that reflects the resident's hospital stay prior to admission, if the dates are within the observation period that ends on the ARD date.

- The ARD date is the last day of the MDS observation period. This date refers to a specific end-point in the MDS assessment process. The ARD date sets the designated end-point of the observation period; all MDS items refer back in time from this end-point.

- CMS Clarification: "For example, for a MDS item with a 7-day period of observation (look back period), assessment information is collected for a 7-day period ending on and including the Assessment Reference Date (ARD), which is the 7th day of this observation period. For an item with a 14-day observation period (look back period), the information is collected for a 14-day period ending on and including the ARD."

- For validation purposes, number codes and dates that are "written over" will not be considered. Only legal corrections will be accepted.

- For validation purposes, electronic signatures/initials are acceptable.

- The Care Area Assessment (CAA) documentation occurs after the ARD date and, therefore, will NOT be utilized to validate the Minimum Data Set (MDS). The focus is on documentation during the observation period that ends on the ARD date.

- CMS – "It is important to observe, interview and physically assess the resident, and to interview staff. The MDS was designed to consider information obtained from family members, although it is not necessary that every discussion with them be face-to-face. Assessors should capture information that is based on what actually happened during the observation period, not what usually happens. Problems may be missed when the resident's actual status over the entire observation period is not considered."

- CMS – "Assessors must capture the resident's ACTUAL status and performance, and what care was ACTUALLY provided during the entire observation period. This includes gathering information from a variety of staff and/or gathering information across shifts, when indicated by the MDS item coding instructions. Not every nuance will be documented in the clinical record. Therefore, it's important to obtain information from the residents and direct care givers. To code the MDS accurately, multiple sources of information must be used, such as: interview, observation and assessment of the resident, communication with direct care staff and other disciplines working with the resident, contact with family, and clinical records review. It is not necessary that one assessor must do all of this him/herself. It's up to the facility to establish systems, policies and procedures to facilitate the RAI processes, and accurate MDS coding."

ADDENDUM (Continued)

- CMS – "Facilities exhibiting a pattern of multiple corrections may be subject to stringent MDS review during survey. If the surveyor identifies an error pattern impacting Medicare or Medicaid reimbursement, we would expect the survey agency to alert the FI or state Medicaid agency of the problem."

- DMS – Hospice residents shall not be included on RUG validation reviews. If a Hospice resident is included on the resident roster during the look back period, the field review nurse will be required to choose an alternate resident to review and contact Myers & Stauffer.|

- DMS – "Facilities may print computer generated or manual resident assessment records. There is no requirement to maintain two copies of the form in the resident's record. (Either a hand written or a computer-generated form is equally acceptable.) It is required that the record be completed, signed and dated within the regulatory time frames, and maintained for 15 months in the resident's active record. (For those providers who maintain manual records, it is acceptable for 15 months of MDS information to be kept at the nurse's station in a binder.) If changes are made after completion, those changes must be made to the electronic record, and indicated on the form using standard medical record procedures. It may also be appropriate to update the resident's care plan, based on the revised assessment. Resident assessment forms must accurately reflect the resident's status, and agree with the record submitted to the CMS standard system at the State."

- DMS – "Some nursing facilities are now changing to all electronic medical records. DMS shall require those nursing facilities to provide the PRO nurse(s) access to a computer to complete any on-site review required for Medicaid reimbursement."

MDS 3.0 Item, Look-Back Period, Manual Location	Definitions and MDS 3.0 Documentation Guidelines for Required Look-Back Periods	Documentation Guidelines and Review Standards for Required Look-Back Periods
B0100 **Comatose** **7-day look-back** **p. B-1 – B-2**	**Comatose (coma):** A pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; he/she does not open his/her eyes, does not speak and does not move his/her extremities on command or in response to noxious stimuli (e.g. pain). (p. B-1) **Persistent Vegetative State:** Sometimes residents, who were comatose after an anoxic-ischemic injury (i.e., not enough oxygen to the brain) from a cardiac arrest, head trauma, or massive stroke, regain wakefulness but do not evidence any purposeful behavior or cognition. Their eyes are open, and they may grunt, yawn, pick with their fingers, and have random body movements. Neurological exam shows extensive damage to both cerebral hemispheres (p. B-2).	**Requirement:** • Documentation of a neurological diagnosis of comatose or persistent vegetative state that has been documented by a physician, or nurse practitioner, physician assistant, or clinical nurse specialist, if allowable under state licensure laws, shall be present in the medical record that is applicable during the 7-day look-back period that ends on the ARD. **Does NOT include:** • Residents in advanced stages of progressive neurologic disorders such as Alzheimer's disease. They may have severe cognitive impairment, be non-communicative and sleep a great deal of time; however, they are usually not comatose or in a persistent vegetative state, as defined here (p. B-2).
B0700 **Makes Self Understood** **7-day look-back** **p. B-6 – B-7**	**Makes Self Understood** Able to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language, whether in speech, writing, sign language, gestures, or a combination of these. Deficits in the ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing and/or gesturing (p. B-6).	**Requirement:** • Documentation of actual examples of the resident's ability to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language, whether in speech, writing, sign language, gestures or a combination of these shall be present in the medical record during the 7-day look-back period that ends on the ARD. A check off sheet would be acceptable IF it includes the MDS 3.0 User's Manual definition of each area OR an example that fits the definition AND occurs during the 7-day look-back period that ends on the ARD.

C0200-C0400 BIMS **7-day look-back p. C-2 – C-14**	**Nonsensical Response** Any response that is unrelated, incomprehensible, or incoherent; it is not informative with respect to the item being rated (p. C-5).	**Requirement:** • A signed and dated note by the person conducting the interview shall be present in the medical record during the 7-day look-back period that ends on the ARD.
C0500 BIMS Summary Score **7-day look-back p. C-14 – C-16**	**To be considered a completed interview, the resident had to attempt and provide relevant answers to at least four of the questions in C0200-C0400.** To be relevant, a response only has to be related to the question (logical); it does not have to be correct (p. C-15).	**Brief Interview for Mental Status (BIMS) score defined as:** Score range is 0-15 **BIMS score can be interpreted as follows:** • Less than or equal to 9 cognitively impaired; • Greater than 9 cognitively intact.
C0700 Short-Term Memory **7-day look-back p. C-17 – C-20**	This section is completed to assess the mental state of residents who cannot be interviewed. Staff should complete the Staff Assessment for Mental Status Item, C0700 – C1000.	**Requirement:** • Documentation of actual examples demonstrating how the short-term memory problem was determined shall be present in the medical record during the 7-day look-back period that ends on the ARD.
C1000 Cognitive Skills for Daily Decision Making **C1000 Cognitive Skills for**	**Daily Decision Making** Includes: choosing clothing; knowing when to go to meals; using environmental cues to organize and plan (e.g., clocks, calendars, posted event notices); in the absence of environmental cues, seeking information appropriately (i.e., not repetitively) from others in order to plan the day; using awareness of one's own strengths and limitations to regulate the day's events (e.g., asks for help when necessary); acknowledging need to use appropriate assistive equipment such as a walker (C-23).	**Requirement:** • Documentation of the resident's ACTUAL performance in making "everyday" decisions about tasks or activities of daily living shall be present in the medical record during the 7-day look-back period that ends on the ARD. It is NOT a requirement to have "daily" documentation of the decision-making but it is necessary to document the resident's ACTUAL performance. A check off sheet shall be acceptable for validation purposes, IF examples use the MDS 3.0 language. *The statement, "Cognition is severely impaired." is NOT

Daily Decision Making **7-day look-back** **p. C-23 – C-25**		acceptable because it does not give actual examples. If more than one example is given, there shall be a "key" to determine how final decision was made. **Does NOT include:** • A resident's considered decision to exercise his/her right to decline treatment or recommendations by interdisciplinary team members (p. C-24).
D0200A – I, Column 2 **Resident Mood Interview (PHQ-9©)** **14-day look-back** **p. D-3 – D-8**	**9-Item Patient Health Questionnaire (PHQ-9)** A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder (p. D-3).	**Requirement:** • A signed and dated note by the person conducting the PHQ-9 interview **preferably the day before or day of the ARD** (p. D-4) shall be present in the medical record during the 14-day look-back period that ends on the ARD.
D0300 **Total Severity Score (PHQ-9)** **14-day look-back** **p. D-8 – D-9**	**Total Severity Score** A summary of the frequency scores that indicates the extent of potential depression symptoms. The score does NOT diagnose a mood disorder, but provides a standard of communication with clinicians and mental health specialists (p. D-8). **The software will calculate the Total Severity Score. For detailed instructions on manual calculations and examples, See Appendix E: PHQ-9 Total Severity Score Scoring Rules (D-9).**	Total Severity Score: • Sum of all symptom frequency items in D0200, Column 2 • Total Severity Score range is 00-27. Total Severity Score can be interpreted as follows: • Greater than or equal to 10 depression indicated; • Less than 10 depression not indicated.
D0500 A – J, Column 2 **14-day look-back** **p. D-11 – D-14**	This section is completed if a resident is unable or unwilling to complete the PHQ-9 **Resident Mood Interview**. Therefore, staff should complete the PHQ-9-OV **Staff Assessment of Mood** in these instances so that any behaviors, signs, or symptoms of mood distress are identified. PHQ-9 **Resident Mood Interview** is preferred as it improves the detection of possible mood disorder (p. D-11).	**Requirement:** • Documentation of examples demonstrating how the resident's mood status and frequency of mood was determined shall be present in the medical record during the 14-day look-back period that ends on the ARD.
D0600 **Total Severity Score (PHQ-9-OV©)**	**The interview is successfully completed if the staff members were able to answer the frequency responses of at least 8 out of 10**	Total Severity Score: • Add scores for all frequency items (D0500) Column 2 • Maximum score is 30

