

SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

Intent: The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received during the specified time periods.

O0100: Special Treatments, Procedures, and Programs

Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.

O0100. Special Treatments, Procedures, and Programs		
Check all of the following treatments, procedures, and programs that were performed during the last 14 days		
1. While NOT a Resident Performed <i>while NOT a resident</i> of this facility and within the last 14 days . Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank 2. While a Resident Performed <i>while a resident</i> of this facility and within the last 14 days	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
Cancer Treatments		
A. Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
B. Radiation	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Treatments		
C. Oxygen therapy	<input type="checkbox"/>	<input type="checkbox"/>
D. Suctioning	<input type="checkbox"/>	<input type="checkbox"/>
E. Tracheostomy care	<input type="checkbox"/>	<input type="checkbox"/>
F. Ventilator or respirator	<input type="checkbox"/>	<input type="checkbox"/>
G. BiPAP/CPAP	<input type="checkbox"/>	<input type="checkbox"/>
Other		
H. IV medications	<input type="checkbox"/>	<input type="checkbox"/>
I. Transfusions	<input type="checkbox"/>	<input type="checkbox"/>
J. Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
K. Hospice care	<input type="checkbox"/>	<input type="checkbox"/>
L. Respite care	<input type="checkbox"/>	<input type="checkbox"/>
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	<input type="checkbox"/>	<input type="checkbox"/>
None of the Above		
Z. None of the above	<input type="checkbox"/>	<input type="checkbox"/>

Item Rationale

Health-related Quality of Life

- The treatments, procedures, and programs listed in Item O0100, Special Treatments, Procedures, and Programs, can have a profound effect on an individual's health status, self-image, dignity, and quality of life.

00100: Special Treatments, Procedures, and Programs (cont.)

Planning for Care

- Reevaluation of special treatments and procedures the resident received or performed, or programs that the resident was involved in during the 14-day look-back period is important to ensure the continued appropriateness of the treatments, procedures, or programs.
- Residents who perform any of the treatments, programs, and/or procedures below should be educated by the facility on the proper performance of these tasks, safety and use of any equipment needed, and be monitored for appropriate use and continued ability to perform these tasks.

Steps for Assessment

1. Review the resident's medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the last 14 days.

Coding Instructions for Column 1

Check all treatments, procedures, and programs received or performed by the resident **prior** to admission/entry or reentry to the facility and within the 14-day look-back period. Leave Column 1 blank if the resident was admitted/entered or reentered the facility more than 14 days ago. If no items apply in the last 14 days, **check Z, none of the above**.

Coding Instructions for Column 2

Check all treatments, procedures, and programs received or performed by the resident **after** admission/entry or reentry to the facility and within the 14-day look-back period.

Coding Tips

- Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.
- **00100A, Chemotherapy**

Code any type of chemotherapy agent administered as an antineoplastic given by any route in this item. 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. For example, megestrol acetate is classified in the **Physician's Desk Reference (PDR)** as an antineoplastic drug. One of its side effects is appetite stimulation and weight gain. If megestrol acetate is being given only for appetite stimulation, do **not** code it as chemotherapy in this item, as the resident is not receiving the medication for chemotherapy purposes in this situation. IV's, IV medication, and blood transfusions administered during chemotherapy are **not** recorded under items K0510A (Parenteral/IV), O0100H (IV Medications), or O01001 (Transfusions).

- **00100B, Radiation**

Code intermittent radiation therapy, as well as radiation administered via radiation implant in this item.

O0100: Special Treatments, Procedures, and Programs (cont.)

- **O0100C, Oxygen therapy**

Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item. This item may be coded if the resident places or removes his/her own oxygen mask, cannula.

- **O0100D, Suctioning**

Code only tracheal and/or nasopharyngeal suctioning in this item. Do not code oral suctioning here. This item may be coded if the resident performs his/her own tracheal and/or nasopharyngeal suctioning.

- **O0100E, Tracheostomy care**

Code cleansing of the tracheostomy and/or cannula in this item. This item may be coded if the resident performs his/her own tracheostomy care.

- **O0100F, Ventilator or respirator**

Code 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 in this item. A resident who is being weaned off of a respirator or ventilator in the last 14 days should also be coded here. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.

- **O0100G, BiPAP/CPAP**

Code any type of CPAP or BiPAP respiratory support devices that prevent the airways from closing by delivering slightly pressurized air through a mask continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask enables the individual to support his or her own respiration by providing enough pressure when the individual inhales to keep his or her airways open, unlike ventilators that “breathe” for the individual. If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes his/her own BiPAP/CPAP mask.

- **O0100H, IV medications**

Code any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Do **not** code flushes to keep an IV access port patent, or IV fluids without medication here. 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. Subcutaneous pumps are **not** coded in this item. Do **not** include IV medications of any kind that were administered during dialysis or chemotherapy. Dextrose 50% and/or Lactated Ringers given IV are not considered medications, and should not be coded here. To determine what products are considered medications or for 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>

O0100: Special Treatments, Procedures, and Programs (cont.)

- **O0100I, Transfusions**

Code transfusions of blood or any blood products (e.g., platelets, synthetic blood products), which are administered directly into the bloodstream in this item. Do **not** include transfusions that were administered during dialysis or chemotherapy.

- **O0100J, Dialysis**

Code peritoneal or renal dialysis that occurs at the nursing home or at another facility in this item. Record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are **not** to be coded under items K0510A (Parenteral/IV), O0100H (IV medications), or O0100I (transfusions). This item may be coded if the resident performs his/her own dialysis.

- **O0100K, Hospice care**

Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.

- **O0100L, Respite care**

Code only when the resident's care program involves a short-term stay in the facility for the purpose of providing relief to a primary home-based caregiver(s) in this item.

- **O0100M, Isolation for active infectious disease (does not include standard precautions)**

Code only when the resident requires transmission-based precautions and single room isolation (alone in a separate room) because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. Do not code this item if the resident only has a history of infectious disease (e.g., s/p MRSA or s/p C-Diff - no active symptoms). Do not code this item if the precautions are standard precautions, because these types of precautions apply to everyone. Standard precautions include hand hygiene compliance, glove use, and additionally may include masks, eye protection, and gowns. Examples of when the isolation criterion would not apply include urinary tract infections, encapsulated pneumonia, and wound infections.

Code for "single room isolation" only when all of the following conditions are met:

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

O0100: Special Treatments, Procedures, and Programs (cont.)

- The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

The following resources are being provided to help the facility interdisciplinary team determine the best method to contain and/or prevent the spread of infectious disease based on the type of infection and clinical presentation of the resident related to the specific communicable disease. The CDC guidelines also outline isolation precautions and go into detail regarding the different types of Transmission-Based Precautions (Contact, Droplet, and Airborne).

- 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings <http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html>
- SHEA/APIC Guideline: Infection Prevention and Control in the Long Term Care Facility http://www.apic.org/Resource_/TinyMceFileManager/Practice_Guidance/id_APIC-SHEA_GuidelineforICinLTCFs.pdf

As the CDC guideline notes, there are psychosocial risks associated with such restriction, and it has been recommended that psychosocial needs be balanced with infection control needs in the long-term care setting.

If a facility transports a resident who meets the criteria for single room isolation to another healthcare setting to receive medically needed services (e.g. dialysis, chemotherapy, blood transfusions, etc.) which the facility does not or cannot provide, they should follow CDC guidelines for transport of patients with communicable disease, and may still code O0100M for single room isolation since it is still being maintained while the resident is in the facility.

Finally, when coding for isolation, the facility should review the resident’s status and determine if the criteria for a Significant Change of Status Assessment (SCSA) is met based on the effect the infection has on the resident’s function and plan of care. The definition and criteria of “significant change of status” is found in Chapter 2, page 20. Regardless of whether the resident meets the criteria for an SCSA, a modification of the resident’s plan of care will likely need to be completed.

- O0100Z, None of the above**

Code if none of the above treatments, procedures, or programs were received or performed by the resident.

O0250: Influenza Vaccine

O0250. Influenza Vaccine - Refer to current version of RAI manual for current flu season and reporting period	
Enter Code <input type="checkbox"/>	A. Did the resident receive the Influenza vaccine in this facility for this year's Influenza season? 0. No → Skip to O0250C, If Influenza vaccine not received, state reason 1. Yes → Continue to O0250B, Date vaccine received
	B. Date vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date? <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year
Enter Code <input type="checkbox"/>	C. If Influenza vaccine not received, state reason: 1. Resident not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible - medical contraindication 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine due to a declared shortage 9. None of the above

O0250: Influenza Vaccine (cont.)

Item Rationale

Health-related Quality of Life

- When infected with influenza, older adults and persons with underlying health problems are at increased risk for complications and are more likely than the general population to require hospitalization.
- An institutional Influenza A outbreak can result in up to 60 percent of the population becoming ill, with 25 percent of those affected developing complications severe enough to result in hospitalization or death.
- Influenza-associated mortality results not only from pneumonia, but also from subsequent events arising from cardiovascular, cerebrovascular, and other chronic or immunocompromising diseases that can be exacerbated by influenza.

Planning for Care

- Influenza vaccines have been proven effective in preventing hospitalizations.
- Determining the rate of vaccination and causes for non-vaccination assists nursing homes in reaching the Healthy People 2020 (<http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=23>) national goal of 90 percent immunization among nursing home residents.

Steps for Assessment

1. Review the resident's medical record to determine whether an influenza vaccine was received in the facility for this year's influenza season. If vaccination status is unknown, proceed to the next step.
2. Ask the resident if he or she received an influenza vaccine outside of the facility for this year's Influenza season. If vaccination status is still unknown, proceed to the next step.
3. If the resident is unable to answer, then ask the same question of the responsible party/legal guardian and/or primary care physician. If vaccination status is still unknown, proceed to the next step.
4. If vaccination status cannot be determined, administer the vaccine to the resident according to standards of clinical practice.

Coding Instructions for O0250A, Did the Resident Receive the Influenza Vaccine in This Facility for This Year's Influenza Season?

