Centers for Medicare and Medicaid Services

Revised

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REVISED SWING BED MINIMUM DATA SET ASSESSMENT TRAINING MANUAL

For Use With The Swing Bed Minimum Data Set Assessment

Centers for Medicare and Medicaid Services

The *Revised Swing Bed Minimum Data Set Assessment Training Manual* is published by the Centers for Medicare and Medicaid Services (CMS) and is a public document. It may be copied freely, as our goal is to disseminate information broadly to facilitate accurate and effective use of the MDS for swing bed hospitals. This revised manual replaces the original May 2002 manual.

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CENTERS FOR MEDICARE AND MEDICAID SERVICES
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For questions related to the SB-MDS assessment, please refer to the list of contacts included in the appendix.

For information, please check our CMS web site:

www.cms.hhs.gov/providers/snfpps/snfpps_swingbed.asp.

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Chapter 1: Overview of the Swing Bed Minimum Data Set Assessment

1.1 Background

The 1986 Institute of Medicine (IOM) report recommended nursing facilities complete comprehensive assessments, utilizing a minimum data set, to identify potential care problems to be addressed in the resident's individualized care plan. The Omnibus Budget Reconciliation Act of 1987 (OBRA '87) mandated the development of a resident assessment instrument (RAI) for individual's residing in nursing facilities. The tool was required by law to produce a "comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity." This minimum data set became the federally mandated Minimum Data Set (MDS) used in all Medicaid and Medicare certified nursing facilities. The MDS contains items that reflect the acuity level of the resident, including diagnoses, treatments and an evaluation of the resident's functional status. Nursing facilities have been completing the MDS since October 1990 and submitting their electronic MDS data to state repositories since June 22, 1998. The MDS is also used as a data collection tool for Medicare and Medicaid payment systems, as well as for publicly reported Quality Measures.

1.2 Regulatory Authority

Section 4432(a) of the Balanced Budget Act (BBA) of 1997 specifies that swing bed hospitals providing Part A skilled nursing facility-level services must be incorporated into the Skilled Nursing Facility Prospective Payment System (SNF PPS) by the end of the statutory transition period. For the purposes of this manual, "swing bed" will be used to describe the facility that provides the Part A SNF-level services reimbursable under the SNF PPS. Effective with cost reporting periods beginning on or after July 1, 2002, swing bed payment is based on SNF PPS instead of the cost-related method. These payment rates cover all costs of furnishing covered swing bed services (routine, ancillary, and capital-related costs) other than costs associated with operating approved educational activities as defined in 42 CFR 413.85. The SNF PPS applies to Short-Term Hospitals, Long-Term Hospitals, and Rehabilitation Hospitals certified as swing bed hospitals. **Critical Access Hospitals (CAHs) with swing beds are exempt from the SNF PPS**.

Beginning on the first day of each hospital's next cost reporting year, on and after July 1, 2002, swing bed hospitals are required to complete a unique two-page MDS assessment form that will be used to determine payment levels for Medicare beneficiaries. The Swing Bed MDS (SB-MDS) assessment data is submitted electronically to a National Assessment Collection Database (national database). The new SB-MDS uses a subset of the MDS information and includes only those items required for payment and the ongoing analysis of swing bed utilization under the SNF PPS. A registered nurse following the Medicare PPS assessment schedule will complete or coordinate the

SB-MDS data set. A copy of the SB-MDS is included in this chapter, Pages 1-11 and 1-12. The SB-MDS form can be downloaded at the following web site:

www.cms.hhs.gov/providers/snfpps/snfpps_swmds.asp.

It is the intent of this manual to offer clear guidance, through instruction and example, for the effective completion of the SB-MDS assessment instrument. Basically, when everyone is speaking the same language, the opportunity for misunderstanding or error is diminished considerably.

1.3 Protecting the Privacy of SB-MDS

SB-MDS assessment data is personal information about swing bed patients that facilities are required to collect and keep confidential in accordance with federal law. The CFR Part 483.20 requires Medicare and Medicaid certified swing bed providers to collect patient assessment data that comprises the SB-MDS. This data is considered part of the patient's medical record and is protected from improper disclosure by Medicare and Medicaid certified facilities under the Conditions of Participation (CoP). By regulation at CFR 483.75(L)(2)(3) and 483.75(L)(2)(4)(i)(ii)(iii), release of information from the patient's clinical record is permissible only when required by:

1. transfer to another health care institution,
2. law (both State and Federal), and/or
3. the patient.

Otherwise, providers cannot release SB-MDS data in individual level format or in the aggregate. Swing bed providers are also required under CFR 483.20 to transmit SB-MDS data to a Federal data repository. Any personal data maintained and retrieved by the Federal government is subject to the requirements of the Privacy Act of 1974. The Privacy Act specifically protects the confidentiality of personal identifiable information and safeguards against its misuse. The Privacy Act can be found at **www.usbr.justice.gov/04foia/privstat.htm**.

The Privacy Act requires by regulation that all individuals whose data are collected and maintained in a federal database must receive notice. Therefore, patients in swing bed facilities must be informed that the SB-MDS data is being collected and submitted to the national database. The notice shown on Page 1-4 of this section meets the requirements of the Privacy Act of 1974 for swing beds. The form is a notice and not a consent to release or use SB-MDS data for health care information. Each patient or family member must be given the notice containing submission information at the time of admission. It is important to remember that patient consent is not required to complete and submit SB-MDS assessments that are required for Medicare payment purposes.

Contractual Agreements

In the case where a swing bed submits SB-MDS data to CMS through a contractor or through its corporate office, the contractor or corporate office has the same rights and restrictions as the swing bed does under the Federal and State regulations with respect to maintaining patient data, keeping such data confidential, and making disclosures of such data. This means that a contractor may

maintain a database, but must abide by the same rules and regulations as the swing bed. Moreover, the fact that there may have been a change of ownership of a swing bed that has been transferring data through a contractor should not alter the contractor's rights and responsibilities; presumably, the new owner has assumed existing contractual rights and obligations, including those under the contract for submitting SB-MDS information. All contractual agreements, regardless of their type, involving the SB-MDS data should not violate the requirements of participation in the Medicare and/or Medicaid program, the Privacy Act of 1974 or any applicable State laws.

SWING BED HOSPITALS
PRIVACY ACT STATEMENT – HEALTH CARE RECORDS

THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974. THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER OR NOT DISCLOSURE IS MANDATORY OR VOLUNTARY.

Sections 1819(f), 1919(f), 1819(b)(3)(A), 1919(b)(3)(A), and 1864 of the Social Security Act.

Medicare and Medicaid participating swing bed hospitals are required to establish a database of patient assessment information (SB-MDS), and to electronically transmit this information to the Centers for Medicare & Medicaid Services (CMS).

Because the law requires disclosure of this information to Federal sources as discussed above, a patient does not have the right to refuse consent to these disclosures.

These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS Long-Term Care System of Records.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate tracking of changes in your health and functional status over time for purposes of determining payment and evaluating the quality of care provided by swing bed hospitals that participate in Medicare or Medicaid.

3. ROUTINE USES

The primary use of this information is to study the effectiveness and quality of care given in swing bed hospitals and to aid in the administration of the Skilled Nursing Facility Prospective Payment System (SNF PPS). This system will also support regulatory, reimbursement analysis, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose.