14-day look-back **p. D-14 – D-15**	**items on the PHQ-9-OV** (p. D-15). The software will calculate the Total Severity Score. For detailed instructions on manual calculations and examples, See Appendix E: PHQ-9-OV Total Severity Score Scoring Rules.	Total Severity Score can be interpreted as follows: • Greater than or equal to 10 depression indicated; • Less than 10 depression not indicated
E0100A **Hallucinations** **7-day look-back** **p. E-1 – E-4**	**Hallucination** The perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch (p. E-1). This section focuses on the resident's actions, NOT the intent of his or her behavior (p. E-1). Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis (p. E-2).	**Requirement:** • Documentation of actual examples of the resident's perception of the presence of something that is not actually there shall be present in the medical record during the 7-day look-back period that ends on the ARD. It may be auditory or visual or involve smells, tastes or touch. Simply stating, 'Resident is having hallucinations' shall not be acceptable for validation purposes.
E0100B **Delusions** **E0100B** **Delusions** **7-day look-back** **p. E-1 – E-4**	**Delusion** A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary (p. E-1). This section focuses on the resident's actions, NOT the intent of his or her behavior (p. E-1). Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis (p. E-2).	**Requirement:** • Documentation of actual examples of the resident's fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary shall be present in the medical record during the 7-day look-back period that ends on the ARD. **Does NOT include:** • A belief that cannot be objectively shown to be false or it is not possible to determine whether it is false (p. E-3). • A resident's expression of a false belief when he/she easily accepts a reasonable alternative explanation (p. E-3). Simply stating 'Resident is

		delusional' shall not be acceptable for validation purposes.
E0200 A – C Behavioral Symptom – Presence and Frequency **7-day look-back p. E-4 – E-6**	This item is based on whether the symptoms occurred and NOT based on an interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated (p. E-5).	**Requirement:** • Documentation of actual examples that the resident exhibited and how the identification of the frequency and the impact of behavioral symptoms on self and on others was determined shall be present in the medical record during the 7-day look-back period that ends on the ARD.
E0800 Rejection of Care – Presence & Frequency **7-day look-back p. E-13 – E-17**	**Rejection of Care** Behavior that interrupts or interferes with the delivery or receipt of care. Care rejection may be manifested by verbally declining or statements of refusal or through physical behaviors that convey aversion to or result in avoidance of or interfere with the receipt of care (p. E-14). The intent of this item is to identify potential behavioral problems, not situations in which care has been rejected based on a choice that is consistent with the resident's preferences or goals for health and well-being or a choice made on behalf of the resident by a family member or other proxy decision maker (p. E-15).	**Requirement:** • Documentation of actual examples and frequency of the resident's rejection of care that is necessary to achieve the health and well-being of the resident shall be present in the medical record during the 7-day look-back period that ends on the ARD. **Does NOT include:** • Behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family) and/or determined to be consistent with resident values, preferences or goals (p. E-15).
E0900 Wandering – Presence and Frequency **E0900 Wandering – Presence and Frequency**	**Wandering** 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	**Requirement:** • Documentation of actual examples and frequency of wandering shall be present in the medical record during the 7-day look-back period that ends on the ARD. **Does NOT include:** • Pacing (repetitive walking with a driven/pressured quality) within a constrained space (p. E-18). • Traveling via a planned course to another specific place (such as

7-day look-back p. E-17 – E-18	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 knows is deceased). p. E-18	going to the dining room to eat a meal or to an activity). p. E-18
G0110A1, Bed Mobility G0110B1, Transfers G0110H1, Eating G0110I1, Toilet Use **G0110A2, G0110B2, G0110H2, G0110I2,**	**ADL Self-Performance** Measures what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last 7 days according to a performance-based scale (p. G-2). The ADL Self-Performance coding level definitions are intended to reflect real world situations where slight variations in level of ADL self-performance are common. (p. G-4). • **Differentiating between guided maneuvering and weight-bearing assistance:** determine **who** is supporting the weight of the resident's extremity or body. For example, if the staff member supports some of the weight of the resident's hand while helping the resident to eat (e.g., lifting a spoon or a cup to mouth), or performs part of the activity for the resident, this is "weight-bearing" assistance for this activity. (p. G-8). • If the resident can lift the utensil or cup, but staff assistance is needed to guide the resident's hand to his or her mouth, this is guided maneuvering (p. G-8). The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day (i.e. not only how the evaluating clinician sees the resident, but how the resident performs on	**DMS Minimum Requirements:** If an ADL tracking tool is used to code self-performance (what resident actually did) and support provided for coding bed mobility, transfer, toilet use and eating (while in the facility); the following shall be clearly documented during the 7-day look-back period that ends on the ARD: • An observation period with the month, day, year and resident's name clearly identified; • An ADL "key" for self-performance and support provided shall meet the definition of the MDS 3.0 key; • Initials and dates to support the services were provided; • Signatures to identify initials. (Signature logs are acceptable); • When the ADL's are NOT captured on a tracking tool, the above criteria shall be established and clearly documented. **Providers with two different ADL tools per assessment shall be asked by the PRO nurse to designate the one to be used for the review.** **KY is allowing each individual NF provider to choose to include the "7" or to NOT include the "7" on their ADL Tracking Tool. The field review nurse will accept either choice and review it accordingly.** Electronic signatures/initials are acceptable.

	other shifts as well) (G-3).	If using an ADL tracking form, each day or shift shall be initialed or signed by the person(s). One signature/initial with a line drawn through the 7-day look-back period on an ADL tracking form for supporting documentation shall not be accepted for validation purposes. **Does NOT include:** • The emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag in G0110I (G-8); • The staff's assessment of the resident's potential capability to perform the ADL activity (G-8); • The type and level of assistance that the resident "should" be receiving according to the written plan of care. The level of assistance **actually provided** might be very different from what is indicated in the plan. **Record what actually happened (G-8);** • Assistance provided by family or other visitors (G-8). "Write-over's" or white-out shall **NOT** be accepted. **Only** legal corrections shall be acceptable.
G0110A2, G0110B2, G0110H2, G0110I2	**ADL Support Provided** Measures the most support provided by staff over the last 7 days, even if that level of support only occurred once. (p. G-3). The responsibility of the person completing the assessment,	The CATs and CAAs occur after the ARD and, therefore, shall NOT be accepted to validate the MDS 3.0. The focus is on documentation during the look-back periods that end on the ARD.

7-day look-back **p. G-1 – G-22**	therefore, is to capture the maximum amount of support provided to the resident over the 7-day period, 24 hours a day (i.e. not only how the evaluating clinician sees the resident, but how much support is provided on other shifts as well). (p. G-3). Examples of ADL Support Setup Help Bed Mobility – handing the resident the bar on a trapeze, staff raises the ½ rails for the resident's use and the provides no other help. Transfer – giving the resident a transfer board or locking the wheels on a wheelchair for safe transfer. Eating – cutting meat and opening containers at meals; giving one food item at a time. Toilet Use – handing the resident a bedpan or placing articles necessary for changing an ostomy appliance within reach. (G-8&9).	

MDS 3.0 ADL Self-Performance Rule of 3

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.

Rule of 3:

1. When an 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).

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

H0200C **Current Urinary Toileting Program or Trial** **7-day look back period** **p. H-3 – H-7**	Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice (p. H-6). • Residents who do NOT respond to a toileting trial and for whom other reversible or treatable causes are not found should receive **supportive management** (such as checking the resident for incontinence and changing his or her brief if needed and providing good skin care). (p. H-3); • Simply tracking continence status using a bladder record or voiding diary should NOT be considered a trial of an individualized, resident-centered toileting program (p. H-4).	**Requirement:** • Documentation of a toileting program being used to manage incontinence shall be present in the medical record during the 7-day look-back period that ends on the ARD noting the number of days during the look-back period that the toileting program was implemented or carried out. **The following three requirements shall also be met during the 7-day look-back period that ends on the ARD:** • Implementation of an individualized, resident-specific toileting program that was based on an assessment of the resident's unique voiding pattern. (p. H-5) • Evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report; (p. H-5) **and** • Notations of the resident's response to the toileting program and subsequent evaluations, as needed (p. H-5). **Does NOT include:** • An individualized resident-centered toileting program (i.e., prompted voiding, scheduled toileting, or bladder training) that is used **less than 4 days of the 7-day look-back period** to manage the resident's urinary continence, • Simply tracking continence status, • Changing pads or wet garments, **and** • Random assistance with toileting or hygiene (p. H-6).
H0500	• If the bowel toileting program	**Requirement:**

Bowel Toileting Program **7-day look-back p. H11 – H-12**	leads to a decrease or resolution of incontinence, the program should be maintained. (p. H-11) • If bowel incontinence is NOT decreased or resolved with a bowel toileting trial, consider whether other reversible or treatable causes are present. (p. H-11). • Residents who do NOT respond to a bowel toileting trial and for whom other reversible or treatable causes are NOT found should receive **supportive management** (such as a regular check and change program with good skin care). (p. H-11).	• Documentation of a bowel toileting program being used to manage bowel incontinence shall be present in the medical record during the 7-day look-back period that ends on the ARD noting the number of days during the look-back period that the toileting program was implemented or carried out. **The following three requirements shall also be met during the 7-day look-back period that ends on the ARD:** • Implementation of an individualized, resident-specific bowel toileting program based on an assessment of the resident's unique bowel pattern, (p. H-12) • Evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records and a written report; (p. H-12) **and** • Notations of the resident's response to the toileting program and subsequent evaluations, as needed (p. H-12). **Does NOT include:** • Simply tracking bowel continence status, • Changing pads or soiled garments **and** • Random assistance with toileting or hygiene (Same as Urinary Toileting Program on p. H-6).