- Code 0, no: if the resident did NOT receive the influenza vaccine in this facility during this year's influenza season. Proceed to **If influenza vaccine not received, state reason** (O0250C).
- Code 1, yes: if the resident did receive the influenza vaccine in this facility during this year's influenza season. Continue to **Date Vaccine Received** (O0250B).

O0250: Influenza Vaccine (cont.)

Coding Instructions for O0250B, Date Vaccine Received

- Enter date vaccine received. Do not leave any boxes blank. If the month contains only a single digit, fill in the first box of the month with a “0”. For example, January 7, 2012 should be entered as 01-07-2012. If the day only contains a single digit, then fill the first box of the day with the “0”. For example, May 6, 2012 should be entered as 05-06-2012. A full 8 character date is required. If the date is unknown or the information is not available, a single dash needs to be entered in the first box.

Coding Instructions for O0250C, If Influenza Vaccine Not Received, State Reason

If the resident has not received the influenza vaccine for this year's influenza season (i.e., O250A=0), code the reason from the following list:

- Code 1, Resident not in facility during this year's influenza season: resident not in the facility during this year's influenza season.
- Code 2, Received outside of this facility: includes influenza vaccinations administered in any other setting (e.g., physician office, health fair, grocery store, hospital, fire station) during this year's influenza season.
- Code 3, Not eligible—medical contraindication: if influenza vaccine not received due to medical contraindications, including allergic reaction to eggs or other vaccine component(s), a physician order not to immunize, or an acute febrile illness is present. However, the resident should be vaccinated if contraindications end.
- Code 4, Offered and declined: resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the influenza vaccine.
- Code 5, Not offered: resident or responsible party/legal guardian not offered the influenza vaccine.
- Code 6, Inability to obtain vaccine due to a declared shortage: influenza vaccine unavailable at the facility due to declared influenza vaccine shortage. However, the resident should be vaccinated once the facility receives the vaccine. The annual supply of inactivated influenza vaccine and the timing of its distribution cannot be guaranteed in any year.
- Code 9, None of the above: if none of the listed reasons describe why the influenza vaccine was not administered. This code is also used if the answer is unknown.

Coding Tips and Special Populations

- The influenza season varies annually. Information about current influenza season can be obtained by accessing the CDC Seasonal Influenza (Flu) website. This website provides information on influenza activity and has an interactive map that shows geographic spread of influenza: <http://www.cdc.gov/flu/weekly/fluactivitysurv.htm>, <http://www.cdc.gov/flu/weekly/usmap.htm>. Facilities can also contact their local health department website for their local influenza surveillance information. The influenza season ends when influenza is no longer active in your geographic area.
- Once the influenza vaccination has been administered to a resident for the current influenza season, this value is carried forward until the new influenza season begins.

O0250: Influenza Vaccine (cont.)

Examples

1. Mrs. J. received the influenza vaccine in the facility during this year's influenza season, on January 7, 2010.

Coding: O0250A would be coded 1, yes; O0250B would be coded 01-07-2010, and O0250C would be skipped.

Rationale: Mrs. J. received the vaccine in the facility on January 7, 2010, during this year's influenza season.

2. Mr. R. did not receive the influenza vaccine in the facility during this year's influenza season due to his known allergy to egg protein.

Coding: O0250A would be coded 0, no; O0250B is skipped, and O0250C would be coded 3, not eligible-medical contraindication.

Rationale: Allergies to egg protein is a medical contraindication to receiving the influenza vaccine, therefore, Mr. R did not receive the vaccine.

3. Resident Mrs. T. received the influenza vaccine at her doctor's office during this year's Influenza season. Her doctor provided documentation of Mrs. T.'s receipt of the vaccine to the facility to place in Mrs. T.'s medical record. He also provided documentation that Mrs. T. was explained the benefits and risks for the vaccine prior to administration.

Coding: O0250A would be coded 0, no; and O0250C would be coded 2, received outside of this facility.

Rationale: Mrs. T. received the influenza vaccine at her doctor's office during this year's Influenza season.

4. Mr. K. wanted to receive the influenza vaccine if it arrived prior to his scheduled discharge October 5th. Mr. K. was discharged prior to the facility receiving their annual shipment of influenza vaccine, and therefore, Mr. K. did not receive the influenza vaccine in the facility. Mr. K. was encouraged to receive the influenza vaccine at his next scheduled physician visit.

Coding: O0250A would be coded 0, no; O0250B is skipped, and O0250C would be coded 9, none of the above.

Rationale: Mr. K. was unable to receive the influenza vaccine in the facility due to the fact that the facility did not receive its shipment of influenza vaccine until after his discharge. None of the codes in O0250C, Influenza vaccine not received, state reason, are applicable.

O0300: Pneumococcal Vaccine

O0300. Pneumococcal Vaccine	
Enter Code <input type="checkbox"/>	A. Is the resident's Pneumococcal vaccination up to date? 0. No → Continue to O0300B, If Pneumococcal vaccine not received, state reason 1. Yes → Skip to O0400, Therapies
Enter Code <input type="checkbox"/>	B. If Pneumococcal vaccine not received, state reason: 1. Not eligible - medical contraindication 2. Offered and declined 3. Not offered

Item Rationale

Health-related Quality of Life

- Pneumococcal disease accounts for more deaths than any other vaccine-preventable bacterial disease.
- Case fatality rates for pneumococcal bacteremia are approximately 20%; however, they can be as high as 60% in the elderly (CDC, 2009).

Planning for Care

- Early detection of outbreaks is essential to control outbreaks of pneumococcal disease in long-term care facilities.
- Conditions that increase the risk of invasive pneumococcal disease include: decreased immune function, damaged or no spleen, chronic diseases of the heart, lungs, liver and kidneys. Other risk factors include smoking and cerebrospinal fluid (CSF) leak (CDC, 2009).
- Determining the rate of pneumococcal vaccination and causes for non-vaccination assists nursing homes in reaching the Healthy People 2020 (<http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=23>) national goal of 90% immunization among nursing home residents.

Steps for Assessment

1. Determine whether or not the resident should receive the vaccine.
 - All adults 65 years of age or older should receive the pneumococcal vaccine. However, certain person should be vaccinated before the age of 65, which include but are not limited to the following:
 - Immunocompromised persons 2 years of age and older who are at increased risk of pneumococcal disease should be vaccinated. This group includes those with the risk factors listed under **Planning for Care**, as well as Hodgkin’s disease, leukemia, lymphoma, multiple myeloma, nephrotic syndrome, cochlear implant, or those who have had organ transplants and are on immunosuppressive protocols. Those on chemotherapy who are immunosuppressed, or those taking high-dose corticosteroids (14 days or longer) should also be vaccinated.
 - Individuals 2 years of age or older with asymptomatic or symptomatic HIV should be vaccinated.

O0300: Pneumococcal Vaccine (cont.)

- Individuals living in environments or social settings (e.g., nursing homes and other long-term care facilities) with an identified increased risk of invasive pneumococcal disease or its complications should be considered for vaccination populations.
- If vaccination status is unknown or the resident/family is uncertain whether or not the vaccine was received, the resident should be vaccinated.
- Pneumococcal vaccine is given once in a lifetime, with certain exceptions. Revaccination is recommended for the following:
 - Individuals 2 years of age or older who are at highest risk for serious pneumococcal infection and for those who are likely to have a rapid decline in pneumococcal antibody levels. Those at highest risk include individuals with asplenia (functional or anatomic), sickle-cell disease, HIV infections or AIDS, cancer, leukemia, lymphoma, Hodgkin disease, multiple myeloma, generalized malignancy, chronic renal failure, nephrotic syndrome, or other conditions associated with immunosuppression (e.g., organ or bone marrow transplant, medication regimens that lower immunity (such as chemotherapy or long-term steroids).
 - Persons 65 years or older should be administered a second dose of pneumococcal vaccine if they received the first dose of vaccine more than 5 years earlier and were less than 65 years old at the time of the first dose.
- If the resident has had a severe allergic reaction to vaccine components or following a prior dose of the vaccine, they should not be vaccinated.

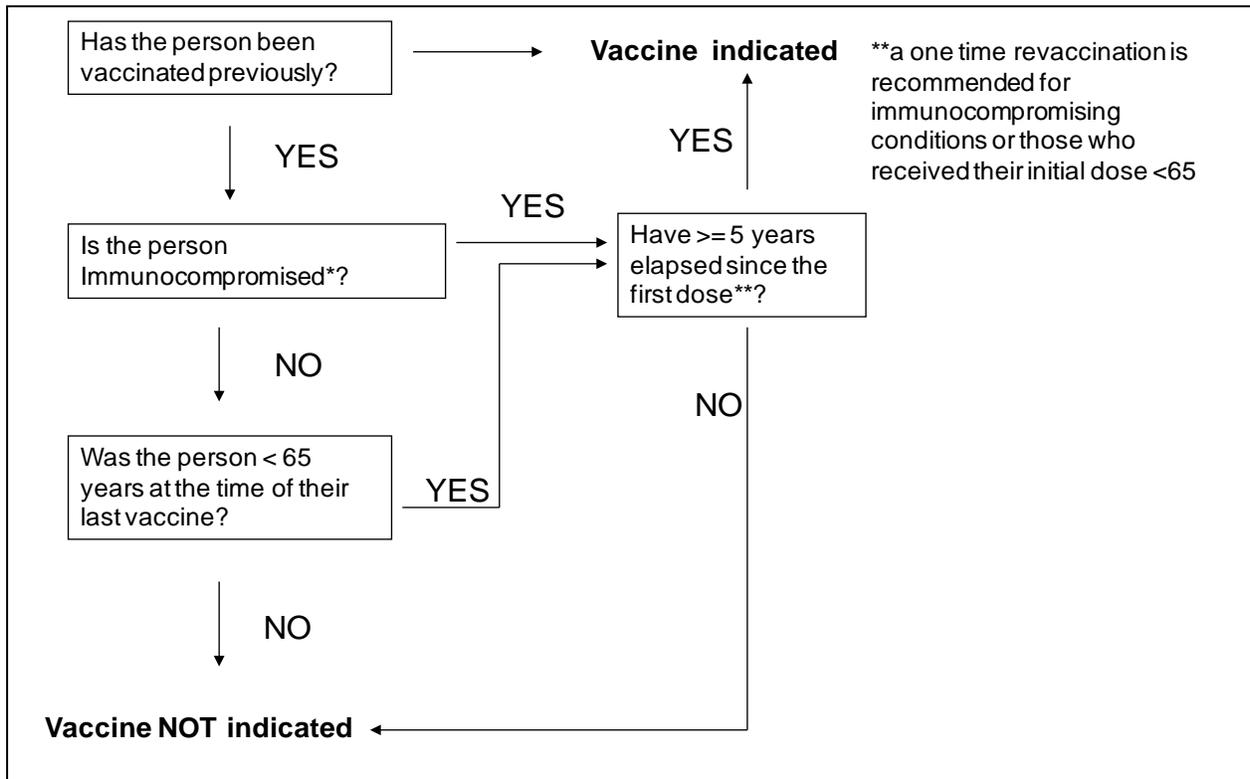
If the resident has a moderate to severe acute illness, he or she should not be vaccinated until his or her condition improves. However, someone with a minor illness (e.g., a cold) should be vaccinated since minor illnesses are not a contraindication to receiving the vaccine.