The information collected will be entered into the Swing Bed Minimum Data Set (SB-MDS) system of records, System No. 09-70-1517. Information from this system may be disclosed, under specific circumstances, to the Census Bureau and to: (1) Agency contractors, or consultants who have been engaged by the Agency to assist in accomplishment of a CMS function, (2) another Federal or State agency, agency of a State government, an agency established by State law, or its fiscal agent to administer a Federal health program or a Federal/State Medicaid program and to contribute to the accuracy of reimbursement made for such programs, (3) to Quality Improvement Organizations (QIOs) to perform Title XI or Title XVIII functions, (4) to insurance companies, underwriters, third party administrators (TPA), employers, self-insurers, group health plans, health maintenance organizations (HMO) and other groups providing protection against medical expenses to verify eligibility for coverage or to coordinate benefits with the Medicare program, (5) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or the restoration of health, or payment related projects, (6) to a member of Congress or congressional staff member in response to an inquiry from a constituent, (7) to the Department of Justice, (8) to a CMS contractor that assists in the administration of a CMS-administered health benefits program or to a grantee of a CMS-administered grant program, (9) to another Federal agency or to an instrumentality of any governmental jurisdiction that administers, or that has the authority to investigate potential fraud or abuse in a health benefits program funded in whole or in part by Federal funds to prevent, deter, and detect fraud and abuse in those programs, (10) to national accrediting organizations, but only for those facilities that these accredit and that participate in the Medicare program.

4. EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

The information contained in the Swing Bed Minimum Data Set (SB-MDS) is generally necessary for the facility to provide appropriate and effective care to each patient. If a patient fails to provide such information, for example on medical history, inappropriate and potentially harmful care may result. Moreover, payment for such services by third parties, including Medicare and Medicaid, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

1.4 Participants in the Assessment Process

Facilities have flexibility in determining who should participate in the assessment process, as long as it is accurately conducted. A facility may assign responsibility for completing the SB-MDS to a number of qualified staff members. In most cases, participants in the assessment process are licensed health professionals. It is the facility's responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. The SB-MDS must be conducted or coordinated by an RN who signs and certifies the completion of the assessment.

The attending physician is also an important participant in the SB-MDS process. The facility needs the physician's evaluation and orders for the patient's immediate care, as well as for a variety of treatments and laboratory tests. Furthermore, the attending physician may provide valuable input on items in the SB-MDS.

1.5 Sources of Information for Completion of the SB-MDS Assessments

The process for performing an accurate assessment requires that information about patients be gathered from multiple sources. It is the role of the individual completing the assessment to validate the information obtained from the patient, patient's family, or other health care team members through observation, interviewing, reviewing lab results, and so forth to ensure accuracy. Similarly, information in the patient's record is verified by interacting with the patient and direct care staff.

The following sources of information must be used in completing the SB-MDS. Although not required, the review sequence for the assessment process generally follows the order below:

- **Review of the patient's record.** Depending on whether the assessment is a 5-Day or another scheduled assessment, the review could include: preadmission, admission or transfer notes, current plan of care, recent physician notes and/or orders, documentation of services currently provided, results of recent diagnostic and/or other test procedures, monthly nursing summary notes, medical consultations, and a record of medications since admission.

- **Communication with and observation of the patient.**

- **Communication with direct-care staff** (e.g., nursing assistants) from all shifts.

- **Communication with licensed professionals** (from all disciplines) who have recently observed, evaluated, or treated the patient. Communication can be based on discussion or licensed staff can be asked to document their impressions of the patient.

- **Communication with the patient's physician.**

- **Communication with the patient's family**. For some patients, family members may be unavailable or the patient may request that you not contact them. Where the family is not involved, someone else may be very close to the patient, and the patient may wish that this person be contacted. Even when family is involved, the patient may still wish for you to contact another non-family member.

Review of the Patient's Record

The patient's record provides a starting point in the assessment process for reviewing information about the patient in written staff notes across all shifts over multiple days. Starting with the patient record, however, does not indicate that it is the most critical source of information, but only a convenient source.

At admission, record review includes an examination of notes written since admission to the swing bed for Part A SNF-level services, documentation that accompanied the patient at admission, facility intake forms, acute care hospital information, or acute care hospital discharge information if admitted from another hospital, and any preadmission test results.

Subsequent reassessments should focus on recorded information from earlier SB-MDS assessments and written information from the previous assessment time frames that remains applicable to the patient's current status.

The following are important considerations when reviewing the patient's record:

- **Review the information documented in the record, keeping in mind the required SB-MDS definitions.**

- **Ensure that the information taken from the record covers the same observation period as that specified by the SB-MDS items.** The SB-MDS refers to specific time frames for each item; for example, ADL status is based on patient performance over a 7-day period. To ensure uniformity, the SB-MDS has an Assessment Reference Date (**Item 10a**) that establishes a common reference end-point for all items. Consequently, it is necessary to pay careful attention to the notes regarding time frames for each section of the SB-MDS, and also to the Item-by-Item instructions in Chapter 3.

- **Be aware of discrepancies and view the record information as preliminary only.** Clarify and verify all information during the assessment process. Be alert to information in the record that is not consistent with verbal information or physical assessment findings. Discuss discrepancies with other interdisciplinary team members (e.g., nurses, social workers, therapists). The extent to which the record can be relied upon for information will depend on the comprehensiveness of the record system. Note what information the record usually contains (e.g., current service notes, care plans, flow sheets, medication sheets), where different types of information are maintained in the clinical record, and more importantly, what information is missing.

- **Where information in the record is sufficiently detailed and conforms to SB-MDS descriptions and time periods, complete the SB-MDS items.** A few SB-MDS items can be completed in full from information found in the record. Accurate assessment of most items, however, requires information from other sources (e.g., the patient, the patient's family, and facility staff). Where information is incomplete or contradictory, make a note of the issues in question. This note can help plan contacts with the patient, facility staff and the patient's family. There is no requirement that such a note be maintained as part of the patient's permanent record; it is a work tool only.

- **As you observe, talk with, and discuss the patient with other staff members, verify the accuracy of what you learned from reviewing the record.**

Communication With and Observation Of the Patient

The patient is a primary source of information and may be the only source of information for many items. Become familiar with the SB-MDS items to make communication and observation of the patient an ongoing everyday activity in the facility. For example, an RN can observe and interact with a patient when medications are given, during meals, or when the patient comes to ask a question. Interaction with the patient may be a crucial factor in confirming staff judgments of patient problems. Weigh what the patient says and what is observed about the patient against other information obtained from the patient record and facility staff.

To be most efficient, organize a framework for interviewing and observing the patient. Allow flexibility to accommodate the patient. Carefully listen to and observe the patient for guidance as to how to pursue the necessary information gathering. Try to interact with the patient, even if the patient may have difficulty responding. The degree and character of the difficulty in responding, as well as nonverbal responses (e.g., fearfulness) provide important information. Sensitive staff judgment is necessary in gathering information.

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

Any person completing any SB-MDS section is required to follow the Item-by-Item guidelines in Chapter 3 of this manual that specify sources of information necessary for accurate coding. The process of information gathering should include direct observation of the patient; communication with the patient's direct caregivers across all shifts; review of relevant information in the patient's clinical record; and if possible, consultation with family members who have direct knowledge of the patient's behavior in the observation period. If the person completing the SB-MDS did not personally observe a behavior, but others report that it occurred, the behavior must be considered as having occurred when completing the SB-MDS form. In addition, the patient's clinical record should support his/her status as reported on the SB-MDS.