<table>
<tr><th colspan="3">Section I: ACTIVE Diagnoses in the Last 7 Days</th></tr>
<tr><td colspan="2">Step 1: Requirement for Diagnosis Identification:
There are two look-back periods for this section:

• Diagnosis identification (Step 1) is a 60-day look-back period.

• Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period (except for I2300 UTI, which does not use the active 7-day look-back period).</td><td>ACTIVE Diagnoses:
Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period that ends on the ARD (p. I-3).

Does NOT include:
• Conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period that ends on the ARD (p. I-3).</td></tr>
<tr><td>I2000
Pneumonia

I2100
Septicemia

I2900
Diabetes Mellitus (DM) (e.g., Diabetic Retinopathy, Nephropathy, Neuropathy)

I4300
Aphasia

I4400
Cerebral Palsy

I4900
Hemiplegia/ Hemiparesis</td><td>Listing a disease/diagnosis (3.g., arthritis) on the resident's medical record problem list is NOT sufficient for determining ACTIVE or inactive status. (p. I-8).

To determine if arthritis, for example, is an "ACTIVE" diagnosis, the reviewer would check progress notes (including the history and physical) during the 7-day look-back period for notation of treatment of symptoms of arthritis, doctor's orders for medication for arthritis, and documentation of physical or other therapy for functional limitations caused by arthritis (p. I-8).</td><td>Requirement:
See Steps 1 and 2 listed above.

The reviewer will check the following information sources in the medical record to identify ACTIVE diagnoses during the 7-day look-back period that ends on the ARD:
• Transfer documents; physician, nurse practitioner, physician assistant, or clinic nurse specialist progress notes; recent history and physical; recent discharge summaries; nursing assessments; nursing care plans; medication sheets; doctor's orders; consults and official diagnostic reports, and other sources as available (p. I-4).
• In the absence of specific documentation that a disease is ACTIVE, the following indicators may be used to confirm ACTIVE disease:
o Recent onset or acute exacerbation of the disease or condition indicated by a positive study, test or procedure, hospitalization for acute symptoms and/or recent change in therapy in the last 7 days that end on the ARD. Sources may include</td></tr>
</table>

I5100 **Quadriplegia** **I5200** **Multiple Sclerosis (MS)** **7-day look-back** **p. I-1 – I-10**	****January 1, 2018** **Does Require:** **Physicians documentation of an injury to the spinal cord that causes total paralysis of all four limbs (arms and legs) and is not the result of another condition.** ****January 1, 2018** **Does *N*ot Include:** • Functional quadriplegia. • Complete immobility due to severe physical disability or frailty that extends to all limbs. A medication indicates an **ACTIVE** diagnosis if that medication is prescribed to manage an ongoing condition that requires monitoring or is prescribed to decrease active symptoms associated with a condition. This includes medications used to decrease progression and complications. If a medication is prescribed for a condition that requires regular staff monitoring of the drug's effect on that condition (therapeutic efficacy), then the prescription of the medication would indicate **ACTIVE** disease (p. I-8).	radiological reports, hospital discharge summaries, doctor's orders, etc. during the 7-day look-back period that ends on the ARD. (p. I-7) o Symptoms and abnormal signs indicating ongoing or decompensated disease in the last 7 days. Sources may include radiological reports, nursing assessments and care plans, progress notes, etc. during the 7-day look-back period that ends on the ARD (p. I-7). **Does NOT include:** • Conditions that have been resolved or have **no longer** affected the resident's functioning or plan of care during the 7-day look-back period that ends on the ARD (p. I-3). • **It is expected that nurses monitor all medications for adverse effects as part of usual nursing practice**. For coding purposes, this monitoring relates to management of pharmacotherapy and **NOT** to management or monitoring of the underlying disease (p. I-8).

J1550A **Fever** **7-day look-back** **p. J-24 – J-26**	**Fever** Fever is defined as a temperature 2.4 degrees F higher than baseline. The resident's baseline temperature should be established prior to the Assessment Reference Date (ARD). p. J-25	**Requirement:** Documentation of a fever shall be present in the medical record during the 7-day look-back period that ends on the ARD. **The route (rectal, oral, axillary, etc.) of temperature measurement should be consistent between the baseline and the elevated temperature** and indicate: • 2.4 degrees higher than the resident's baseline temperature **OR** • A temperature of 100.4 degrees F (38 degrees D) on admission (i.e., prior to the establishment of the baseline temperature). p. J-25
J1550B **Vomiting** **7-day look-back** **p. J-24 – J-26**	**Vomiting** Regurgitation of stomach contents; may be caused by many factors (e.g., drug toxicity, infection, psychogenic). p. J-25	**Requirement:** Documentation of regurgitation of stomach contents shall be present in the medical records during the 7-day look-back period that ends on the ARD.
J1550C **Dehydration**		**Requirement:** Documentation of **two or more** of the following indicators shall be present in the medical record during the 7-day look-back period that ends on the ARD: • Resident takes in less than the recommended 1,500 ml of fluids daily (water or liquids in beverages and water in foods with high fluid content, such as gelatin and soups). Note: The recommended intake level has been changed from 2,500 ml to 1,500 ml to reflect current practice standards; • Resident has one or more potential clinical signs (indicators) of dehydration, **including but not limited to** dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, or abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium, albumin, blood urea nitrogen, or urine specific gravity); • Resident's fluid loss exceeds the amount

J1550C **Dehydration** **7-day look-back** **p. J-24 – J-26**		of fluids he or she takes in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement). p. J-26
J1550D **Internal Bleeding** **7-day look-back** **p. J-24 – J-26**	Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools). p. J-26	**Requirement:** Documentation of clinical indicators shall be present in the medical record during the 7-day look-back period that ends on the ARD and includes: • Black, tarry stools; • Vomiting "coffee grounds"; • Hematuria (blood in urine); • Hemoptysis (coughing up blood); • Severe epistaxis (nosebleed) that requires packing. **Does NOT include:** • Nosebleeds that are easily controlled; • Menses or; • A urinalysis that shows a small amount of red blood cells (p. J-26).

K0300 **Weight Loss** **30-day and 6 month look-back** **p. K-4 – K-8**	**5% Weight Loss in 30 days** Start with the resident's weight closest to 30 days ago and multiply it by .95 (or 95%). The resulting figure represents a 5% loss from the weight 30 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost more than 5% body weight (p. K-4). **10% Weight Loss in 180 days** Start with the resident's weight closest to 180 days ago and multiply it by .90 (or 90%). The resulting figure represents a 10% loss from the weight 180 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost 10% or more body weight (p. K-4). **Physician-Prescribed Weight-Loss Regimen** A weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. May employ a calorie-restricted diet or other weight loss diets and exercise. Also includes planned diuresis. It is important that weight loss is intentional (p. K-5). **Body Mass Index (BMI)** Number calculated from a person's weight and height. BMI is used as a screening tool to identify possible weight problems for adults. Visit: http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html. (p. K-5.)	**Requirement:** Documentation with calculated weight loss in percentages shall be present in the medical record during the look-back periods that end on the ARD of the resident's weight loss of 5% or more in **last 30 days OR** 10% or more in **last 6 months.** • Mathematical rounding: If weight is X.5 pounds (lbs) or more, round weight upward to the nearest whole pound. If weight is X.1 to X.4 lbs, round down to the nearest whole pound. For example, a weight of 152.5 lbs would be rounded to 153 lbs and a weight of 152.4 lbs would be rounded to 152 lbs (p. K-3). **Does Not Include:** • A resident may experience weight variances in between the snapshot time periods. Although these require follow up at the time, they are **NOT** captured on the MDS. • On occasion, a resident with normal BMI or even low BMI is placed on a diabetic or otherwise calorie-restricted diet. In this instance, the intent of the diet is **NOT** to induce weight loss, and it would **NOT** be considered a physician-ordered weight-loss regimen (p. K-6).