[Centers for Disease Control and Prevention. (2009, May). *The Pink Book: Chapters: Epidemiology and Prevention of Vaccine Preventable Diseases (11th ed.)*. Retrieved from <http://www.cdc.gov/vaccines/pubs/pinkbook/index.html#chapters>]

Note: Please refer to the algorithm below for pneumococcal vaccine administration ONLY.

O0300: Pneumococcal Vaccine (cont.)

Figure 1 Adopted from the CDC Recommendations and Reports, Prevention of Pneumococcal Disease: Recommendations of the Advisory Committee on Immunization Practices (ACIP) Recommended Adult Immunization Schedule --- United States. (2009, January 9). *MMWR*, 57(53),Q-1-Q-4.



2. Review the resident’s medical record and interview resident or responsible party/legal guardian and/or primary care physician to determine pneumococcal vaccination status, using the following steps:
 - Review the resident’s medical record to determine whether a pneumococcal vaccine has been received. If vaccination status is unknown, proceed to the next step.
 - Ask the resident if he/she received a pneumococcal vaccine. If vaccination status is still unknown, proceed to the next step.
 - If the resident is unable to answer, ask the same question of a responsible party/legal guardian and/or primary care physician. If vaccination status is still unknown, proceed to the next step.
 - If vaccination status cannot be determined, administer the appropriate vaccine to the resident, according to the standards of clinical practice.

O0300: Pneumococcal Vaccine (cont.)

Coding Instructions O0300A, Is the Resident's Pneumococcal Vaccination Up to Date?

- Code 0, no: if the resident's pneumococcal vaccination status is not up to date or cannot be determined. Proceed to item O0300B, **If Pneumococcal vaccine not received, state reason.**
- Code 1, yes: if the resident's pneumococcal vaccination status is up to date. Skip to O0400, **Therapies.**

Coding Instructions O0300B, If Pneumococcal Vaccine Not Received, State Reason

If the resident has not received a pneumococcal vaccine, code the reason from the following list:

- Code 1, Not eligible: if the resident is not eligible due to medical contraindications, including a life-threatening allergic reaction to the pneumococcal vaccine or any vaccine component(s) or a physician order not to immunize.
- Code 2, Offered and declined: resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the pneumococcal vaccine.
- Code 3, Not offered: resident or responsible party/legal guardian not offered the pneumococcal vaccine.

Coding Tips

- The CDC has evaluated inactivated influenza vaccine co-administration with the pneumococcal vaccine systematically among adults. It is safe to give these two vaccinations simultaneously. If the influenza vaccine and pneumococcal vaccine will be given to the resident at the same time, they should be administered at different sites (CDC, 2009). If the resident has had both upper extremities amputated or intramuscular injections are contraindicated in the upper extremities, administer the vaccine(s) according to clinical standards of care.

Examples

1. Mr. L., who is 72 years old, received the pneumococcal vaccine at his physician's office last year.

Coding: O0300A would be coded 1, yes; skip to O0400, Therapies.

Rationale: Mr. L is over 65 years old and received the pneumococcal vaccine in his physician's office last year at age 71.

O0300: Pneumococcal Vaccine (cont.)

2. Mrs. B, who is 95 years old, has never received a pneumococcal vaccine. Her physician has an order stating that she is NOT to be immunized.

Coding: O0300A would be coded 0, no; and O0300B would be coded 1, not eligible.

Rationale: Mrs. B. has never received the pneumococcal vaccine, therefore, her vaccine is not up to date. Her physician has written an order for her not to receive a pneumococcal vaccine, thus she is not eligible for the vaccine.

3. Mrs. A. received the pneumococcal vaccine at age 62 when she was hospitalized for a broken hip. She is now 78 and is being admitted to the nursing home for rehabilitation. Her covering physician offered the pneumococcal vaccine to her during his last visit in the nursing home, which she accepted. The facility administered the pneumococcal vaccine to Mrs. A.

Coding: O0300A would be coded 1, yes; skip to O0400, Therapies.

Rationale: Mrs. A. received the pneumococcal vaccine prior to the age of 65.

Guidelines suggest that she should be revaccinated since she is over the age of 65 and 5 years have passed since her original vaccination. Mrs. A received the pneumococcal vaccine in the facility.

4. Mr. T. received the pneumococcal vaccine at age 62 when he was living in a congregate care community. He is now 65 years old and is being admitted to the nursing home for chemotherapy and respite care.

Coding: O0300A would be coded 1, yes; skip to O0400, Therapies.

Rationale: Mr. T. received his first dose of pneumococcal vaccine prior to the age of 65 due to him residing in congregate care at the age of 62. Even though Mr. T. is now immunocompromised, less than 5 years have lapsed since he originally received the vaccine. He would be considered up to date with his vaccination.

O0400: Therapies

O0400. Therapies	
<p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Days <input type="text"/></p> <p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Days <input type="text"/></p>	<p>A. Speech-Language Pathology and Audiology Services</p> <p>1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days</p> <p>2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days</p> <p>3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days</p> <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400A5, Therapy start date</p> <p>3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days</p> <p>4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</p> <p>5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started</p> <p style="text-align: center;"> <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/><input type="text"/><input type="text"/> Month Day Year </p> <p>6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing</p> <p style="text-align: center;"> <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/><input type="text"/><input type="text"/> Month Day Year </p> <p>B. Occupational Therapy</p> <p>1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days</p> <p>2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days</p> <p>3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days</p> <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B5, Therapy start date</p> <p>3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days</p> <p>4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</p> <p>5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started</p> <p style="text-align: center;"> <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/><input type="text"/><input type="text"/> Month Day Year </p> <p>6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing</p> <p style="text-align: center;"> <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/><input type="text"/><input type="text"/> Month Day Year </p>
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O0400: Therapies (cont.)

O0400. Therapies - Continued	
<p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Days <input type="text"/></p>	<p>C. Physical Therapy</p> <p>1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days</p> <p>2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days</p> <p>3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days</p> <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date</p> <p>3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days</p> <p>4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</p> <p>5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started</p> <p style="text-align: center;"> <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/><input type="text"/><input type="text"/> Month Day Year </p> <p>6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing</p> <p style="text-align: center;"> <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/> - <input type="text"/><input type="text"/><input type="text"/><input type="text"/> Month Day Year </p>
<p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Days <input type="text"/></p>	<p>D. Respiratory Therapy</p> <p>1. Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0400E, Psychological Therapy</p> <p>2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</p>
<p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Days <input type="text"/></p>	<p>E. Psychological Therapy (by any licensed mental health professional)</p> <p>1. Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0400F, Recreational Therapy</p> <p>2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</p>
<p>Enter Number of Minutes <input type="text"/><input type="text"/><input type="text"/><input type="text"/></p> <p>Enter Number of Days <input type="text"/></p>	<p>F. Recreational Therapy (includes recreational and music therapy)</p> <p>1. Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0420, Distinct Calendar Days of Therapy</p> <p>2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</p>

Item Rationale

Health-related Quality of Life

- Maintaining as much independence as possible in activities of daily living, mobility, and communication is critically important to most people. Functional decline can lead to depression, withdrawal, social isolation, breathing problems, and complications of immobility, such as incontinence and pressure ulcers, which contribute to diminished quality of life. The qualified therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents.
- Rehabilitation (i.e., via Speech-Language Pathology Services and Occupational and Physical Therapies) and respiratory, psychological, and recreational therapy can help residents to attain or maintain their highest level of well-being and improve their quality of life.

O0400: Therapies (cont.)

Planning for Care

- Code only medically necessary therapies that occurred after admission/readmission to the nursing home that were (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. Therapy treatment may occur either inside or outside of the facility.
- **For definitions of the types of therapies listed in this section, please refer to the Glossary in Appendix A.**

Steps for Assessment

1. Review the resident's medical record (e.g., rehabilitation therapy evaluation and treatment records, recreation therapy notes, mental health professional progress notes), and consult with each of the qualified care providers to collect the information required for this item.

Coding Instructions for Speech-Language Pathology and Audiology Services and Occupational and Physical Therapies

- **Individual minutes**—Enter the total number of minutes of therapy that were provided on an individual basis in the last 7 days. **Enter 0** if none were provided. Individual services are provided by one therapist or assistant to one resident at a time.
- **Concurrent minutes**—Enter the total number of minutes of therapy that were provided on a concurrent basis in the last 7 days. **Enter 0** if none were provided. 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. When a Part A resident receives therapy that meets this definition, it is defined as concurrent therapy for the Part A resident regardless of the payer source for the second resident. 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). For all other payers, follow Medicare Part A instructions.
- **Group minutes**—Enter the total number of minutes of therapy that were provided in a group in the last 7 days. **Enter 0** if none were provided. Group therapy is defined for Part A as the treatment of 4 residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals. For Medicare Part B, treatment of two patients (or more), regardless of payer source, at the same time is documented as group treatment. For all other payers, follow Medicare Part A instructions.

O0400: Therapies (cont.)