Communication With Direct Care Staff

Direct care staff (e.g., nursing assistants) have daily, intimate contact with patients and are often the most knowledgeable source of information about the patient. Direct care staff talk with and listen to the patient. They observe and assist the patient's performance of ADLs and involvement in activities. They observe the patient's physical, cognitive and psychosocial status daily during all shifts, seven days a week. Key considerations when communicating with direct care staff are:

- **Be sure to speak with a person who has first-hand knowledge of the patient.** Plan for sufficient time to talk with direct care staff.

- **Start by asking about the patient's performance on ADLs and activities.** What can the patient do without assistance? What do staff members do for the patient? What might the patient be able to do that he or she is not doing now? Continue by asking about communication and memory skills, body control, and the presence of mood or other behavioral symptoms.

- **Talk with direct care staff across all shifts, if possible.** The information from other shifts may also be obtained in other ways (e.g., from change-of-shift reports if direct care staff comments are included).

Communication With Licensed Professionals, Patient's Physician, and Family

Licensed practical nurses (LPNs), RNs, social workers, activities professionals, occupational therapists, physical therapists, speech therapists, pharmacists, dietitians and other professionals who have observed, evaluated, or treated the patient should be interviewed about their knowledge of patient abilities, performance patterns and problems. Their special expertise will enhance the accuracy of the patient assessment.

The physician's role is central to the overall management and outcome of patient care. The SB-MDS assessment process should include a review of the physician's examination of the patient, plan of care, acute care hospital discharge plan, goals of the swing bed care, and medication and treatment orders. Review the SB-MDS with the patient's attending physician to share and validate pertinent information.

The patient's family (or persons close to the patient) can be a valuable source of information about the patient's health history, history of strengths and problems in various functional areas, and customary routine prior to the first swing bed admission. This information is particularly necessary when the patient is cognitively impaired or has a great deal of difficulty communicating. Using this source obviously depends on the presence of family members, their willingness to participate, and the patient's preferences. Facilities need to respect the cognitively intact patient's right to privacy and should have permission from the individual for staff to ask questions of family members. In

most instances, family will not be the sole source of information, but will supplement information from other sources. The assessment process provides an excellent opportunity for caregivers to develop trusting, working relationships with the patient and the patient's family.

1.6 CMS Clarification Regarding Documentation Requirements

CMS has always accepted the SB-MDS as a primary data source, and duplicative documentation is not required. However, clinical documentation that furnishes a picture of the patient's care needs and response to treatment is an accepted standard of practice and is part of good patient care and staff care planning. For this reason, it is always expected that information contained in the clinical record supports rather than conflicts with the SB-MDS. Completion of the SB-MDS does not remove the swing bed's responsibility to document a more detailed assessment of particular issues of relevance for the patient. In addition, for the Medicare prospective payment system, documentation must substantiate the patient's need for Part A SNF-level services and his/her response to those services.

Swing bed hospitals are required to document the patient's care and response to care during the course of the stay, and it is expected that this documentation would be chronological, support and be consistent with the findings of each SB-MDS assessment. Always keep in mind that government requirements are not the only or even the major reason for clinical documentation. The SB-MDS has simply codified some documentation requirements into a standard format.

Clinical documentation that contributes to identification and communication of patients' problems, needs and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and is an expectation of trained and licensed health care professionals. Good clinical practice has always dictated documentation of certain treatments and conditions such as the amount of IV nutrient intake and the number of minutes of therapy actually provided to a swing bed patient. For these types of services, the more detailed documentation needed for good patient care also provides all the data needed to code the SB-MDS. The SB-MDS does not require duplication of the more detailed treatment logs; the data are simply summarized on the SB-MDS.

In addition, it is important to note that CMS does not impose specific documentation procedures to swing bed facilities. Some facilities have developed tools to collect data across shifts or throughout an assessment period; e.g., ADL support needs, type and duration of restorative nursing services, etc. Some facilities have found flow sheets useful for this purpose. The form and format of such documentation is determined by the facility. These tools may provide more accurate data for SB-MDS reporting and planning care, and may provide real value to the facilities utilizing them. However, these tools are not mandated by CMS or by Fiscal Intermediaries.

When available, State Agency and Fiscal Intermediary (FI) staff will utilize these data collection tools as part of an SB-MDS validation review. In the absence of this type of documentation, the SB-MDS can still be verified by a review of the entire record to verify that the medical record supports and is consistent with the responses on the SB-MDS.

Some states may have regulations that require supporting documentation elsewhere in the record to substantiate the patient's status on particular SB-MDS items used to calculate payment under the State's Medicaid system. If your state requires the SB-MDS to be completed for the Medicaid program, they may have additional documentation requirements. Contact your State Agency's Resident Assessment Coordinator or your Medicaid program for state specific requirements. (See Appendix B for a list of the State RAI Coordinators.)

1.7 Reproduction of the SB-MDS in the Patient's Record and Maintenance of the Assessments

SB-MDS records are subject to the same record retention requirements as all other hospital clinical records. All SB-MDS assessments, and Discharge and Reentry tracking information must be kept in the medical record for active patients. Active records must be accessible to all professional staff (including consultants) who need to review the information in order to provide care to the patient. In addition, all data from closed records, including the SB-MDS data, must be maintained to provide access when needed for survey, medical review or other program purposes.

There is no requirement to maintain a hard copy and an electronic copy of the SB-MDS. It is required that the record be completed, signed, and dated within the regulatory time frames. If corrections are required after completion and submission of the SB-MDS to the national database, CMS has specific procedures that must be followed. Refer to Chapter 4 for correction procedures. It may be appropriate to update the patient's care plan, based on the revised assessment record. Patient assessment forms must accurately reflect the patient's status, and agree with the record that is submitted to the CMS national database.

When a discharged patient is admitted at a later date, the swing bed hospital must open a new record. The swing bed hospital may transfer copies of previous SB-MDS assessments and other clinical information to the new record, but is not required to do so. Swing bed hospitals should develop their own specific medical record policies for readmissions.

MINIMUM DATA SET (MDS) FOR SWING BED HOSPITALS

1.	RESIDENT NAME AA1	a. (First) b. (Middle Initial) c. (Last) d. (Suffix)
2.	GENDER AA2	1. Male 2. Female
3.	BIRTHDATE AA3	__ - __ - ____
4.	MARITAL STATUS A5	1. Never Married 2. Married 3. Widowed 4. Separated 5. Divorced
5.	RACE/ ETHNICITY	(*Check all that apply*) a. American Indian/Alaskan Native b. Asian c. Black or African American d. Hispanic or Latino e. Native Hawaiian or other Pacific Islander f. White
6.	ZIP CODE AB4	Enter code for the pre-hospital residence
7.	RESIDENT SSN and MEDICARE NUMBERS AA5	a. Social Security Number b. Medicare or Railroad Insurance Number
8.	RESIDENT MEDICAID NUMBER AA7	Enter + if pending or N if not a Medicaid recipient in first digit followed by blanks
9.	FACILITY PROVIDER NUMBER AA6a	a. State Medicaid Provider Number b. Medicare Provider Number
10.	ASSESSMENT REFERENCE DATE A3a	a. Last day of MDS observation period b. Original (00) or correction (enter number of correction)
11.	REASONS FOR ASSESSMENT AA8	a. **Primary Reasons for Assessment** 00. PPS assessment for Medicare Payment 06. Discharged–Return Not Anticipated 07. Discharged–Return Anticipated 09. Reentry 11. Assessment–Not for Medicare payment
		b. **PPS Scheduled Assessments** 1. 5-day 2. 30-day 3. 60-day 4. 90-day 5. Readmission/Return 7. 14-day 9. Other
		c. **OMRA Assessment** 0. No 1. Yes
		d. **Clinical Change Assessment** 0. No 1. Yes
		e. **State-Required Assessment** 0. No 1. Yes
		f. **Assessment Needed for Other Reasons** (e.g., HMOs, MSP, sanction situations, etc.) 0. No 1. Yes
12.	PRIOR ACUTE CARE STAY	Date of admission for prior qualifying hospital stay
13.	ADMISSION DATE AB1	Date of initial admission for extended care swing bed services
14.	ADMISSION/ DISCHARGE STATUS CODE	01. Private Home/apt with no home health care 02. Private Home/apt with home health care 03. Board and Care/assisted living/group home 04. Another nursing facility 05. Acute unit at own hospital 06. Acute unit at another hospital 07. Psychiatric hospital 08. Rehabilitation hospital 09. MR/DD facility 10. Hospice 11. Deceased 12. Other
		a. Admitted From – Code with all records
		b. Discharge Status – Complete if Item 11a = 06 or 07
		c. Reentered From – Complete if Item 11a = 09