K0510A Parenteral /IV Feeding	**Parenteral/IV Feeding** K0510A includes any and all nutrition and hydration received by the nursing home resident in the last 7 days either at the nursing home, at the hospital as an outpatient or an inpatient, provided they were administered for nutrition or hydration. (p. K-11) Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous). p. K-10 • Guidelines on basic fluid and electrolyte replacement can be found online at: • http://guidelines.gov/content.aspx?id=15590&search=fluid+and+electrolyte+replacement+amda. (p. K-12) • Enteral feeding formulas: o Should **NOT** be coded as a mechanically altered diet. o Should only be coded as **K0510D, Therapeutic Diet** when the enteral formula is to manage problematic health conditions, e.g. enteral formulas specific to diabetics (p. K-12).	**Requirement:** Documentation of a nutritive substance into the body by means other than the intestinal tract (e.g. subcutaneous, intravenous) shall be present in the medical record during the 7-day look-back period that ends on the ARD. The following fluids may be included when there is supporting documentation that reflects the need for additional fluid intake specifically addressing nutrition or hydration needs. **This supporting documentation should be noted in the resident's medical record according to State and/or internal facility policy**: • IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently; • IV fluids running at KVO (Keep Vein Open); • IV fluids contained in IV Piggybacks; • Hypodermoclysis and subcutaneous ports in hydration therapy. (p. K-11). **Does NOT include:** • IV medications – **Code these in O0100H, IV Medications (K-12);** • Additives, such as electrolytes and insulin, that are added to TPN or IV fluids – **Code these in O0100H, IV Medications;**

K0510A **Parenteral /IV Feeding** **7-day look-back** **p. K-10 – K-13**		• IV fluids administered solely for the purpose of "prevention" of dehydration. **ACTIVE diagnosis of dehydration must be present in order to code this fluid in K0510A (K-12)**; • IV fluids used to reconstitute and/or dilute medications for IV administration (K-12); • IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay; • IV fluids administered solely as flushes (K-12); • Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis (p. K-12); • IV's, IV medication, and blood transfusions administered during chemotherapy (p. O-2).
K0510B **Feeding Tube** **7-day look-back** **p. K-10 – K-13**	**Feeding Tube** Presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes; gastrostomy tubes; jejunostomy tubes; percutaneous endoscopic gastrotomy (PEG) tubes (p. K-10).	**Requirement:** Documentation of any and all nutrition and hydration provided to the resident for the purpose of nutrition or hydration via a feeding tube shall be present in the medical record during the 7-day look-back period that ends on the ARD. Care planning should include periodic reevaluation of the appropriateness of the approach (p. K-10).
K0710A3 **Proportion of Total Calories the Resident Received through Parenteral or Tube Feedings DURING THE ENTIRE 7 DAYS**	Periodic reassessment is necessary to facilitate transition to increased oral intake as indicated by the resident's condition (p. K-14).	**Requirement** Documentation of the proportion of calories **actually received** through artificial routes (if the resident took no food or fluids by mouth or took just sips of fluid) shall be present in the medical record during the 7-day look-back period that ends on the ARD. For residents receiving nutrition by mouth and tube feeding, documentation shall be present in the medical record during the 7-day look-back period that ends on the ARD to demonstrate how the facility calculated the percentage of intake by mouth and artificial routes and shall include:

K0710A3 **Proportion of Total Calories the Resident Received through Parenteral or Tube Feedings DURING THE ENTIRE 7 DAYS** **7-day look-back** **p. K-13 – K-15**		• Actual calories by oral intake per day; • Actual calories by tube feeding per day; and • Total calories; • Calculation of the percentage of total calories received by tube feeding (See example on p. K-14). • Documentation provided after the ARD will not be considered for validation purposes.
K0710B3 **Average Fluid Intake per Day by IV or Tube Feeding DURING THE ENTIRE 7 DAYS** **7-day look-back** **p. K-15 – K-16**	1. Review intake records from the last 7 days. 2. Add up the total amount of fluid received each day by IV and/or tube feedings only. 3. Divide the week's total fluid intake by 7 to calculate the average of fluid intake per day. 4. Divide by 7 even if the resident did NOT receive IV fluids and/or tube feeding on each of the 7 days (p. K-15).	**Requirement:** Documentation of how the average number of cc of fluid the resident **actually received** per day was determined shall be present in the medical record during the 7-day look-back period that ends on the ARD. (Divide the 7 day total fluid intake by 7 to validate the average number of cc of fluid intake per day.) See examples on p. K-14 – K-16. **Record what was actually received by the resident, NOT what was ordered (p. K-15).**

M0300A – Stage 1 (page M6 – M8)	**Stage 1 Pressure Ulcer** An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues (p. M-8). **Non-Blanchable** Reddened areas of tissue that do not turn white or pale when firmly pressed with a finger or device (p. M-8). For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or sDTI that declares itself, should be coded in terms of what is assessed (seen or palpated, i.e. visible tissue, palpable bone) during the look-back period. Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. However, since CMS has adapted the NPUAP guidelines for MDS purposes, the definitions do not perfectly correlate with each stage as described by NPUAP. Therefore, you cannot use the NPUAP definitions to code the MDS. You must code the MDS according to instructions in the RAI manual. (p. M-4).	**Requirement:** Documentation to identify the presence of a pressure ulcer(s). Ulcer staging should be based on the ulcer's deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer's tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable. Documentation must be present in the medical record during the 7-day look-back period that ends on the ARD (p. M-6). Determine that each lesion being assessed is **primarily** related to pressure and that other conditions have been ruled out. If pressure is **NOT** the **primary** cause, do **NOT** code in this section (p. M-8, 9, 11, 14). Documentation in the care plan should include individualized interventions and evidence that the interventions have been monitored and modified as appropriate (p. M-9). **M0300A – Stage 1:** • A pressure ulcer with intact skin that is suspected deep tissue injury (sDTI) should **NOT** be coded as Stage 1 pressure ulcers. It should be coded as unstageable, as illustrated at http://www.npuap.org/images/NPUAP-SuspectDTI.jpb. (p. M-6).

	Stage 2 Pressure Ulcer Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, **without slough.** May also present as an intact or open/ruptured blister (p. M-9)**.** **Most Stage 2** pressure ulcers should heal in a reasonable time frame (e.g., 60 days) p. M-9 For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or sDTI that declares itself, should be coded in terms of what is assessed (seen or palpated, i.e. visible tissue, palpable bone) during the look-back period. Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. However, since CMS has adapted the NPUAP guidelines for MDS purposes, the definitions do not perfectly correlate with each stage as described by NPUAP. Therefore, you cannot use the NPUAP definitions to code the MDS. You must code the MDS according to instructions in the RAI manual. (p. M-4).	**Requirement:** Documentation to identify the presence of a pressure ulcer(s). Ulcer staging should be based on the ulcer's deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer's tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable. Documentation must be present in the medical record during the 7-day look-back period that ends on the ARD. Determine that each lesion being assessed is **primarily** related to pressure and that other conditions have been ruled out. If pressure is **NOT** the **primary** cause, do **NOT** code in this section (p. M-8, 9, 11, 14). Documentation in the care plan should include individualized interventions and evidence that the interventions have been monitored and modified as appropriate (p. M-9). • Stage 2 pressure ulcers are often related to friction and/or shearing force, and the care plan should incorporate efforts to limit these forces on the skin and tissues (p. M-9). • A Stage 2 pressure ulcer presents as a shiny or dry shallow ulcer without slough or bruising (p. M-10). • Do **NOT** code skin tears, tape burns, moisture associated skin damage, excoriation, or suspected deep tissue injury here. (p. M-10). • Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage (e.g. color change, tenderness, bogginess or firmness, warmth or coolness)

M0300B1 – Stage 2 **(page M9 – M10)**		these characteristics suggest a suspected deep tissue injury rather than a Stage 2 Pressure Ulcer. When a deep tissue injury **is** determined, do **NOT** code as a Stage 2 (p. M-10).
M0300C1 – Stage 3 **(page M11- M13)**	**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 the depth of tissue loss. May include undermining or tunneling (p. M-11). For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or sDTI that declares itself, should be coded in terms of what is assessed (seen or palpated, i.e. visible tissue, palpable bone) during the look-back period. Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. However, since CMS has adapted the NPUAP guidelines for MDS purposes, the definitions do not perfectly correlate with each stage as described by NPUAP. Therefore, you cannot use the NPUAP definitions to code the MDS. You must code the MDS according to instructions in the RAI manual. (p. M-4).	**Requirement:** Documentation to identify the presence of a pressure ulcer(s). Ulcer staging should be based on the ulcer's deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer's tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable. Documentation must be present in the medical record during the 7-day look-back period that ends on the ARD. Determine that each lesion being assessed is **primarily** related to pressure and that other conditions have been ruled out. If pressure is **NOT** the **primary** cause, do **NOT** code in this section (p. M-8, 9, 11, 14). **M0300C1 – Stage 3:** • Stage 3 pressure ulcers can be shallow, particularly on areas that do NOT have subcutaneous tissue, such as the bridge of the nose, ear, occiput, and malleolus (p. M-12). • In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure ulcers (p. M-12). • Bone/tendon/muscle is **NOT** visible or directly palpable in a Stage 3 pressure ulcer (p. M-12).
M0300D1 – Stage 4 **(page M13-M15)**	**Stage 4 Pressure Ulcer** Full thickness tissue loss with exposed bone, tendon or muscle.	**Requirement:** Documentation to identify the presence of a pressure ulcer(s). Ulcer staging

	Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling (p. M-13). **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 (p. M-14). **Undermining** The destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface (p. M-14). For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or sDTI that declares itself, should be coded in terms of what is assessed (seen or palpated, i.e. visible tissue, palpable bone) during the look-back period. Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. However, since CMS has adapted the NPUAP guidelines for MDS purposes, the definitions do not perfectly correlate with each stage as described by NPUAP. Therefore, you cannot use the NPUAP definitions to code the MDS. You must code the MDS according to instructions in the RAI manual. (p. M-4).	should be based on the ulcer's deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer's tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable. Documentation must be present in the medical record during the 7-day look-back period that ends on the ARD. Determine that each lesion being assessed is **primarily** related to pressure and that other conditions have been ruled out. If pressure is **NOT** the **primary** cause, do **NOT** code in this section (p. M-8, 9, 11, 14). • The depth of a Stage 4 pressure ulcer varies by anatomical location and can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule) making osteomyelitis possible (p. M-15).
M0300F1 – Unstageable Related to Slough and/or Eschar (page M16-M18) **M0300F1 – Unstageable Related to Slough and/or Eschar (page M16-M18)**	**Slough Tissue** Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed (p. M-16). **Eschar Tissue** Dead or devitalized tissue that is	• Pressure ulcers that are covered with slough and/or eschar should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, can the stage of the wound be

M0300F1 – Unstageable Related to Slough and/or Eschar (page M16-M18)	hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound (p. M-16). **Fluctuance** Used to describe the texture of wound tissue indicative of underling unexposed fluid (p. M-17)	determined (p. M-17). • Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heels serves as "the body's natural (biological) cover" and should only be removed after careful clinical consideration, including ruling out ischemia, and consultation with the resident's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws (p. M-17). • Once the pressure ulcer is debrided of slough and/or eschar such that the anatomic depth of soft tissue involved can be determined, then code the ulcer for the reclassified stage. The pressure ulcer does **NOT** have to be completely debrided or free of all slough and/or eschar tissue in order for reclassification of stage to occur (p. M-17). • The presence of pressure ulcers and other skin changes should be accounted for in the interdisciplinary care plan. (p. M-16). **Does NOT include:** • Coding unstageable when the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured (p. M-6); • For the purposes of coding, determine that the lesion being assessed is **primarily** related to pressure and that other conditions have been ruled out. If pressure is **NOT** the primary cause, do **NOT** code. A weekly skin assessment recorded on a log, along with other residents which does not become part of the individual resident's medical record shall **NOT** be considered as supporting documentation for validation purposes.

		A weekly skin assessment shall be part of the individual resident's medical record during the 7-day look-back period that ends on the ARD.
M1030 Number of Venous and Arterial Ulcers (page M30-M32)	**Venous Ulcers** Ulcers caused by peripheral venous disease, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg (p. M-31). • Venous ulcers may or may not be painful and are typically shallow with irregular wound edges, a red granular (e.g., bumpy) wound bed, minimal to moderate amounts of yellow fibrinous material, and moderate to large amounts of exudate. The surrounding tissues may be erythematous or reddened, or appear brown-tinged due to hemosiderin staining. Leg edema may also be present (p. M-31). • The wound may start with some kind of minor trauma, such as hitting the leg on a wheelchair. The wound does not typically occur over a bony prominence, and pressure forces play virtually **NO** role in the development of the ulcer (p. M-32).	**Requirement:** Documentation of the presence of any venous or arterial ulcers shall be present in the medical record, including skin care flow sheet or other skin tracking form during the 7-day look-back period that ends on the ARD. • The presence of venous and arterial ulcers should be accounted for in the interdisciplinary care plan (p. M-31). **Does NOT include:** • Pressure ulcers coded in M0210 through M0900 (p. M-31).
M1030 Number of Venous and Arterial Ulcers (page M30-M32)	**Hemosiderin** An intracellular storage form of iron; the granules consist of an ill-defined complex of ferric hydroxides, polysaccharides, and proteins having an iron content of approximately 33% by weight. It appears as a dark yellow-brown pigment (p. M-31). **Arterial Ulcers**	

	Ulcers caused by peripheral arterial disease, which commonly occur on the tips and tops of toes, tops of the foot, or distal to the medial malleolus (p. M-31). • Arterial ulcers are often painful and have a pale pink wound bed, necrotic tissue, minimal exudate, and minimal bleeding (p. M-31). • Include trophic skin changes (e.g., dry skin, loss of hair growth, muscle atrophy, brittle nails) may also be present. The wound may start with some kind of minor trauma, such as hitting the leg on a wheelchair. The wound does NOT typically occur over a bony prominence, however, can occur on the tops of the toes. Pressure forces play virtually no role in the development of the ulcer, however, for some residents, pressure may play a part. Ischemia is the major etiology of these ulcers. Lower extremity and foot pulses may be diminished or absent (p. M-32).	
M1040A Infection of the Foot	• Cellulitis; • Purulent drainage	**Requirement:** Documentation of signs, symptoms and a corresponding physician order for treatment of infection of the foot shall be present in the medical record, including skin care flow sheet or other skin tracking form during the 7-day look-back period that ends on the ARD: • Description of diabetic foot ulcer(s), (i.e., location, appearance, etc.); • The presence of wounds and skin changes should be

		accounted for in the interdisciplinary care plan (p. M-33). **Does NOT include:** • Ankle. The ankle is **NOT** part of the foot (p. M-40); • Pressure ulcers coded in M0200 through M0900 (p. M-33).
M1040B **Diabetic Foot Ulcer(s)** **(Page M-33, 34)** **M1040B** **Diabetic Foot Ulcer(s)**	**Diabetic Foot Ulcers** Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load-bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate and callused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. The wounds are typically not painful (p. M-33).	**Requirement:** Documentation of signs, symptoms and a corresponding physician order for treatment of diabetic foot ulcer(s) shall be present in the medical record, including skin care flow sheet or other skin tracking form during the 7-day look-back period that ends on the ARD: • Description of diabetic foot ulcer(s), (i.e., location, appearance, etc.) and • The presence of wounds and skin changes should be accounted for in the interdisciplinary care plan (p. M-33). **Does NOT include:** • Pressure ulcers that occur on residents with diabetes mellitus here. For example, an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and **NOT** a diabetic foot ulcer (p. M-34); • Ankle. The ankle is **NOT** part of the foot (p. M-40); • Pressure ulcers coded in M0200-M0900 (p. M-33).
M1040C **Other Open Lesion(s) on the Foot**	**Example: Cuts, Fissures**	**Requirement:** Documentation of signs, symptoms and a corresponding physician order for treatment of other open lesion(s) on the foot shall be present in the medical record, including skin care flow sheet or other skin tracking form during the 7-day look-back period that ends on the ARD. **Does NOT Include:**

(page M-33)		• Ankle. The ankle is **NOT** part of the foot (p. M-40); • Pressure ulcers that occur on residents with diabetes mellitus here. For example, an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and **NOT** a diabetic foot ulcer (p. M-34); A "cyst", not otherwise described, would **NOT** be coded as an open lesion. Documentation of a cyst does **NOT** meet the criteria of "open".
M1040D **Open Lesion(s) Other than Ulcers, Rashes, Cuts** **(page M-33, 34)** **M1040D** **Open Lesion(s) Other than Ulcers, Rashes, Cuts**	**Open Lesion Other Than Ulcers, Rashes, Cuts** Most typically skin ulcers that develop as a result of disease and conditions such as syphilis and cancer. (page M-33)	**Requirement:** Documentation of signs, symptoms and a corresponding physician order for treatment of open lesion(s) other than ulcers, rashes, cuts shall be present in the medical record, including skin care flow sheet or other skin tracking form during the 7-day look-back period that ends on the ARD. **Does NOT include:** • Rashes; • Skin tears, • Cuts or • Lacerations (p. M-34) Although **NOT** recorded on the MDS assessment, these open lesions should be considered in the plan of care (p. M-34). A cyst, not otherwise described, would **NOT** be coded as an open lesion. Documentation of a cyst does **NOT** meet the criteria of being **"open".**

M1040E **Surgical Wound(s)** **(page M-33, 34)**	**Surgical Wounds** Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites (p. M-33).	**Requirement:** Documentation of the location, appearance and a corresponding physician order for treatment of the surgical wound shall be present in the medical record, including skin care flow sheet or other skin tracking form during the 7-day look-back period that ends on the ARD. Pressure ulcers that are surgically repaired with grafts and flap procedures are appropriate here (p. M-31) **Does NOT include:** • Healed surgical sites and stomas or lacerations that require suturing or butterfly closure;(p. M-34) • PICC sites, central line sites and peripheral IV sites; (p. M-34) • Pressure ulcers that have been surgically debrided. They continue to be coded as pressure ulcers (p. M-34)
M1040F **Burn(s)** **(page M-33, 35)**	**Burns (Second or Third Degree)** Skin and tissue injury caused by heat or chemicals and may be in any stage of healing (p. M-33).	**Requirement:** Documentation of burns (second or third degree only) caused by heat or chemicals including location, appearance and a corresponding physician order for treatment of the burn shall be present in the medical record, including skin care flow sheet or other skin tracking form during the 7-day look-back period that ends on the ARD. **Does NOT include:** • First-degree burns (changes in skin color only). (p. M-35)