- **Co-treatment minutes**—Enter the total number of minutes each discipline of therapy was administered to the resident in co-treatment sessions in the last 7 days. Enter 0 if none were provided.
- **Days**—Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as skilled treatment for 15 minutes or more during the day. Use total minutes of therapy provided (individual plus concurrent plus group), without any adjustment, to determine if the day is counted. For example, if the resident received 20 minutes of concurrent therapy, the day requirement is considered met. **Enter 0** if therapy was provided but for less than 15 minutes every day for the last 7 days. If the total number of minutes (individual plus concurrent plus group) during the last 7 days is 0, skip this item and leave blank.
- **Therapy Start Date**—Record the date the most recent therapy regimen (since the most recent entry/reentry) started. This is the date the initial therapy evaluation is conducted regardless if treatment was rendered or not or the date of resumption (O0450B) on the resident's EOT OMRA, in cases where the resident discontinued and then resumed therapy.
- **Therapy End Date**—Record the date the most recent therapy regimen (since the most recent entry) ended. This is the last date the resident received skilled therapy treatment. Enter dashes if therapy is ongoing.

Coding Instructions for Respiratory, Psychological, and Recreational Therapies

- **Total Minutes**—Enter the actual number of minutes therapy services were provided in the last 7 days. **Enter 0** if none were provided.
- **Days**—Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as treatment for 15 minutes or more in the day. **Enter 0** if therapy was provided but for less than 15 minutes every day for the last 7 days. If the total number of minutes during the last 7 days is 0, skip this item and leave blank.

Coding Tips and Special Populations

- **Therapy Start Date:**
 1. Look at the date at A1600.
 2. Determine whether the resident has had skilled rehabilitation therapy at any time from that date to the present date.
 3. If so, enter the date that the therapy regimen started; if there was more than one therapy regimen since the A1600 date, enter the start date of the most recent therapy regimen.

O0400: Therapies (cont.)

- Psychological Therapy is provided by any licensed mental health professional, such as psychiatrists, psychologists, clinical social workers, and clinical nurse specialists in mental health as allowable under applicable state laws. Psychiatric technicians are not considered to be licensed mental health professionals and their services may not be counted in this item.

Minutes of therapy

- Includes only therapies that were provided once the individual is actually living/being cared for at the long-term care facility. Do **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.
- 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.
- The therapist's time spent on documentation or on initial evaluation is not included.
- The therapist's time spent on subsequent reevaluations, conducted as part of the treatment process, should be counted.
- Family education when the resident is present is counted and must be documented in the resident's record.
- Only skilled therapy time (i.e., requires the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met) shall be recorded on the MDS. In some instances, the time during which a resident received a treatment modality includes partly skilled and partly unskilled time; only time that is skilled may be recorded on the MDS. Therapist time during a portion of a treatment that is non-skilled; during a non-therapeutic rest period; or during a treatment that does not meet the therapy mode definitions may not be included.
- The time required to adjust equipment or otherwise prepare the treatment area for skilled rehabilitation service is the set-up time and is to be included in the count of minutes of therapy delivered to the resident. Set-up may be performed by the therapist, therapy assistant, or therapy aide.
- Set-up time shall be recorded under the mode for which the resident receives initial treatment when he/she receives more than one mode of therapy per visit.
 - Code as individual minutes when the resident receives only individual therapy or individual therapy followed by another mode(s);
 - Code as concurrent minutes when the resident receives only concurrent therapy or concurrent therapy followed by another mode(s); and
 - Code as group minutes when the resident receives only group therapy or group therapy followed by another mode(s).

O0400: Therapies (cont.)

- For Speech-Language Pathology Services (SLP) and Physical (PT) and Occupational Therapies (OT) include only skilled therapy services. Skilled therapy services **must** meet **all** of the following conditions (Refer to Medicare Benefit Policy Manual, Chapters 8 and 15, for detailed requirements and policies):
 - for Part A, services must be ordered by a physician. For Part B the plan of care must be certified by a physician following the therapy evaluation;
 - the services must be directly and specifically related to an active written treatment plan that is approved by the physician after any needed consultation with the qualified therapist and is based on an initial evaluation performed by a qualified therapist prior to the start of therapy services in the facility;
 - the services must be of a level of complexity and sophistication, or the condition of the resident must be of a nature that requires the judgment, knowledge, and skills of a therapist;
 - the services must be provided with the expectation, based on the assessment of the resident's restoration potential made by the physician, that the condition of the patient will improve materially in a reasonable and generally predictable period of time; or, the services must be necessary for the *establishment* of a safe and effective maintenance program; or, the services must require the skills of a qualified therapist for the *performance* of a safe and effective maintenance program.
 - the services must be considered under accepted standards of medical practice to be specific and effective treatment for the resident's condition; and,
 - the services must be reasonable and necessary for the treatment of the resident's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable and they must be furnished by qualified personnel.
- Include services provided by a qualified occupational/physical therapy assistant who is employed by (or under contract with) the long-term care facility only if he or she is under the direction of a qualified occupational/physical therapist. Medicare does not recognize speech-language pathology assistants; therefore, services provided by these individuals are not to be coded on the MDS.
- For purposes of the MDS, when the payer for therapy services is not Medicare Part B, follow the definitions and coding for Medicare Part A.
- Record the actual minutes of therapy. **Do not round therapy minutes (e.g., reporting) to the nearest 5th minute.** The conversion of units to minutes or minutes to units is not appropriate. 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.
- When therapy is provided staff need to document the different modes of therapy and set up minutes that are being included on the MDS. It is important to keep records of time included for each. When submitting a part B claim, minutes reported on the MDS may not match the time reported on a claim. For example, therapy aide set-up time is recorded on the MDS when it precedes skilled therapy; however, the therapy aide set-up time is not included for billing purposes on a therapy Part B claim.

O0400: Therapies (cont.)

- For purposes of the MDS, providers should record services for respiratory, psychological, and recreational therapies (Item O0400D, E, and F) when the following criteria are met:
 - 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 qualified personnel (See Glossary in Appendix A for definitions of respiratory, psychological and recreational therapies);
 - the services are required and provided by qualified personnel (See Glossary in Appendix A for definitions of respiratory, psychological and recreational therapies);
 - the services must be reasonable and necessary for treatment of the resident's condition.

Non-Skilled Services

- Services provided at the request of the resident or family that are not medically necessary (sometimes referred to as family-funded services) shall **not** be counted in item O0400 **Therapies**, even when performed by a therapist or an assistant.
- As noted above, therapy services can include the actual performance of a maintenance program in those instances where the skills of a qualified therapist are needed to accomplish this safely and effectively. However, when the performance of a maintenance program does not require the skills of a therapist because it could be accomplished safely and effectively by the patient or with the assistance of non-therapists (including unskilled caregivers), such services are not considered therapy services in this context. Sometimes a nursing home may nevertheless elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services even when the involvement of a qualified therapist is not medically necessary. In these situations, the services shall **not** be coded as therapy in item O0400 **Minutes**, since the specific interventions would be considered restorative nursing care when performed by nurses or aides. Services provided by therapists, licensed or not, that are not specifically listed in this manual or on the MDS item set shall **not** be coded as therapy in Item O400. These services should be documented in the resident's medical record.
- In situations where the ongoing performance of a safe and effective maintenance program does not require any skilled services, once the qualified therapist has designed the maintenance program and discharged the resident from a rehabilitation (i.e., skilled) therapy program, the services performed by the therapist and the assistant are **not** to be reported in item O0400A, B, or C **Therapies**. The services may be reported on the MDS assessment in item O0500 **Restorative Nursing Care**, provided the requirements for restorative nursing program are met.
- Services provided by therapy aides are **not** skilled services (see therapy aide section below).
- When a resident refuses to participate in therapy, it is important for care planning purposes to identify why the resident is refusing therapy. However, the time spent investigating the refusal or trying to persuade the resident to participate in treatment is not a skilled service and shall not be included in the therapy minutes.

O0400: Therapies (cont.)

Co-treatment

For Part A:

When two clinicians (therapists or therapy assistants), each from a different discipline, treat one resident at the same time with different treatments, both disciplines may code the treatment session in full. All policies regarding mode, modalities and student supervision must be followed as well as all other federal, state, practice and facility policies. For example, if two therapists (from different disciplines) were conducting a group treatment session, the group must be comprised of four participants who were doing the same or similar activities in each discipline. The decision to co-treat should be made on a case by case basis and the need for co-treatment should be well documented for each patient. Because co-treatment is appropriate for specific clinical circumstances and would not be suitable for all residents, its use should be limited.

For Part B:

Therapists, or therapy assistants, working together as a "team" to treat one or more patients **cannot** each bill separately for the same or different service provided at the same time to the same patient.

CPT codes are used for billing the services of one therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same patient(s). Where a physical and occupational therapist both provide services to one patient at the same time, only one therapist can bill for the entire service or the PT and OT can divide the service units. For example, a PT and an OT work together for 30 minutes with one patient on transfer activities. The PT and OT could each bill one unit of 97530. Alternatively, the 2 units of 97530 could be billed by either the PT or the OT, but not both.

Similarly, if two therapy assistants provide services to the same patient at the same time, only the service of one therapy assistant can be billed by the supervising therapist or the service units can be split between the two therapy assistants and billed by the supervising therapist(s).

Therapy Aides and Students

Therapy Aides

Therapy Aides cannot provide skilled services. Only the time a therapy aide spends on set-up preceding skilled therapy may be coded on the MDS (e.g., set up the treatment area for wound therapy) and should be coded under the appropriate mode for the skilled therapy (individual, concurrent, or group) in O0400. The therapy aide must be under direct supervision of the therapist or assistant (i.e., the therapist/assistant must be in the facility and immediately available).

O0400: Therapies (cont.)

Therapy Students

Medicare Part A—Therapy students are not required to be in line-of-sight of the professional supervising therapist/assistant (**Federal Register**, August 8, 2011). Within individual facilities, supervising therapists/assistants must make the determination as to whether or not a student is ready to treat patients without line-of-sight supervision. Additionally all state and professional practice guidelines for student supervision must be followed.

Time may be coded on the MDS when the therapist provides skilled services and direction to a student who is participating in the provision of therapy. All time that the student spends with patients should be documented.