15.	DISCHARGE DATE R4	Complete if Item 11a = 06 or 07 __ - __ - ____
16.	REENTRY DATE A4	Complete if Item 11a = 09 __ - __ - ____

CLINICAL DATA

17.	COMATOSE B1	Persistent vegetative state with no discernible consciousness If yes, skip to Item 23 0. No 1. Yes
18.	SHORT TERM MEMORY B2a	Seems/appears to recall after 5 minutes 0. Memory okay 1. Memory problem
19.	COGNITIVE SKILLS B4	Makes decisions regarding tasks of daily life 0. Independent 1. Modified independence 2. Moderately impaired 3. Severely impaired
20.	MAKING SELF UNDERSTOOD C4	Expressing information content – (however able) 0. Understood 1. Usually understood 2. Sometimes understood 3. Rarely/never understood
21.	INDICATORS OF DEPRESSION E1	**Code for indicators observed in the last 30 days, regardless of the assumed cause** 0. Indicator not exhibited in last 30 days 1. Indicator exhibited up to five days a week 2. Indicator exhibited daily or almost daily (6 or 7 days a week) a. Negative statements b. Repetitive questions c. Repetitive verbalizations d. Persistent anger with self/others e. Self deprecation f. Expression of unrealistic fears g. Recurrent statements that something terrible is about to happen. h. Repetitive health complaints i. Repetitive anxious complaints/concerns j. Unpleasant mood in morning k. Insomnia/change in usual sleep pattern l. Sad, pained, worried facial expression m. Crying,tearfulness n. Repetitive physical movements o. Withdrawal from activities of interest p. Reduced social interaction
22.	BEHAVIORAL SYMPTOMS E4	***Behavioral symptom frequency in last 7 days*** 0. Behavior NOT exhibited in last 7 days 1. Behavior occurred 1 to 3 days in last 7 days 2. Behavior occurred 4 to 6 days, but less than daily 3. Behavior occurred daily a. Wandering (E4aA) b. Verbally abusive behavioral symptoms (E4bA) c. Physically abusive behavioral symptoms (E4cA) d. Socially inappropriate/disruptive behavioral symptom (E4dA) e. Resists care (E4eA)
23.	ADLs G1	(A) ADL Self-Performance—Code for resident's performance over all shifts **during the last 7 days** 0. Independent 1. Supervision 2. Limited assistance 3. Extensive assistance 4. Total dependence 8. Activity did not occur (B) ADL support provided—Code for most support provided over all shifts **during last 7 days** 0. No setup or physical help 1. Setup help only 2. One person assist 3. Two + persons physical assist 8. Activity did not occur

	A	B
a. Bed Mobility (G1a)		
b. Transfer (G1b)		
c. Eating (G1h)		
d. Toilet Use (G1i)		

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Resident Name _____ **Numeric Identifier** _____

24.	TOILETING PROGRAMS H3	*Check any that apply during the last 14 days* a. Any scheduled toileting plan b. Bladder retraining program
25.	DISEASES I1	*Check only* those conditions/diseases that have a relationship to current ADL status, medical treatments, nursing monitoring or risk of death. Do not code inactive diagnoses. a. Diabetes mellitus (I1a) b. Aphasia (I1r) c. Cerebral palsy (I1s) d. Hemiplegia/hemiparesis (I1v) e. Multiple sclerosis (I1w) f. Quadriplegia (I1z)
26.	INFECTIONS I2	*Check any that apply* a. Pneumonia (I2e) b. Septicemia (I2g)
27.	PROBLEM CONDITIONS J1	**Check all problems present in the last 7 days** a. Dehydrated, output exceeds input (J1c) b. Delusions (J1e) c. Fever (J1h) d. Hallucinations (J1i) e. Internal bleeding (J1j) f. Vomiting (J1o)
28.	WEIGHT LOSS K3a	Weight loss - 5% **or more in last 30 days or 10% or more in the last 180 days** 0. No 1. Yes
29.	NUTRITIONAL APPROACHES K5	*Check all that apply in last 7 days* a. Parenteral/IV b. Feeding tube
30.	PARENTERAL OR ENTERAL INTAKE K6	Skip to item 31 if neither 29a nor 29b is coded a. Code the proportion of total calories the resident received through parenteral or tube feedings **in the last 7 days** 0. None 1. 1% to 25% 2. 26% to 50% 3. 51% to 75% 4. 76% to 100% b. Code the average fluid intake per day by IV or tube feedings **in last 7 days** 0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day
31.	ULCERS M1	Record the number of ulcers at each ulcer stage — regardless of cause. If none present at a stage, record "0". Code all that apply **during last 7 days**. Code 9 for 9 or more. a. Stage 1 A persistent area of skin redness b. Stage 2 A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater c. Stage 3 A full thickness of skin is lost, exposing the subcutaneous tissues d. Stage 4 A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.
32.	PRESSURE ULCERS M2a	Code pressure ulcers for the highest stage **in the last** 7 days (0=None, stages =1, 2, 3, or 4)
33.	OTHER SKIN PROBLEMS OR LESIONS M4	*Check all that apply in last 7 days* a. Burns (second or third degree) (M4b) b. Open lesions other than ulcers, rashes, cuts (M4c) c. Surgical Wounds (M4g)
34.	SKIN TREATMENTS M5	*Check all that apply in last 7 days* a. Pressure relieving device(s) for chair b. Pressure relieving device(s) for bed c. Turning/repositioning program d. Nutrition or hydration intervention to manage skin problems e. Ulcer Care f. Surgical wound care g. Application of dressings (with or without topical medications) other than to feet. h. Application of ointments/medications (other than to feet)
35.	FOOT CARE PROBLEMS M6	*Check all that apply in last 7 days* a. Infection of the foot – e.g., cellulitis, purulent drainage (M6b) b. Open lesions on the foot (M6c) c. Application of dressings (with or without topical medications) (M6f)