M1200A Pressure Reducing Device for Chair **M1200B Pressure Reducing Device for Bed** **M1200A, M1200B** **(PAGE M-37)**	**Pressure Reducing Device(s)** Equipment that aims to relieve pressure away from areas of high risk. May include foam, air, water, gel or other cushioning placed on a chair, wheelchair or bed. Include pressure relieving, pressure reducing and pressure redistributing devices. Devices are available for use with beds and seating (p. M-37). Some skin treatments can be determined by observation. For example, observation of the resident's wheelchair and bed will reveal if the resident is using pressure-reducing devices for the bed or wheelchair (p. M-37). Pressure reducing devices redistribute pressure so that there is some relief on or near the area of the ulcer. The appropriate reducing (redistribution) device should be selected based on the individualized needs of the resident (p. M-38).	**Requirement:** Documentation of equipment that aims to relieve pressure away from areas of high risk with a health care provider (physician) order shall be present in the medical record, including treatment records during the 7-day look-back period that ends on the ARD. Some skin treatments may be part of routine standard care for residents, so check the nursing home's policies and procedures and indicate here if administered during the look-back period (p. M-37). Documentation for a pressure reducing device to chair or bed shall include the type of device (e.g., foam, air, low air-loss therapy beds, flotation, etc.) or the brand name. **Does NOT include:** • Egg crate cushions of any type in this category; • Doughnut or ring devices in chairs (p. M-38); A bed pillow in a chair or wheelchair; A foot cradle. Clinically speaking, a foot cradle is used to relieve the weight of the bed linens from the feet and lower legs. Therefore, it is a mattress device used for different reasons.

M1200C Turning/ Repositioning Program (page M-38)	**Turning/Repositioning Program** Includes a consistent program for changing the resident's position and realigning the body. **"Program is defined as a specific approach that is organized, planned, documented, monitored and evaluated based on an assessment of the resident's needs." (p. M-38).**	**Requirement:** Documentation of a **program** specific as to the approaches for changing the resident's position and realigning the body. The **program** should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours). Progress notes, assessments and other documentation (as dictated by facility policy) should support that the turning/repositioning **program** is monitored and reassessed to determine the effectiveness of the intervention and shall be present in the medical record during the 7-day look-back period that ends on the ARD (p. M-38).
M1200D Nutrition or Hydration Intervention to Manage Skin Problems (page M-38)	**Nutrition or Hydration Intervention to Manage Skin Problems** Dietary measures received by the resident for the **purpose of preventing or treating specific skin conditions,** (e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplements to prevent skin breakdown, high protein supplements for wound healing). P. M-38.	**Requirement:** Documentation of dietary measures received by the resident for the **purpose of preventing or treating any specific documented skin conditions(s)** with a corresponding physician order shall be present in the medical record during the 7-day look-back period that ends on the ARD (p. M-38).
M1200E Pressure Ulcer Care (page M-39)	Pressure ulcer care includes **any** intervention for treating pressure ulcers coded in **Current Number of Unhealed Pressure Ulcers at Each Stage, (M0300).** Examples may include the use of topical dressings, enzymatic, mechanical, or surgical debridement, wound irrigations, negative pressure wound therapy (NPWT), and/or hydrotherapy (p. M-39).	**Requirement:** Documentation of ulcer care with a corresponding physician order shall be present in the medical record during the 7-day look-back period that ends on the ARD (p. M-39). Examples may include: • Use of topical dressings; • Enzymatic, Mechanical or Surgical debridement; • Wound irrigations; • Negative pressure wound therapy (NPWT); and/or Hydrotherapy.

M1200F Surgical Wound Care (page M-39)	Surgical wound care may include any intervention for treating or protecting any type of surgical wound. (page M-39)	**Requirement:** Documentation of any intervention for treating or protecting any type of surgical wound with a corresponding physician order shall be present in the medical record during the 7-day look-back period that ends on the ARD. Examples may include: • Topical cleansing; • Wound irrigation; • Application of antimicrobial ointments; • Application of dressings of any type; • Suture/staple removal; • Warm soaks or heat application (p. M-39). **Does NOT include:** • Post-operative care following eye or oral surgery; • Surgical debridement of a pressure ulcer continues to be coded as a pressure ulcer (p. M-39). ***Observation only** of the surgical wound.
M1200G Application of Non-Surgical Dressings (with or without Topical Medications) Other than to Feet **(page M-40)**	Dressings do **NOT** have to be applied daily in order to be coded on the MDS assessment. If any dressing meeting the MDS definitions was applied even once during the 7-day look-back period, the assessor should check that MDS item (p. M-40).	**Requirement:** Documentation of application of non-surgical dressings (with or without topical medications) other than to the feet with a corresponding physician order shall be present in the medical record during the 7-day look-back period that ends on the ARD. This may include but is not limited to: • Dry gauze dressings; • Dressings moistened with saline or other solutions; • Transparent dressings; • Hydrogel dressings; • Dressings with hydrocolloid or hydroactive particles used to treat a skin condition; • Compression bandages (p. M-35). Curagel dressings are pre-treated and should be coded under M1200G.

M1200G Application of Non-Surgical Dressings (with or without Topical Medications) Other than to Feet		**Does NOT include:** • Application of non-surgical dressings for pressure ulcer(s) on the foot in this item; use **Ulcer Care** (M1200E) p. M-40. The application of a Band-Aid does **NOT** meet the definition of a dressing **IF** applied for ulcer care or wound care. A Tegaderm dressing that was applied prior to the 7-day observation period and nurses are only checking to see that it is still intact does **NOT** meet the definition of application of dressing. If the dressing was **NOT APPLIED** during the 7-day look-back period that ends on the ARD, do **NOT** code it as it will **NOT** be supported for validation purposes.
M1200H Application of Ointments/ Medications Other than to Feet **(page M-40)**	Applications of ointments/medications **not applied to feet**	**Requirement:** Documentation of application of ointments/medications other than to feet with a corresponding physician order shall be present in the medical record during the 7-day look-back period that ends on the ARD. This may include: • Ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents); • Topical creams; • Powders; and • Liquid sealants used to treat or prevent skin conditions (p. M-40).

M1200H Application of Ointments/ Medications Other than to Feet		**Does NOT include:** • Application of ointments/medications (e.g., chemical or enzymatic debridement) for pressure ulcers here; use **Ulcer Care**, (M1200E). p. M-40 • Ointments/medications used to treat • non-skin conditions (e.g., nitro-paste for chest pain). p. M-40 Crisco does **NOT** meet the criteria for application of ointments/medications. Crisco is neither an ointment nor a medication. Eye drops do **NOT** meet the criteria for application of ointments/ medications. Normal saline does **NOT** meet the criteria for application of ointments/ medications. Curagel dressings are pre-treated and should **NOT** be coded under M1200H.
M1200I Application of Dressings to the Feet (with or without Topical Medications) **(page M-40)**		**Requirement:** Documentation of application of dressings to the feet (with or without topical medication) including interventions to treat any foot wound or ulcer **other than a pressure ulcer** with a corresponding physician order shall be present in the medical record during the 7-day look-back period that ends on the ARD. **Does NOT include:** • Application of dressings to pressure ulcers on the foot, use Pressure Ulcer Care (M1200E); • Application of dressings to the ankle. The ankle is **NOT** part of the foot (p. M-40).

N0300 **Injections** **7-day look-back** **p. N-1 – N-2**	• For subcutaneous pumps, code only the number of days that the resident **ACTUALLY** required a subcutaneous injection to restart the pump (p. N-2). • If an antigen or vaccination is provided on 1 day, and another vaccine provided on the next day, the number of days the resident received injections would be **coded 2 days** (p. N-2). • If two injections were administered on the same day, the number of days the resident received injections would be **coded 1 day** (p. N-2).	**Requirement:** Documentation of the number of days that the resident received any type of medication, antigen, vaccine, etc., by subcutaneous, intramuscular, or intradermal injection **while a resident of the nursing home** (p. N-1) shall be present in the resident's medication administration records during the 7-day look-back period that ends on the ARD (or since admission/reentry if less than 7 days). P. N-1 Review documentation from other health care locations where the resident may have received injections **while a resident of the nursing home** (e.g., flu vaccine in a physician's office, in the emergency room – **as long as the resident was not admitted**). p. N-1 Insulin injections are counted in this item as well as in N0350 (p. N-1).

O0100A 1 or 2 Chemotherapy **O0100A 1 or 2 14-day look-back p. O-1 – O-5**	Each drug should be evaluated to determine its reason for use before coding it here. The drugs coded here are those **actually used for cancer treatment** (p. O-2).	Documentation of any type of chemotherapy agent administered as an anti-neoplastic (only those actually used for cancer treatment) given by any route with a corresponding physician order shall be present in the medical record during the 14-day look-back period that ends on the ARD. **Does NOT include:** • Megace being given only for appetite stimulation as the resident is **NOT** receiving the Megace for chemotherapy purposes ;(p. O-2). • IV's, IV medication, and blood transfusion administered during chemotherapy are **NOT** recorded under K0500A (Parenteral/IV), O0100H (IV Medications) and O0100I (Transfusions), (p. O-2). When a resident with a cancer diagnosis is given a long-acting chemotherapy treatment once every 3 months, it should **NOT** be coded unless it was given within the 14-day look-back period that ends on the ARD.
O0100B 1 or 2 Radiation **14-day look back p. O-1 – O-5**		**Requirement:** Documentation of the resident receiving intermittent radiation therapy, as well as, radiation administered via radiation implant with a corresponding physician order shall be present in the medical record during the 14-day look-back period that ends on the ARD.
O0100C 1 or 2 Oxygen Therapy	* The use of "emergency oxygen" <u>without a physician's order</u> will still apply when supporting documentation is present in the medical record during the 14-day look-back period that ends on the ARD.	**Requirement:** Documentation of continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia or oxygen used in BiPAP/CPAP with a corresponding physician order shall be present in the medical record during the 14-day look-back period that ends on the ARD.