- Medicare Part B—The following criteria must be met in order for services provided by a student to be billed by the long-term care facility:
 - The qualified professional is present and in the room for the entire session. The student participates in the delivery of services when the qualified practitioner is directing the service, making the skilled judgment, and is responsible for the assessment and treatment.
 - The practitioner is not engaged in treating another patient or doing other tasks at the same time.
 - The qualified professional is the person responsible for the services and, as such, signs all documentation. (A student may, of course, also sign but it is not necessary because the Part B payment is for the clinician's service, not for the student's services.)
 - Physical therapy assistants and occupational therapy assistants are not precluded from serving as clinical instructors for therapy assistant students while providing services within their scope of work and performed under the direction and supervision of a qualified physical or occupational therapist.

Modes of Therapy

A resident may receive therapy via different modes during the same day or even treatment session. When developing the plan of care, the therapist and assistant must determine which mode(s) of therapy and the amount of time the resident receives for each mode and code the MDS appropriately. The therapist and assistant should document the reason a specific mode of therapy was chosen as well as anticipated goals for that mode of therapy. For any therapy that does not meet one of the therapy mode definitions below, those minutes may not be counted on the MDS. (Please also see the section on group therapy for limited exceptions related to group size.) The therapy mode definitions must always be followed and apply regardless of when the therapy is provided in relationship to all assessment windows (i.e., applies whether or not the resident is in a look back period for an MDS assessment).

O0400: Therapies (cont.)

Individual Therapy

The treatment of one resident at a time. The resident is receiving the therapist's or the assistant's full attention. Treatment of a resident individually at intermittent times during the day is individual treatment, and the minutes of individual treatment are added for the daily count. For example, the speech-language pathologist treats the resident individually during breakfast for 8 minutes and again at lunch for 13 minutes. The total of individual time for this day would be 21 minutes.

When a therapy student is involved with the treatment of a resident, the minutes may be coded as individual therapy when only one resident is being treated by the therapy student and supervising therapist/assistant (Medicare A and Medicare B). The supervising therapist/assistant shall not be engaged in any other activity or treatment when the resident is receiving therapy under Medicare B. However, for those residents whose stay is covered under Medicare A, the supervising therapist/assistant shall not be treating or supervising other individuals **and** he/she is able to immediately intervene/assist the student as needed.

Example:

- A speech therapy graduate student treats Mr. A for 30 minutes. Mr. A.'s therapy is covered under the Medicare Part A benefit. The supervising speech-language pathologist is not treating any patients at this time but is not in the room with the student or Mr. A. Mr. A.'s therapy may be coded as 30 minutes of individual therapy on the MDS .

Concurrent Therapy

Medicare Part A

The treatment of 2 residents, who are not performing the same or similar activities, at the same time, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant.

- NOTE: The minutes being coded on the MDS are unadjusted minutes, meaning, the minutes are coded in the MDS as the full time spent in therapy; however, the software grouper will allocate the minutes appropriately. In the case of concurrent therapy, the minutes will be divided by 2.

When a therapy student is involved with the treatment, and one of the following occurs, the minutes may be coded as concurrent therapy:

- The therapy student is treating one resident and the supervising therapist/assistant is treating another resident, and both residents are in line of sight of the therapist/assistant or student providing their therapy.; or
- The therapy student is treating 2 residents, regardless of payer source, both of whom are in line-of-sight of the therapy student, and the therapist is not treating any residents and not supervising other individuals; or
- The therapy student is not treating any residents and the supervising therapist/assistant is treating 2 residents at the same time, regardless of payer source, both of whom are in line-of-sight.

O0400: Therapies (cont.)

Medicare Part B

- The treatment of two or more residents who may or may not be performing the same or similar activity, regardless of payer source, at the same time is documented as group treatment

Examples:

- A physical therapist provides therapies that are not the same or similar, to Mrs. Q and Mrs. R at the same time, for 30 minutes. Mrs. Q's stay is covered under the Medicare SNF PPS Part A benefit. Mrs. R. is paying privately for therapy. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - Mrs. Q. received concurrent therapy for 30 minutes.
 - Mrs. R received concurrent therapy for 30 minutes.
- A physical therapist provides therapies that are not the same or similar, to Mrs. S. and Mrs. T. at the same time, for 30 minutes. Mrs. S.'s stay is covered under the Medicare SNF PPS Part A benefit. Mr. T.'s therapy is covered under Medicare Part B. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - Mrs. S. received concurrent therapy for 30 minutes.
 - Mr. T. received group therapy (Medicare Part B definition) for 30 minutes. (Please refer to the Medicare Benefit Policy Manual, Chapter 15, and the Medicare Claims Processing Manual, Chapter 5, for coverage and billing requirements under the Medicare Part B benefit.)
- An Occupational Therapist provides therapy to Mr. K. for 60 minutes. An occupational therapy graduate student who is supervised by the occupational therapist, is treating Mr. R. at the same time for the same 60 minutes but Mr. K. and Mr. R. are not doing the same or similar activities. Both Mr. K. and Mr. R's stays are covered under the Medicare Part A benefit. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - Mr. K. received concurrent therapy for 60 minutes.
 - Mr. R. received concurrent therapy for 60 minutes.

Group Therapy

Medicare Part A

The treatment of 4 residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or assistant who is not supervising any other individuals.

- NOTE: The minutes being coded on the MDS are unadjusted minutes, meaning, the minutes are coded in the MDS as the full time spent in therapy; however, the software grouper will allocate the minutes appropriately. In the case of group therapy, the minutes will be divided by 4.

O0400: Therapies (cont.)

When a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:

- The therapy student is providing the group treatment and the supervising therapist/assistant is not treating any residents and is not supervising other individuals (students or residents); or
- The supervising therapist/assistant is providing the group treatment and the therapy student is not providing treatment to any resident. In this case, the student is simply assisting the supervising therapist.

Medicare Part B

The treatment of 2 or more individuals simultaneously, regardless of payer source, who may or may not be performing the same activity.

- When a therapy student is involved with group therapy treatment, and one of the following occurs, the minutes may be coded as group therapy:
- The therapy student is providing group treatment and the supervising therapist/assistant is not engaged in any other activity or treatment; or
- The supervising therapist/assistant is providing group treatment and the therapy student is not providing treatment to any resident.

Examples:

- A Physical Therapist provides similar therapies to Mr. W, Mr. X, Mrs. Y. and Mr. Z. at the same time, for 30 minutes. Mr. W. and Mr. X.'s stays are covered under the Medicare SNF PPS Part A benefit. Mrs. Y.'s therapy is covered under Medicare Part B, and Mr. Z has private insurance paying for therapy. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - Mr W. received group therapy for 30 minutes.
 - Mr. X. received group therapy for 30 minutes.
 - Mrs. Y. received group therapy for 30 minutes. (Please refer to the Medicare Benefit Policy Manual, Chapter 15, and the Medicare Claims Processing Manual, Chapter 5, for coverage and billing requirements under the Medicare Part B benefit.)
 - Mr. Z. received group therapy for 30 minutes.
- Mrs. V, whose stay is covered by SNF PPS Part A benefit, begins therapy in an individual session. After 13 minutes the therapist begins working with Mr. S., whose therapy is covered by Medicare Part B, while Mrs. V. continues with her skilled intervention and is in line-of-sight of the treating therapist. The therapist provides treatment during the same time period to Mrs. V. and Mr. S. for 24 minutes who are not performing the same or similar activities, at which time Mrs. V.'s therapy session ends. The therapist continues to treat Mr. S. individually for 10 minutes. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - Mrs. V. received individual therapy for 13 minutes and concurrent therapy for 24.

O0400: Therapies (cont.)

- Mr. S. received group therapy (Medicare Part B definition) for 24 minutes and individual therapy for 10 minutes. (Please refer to the **Medicare Benefit Policy Manual**, Chapter 15, and the **Medicare Claims Processing Manual**, Chapter 5, for coverage and billing requirements under the Medicare Part B benefit.)
- Mr. A. and Mr. B., whose stays are covered by Medicare Part A, begin working with a physical therapist on two different therapy interventions. After 30 minutes, Mr. A. and Mr. B. are joined by Mr. T. and Mr. E., whose stays are also covered by Medicare Part A., and the therapist begins working with all of them on the same therapy goals as part of a group session. After 15 minutes in this group session, Mr. A. becomes ill and is forced to leave the group, while the therapist continues working with the remaining group members for an additional 15 minutes. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - Mr. A. received concurrent therapy for 30 minutes and group therapy for 15 minutes.
 - Mr. B. received concurrent therapy for 30 minutes and group therapy for 30 minutes.
 - Mr. T. received group therapy for 30 minutes.
 - Mr. E. received group therapy for 30 minutes.

Therapy Modalities

Only skilled therapy time (i.e., require the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met, see page O-17) shall be recorded on the MDS. In some instances, the time a resident receives certain modalities is partly skilled and partly unskilled time; only the time that is skilled may be recorded on the MDS. For example, a resident is receiving TENS (transcutaneous electrical nerve stimulation) for pain management. The portion of the treatment that is skilled, such as proper electrode placement, establishing proper pulse frequency and duration, and determining appropriate stimulation mode, shall be recorded on the MDS. In other instances, some modalities only meet the requirements of skilled therapy in certain situations. For example, the application of a hot pack is often not a skilled intervention. However, when the resident's condition is complicated and the skills, knowledge, and judgment of the therapist are required for treatment, then those minutes associated with skilled therapy time may be recorded on the MDS. The use and rationale for all therapy modalities, whether skilled or unskilled should always be documented as part of the patient's plan of care.

Dates of Therapy

A resident may have more than one regimen of therapy treatment during an episode of a stay. When this situation occurs the Therapy Start Date for the most recent episode of treatment for the particular therapy (SLP, PT, or OT) should be coded. When a resident's episode of treatment for a given type of therapy extends beyond the ARD (i.e., therapy is ongoing), enter dashes in the appropriate Therapy End Date. Therapy is considered to be ongoing if:

- The resident was discharged and therapy was planned to continue had the resident remained in the facility, or
- The resident's SNF benefit exhausted and therapy continued to be provided, or

O0400: Therapies (cont.)