36.	TIME AWAKE N1	Check appropriate time periods over the last 7 days the Resident was awake all or most of time (i.e., naps no more than one hour per time period) in the: a. Morning b. Afternoon c. Evening
37.	INJECTIONS O3	Record the **number of days** injections of any type received **in last 7 days**. If none, enter "0".
38.	SPECIAL TREATMENTS AND PROCEDURES P1	**a. SPECIAL CARE** – Check treatments received **during the the last 14 days** a. Chemotherapy (P1aa) b. Dialysis (P1ab) c. IV medication (P1ac) d. Oxygen therapy (P1ag) e. Radiation (P1ah) f. Suctioning (P1ai) g. Tracheostomy care (P1aj) h. Transfusions (P1ak) i. Ventilator or respirator (P1al) **b. THERAPIES** – *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days.* Note: Count only therapies provided after admission for extended care swing bed services. **(A) = # of days** administered for **15 minutes or more** **(B) = total # of minutes** provided in the **last 7 days** DAYS (A) MIN (B) a. Speech language pathology and audiology b. Occupational therapy c. Physical therapy d. Respiratory therapy
39.	NURSING REHABILITATION/ RESTORATIVE CARE P3	Record the number of days each of the following was provided to the resident for **more than or equal to 15 minutes per day in the last 7 days.** (Enter 0 if none or less than 15 minutes per day.) a. Range of motion(passive) b. Range of motion(active) c. Splint/Brace assistance d. Bed mobility e. Transfer f. Walking g. Dressing or grooming h. Eating or swallowing i. Amputation/ Prosthesis Care j. Communication
40.	PHYSICIAN VISITS P7	**In the last 14 days** (or since swing bed admission/ readmission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident. (Enter 0 if none.).
41.	PHYSICIAN ORDERS P8	**In the last 14 days** (or since swing bed admission/ readmission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter 0 if none)..
42.	ORDERED THERAPIES T1	Skip unless this is a PPS 5 day or PPS Readmission/Return assessment. a. **Ordered Therapies:** Has physician ordered any of the following therapy services to begin in the **FIRST 14 days of stay** — physical therapy, occupational therapy or speech pathology services. (T1b) 0. No 1. Yes If No, skip to item 45. b. **Through day 15**, provide an estimate of the number of days when at least 1 therapy can be expected to be delivered. (T1c) c. **Through day 15**, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered. (T1d) .
43.	CASE MIX GROUP T3	Medicare State
44.	HIPPS Code.	
45.	SIGNATURE R2	a. Name/Signature of RN Coordinating Assessment b. Date RN Assessment Coordinator signed as complete

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Chapter 2: Assessment Schedule for the Swing Bed Minimum Data Set

2.1 Minimum Data Set Requirements for Swing Bed Hospitals

The SB-MDS assessment consists of the two-page Minimum Data Set for Swing Bed Hospitals, and two subsets of SB-MDS items used to track patient readmissions and discharges.

- **Minimum Data Set for Swing Bed Hospitals** - A core set of screening, clinical and functional status elements used to classify Medicare patients into one of 53 Resource Utilization Groups (RUG-III) that will be used to bill the fiscal intermediary for Part A SNF-level services. Swing bed hospitals do not have to complete the SB-MDS once the patient is no longer eligible for Part A SNF-level services. The SB-MDS can also be completed for other swing bed patients if required by other payers, such as the State Medicaid agency, health maintenance organizations or other secondary payers. The SB-MDS completed for other payers can be submitted to the national database, as long as the assessments were performed on patients in Medicare or Medicaid certified beds.

Clarification: ◆ If the patient enrolls in the Medicare hospice program and Medicare hospice benefits have been established, the patient's care is no longer paid through the Part A SNF-level PPS and the SB-MDS assessments are no longer completed. However, the hospice organization may require the completion of the assessments.

Swing bed providers using the SB-MDS will follow the same schedule used by skilled nursing facilities for the SNF PPS. The admission day is day one of the stay. The assessment schedule includes 5-Day, 14-Day, 30-Day, 60-Day and 90-Day assessments. Other off-cycle assessments are completed to report a clinical change or that all therapies are discontinued. A Readmission/Return assessment may be required after an inpatient acute hospital stay.

The SB-MDS must be completed within 14 days of the assessment reference date. The Assessment Reference Date (ARD) establishes a common reference end-point for all items. Chapter 3, **Item 10a**, provides more detail about the ARD.

Swing bed staff should make every effort to complete assessments in a timely manner. Each of the SB-MDS scheduled assessments has defined days when the assessment reference date can be set. For example, the Medicare 5-Day assessment, days one through five have been defined as the optimal days for setting the assessment reference date. However, there may be situations when an assessment might be delayed and CMS has allowed for these situations by defining a number of grace days for each PPS assessment. Grace days for the Medicare 5-Day assessment reference date can be extended one to three grace days.

Grace days can be added to the assessment reference date in situations such as an absence/illness of the RN assessor, reassignment of the assessor to other duties for a short period of time, or an unusually large number of assessments due at approximately the same time. Grace days may also be used to more fully capture therapy minutes or other treatments.

An SB-MDS assessment is considered complete on the day that the registered nurse (RN) coordinating the assessment signs and dates the assessment. Each SB-MDS record must be encoded and edited at the swing bed hospital. The SB-MDS records must then be submitted electronically to the national database. It will be considered timely if transmitted and accepted into the database within 14 days of completion. The SB-MDS assessment is used to classify patients into a RUG-III Classification group for the purpose of Medicare reimbursement.

2.2 Types of SB-MDS Assessments and Timing of Assessments

5-Day - The first Medicare assessment completed upon admission to the swing bed hospital for Part A SNF-level services; i.e. swing bed services. The 5-Day Medicare assessment usually will have an ARD (**Item 10a**) established between days 1-5 of the swing bed stay. The ARD (**Item 10a**) can be extended to day 8 if using the designated "Grace Days." The 5-Day Medicare assessment must be completed (**Item 45b**) within 14 days of the ARD. The 14-day calculation is based on calendar days and includes weekends. The 5-Day assessment authorizes payment from days 1 through 14 of the stay, as long as the patient remains eligible for Part A SNF-level services. The SB-MDS records must be submitted electronically to the national database and will be considered timely if submitted and accepted into the database within 14 days of completion (**Item 45b**).

14-Day - Medicare assessment that usually will have an ARD (**Item 10a**) established between days 11-14 of the swing bed stay. The ARD (**Item 10a**) can be extended to day 19 if using the designated "Grace Days." The 14-Day assessment must be completed (**Item 45b**) within 14 days of the ARD. The 14-Day assessment authorizes payment from days 15 through 30 of the stay, as long as the patient remains eligible for Part A SNF-level services. The SB-MDS records must be submitted electronically to the national database and will be considered timely if submitted and accepted into the database within 14 days of completion (**Item 45b**).

30-Day - Medicare assessment that usually will have an ARD (**Item 10a**) established between days 21-29 of the swing bed stay. The ARD (**Item 10a**) can be extended to day 34 if using the designated "Grace Days." The 30-Day Medicare assessment must be completed (**Item 45b**) within 14 days of the ARD. The 30-Day assessment authorizes payment from days 31 through 60 of the stay, as long as the patient remains eligible for Part A SNF-level services. The SB-MDS records must be submitted electronically to the national database and will be considered timely if submitted and accepted into the database within 14 days of completion (**Item 45b**).

60-Day - Medicare assessment that usually will have an established ARD (**Item 10a**) between days 50-59 of the swing bed stay. The ARD (**Item 10a**) can be extended to day 64 if using the designated "Grace Days." The 60-Day Medicare assessment must be completed (**Item 45b**) within 14 days of the ARD. The 60-Day assessment authorizes payment from days 61 through 90 of the stay, as long as the patient remains eligible for Part A SNF-level services. The SB-MDS records must be

submitted electronically to the national database and will be considered timely if submitted and accepted into the database within 14 days of completion (**Item 45b**).