O0100C 1 or 2 Oxygen Therapy **14-day look-back p. O-1 – O-5**		**Does NOT include:** Hyperbaric oxygen for wound therapy (p. O-3).
O0100D 1 or 2 Suctioning **14-day look-back p. O-1 – O-5**		**Requirement:** Documentation of the resident receiving tracheal and/or nasopharyngeal suctioning with a corresponding physician order shall be present in the medical record during the 14-day look-back period that ends on the ARD. **Does NOT include:** • Oral suctioning (p. O-3).
O0100E 1 or 2 Tracheostomy Care **14-day look-back p. O-1 – O-5**		**Requirement:** Documentation of cleansing of the tracheostomy and/or cannula with a corresponding physician order shall be present in the medical record during the 14-day look-back period that ends on the ARD (p. O-3). *When a resident has a tracheostomy with a disposable cannula and there is no cleansing required (only replacement), it would **NOT** be coded as "tracheostomy care" **UNLESS** the disposable cannula was changed during the 14-day look-back period that ends on the ARD.
O0100F 1 or 2 Ventilator or Respirator		**Requirement:** Documentation of any type of electrically or pneumatically powered closed-system mechanical ventilator support devices that ensure adequate ventilation in the resident who is, or who may become, unable to support his or her own respiration with a corresponding physician order shall be present in the medical record during the 14-day look-back period that ends on the ARD. This item also includes a resident who is being weaned off of a respirator or ventilator in the last 14 days.

O0100F 1 or 2 Ventilator or Respirator **14-day look-back p. O-1 – O-5**		**Does NOT include:** • When the ventilator or respirator is used ONLY as a substitute for BiPAP or CPAP (p. O-3).
O0100H, 1 or 2 IV Medications **14-day look-back p. O-1 – O-5**	Epidural, intrathecal, and baclofen pumps may be coded here, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance (p. O-3). To determine what products are considered medication or more information consult the FDA website: The Orange Book, http://www.fda.gov/cder/ob/default.htm The National Drug Code Directory, http://www.fda.gov.cder/ndc/database/default.htm	**Requirement:** Documentation of any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port with a corresponding physician order shall be present in the medical record during the 14-day look-back period that ends on the ARD. **Does NOT include:** • Flushes to keep an IV access port patent; • IV fluids without medication; • Subcutaneous pumps; • IV medications of any kind that were administered during dialysis or chemotherapy; • Dextrose 50% and/or Lactated Ringers given IV (p. O-3).

O0100I, 1 or 2 Transfusions **14-day look-back p. O-1 – O-5**		**Requirement:** Documentation of transfusions of blood or any blood products (e.g., platelets, synthetic blood products) which are administered directly into the bloodstream with a corresponding physician order shall be present in the medical record during the 14-day look-back period that ends on the ARD. **Does NOT include:** • Transfusions that were administered during dialysis or chemotherapy (p. O-4).
O0100J, 1 or 2 Dialysis **14-day look-back p. O-1 – O-5**		**Requirement:** Documentation of peritoneal or renal dialysis that occurs at the nursing home or at another facility and treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) with a corresponding physician order shall be present in the medical record during the 14-day look-back period that ends on the ARD. • IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are **NOT** to be coded under K0510A (Parenteral/IV), O0100H (IV medications) and O0100I (Transfusions), (p. O-4).

O0400A, Speech-Language Pathology and Audiology Services 1, 2 & 3 **O0400B, Occupational Therapy 1, 2 & 3** **O0400C, Physical Therapy 1, 2 & 3** **<u>Therapy Minutes</u>**	1. **Individual minutes:** total number of minutes of therapy that were provided on an individual basis in the last 7 days. Individual services are provided by one therapist or assistant to one resident at a time (p. O-16). 2. **Concurrent minutes:** total number of minutes of therapy that were provided on a concurrent basis in the last 7 days (p. O-16). **Concurrent therapy** is defined as the treatment of 2 residents at the same time, when the residents are not performing the same or similar activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant for Medicare Part A. **For Part B**, residents may **NOT** be treated concurrently: a therapist may treat one resident at a time, and the minutes during the day when the resident is treated individually are added, even if the therapist provides that treatment intermittently (first to one resident and then to another). P. O-16 3. **Group minutes:** total number of minutes of therapy that were provided in a group in the last 7 days (p. O-16). **Group therapy** is defined for Part A as the treatment of 4 residents, regardless of payer source, who are performing similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals (p. O-24).	**Requirement:** Documentation of actual therapy minutes with associated initials/signature(s) shall be present in the medical record (e.g., rehabilitation therapy evaluation and treatment records, therapy notes and progress notes) on a daily basis to support the total number of minutes of therapy provided with a corresponding physician order during the 7-day look-back period that ends on the ARD. **The medically necessary therapies shall meet ALL of the following criteria:** **1. Ordered by a physician (physician's assistant, nurse practitioner, and/or clinical nurse specialist) based on a qualified therapist's assessment (i.e., one who meets Medicare requirements or, in some instances, under such a person's direct supervision) and treatment plan,** **2. Documented in the resident's medical record AND** **3. Care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective (p. O-16).** **Includes:** • Only medically necessary therapies that occurred after admission/readmission to the nursing home; • If a resident returns from a hospital stay, an initial evaluation must be performed after entry to the facility, and only those therapies that occurred since admission/reentry to the facility and after the initial evaluation shall be counted; • **Actual therapy minutes ONLY;**

7-day look-back p. O-14 – O-32	**For Medicare Part B,** treatment of 2 or more individuals simultaneously who may or may not be performing the same activity, regardless of payer source, at the same time is documented as group treatment (p. O-25). ***Co-treatment** is defined as two clinicians, each from a different discipline, treating one resident at the same time. The clinicians must split the time between the two disciplines as they deem appropriate. They may not each count the treatment session in full, and the split times when added may not exceed the actual total amount of the treatment session (p. O-21). Please note that **therapy logs** are not an MDS requirement but reflect a standard clinical practice expected of all therapy professionals. **These therapy logs may be used to verify the provision of therapy services in accordance with the plan of care and to validate information reported on the MDS assessment (p. O-19).** **For definitions of the types of therapies listed in this section, please refer to the Glossary in Appendix A (p. O-16).**	• Time provided for each therapy must be documented separately; • Therapist's time spent on subsequent reevaluations; • Set-up time required to adjust equipment or otherwise prepare for the individualized therapy of a particular resident; • Co-treatment when minutes are split between disciplines and do not exceed the total time • Therapy treatment inside or outside the facility **Does NOT include:** • Therapies that occurred while the person was an inpatient at a hospital or recuperative/rehabilitation center or other long-term care facility, or a recipient of home care or community-based services; • Therapist's time spent on documentation or on initial evaluation; • Conversion of units to minutes; • **Rounding to the nearest 5th minute;** • Services provided, at the request of the resident or family, that are **NOT** medically necessary (sometimes referred to as family-funded services) even when performed by a therapist or an assistant; • Restorative nursing program; • Services provided by therapy aides; • Services provided by a speech language pathology assistant (p. O-14 – O-32). CMS has not approved Anodyne (Infrared) treatments. They are still considered "investigative/ experimental" at this time. The review nurse(s) shall **NOT** give credit for these treatments if documented on the MDS. All such treatments will be referred to DMS until further clarification is received from CMS.