- The resident's payer source changed and therapy continued to be provided.

For example, Mr. N. was admitted to the nursing home following a fall that resulted in a hip fracture in November 2011. Occupational and Physical therapy started December 3, 2011. His physical therapy ended January 27, 2012 and occupational therapy ended January 29, 2012. Later on during his stay at the nursing home, due to the progressive nature of his Parkinson's disease, he was referred to SLP and OT February 10, 2012 (he remained in the facility the entire time). The speech-language pathologist evaluated him on that day and the occupational therapist evaluated him the next day. The ARD for Mr. N.'s MDS assessment is February 28, 2012. Coding values for his MDS are:

- O0400A5 (SLP start date) is 02102012,
- O0400A6 (SLP end date) is dash filled,
- O0400B5 (OT start date) is 02112012,
- O0400B6 (OT end date) is dash filled,
- O0400C5 (PT start date) is 12032011, and
- O0400C6 (PT end date) is 01272012.

NOTE: When an EOT-R is completed, the Therapy Start Date (O0400A5, O0400B5, and O0400C5) on the next PPS assessment is the same as the Therapy Start Date on the EOT-R. If therapy is ongoing, the Therapy End Date (O0400A6, O0400B6, and O0400C6) would be dash filled.

For example, Mr. T. was admitted to the nursing home following a fall that resulted in a hip fracture in May 2013. Occupational and Physical therapy started May 10, 2013. His physical therapy ended May 23, 2013 but the occupational therapy continued. Due to observed swallowing issues, he was referred to SLP on May 31, 2013 and the speech-language pathologist evaluated him on that day. Though Mr. T was able to receive both occupational therapy and speech therapy on June 12, he is unable to receive therapy on June 13 or June 14 due to a minor bout with the flu. The facility does not provide therapy on the weekends, which means that June 15, 2013 represents the third day of missed therapy, triggering an EOT OMRA. The therapy staff and nurses discuss Mr. T's condition and agree that Mr. T should be able to resume the same level of therapy beginning on June 18, 2013, so the facility decides to complete the EOT OMRA as an EOT-R, with an ARD of June 15, 2013.

Coding values for Mr. T's EOT-R are:

- O0400A5 (SLP start date) is 05312013,
- O0400A6 (SLP end date) is 06122013,
- O0400B5 (OT start date) is 05102013,
- O0400B6 (OT end date) is 06122013,
- O0400C5 (PT start date) is 05102013, and
- O0400C6 (PT end date) is 05232013.

Subsequent to the EOT-R, the next PPS assessment completed for Mr. T is the 30-day assessment, with an ARD of June 23, 2013. There were no changes in the therapy services delivered to Mr. T since the EOT-R was completed.

O0400: Therapies (cont.)

Coding values for Mr. T's 30-day assessment are:

- O0400A5 (SLP start date) is 05312013,
- O0400A6 (SLP end date) is dash filled,
- O0400B5 (OT start date) is 05102013,
- O0400B6 (OT end date) is dash filled,
- O0400C5 (PT start date) is 05102013, and
- O0400C6 (PT end date) is 05232013.

General Coding Example:

Following a stroke, Mrs. F. was admitted to the skilled nursing facility in stable condition for rehabilitation therapy on 10/06/11 under Part A skilled nursing facility coverage. She had slurred speech, difficulty swallowing, severe weakness in both her right upper and lower extremities, and a Stage III pressure ulcer on her left lateral malleolus. She was referred to SLP, OT, and PT with the long-term goal of returning home with her daughter and son-in-law. Her initial SLP evaluation was performed on 10/06/11, the PT initial evaluation on 10/07/11, and the OT initial evaluation on 10/09/11. She was also referred to recreational therapy and respiratory therapy. The interdisciplinary team determined that 10/19/11 was an appropriate ARD for her Medicare-required 14-day MDS. During the look-back period she received the following:

- Speech-language pathology services that were provided over the 7-day look-back period. Individual dysphagia treatments; Monday-Friday for 30 minute sessions each day.
- Cognitive training; Monday and Thursday for 35 minute concurrent therapy sessions and Tuesday, Wednesday and Friday 25 minute group sessions.
- Individual speech techniques; Tuesday and Thursday for 20-minute sessions each day.

Coding:

O0400A1 would be coded 190; O0400A2 would be coded 70; O0400A3 would be coded 75; O0400A4 would be coded 5; O0400A5 would be coded 10062011; and O0400A6 would be coded with dashes.

Rationale:

Individual minutes totaled 190 over the 7-day look-back period $[(30 \times 5) + (20 \times 2) = 190]$; concurrent minutes totaled 70 over the 7-day look-back period $(35 \times 2 = 70)$; and group minutes totaled 75 over the 7-day look-back period $(25 \times 3 = 75)$. Therapy was provided 5 out of the 7 days of the look-back period. Date speech-language pathology services began was 10-06-2011, and dashes were used as the therapy end date value because the therapy was ongoing.

Occupational therapy services that were provided over the 7-day look-back period:

- Individual sitting balance activities; Monday and Wednesday for 30-minute co-treatment sessions with PT each day (OT and PT each code the session as 30 minutes for each discipline).
- Individual wheelchair seating and positioning; Monday, Wednesday, and Friday for the following times: 23 minutes, 18 minutes, and 12 minutes.
- Balance/coordination activities; Tuesday-Friday for 20 minutes each day in group sessions.

O0400: Therapies (cont.)

Coding:

O0400B1 would be coded 113, O0400B2 would be coded 0, O0400B3 would be coded 80, O0400B3A would be coded 60, O0400B4 would be coded 5, O0400B5 would be coded 10092011, and O0400B6 would be coded with dashes.

Rationale:

Individual minutes (including 60 co-treatment minutes) totaled 113 over the 7-day look-back period $[(30 \times 2) + 23 + 18 + 12 = 113]$; concurrent minutes totaled 0 over the 7-day look-back period $(0 \times 0 = 0)$; and group minutes totaled 80 over the 7-day look-back period $(20 \times 4 = 80)$. Therapy was provided 5 out of the 7 days of the look-back period. Date occupational therapy services began was 10-09-2011 and dashes were used as the therapy end date value because the therapy was ongoing.

Physical therapy services that were provided over the 7-day look-back period:

- Individual wound debridement followed by application of routine wound dressing; Monday the session lasted 22 minutes, 5 minutes of which were for the application of the dressing. On Thursday the session lasted 27 minutes, 6 minutes of which were for the application of the dressing. For each session the therapy aide spent 7 minutes preparing the debridement area (set-up time) for needed therapy supplies and equipment for the therapist to conduct wound debridement.
- Individual sitting balance activities; on Monday and Wednesday for 30-minute co-treatment sessions with OT (OT and PT each code the session as 30 minutes for each discipline).
- Individual bed positioning and bed mobility training; Monday-Friday for 35 minutes each day.
- Concurrent therapeutic exercises; Monday-Friday for 20 minutes each day.

Coding:

O0400C1 would be coded 287, O0400C2 would be coded 100, O0400C3 would be coded 0, O0400C3A would be coded 60, O0400C4 would be coded 5, O0400C5 would be coded 10072011, and O0400C6 would be coded with dashes.

Rationale:

Individual minutes (including 60 co-treatment minutes) totaled 287 over the 7-day look-back period $[(30 \times 2) + (35 \times 5) + (22 - 5) + 7 + (27 - 6) + 7 = 287]$; concurrent minutes totaled 100 over the 7-day look-back period $(20 \times 5 = 100)$; and group minutes totaled 0 over the 7-day look-back period $(0 \times 0 = 0)$. Therapy was provided 5 out of the 7 days of the look-back period. Date physical therapy services began was 10-07-2011, and dashes were used as the therapy end date value because the therapy was ongoing.

Respiratory therapy services that were provided over the 7-day look-back period:

Respiratory therapy services; Sunday-Thursday for 10 minutes each day.

Coding:

O0400D1 would be coded 50, O0400D2 would be coded 0.

O0400: Therapies (cont.)

Rationale:

Total minutes were 50 over the 7-day look-back period ($10 \times 5 = 50$). Although a total of 50 minutes of respiratory therapy services were provided over the 7-day look-back period, there were not any days that respiratory therapy was provided for 15 minutes or more. Therefore, O0400D equals **zero days**.

Psychological therapy services that were provided over the 7-day look-back period:

Psychological therapy services were not provided at all over the 7-day look-back period.

Coding:

O0400E1 would be coded 0, O0400E2 would be left blank.

Rationale:

There were no minutes or days of psychological therapy services provided over the 7-day look-back period.

Recreational therapy services that were provided over the 7-day look-back period:

Recreational therapy services; Tuesday, Wednesday, and Friday for 30-minute sessions each day.

Coding:

O0400F1 would be coded 90, O0400F2 would be coded 3.

Rationale:

Total minutes were 90 over the 7-day look-back period ($30 \times 3 = 90$). Sessions provided were longer than 15 minutes each day, therefore each day recreational therapy was performed can be counted.

O0400: Therapies (cont.)

O0400. Therapies	
<p>Enter Number of Minutes <input type="text" value="1"/> <input type="text" value="9"/> <input type="text" value="0"/></p> <p>Enter Number of Minutes <input type="text" value="7"/> <input type="text" value="0"/></p> <p>Enter Number of Minutes <input type="text" value="7"/> <input type="text" value="5"/></p> <p>Enter Number of Minutes <input type="text" value="6"/> <input type="text" value="5"/></p> <p>Enter Number of Days <input type="text" value="5"/></p>	<p>A. Speech-Language Pathology and Audiology Services</p> <p>1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days</p> <p>2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days</p> <p>3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days</p> <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400A5, Therapy start date</p> <p>3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days</p> <p>4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</p> <p>5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started</p> <p style="text-align: center;"> <input type="text" value="1"/> <input type="text" value="0"/> - <input type="text" value="0"/> <input type="text" value="6"/> - <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="1"/> <small>Month Day Year</small> </p> <p>6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing</p> <p style="text-align: center;"> <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/> <small>Month Day Year</small> </p>
<p>Enter Number of Minutes <input type="text" value="1"/> <input type="text" value="1"/> <input type="text" value="3"/></p> <p>Enter Number of Minutes <input type="text" value="0"/></p> <p>Enter Number of Minutes <input type="text" value="8"/> <input type="text" value="0"/></p> <p>Enter Number of Minutes <input type="text" value="6"/> <input type="text" value="0"/></p> <p>Enter Number of Days <input type="text" value="5"/></p>	<p>B. Occupational Therapy</p> <p>1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days</p> <p>2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days</p> <p>3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days</p> <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B5, Therapy start date</p> <p>3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days</p> <p>4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</p> <p>5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started</p> <p style="text-align: center;"> <input type="text" value="1"/> <input type="text" value="0"/> - <input type="text" value="0"/> <input type="text" value="9"/> - <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="1"/> <small>Month Day Year</small> </p> <p>6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing</p> <p style="text-align: center;"> <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/> <small>Month Day Year</small> </p>

O0400 continued on next page

O0400: Therapies (cont.)