90-Day - Medicare assessment that usually will have an ARD (**Item 10a**) established between days 80-89 of the swing bed stay. The ARD (**Item 10a**) can be extended to day 94 if using the designated "Grace Days." The 90-Day Medicare assessment must be completed (**Item 45b**) within 14 days of the ARD. The 90-Day assessment authorizes payment from days 91 through 100 of the stay, as long as the patient remains eligible for Part A SNF-level services. The SB-MDS records must be submitted electronically to the national database and will be considered timely if submitted and accepted into the database within 14 days of completion (**Item 45b**).

Readmission/Return - Medicare assessment that is completed when a patient whose stay was being reimbursed by SNF PPS was hospitalized for more than 24 hours or was discharged with return anticipated and later readmitted to the swing bed. The Readmission/Return assessment, like the 5-Day assessment, must have an ARD (**Item 10a**) established between days 1-8 of the return. The Readmission/Return assessment must be completed (**Item 45b**) within 14 days of the ARD. The Readmission/Return assessment restarts the Medicare schedule and the next required assessment would be the Medicare 14-Day assessment. The SB-MDS records must be submitted electronically to the national database and will be considered timely if submitted and accepted into the database within 14 days of completion (**Item 45b**).

Other Medicare Required Assessment (OMRA) - The OMRA must be completed only if the patient was in a RUG-III Rehabilitation Plus Extensive Services or Rehabilitation classification and will continue to need Part A SNF-level services after the discontinuation of therapy. The last day in which therapy treatment was furnished is day zero. The OMRA ARD (**Item 10a**) must be set on day eight, nine, or ten after the last day that all rehabilitation therapies have been discontinued. The OMRA must be completed (**Item 45b**) within 14 days of the ARD. The OMRA will establish a new non-therapy RUG-III group and Medicare payment rate. The SB-MDS records must be submitted electronically to the national database and will be considered timely if submitted and accepted into the database within 14 days of completion (**Item 45b**).

Clinical Change Assessment (CCA)- Staff are responsible for determining whether a change (either an improvement or decline) in the patient's condition constitutes a "clinical change" in the patient's status. When a clinical change has occurred, the Clinical Change Assessment is completed within 14 days of the determination that the clinical change has occurred. The SB-MDS records must be submitted electronically into the national database within 14 days of completion (**Item 45b**).

A "clinical change" is a decline or improvement in a patient's status that:

- will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions,
- impacts more than one area of the patient's health status, and
- requires interdisciplinary review and/or revision of the plan of care.

Document the initial identification of a clinical change in the progress notes. The following guidelines indicate conditions under which a Clinical Change Assessment is required. This list is not exhaustive, and other situations may also meet the clinical change definition.

Guidelines for Determining a Clinical Change in Patient Status

Decline

- Any decline in activities of daily living physical functioning in which a patient is newly coded as 3, 4, or 8 (i.e., extensive assistance, total dependency, activity did not occur);
- Patient's decision-making changes from 0 or 1 to 2 or 3;
- Emergence of an unplanned weight loss problem (5 percent change in 30 days or 10 percent change in 180 days);
- Emergence of a condition or disease in which a facility judges a patient to be unstable;
- Emergence of a pressure ulcer at Stage II or higher, when no ulcers were previously present at Stage II or higher; or
- Overall deterioration of patient's condition; patient receives more support (for example, in activities of daily living or decision-making).

Improvement

- Any improvement in activities of daily living physical functioning where a patient is newly coded as 0, 1 or 2, when previously scored as a 3, 4 or 8;
- Patient's decision-making changes from 2 or 3 to 0 or 1;
- Overall improvement of patient's condition; patient receives fewer supports.

A clinical change may occur at any point during the patient's stay. The Clinical Change Assessment will most likely establish a new RUG-III classification and a new payment rate.

The following chart summarizes completion requirements for the Medicare assessments, Discharge and Reentry tracking information and the Correction Request form.

SWING BED MINIMUM DATA SET (SB-MDS) Assessment Schedule

CODES FOR ASSESSMENTS	ASSESSMENT REFERENCE DATE (Item 10a-ARD) Can be set on any of the following days	GRACE DAYS ARD can also be set on these days	COMPLETION	SUBMISSION	NUMBER OF DAYS AUTHORIZED FOR COVERAGE & PAYMENT	APPLICABLE MEDICARE PAYMENT DAYS
5 Day Item 11a = 00 Item 11b = 1 AND Readmission/ Return Item 11a = 00 Item 11b = 5	Days 1 - 5 Days 1 - 5	6 - 8 6 - 8	Item 45b - Within 14 days of ARD Item 45b - Within 14 days of ARD	Item 45b + 14 Days Item 45b + 14 Days	14 14	1 - 14 1 - 14
14 Day Item 11a = 00 Item 11b = 7	Days 11 - 14	15 - 19	Item 45b - Within 14 days of ARD	Item 45b + 14 Days	16	15 - 30
30 Day Item 11a = 00 Item 11b = 2	Days 21-29	30 - 34	Item 45b - Within 14 days of ARD	Item 45b + 14 Days	30	31 - 60
60 Day Item 11a = 00 Item 11b = 3	Days 50 - 59	60 - 64	Item 45b - Within 14 days of ARD	Item 45b + 14 Days	30	61 - 90
90 Day Item 11a = 00 Item 11b = 4	Days 80 - 89	90 - 94	Item 45b - Within 14 days of ARD	Item 45b + 14 Days	10	91 - 100
Other Medicare Required Assessment/ OMRA Item 11a = 00 Item 11b = 9 Item 11c = 1	• 8 - 10 Days after all therapy (PT, OT, ST) services are discontinued and patient continues to require skilled care. • The first non-therapy day counts as day 1.	N/A	Item 45b - Within 14 days of ARD	Item 45b + 14 Days	N/A	• Not required if the patient has been determined to no longer meet Medicare skilled level of care. • Establishes a new non-therapy RUG-III classification.
Clinical Change Assessment (CCA) Item 11a = 00 Item 11b = 9 Item 11d = 1	Must be completed by the end of the 14th calendar day following determination that a clinical change has occurred.	N/A	Item 45b - By the end of the 14th calendar day following determination of a clinical change	Item 45b + 14 Days	N/A	• Could establish a new RUG-III classification that may remain effective until the next assessment is completed.
Discharge Tracking Information Item 11a = 06 or 07	• Completed when patient is discharged from swing bed. • Patient dies. • Admitted to hospital. • Hospital observation greater than 24 hrs.	N/A	Date of Event at Item 15 + 7 Days	Item 45b + 14 Days	N/A	N/A
Reentry Tracking Information Item 11a = 09	• Patient reenters swing bed following admission to hospital or other health care setting.	N/A	Date of Event at Item 16 + 7 Days	Item 45b + 14 Days	N/A	N/A
Correction Request Form	N/A	N/A	Must be completed within 14 days of identification of an error on an SB-MDS already accepted into the national database.	Within 14 days of completion of the correction record	N/A	• If RUG-III changes due to the error, a billing change must be reported.

2.3 Factors Impacting the Assessment Schedule

The following information further clarifies the SB-MDS assessment schedule.

Patient Expires or Transfers

If a patient expires or transfers to another facility before the 5-Day assessment is completed, the swing bed hospital prepares an SB-MDS assessment as completely as possible to obtain the RUG-III classification so the provider can bill for the appropriate days. If the SB-MDS assessment is not completed then the swing bed provider will have to bill at the default rate.