O0400A4, Speech-Language Pathology and Audiology Services **O0400B4, Occupational Therapy** **O0400C4, Physical Therapy** **<u>Therapy Days</u>** **7-day look-back p. O-14 – O-32**	**Days:** Total number of days therapy services were provide in the last 7 days. A day of therapy is defined as <u>skilled</u> treatment for 15 minutes or more during the day (p. O-17). **Therapy Start Date:** Enter the date the most recent therapy regimen (since the most recent entry) started. This is the date the therapy initial evaluation is conducted regardless if treatment was rendered or not (p. O-17). **Therapy End Date:** Enter the date the most recent therapy regimen (since the most recent entry) ended. This is the last date the resident <u>received</u> skilled therapy treatment (p. O-17).	**Requirement:** Documentation of **actual** therapy days that <u>skilled</u> treatment was provided for 15 minutes or more per day with associated initials/signature(s) shall be present in the medical record to support the total number of days of therapy provided during the 7-day look-back period that ends on the ARD. **The medically necessary therapies shall meet ALL of the following criteria:** 1. **Ordered by a physician based on a qualified therapist's assessment and treatment plan,** 2. **Documented in the resident's medical record AND** 3. **Care planned and periodically evaluated**. **Does NOT include:** • Treatment for less than 15 minutes per day (p. O-17).
O0400D2, Respiratory Therapy	Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function. Respiratory therapy services include coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds and mechanical ventilation, etc. which must be provided by a respiratory therapist or trained respiratory nurse. A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under	**Requirement:** Documentation of actual therapy days that treatment was provided for 15 minutes or more per day with associated initials/signature(s) shall be present in the medical record to support the total number of days of therapy provided during the 7-day look-back period that ends on the ARD. <u>The review nurse(s) shall look at: 1) the respiratory therapy documentation that occurred during the 7-day look-back period that ends on the ARD, 2) verify the physician's order and the therapist's (qualified professional, i.e., trained nurse, respiratory therapist) assessment, and 3) determine that the treatment plan is documented in the resident's medical record.</u> <u>The review nurse **MUST see ACTUAL** therapy minutes in order to give credit for</u>

	applicable state laws. (Appendix A)	respiratory therapy. **The medically necessary therapies shall meet ALL of the following criteria:** **The physician orders the therapy** **The physician's order includes a statement of frequency, duration, and scope of treatment** **The services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by the qualified personnel** **The services are required and provided by qualified personnel** **The services must be reasonable and necessary for treatment of the resident's condition. (p. O-20)** **Does NOT include:** • Treatment for less than 15 minutes per day (p. O-16)
Restorative Nursing Programs **Technique** **Activities provided by restorative nursing staff** **O0500A, Range of Motion (Passive)**	Provision of **passive** movements in order to maintain flexibility and useful motion in the joints of the body. These exercises must be individualized to the resident's needs, planned, monitored, evaluated and documented in the resident's medical record (p. O-37). • For range of motion **(passive)**: the caregiver moves the body part around a fixed point or joint through the resident's available range of motion. **The resident provides no assistance** (p. O-38). • ***** Range of Motion **(Passive)** was not changed by CMS; therefore, Assisted PROM (APROM) will **NOT** be accepted by the review nurse(s) as supporting documentation for validation purposes.	**Requirement:** **Separate documentation of each of the restorative nursing program(s) that are planned, scheduled, supervised, and evaluated** shall be present in the restorative nursing program notes and/or flow sheets in the medical record with initials/signature(s) to support the total number of days that restorative nursing was provided 15 minutes or more during the 7-day look-back period that ends on the ARD. • **IF** the resident is receiving splint or brace assistance, an assessment by a licensed nurse that includes an evaluation of the resident's skin and circulation under the device and repositioning the limb in correct alignment for splint or brace assistance shall be present in the restorative nursing program notes and/or flow sheets in the medical record during the 7-day look-back period that ends on the ARD.

O0500B, Range of Motion (Active)	Exercises performed by the resident with cueing, supervision, or physical assist by staff that are individualized to the resident's needs, planned, monitored, evaluated and documented in the resident's medical record. Include **active** ROM and **active-assisted** ROM (p. O-37). • For range of motion **(active)**: any participation by the resident in the ROM activity should be coded here (p. O-38).	**The restorative nursing program shall meet ALL of the following criteria:** **1. Measurable objectives and interventions must be documented in the care plan and in the medical record.** If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals and duration/frequency as part of the care planning process. **Good clinical practice would indicate that the results of this reassessment should be documented in the record.** **2.** Evidence of periodic evaluation by the licensed nurse must be present in the medical record. A progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established. **3.** Nursing assistants/aides must be trained skilled in the techniques that promote resident involvement in the activity. *The field review nurse(s) shall look for training **IF** a nursing assistant/aide provides the services. **4.** A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a nursing restorative program. **5.** This category does **NOT** include groups with more than four residents per supervising helper or caregiver (p. O-36). ***When residents are part of a group, documentation shall identify the residents in the group, the program(s)**
O0500C, Splint or Brace Assistance **<u>Training and Skill Practice</u>** **Activities including repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse.**	Provision of (1) verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint; **OR** (2) a scheduled program of applying and removing a splint or brace. These sessions are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record (p. O-37). • **For splint or brace assistance: assess the resident's skin and circulation under the device, and reposition the limb in correct alignment (p. O-38).**	

O0500D, Bed Mobility	Activities provided to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side and positioning himself or herself in bed. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record (p. O-37).	**provided, the minutes and days and the initials/signatures of nursing staff providing the program(s).** • The use of continuous passive motion (CPM) devices as nursing restorative care can be coded when the following criteria are met: 1. Ordered by a physician; 2. Nursing staff have been trained in technique (e.g., properly aligning resident's limb in device, adjusting available range of motion) **AND** 3. Monitoring of the device. Nursing staff should document the application of the device and the effects on the resident. Do **NOT** include the time the resident is receiving treatment in the device. Include only the actual time staff was engaged in applying and monitoring the device (p. O-38-39). **Does NOT include:** • Procedures or techniques carried out by or under the direction of qualified therapists, (p. O-36); • For both active and passive range of motion, movement by a resident that is incidental to dressing, bathing, etc. (p. O-38).
O0500E, Transfer	Activities provided to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record (p. O-37).	
O0500F, Walking	Activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record (p. O-37).	
O0500G, Dressing and/or Grooming	Activities provided to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record (p. O-38). Grooming programs, including programs to help residents learn to apply make-up, may be considered restorative nursing programs when	

	conducted by a member of the activity staff. These grooming programs would need to be individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record (p. O-39).	
O0500H, Eating and/or Swallowing	Activities provided to improve or maintain the resident's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record (p. O-38).	
O0500I, Amputation/ Prosthesis Care	Activities provided to improve or maintain the resident's self-performance in putting on and removing prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket). **Dentures are NOT considered to be prostheses for coding this item.** These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record (p. O-38).	
O0500J, Communication **7-day look-back p. O-35 – O-41**	Activities provided to improve or maintain the resident's self-performance in functional communication skills or assisting the resident in using residual communication skills and adaptive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record (p. O-38).	

O0600 Physician Examination	*Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law (p. O-42). Examination (partial or full) can occur in the facility or in the physician's office. Included in this item are telehealth visits as long as the requirements are met for physician/practitioner type as defined above and whether it qualifies as a telehealth billable visit. For eligibility requirements and additional information about Medicare telehealth services refer to: Chapter 15 of the Medicare Benefit Policy Manual (Pub. 100-2) and Chapter 12 of the Medicare Claims Processing Manual (Pub. 100-4) may be accessed at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html. (p.O-42)	**Requirement:** Documentation shall establish **the number of days** an exam was **actually** conducted by the *physician to be counted as a physician examination (e.g., partial or full exam in the facility or in the physician's office) in the medical record during the 14-day look-back period that ends on the ARD (p.O-42). If a resident is evaluated by a physician off-site (e.g., while undergoing dialysis or radiation therapy), it can be coded as a physician examination as long as documentation of the physician's evaluation is included in the medical record. The physician's evaluation can include partial or complete examination of the resident, monitoring the resident for response to the treatment, or adjusting the treatment as a result of the examination (p. O-42). **Does NOT include:** • Exams that occurred prior to admission or readmission to the facility (e.g., during the resident's acute care stay); • Exams that occurred during an ER visit or hospital observation stay; • Visits by Medicine Men (p. O-42); Nursing note simply stating, "MD here. New orders noted." The licensed psychological therapy by a Psychologist (PhD) should be recorded in O0400E, **Psychological Therapy** (p. O-42).

O0700 **Physician Orders**	*Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law (p. O-43). If a resident has multiple physicians (e.g., surgeon, cardiologist, internal medicine), and they all visit and write orders on the same day, the MDS must be coded as 1 day in which orders were changed (p.O-44) *A lab order is considered to be a physician's order for validation purposes if the order is documented in the medical record and dated during the 14-day look-back period that ends on the ARD.	**Requirement:** Documentation shall establish **the number of days** the *physician changed the resident's orders in the medical record during the 14-day look-back period that ends on the ARD. This may include: • Written, telephone, fax, or consultation orders for new or altered treatment • Orders written on the day of admission as a result of an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes; • Orders requesting a consultation by another physician may be counted. **However, the order must be reasonable (e.g., for a new or altered treatment).** P. O-44 **Does NOT include:** • Standard admission orders; return admission orders, renewal orders, or clarifying orders without changes; • **Orders prior to the date of admission or re-entry;** • A sliding scale dosage schedule that is written to cover different dosages depending on lab values, simply because a different does is administered based on the sliding scale guidelines; • When a PRN (as needed) order was already on file, the potential need for the service had already been identified. Notification of the physician that the PRN order was activated does **NOT** constitute a new or changed order and may **NOT** be counted when coding this item; • A monthly Medicare Certification is a renewal of an existing order and should **NOT** be included when coding this item. • **Orders to increase the resident's RUG classification and facility payment are NOT acceptable;** • Orders for transfer of care to another
O0700 **Physician Orders**	**An order written on the last day of the MDS observation period for a consultation planned 3-6 months in the future should be carefully reviewed (p. O-44).**	

O0700 **Physician Orders**		physician; • Orders written by a pharmacist; (p. O-44) PT Evaluation; Change LOC from SNF to ICF; Move resident from Room 6 to Room 9. D/C Skilled Level of Care; Admit to NF Level of Care.