O0400. Therapies - Continued	
<p>Enter Number of Minutes <input type="text" value="2"/> <input type="text" value="8"/> <input type="text" value="7"/></p> <p>Enter Number of Minutes <input type="text" value="1"/> <input type="text" value="0"/> <input type="text" value="0"/></p> <p>Enter Number of Minutes <input type="text" value=""/> <input type="text" value=""/> <input type="text" value="0"/></p> <p>Enter Number of Minutes <input type="text" value=""/> <input type="text" value=""/> <input type="text" value="3"/> <input type="text" value="0"/></p> <p>Enter Number of Days <input type="text" value="5"/></p>	<p>C. Physical Therapy</p> <p>1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days</p> <p>2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days</p> <p>3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days</p> <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date</p> <p>3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days</p> <p>4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</p> <p>5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started</p> <p style="text-align: center;"> <input type="text" value="1"/> <input type="text" value="0"/> - <input type="text" value="0"/> <input type="text" value="7"/> - <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="1"/> <small>Month Day Year</small> </p> <p>6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing</p> <p style="text-align: center;"> <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/> <small>Month Day Year</small> </p>
<p>Enter Number of Minutes <input type="text" value=""/> <input type="text" value=""/> <input type="text" value="5"/> <input type="text" value="0"/></p> <p>Enter Number of Days <input type="text" value="0"/></p>	<p>D. Respiratory Therapy</p> <p>1. Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0400E, Psychological Therapy</p> <p>2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</p>
<p>Enter Number of Minutes <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value="0"/></p> <p>Enter Number of Days <input type="text" value=""/></p>	<p>E. Psychological Therapy (by any licensed mental health professional)</p> <p>1. Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0400F, Recreational Therapy</p> <p>2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</p>
<p>Enter Number of Minutes <input type="text" value=""/> <input type="text" value=""/> <input type="text" value="9"/> <input type="text" value="0"/></p> <p>Enter Number of Days <input type="text" value="5"/></p>	<p>F. Recreational Therapy (includes recreational and music therapy)</p> <p>1. Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0420, Distinct Calendar Days of Therapy</p> <p>2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</p>

O0420: Distinct Calendar Days of Therapy

O0420. Distinct Calendar Days of Therapy	
<p>Enter Number of Days <input type="text" value=""/></p>	<p>Record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.</p>

Item Rationale

To record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.

Coding Instructions:

Enter the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past

7 days. If a resident receives more than one therapy discipline on a given calendar day, this may only count for one calendar day for purposes of coding Item O0420. Consider the following examples:

- Example 1: Mrs. T. received 60 minutes of physical therapy on Monday, Wednesday and Friday within the 7-day look-back period. Mrs. T also received 45 minutes of occupational therapy on Monday, Tuesday and Friday during the 7-day look-back period. Given the therapy services received by Mrs. T during the 7-day look-back period, item **O0420 would be coded as 4** because therapy services were provided for at least 15 minutes on 4 distinct calendar days during the 7-day look-back period (i.e., Monday, Tuesday, Wednesday, and Friday).
- Example 2: Mr. F. received 120 minutes of physical therapy on Monday, Wednesday and Friday within the 7-day look-back period. Mr. F also received 90 minutes of occupational therapy on Monday, Wednesday and Friday during the 7-day look-back period. Finally, Mr. F received 60 minutes of speech-language pathology services on Monday and Friday during the 7-day look-back period. Given the therapy services received by Mr. F during the 7-day look-back period, item **O0420 would be coded as 3** because therapy services were provided for at least 15 minutes on 3 distinct calendar days during the 7-day look-back period (i.e., Monday, Wednesday, and Friday).

O0450: Resumption of Therapy

O0450. Resumption of Therapy - Complete only if A0310C = 2 or 3 and A0310F = 99	
Enter Code <input type="checkbox"/>	<p>A. Has a previous rehabilitation therapy regimen (speech, occupational, and/or physical therapy) ended, as reported on this End of Therapy OMRA, and has this regimen now resumed at exactly the same level for each discipline?</p> <p>0. No → Skip to O0500, Restorative Nursing Programs</p> <p>1. Yes</p> <p>B. Date on which therapy regimen resumed:</p> <p> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year </p>

Item Rationale

In cases where therapy resumes after the EOT OMRA is performed and the resumption of therapy date is no more than 5 consecutive calendar days after the last day of therapy provided, and the therapy services have resumed at the same RUG-IV classification level that had been in effect prior to the EOT OMRA, an End of Therapy OMRA with Resumption (EOT-R) may be completed. The EOT-R reduces the number of assessments that need to be completed and reduces the number of interview items residents must answer.

Coding Instructions:

When an EOT OMRA has been performed, determine whether therapy will resume. If it will, determine whether therapy will resume no more than five consecutive calendar days after the last day of therapy was provided AND whether the therapy services will resume at the same level for each discipline, if **no, skip to O0500**, Restorative Nursing Programs. If Yes, **code item O0450A as 1**. Determine when therapy will resume and code item **O0450B with the date** that therapy will resume. For example:

- Mrs. A. who was in RVL did not receive therapy on Saturday and Sunday because the facility did not provide weekend services and she missed therapy on Monday because of a doctor's appointment. She resumed therapy on Tuesday, November 13, 2011. The IDT determined that her RUG-IV therapy classification level did not change as she had not had any significant clinical changes during the lapsed therapy days. When the EOT was filled out, item **O0450 A was coded as 1** because therapy was resuming within 5 days from the last day of therapy and it was resuming at the same RUG-IV classification level. Item **O0450B was coded as 11132011** because therapy resumed on November 13, 2011.

NOTE: If the EOT OMRA has not been accepted in the QIES ASAP when therapy resumes, code the EOT-R items (O0450A and O0450B) on the assessment and submit the record. If the EOT OMRA without the EOT-R items have been accepted into the QIES ASAP system, then submit a modification request for that EOT OMRA with the only changes being the completion of the Resumption of Therapy items (O0450A and O0450B) and check X0900E to indicate that the reason for modification is the addition of the Resumption of Therapy date.

O0500: Restorative Nursing Programs

O0500. Restorative Nursing Programs	
Record the number of days each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)	
Number of Days	Technique
<input type="checkbox"/>	A. Range of motion (passive)
<input type="checkbox"/>	B. Range of motion (active)
<input type="checkbox"/>	C. Splint or brace assistance
Number of Days	Training and Skill Practice In:
<input type="checkbox"/>	D. Bed mobility
<input type="checkbox"/>	E. Transfer
<input type="checkbox"/>	F. Walking
<input type="checkbox"/>	G. Dressing and/or grooming
<input type="checkbox"/>	H. Eating and/or swallowing
<input type="checkbox"/>	I. Amputation/prostheses care
<input type="checkbox"/>	J. Communication

Item Rationale

Health-related Quality of Life

- Maintaining independence in activities of daily living and mobility is critically important to most people.
- Functional decline can lead to depression, withdrawal, social isolation, and complications of immobility, such as incontinence and pressure ulcers.

Planning for Care

- Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.
- A resident may be started on a restorative nursing program when he or she is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when restorative needs arise during the course of a longer-term stay, or in conjunction with formalized rehabilitation therapy. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy.

Steps for Assessment

1. Review the restorative nursing program notes and/or flow sheets in the medical record.
2. For the 7-day look-back period, enter the number of days on which the technique, training or skill practice was performed for a total of at least 15 minutes during the 24-hour period.
3. The following criteria for restorative nursing programs must be met in order to code O0500:

O0500: Restorative Nursing Programs (cont.)

- Measureable objective 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 resident's medical record.
- Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record. When not contraindicated by state practice act provisions, 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.
- Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity.
- A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a restorative nursing program. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents. Restorative nursing does not require a physician's order. Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In situations where such services do not actually require the involvement of a qualified therapist, the services may not be coded as therapy in item O0400, Therapies, because the specific interventions are considered restorative nursing services (see item O0400, Therapies). The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.
- This category does not include groups with more than four residents per supervising helper or caregiver.

Coding Instructions

- This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in **Speech-Language Pathology and Audiology Services** item O0400A, **Occupational Therapy** item O0400B, and **Physical Therapy** O0400C.
- The time provided for items O0500A-J must be coded separately, in time blocks of 15 minutes or more. For example, to check **Technique—Range of Motion [Passive]** item O0500A, 15 or more minutes of passive range of motion (PROM) must have been provided during a 24-hour period in the last 7 days. The 15 minutes of time in a day may be totaled across 24 hours (e.g., 10 minutes on the day shift plus 5 minutes on the evening shift). However, 15-minute time increments cannot be obtained by combining 5 minutes of **Technique—Range of Motion [Passive]** item O0500A, 5 minutes of **Technique—Range of Motion [Active]** item O0500B, and 5 minutes of **Splint or Brace Assistance** item O0500C, over 2 days in the last 7 days.
- Review for each activity throughout the 24-hour period. **Enter 0**, if none.

O0500: Restorative Nursing Programs (cont.)

Technique

Activities provided by restorative nursing staff.

- O0500A, Range of Motion (Passive)
Code 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.
- O0500B, Range of Motion (Active)
Code 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.
- O0500C, Splint or Brace Assistance
Code 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.