Physician Hold Occurs

If a physician hold occurs or 30 days has elapsed since a level of care change, the swing bed provider will start the Medicare assessment schedule on the first day that Part A SNF-level services started. An example of when a physician hold may occur is when a patient is admitted to the swing bed for rehabilitation services but is not ready for weight bearing exercises. The physician will write an order to start therapy when the patient is able to do weight bearing. Once the patient is able to start the therapy then the Medicare 5-Day assessment will be completed. Day "1" of the stay will be the first day that the patient is able to start therapy services.

Combining Assessments

Off-cycle SB-MDS assessments, e.g., Clinical Change Assessment (CCA) or the Other Medicare Required Assessment (OMRA), may be completed during the regularly scheduled PPS assessments. If the assessment reference date of either off-cycle assessments (e.g. CCA and OMRA) coincides with a regularly scheduled assessment, a single assessment may be completed and coded as a regularly scheduled assessment (e.g., 5-Day, 14-Day, 30-Day, 60-Day, or 90-Day) and a CCA, OMRA, or both.

The SB-MDS will be coded to indicate that a regularly scheduled assessment is being completed and could also be a CCA, OMRA, or both. The new coding for Reason for Assessment (**Item 11**) for the SB-MDS form allows for these combinations.

Early Assessment

An assessment should be completed according to the designated Medicare assessment schedule. If an assessment is performed earlier than the schedule indicates, (the ARD is not in the defined window), the provider will be paid at the default rate for the number of days the assessment was out of compliance. For example, a Medicare-required 14-Day assessment with an ARD of day 10 (1 day early) would be paid at the default rate for the first day of the payment period that begins on day 15.

Late or Missed Assessment Criteria

When the assessment has an ARD after the mandated grace period, payment will be made at the default rate for covered services, from the first day of the coverage period to the ARD of the late assessment. A late assessment cannot replace the next regularly scheduled assessment. Therefore, if

the ARD of the 14-Day assessment was day 22, it cannot be used as both the Medicare 14-Day and Medicare 30-Day assessments.

In this situation, the late 14-Day assessment would be used to support payment for days 22-30 of the Part A stay. A new 30-Day assessment would need to be completed within the assessment window for the Medicare 30-Day assessment.

Non-Compliance with the Assessment Schedule

According to the Code of Federal Regulation (CFR) section 413.343, assessments that fail to comply with the assessment schedule will be paid at the default rate. Frequent early or late assessment scheduling practices may result in an onsite review.

Default Rate

MDS assessments are completed according to an assessment schedule specifically designed for Medicare payment, and each assessment applies to specific days within a patient's SNF stay to determine the appropriate reimbursement for the patient. Compliance with this assessment schedule is critical to ensure that the appropriate level of payment is established. Accordingly, SNFs that fail to perform assessments timely are to be paid a RUG-III default rate for the days of a patient's care for which they are not in compliance with this schedule. The RUG-III default rate takes the place of the otherwise applicable Federal rate. The RUG-III default rate is equal to the rate paid for the RUG-III group reflecting the lowest acuity level, and would generally be lower than the Medicare rate payable if the SNF had submitted an assessment in accordance with the prescribed assessment schedule.

Midnight Rule

When a beneficiary receives emergency room (ER) care during the swing bed stay and is in the ER at midnight, there are special rules for Medicare payment. The day preceding the midnight on which the beneficiary was absent becomes a non-covered day that cannot be billed to Medicare Part A.

We would not generally expect swing bed patients to require emergency room care within the swing bed hospital. In rare instances, a patient may need to be transferred to another hospital for emergency care.

However, for clinical purposes, as long as the beneficiary returns to the swing bed in less than 24 hours, was not admitted as a hospital inpatient, and was not discharged from the swing bed, this time in the ER is considered a "leave of absence" and does not require any Discharge Tracking information.

Likewise, from the perspective of Medicare payment under PPS, there is no requirement for any additional assessment. The day preceding the midnight is NOT a covered Part A day and, therefore, the Medicare assessment "clock" is adjusted by skipping that day in calculating when the next Medicare assessment is due.

Leave of Absence

In extremely rare instances, a patient may require a temporary leave of absence (e.g. attend funeral for family member). These instances are considered a "therapeutic" leave of absence and do not require Discharge tracking information. There is no requirement for an additional assessment. The days the patient is out of the facility are not covered Part A days, and, therefore, the Medicare assessment "clock" is adjusted by skipping those days in calculating when the next Medicare assessment is due. However, the days the patient is on the temporary absence are included in the observation period, as indicated. The swing bed may include services furnished during the patient's temporary absence when permitted under swing bed MDS coding guidelines.

2.4 Discharge and Reentry Tracking Information

Swing bed hospitals are required to complete discharge and reentry information to "track" the discharges and reentries of the patients. Discharge and reentry tracking information provides key information to identify and track the movement of patients in and out of the swing bed hospital.

The discharge and reentry information is a selected subset of SB-MDS items. When a clinician has determined that a discharge or reentry needs to be reported, he/she will select either **Item 11a** = **06** (Discharged-Return Not Anticipated), **Item 11a = 07** (Discharged-Return Anticipated), or **Item 11a = 09** (Reentry). Following the selection of **Item 11a = 06**, **07**, or **09**, the software program will display the required SB-MDS items to report the discharge or reentry.

The Discharge Tracking Information Contains:

- **Item 1a-d** Name
- **Item 2** Gender
- **Item 3** Birth Date
- **Item 6** Zip Code
- **Item 7a** Social Security Number
- **Item 7b** Medicare or Railroad Insurance Number
- **Item 8** Medicaid Number
- **Item 9a** Medicaid Provider Number
- **Item 9b** Medicare Provider Number
- **Item 10b** Correction Number
- **Item 11a** Primary Reason for Assessment:
  Discharge Code = 06 (Discharged-Return Not Anticipated)
  Discharge Code = 07 (Discharged-Return Anticipated)
- **Item 11e** State-Required Assessment
- **Item 11f** Assessment Needed for Other Reasons
- **Item 13** Admission Date
- **Item 14a** Admitted From
- **Item 14b** Discharge Status Code
- **Item 15** Discharge Date

The following items are not submitted with the discharge information, but must be completed on a hard copy and kept in the record:

- **Item 45a** Name/Signature of RN Coordinating Assessment, and
- **Item 45b** Date RN Assessment Coordinator signed that the assessment was completed.

The Reentry Tracking Information Contains:

- **Item 1a-d** Name
- **Item 2** Gender
- **Item 3** Birth Date
- **Item 6** Zip Code
- **Item 7a** Social Security Number
- **Item 7b** Medicare or Railroad Insurance Number
- **Item 8** Medicaid Number
- **Item 9a** Medicaid Provider Number
- **Item 9b** Medicare Provider Number
- **Item 10b** Correction Number
- **Item 11a** Primary Reason for Assessment = Reentry Code 09
- **Item 11e** State-Required Assessment
- **Item 11f** Assessment Needed for Other Reasons
- **Item 13** Admission Date
- **Item 14a** Admitted From
- **Item 14c** Reentered From
- **Item 16** Reentry Date

The following items are not submitted with the reentry information, but must be completed on a hard copy and kept in the record:

- **Item 45a** Name/Signature of RN Coordinating Assessment, and
- **Item 45b** Date RN Assessment Coordinator signed that the assessment was completed.

In some situations, discharge and reentry tracking information **<u>is not completed</u>**:

- When the patient leaves the swing bed on a temporary visit home, or on another type of therapeutic or social leave.