Training and Skill Practice

Activities including repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse.

- O0500D, Bed Mobility
Code 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.
- O0500E, Transfer
Code 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.
- O0500F, Walking
Code 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.

O0500: Restorative Nursing Programs (cont.)

- O0500G, Dressing and/or Grooming
Code 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.
- O0500H, Eating and/or Swallowing
Code 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.
- O0500I, Amputation/ Prosthesis Care
Code activities provided to improve or maintain the resident's self-performance in putting on and removing a 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.
- O0500J, Communication
Code 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.

Coding Tips and Special Populations

- 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.
- For range of motion (active): any participation by the resident in the ROM activity should be coded here.
- For both active and passive range of motion: movement by a resident that is incidental to dressing, bathing, etc., does not count as part of a formal restorative nursing program. For inclusion in this section, active or passive range of motion must be a component of an individualized program that is planned, monitored, evaluated, and documented in the resident's medical record. Range of motion should be delivered by staff who are trained in the procedures.
- For splint or brace assistance: assess the resident's skin and circulation under the device, and reposition the limb in correct alignment.
- The use of continuous passive motion (CPM) devices in a restorative nursing program is coded when the following criteria are met: (1) ordered by a physician, (2) nursing staff

O0500: Restorative Nursing Programs (cont.)

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 were engaged in applying and monitoring the device.

- Remember that persons with dementia learn skills best through repetition that occurs multiple times per day.
- 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.

Examples

1. Mr. V. has lost range of motion in his right arm, wrist, and hand due to a cerebrovascular accident (CVA) experienced several years ago. He has moderate to severe loss of cognitive decision-making skills and memory. To avoid further ROM loss and contractures to his right arm, the occupational therapist fabricated a right resting hand splint and instructions for its application and removal. The nursing coordinator developed instructions for providing passive range of motion exercises to his right arm, wrist, and hand three times per day. The nurse's aides and Mr. V.'s wife have been instructed in how and when to apply and remove the hand splint and how to do the passive ROM exercises. These plans are documented in Mr. V.'s care plan. The total amount of time involved each day in removing and applying the hand splint and completing the ROM exercises is 30 minutes (15 minutes to perform ROM exercises and 15 minutes to apply/remove the splint). The nurse's aides report that there is less resistance in Mr. V.'s affected extremity when bathing and dressing him.

Coding: Both **Splint or Brace Assistance** item (O0500C), and **Range of Motion (Passive)** item (O0500A), would be coded 7.

Rationale: Because this was the number of days these restorative nursing techniques were provided.

2. Mrs. R.'s right shoulder ROM has decreased slightly over the past week. Upon examination and X-ray, her physician diagnosed her with right shoulder impingement syndrome. Mrs. R. was given exercises to perform on a daily basis to help improve her right shoulder ROM. After initial training in these exercises by the physical therapist, Mrs. R. and the nursing staff were provided with instructions on how to cue and sometimes actively assist Mrs. R. when she cannot make the full ROM required by the exercises on her own. Her exercises are to be performed for 15 minutes, two times per day at change of shift in the morning and afternoon. This information is documented in Mrs. R.'s medical record. The nursing staff cued and sometimes actively assisted Mrs. R. two times daily over the past 7 days.

Coding: **Range of motion (active)** item (O0500B), would be coded 7.

Rationale: Because this was the number of days restorative nursing training and skill practice for active ROM were provided.

O0500: Restorative Nursing Programs (cont.)

3. Mrs. K. was admitted to the nursing facility 7 days ago following repair to a fractured hip. Physical therapy was delayed due to complications and a weakened condition. Upon admission, she had difficulty moving herself in bed and required total assistance for transfers. To prevent further deterioration and increase her independence, the nursing staff implemented a plan on the second day following admission to teach her how to move herself in bed and transfer from bed to chair using a trapeze, the bed rails, and a transfer board. The plan was documented in Mrs. K.'s medical record and communicated to all staff at the change of shift. The charge nurse documented in the nurse's notes that in the 5 days Mrs. K. has been receiving training and skill practice for bed mobility for 20 minutes a day and transferring for 25 minutes a day, her endurance and strength have improved, and she requires only extensive assistance for transferring. Each day the amount of time to provide this nursing restorative intervention has been decreasing, so that for the past 5 days, the average time is 45 minutes.

Coding: Both **Bed Mobility** item (O0500D), **Transfer** item (O0500E), would be coded 5.

Rationale: Because this was the number of days that restorative nursing training and skill practice for bed mobility and transfer were provided.

4. Mrs. D. is receiving training and skill practice in walking using a quad cane. Together, Mrs. D. and the nursing staff have set progressive walking distance goals. The nursing staff has received instruction on how to provide Mrs. D. with the instruction and guidance she needs to achieve the goals. She has three scheduled times each day where she learns how to walk with her quad cane. Each teaching and practice episode for walking, supervised by a nursing assistant, takes approximately 15 minutes.

Coding: **Walking** item (O0500F), would be coded 7.

Rationale: Because this was the number of days that restorative nursing skill and practice training for walking was provided.

5. Mrs. J. had a CVA less than a year ago resulting in left-sided hemiplegia. Mrs. J. has a strong desire to participate in her own care. Although she cannot dress herself independently, she is capable of participating in this activity of daily living. Mrs. J.'s overall care plan goal is to maximize her independence in ADLs. A plan, documented on the care plan, has been developed to assist Mrs. J. in how to maintain the ability to put on and take off her blouse with no physical assistance from the staff. All of her blouses have been adapted for front closure with velcro. The nursing assistants have been instructed in how to verbally guide Mrs. J. as she puts on and takes off her blouse to enhance her efficiency and maintain her level of function. It takes approximately 20 minutes per day for Mrs. J. to complete this task (dressing and undressing).

Coding: **Dressing or Grooming** item (O0500G), would be coded 7.

Rationale: Because this was the number of days that restorative nursing training and skill practice for dressing and grooming were provided.

O0500: Restorative Nursing Programs (cont.)

6. Mr. W.'s cognitive status has been deteriorating progressively over the past several months. Despite deliberate nursing restoration, attempts to promote his independence in feeding himself, he will not eat unless he is fed.

Coding: **Eating and/or Swallowing** item (O0500H), would be coded 0.

Rationale: Because restorative nursing skill and practice training for eating and/or swallowing were not provided over the last 7 days.

7. Mrs. E. has Amyotrophic Lateral Sclerosis. She no longer has the ability to speak or even to nod her head "yes" or "no." Her cognitive skills remain intact, she can spell, and she can move her eyes in all directions. The speech-language pathologist taught both Mrs. E. and the nursing staff to use a communication board so that Mrs. E. could communicate with staff. The communication board has been in use over the past 2 weeks and has proven very successful. The nursing staff, volunteers, and family members are reminded by a sign over Mrs. E.'s bed that they are to provide her with the board to enable her to communicate with them. This is also documented in Mrs. E.'s care plan. Because the teaching and practice using the communication board had been completed 2 weeks ago and Mrs. E. is able to use the board to communicate successfully, she no longer receives skill and practice training in communication.

Coding: **Communication** item (O0500J), would be coded 0.

Rationale: Because the resident has mastered the skill of communication, restorative nursing skill and practice training for communication was no longer needed or provided over the last 7 days.

O0600: Physician Examinations

O0600. Physician Examinations	
Enter Days <input type="text"/>	Over the last 14 days, on how many days did the physician (or authorized assistant or practitioner) examine the resident?

Item Rationale

Health-related Quality of Life

- Health status that requires frequent physician examinations can adversely affect an individual's sense of well-being and functional status and can limit social activities.

Planning for Care

- Frequency of physician examinations can be an indication of medical complexity and stability of the resident's health status.

O0600: Physician Examinations (cont.)

Steps for Assessment

1. Review the physician progress notes for evidence of examinations of the resident by the physician or other authorized practitioners.

Coding Instructions

- Record the **number of days** that physician progress notes reflect that a physician examined the resident (or since admission if less than 14 days ago).

Coding Tips and Special Populations

- 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.
- 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>.
- Do not include physician examinations that occurred prior to admission or readmission to the facility (e.g., during the resident's acute care stay).
- Do not include physician examinations that occurred during an emergency room visit or hospital observation stay.
- 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.
- The licensed psychological therapy by a Psychologist (PhD) should be recorded in O0400E, **Psychological Therapy**.
- Does not include visits made by Medicine Men.

O0700: Physician Orders

O0700. Physician Orders	
Enter Days <input type="text"/>	Over the last 14 days, on how many days did the physician (or authorized assistant or practitioner) change the resident's orders?

Item Rationale

Health-related Quality of Life

- Health status that requires frequent physician order changes can adversely affect an individual's sense of well-being and functional status and can limit social activities.

Planning for Care

- Frequency of physician order changes can be an indication of medical complexity and stability of the resident's health status.

Steps for Assessment

1. Review the physician order sheets in the medical record.
2. Determine the number of days during the 14-day look-back period that a physician changed the resident's orders.

Coding Instructions

- Enter the **number of days** during 14-day look-back period (or since admission, if less than 14 days ago) in which a physician changed the resident's orders.

Coding Tips and Special Populations

- Includes orders written by 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.
- Includes written, telephone, fax, or consultation orders for new or altered treatment. Does **not** include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. Orders written on the day of admission as a result for 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.
- The prohibition against counting standard admission or readmission orders applies regardless of whether or not the orders are given at one time or are received at different times on the date of admission or readmission.
- Do not count 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, does **not** count as an order change simply because a different dose is administered based on the sliding scale guidelines.

O0700: Physician Orders (cont.)

- 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 Medicare Certification/Recertification is a renewal of an existing order and should **not** be included when coding this item.
- 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 during which a physician visited, and 1 day in which orders were changed.
- Orders requesting a consultation by another physician may be counted. However, the order must be reasonable (e.g., for a new or altered treatment).
- 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.
- Orders written to increase the resident's RUG classification and facility payment are **not** acceptable.
- Orders for transfer of care to another physician may **not** be counted.
- Do **not** count orders written by a pharmacist.