- When patients are in a hospital outpatient department for an observational stay of less than 24 hours and the patient is not admitted for acute care as an inpatient.

If the observational stay goes beyond 24 hours or if the patient is admitted for acute care, then discharge tracking information must be completed within 7 days. The discharge date entered at **Item 15** would be the date that the patient actually left the swing bed, not the date he/she was admitted to the hospital.

The clinician must clearly understand the differences between the two types of discharges in order to correctly select the appropriate response at **Item 11a**. They are:

- Discharged-Return Not Anticipated (Reason for Assessment **Item 11a = 06**)
- Discharged-Return Anticipated (Reason for Assessment **Item 11a = 07**)

A **Discharged-Return Not Anticipated** (**Item 11a = 06**) is completed when it is determined that the patient is being discharged with no expectation of return after a Medicare PPS assessment has been completed. A Discharged-Return Not Anticipated can be a formal discharge to home, to another facility, or when the patient dies. The Discharge-Return Not Anticipated must be completed (**Item 45b**) within 7 days of the discharge date (**Item 15**) and must be electronically submitted to and accepted into the national database within 14 days of completion (**Item 45b**). If the patient is formally discharged from the swing bed and returns at a later date, this will be a new admission and requires a new 5-Day Medicare PPS assessment. The SB-MDS assessment schedule will start over with the new 5-Day assessment.

The term "discharged" is also defined as the discontinuation of Part A SNF-level services. Discharge tracking information is required when Medicare Part A SNF-level benefits have been exhausted or when the patient no longer requires skilled services. The discharge tracking information should be coded to indicate "return not anticipated." If the patient remains in the swing bed hospital after the end of the Part A SNF-level stay, the clinician is not required to perform additional SB-MDS assessments. The swing bed hospital may choose to continue the SB-MDS assessment process, if needed for other payers or for its own assessment and care planning purposes.

A **Discharged-Return Anticipated** (**Item 11a = 07**) reports a more temporary absence from the swing bed after any Medicare assessment is completed, and when it is anticipated that the patient will return for Medicare Part-A services. A Discharged-Return Anticipated would be coded when a patient is temporarily admitted for acute care in the hospital or a hospital observation stay lasting more than 24 hours and the patient is expected to return to the swing bed. The Discharge-Return Anticipated must be completed (**Item 45b**) within 7 days of the discharge date (**Item 15**) and must be electronically submitted to and accepted into the national database within 14 days of completion (**Item 45b**).

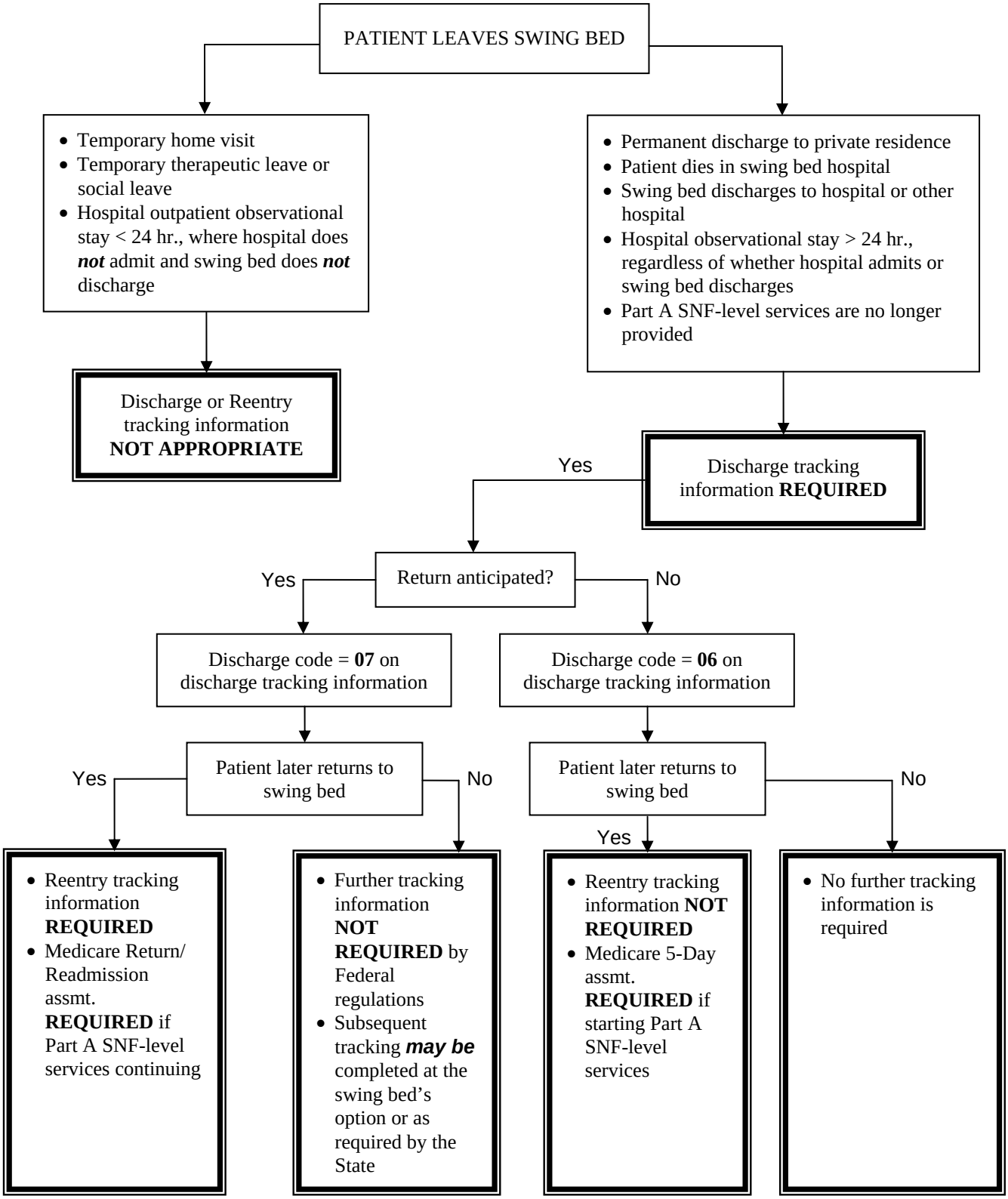
It is possible that a patient would be Discharged-Return Anticipated and later the swing bed learns that he/she will not be returning or has died. If this occurs, additional discharge tracking information (Return Not Anticipated) is not required.

Clarification: ◆ The requirements for completion of discharge tracking information are not associated with bedhold status. Discharge tracking information is required whenever a patient is discharged, regardless of bedhold status. If the bed is being held, it logically follows that return is anticipated, and **Item 11a = 07** is coded Discharged-Return Anticipated.

Reentry tracking information (**Item 11a = 09**) is completed whenever the patient reenters the swing bed hospital following a temporary admission to any hospital, a hospital observation stay greater than 24 hours, or is returning to Part A SNF-level services following a Discharged-Return Anticipated (**Item 11a = 07**). The reentry tracking information is completed, even if the patient's clinical record was not formally closed and regardless of whether or not the patient was formally discharged from the swing bed hospital. The Reentry must be completed (**Item 45b**) within 7 days of the reentry date (**Item 16**) and must be electronically submitted to and accepted into the national database within 14 days of completion (**Item 45b**).

A flow chart has been provided on Page 2-12 to diagram the discharge and reentry process.

SB-MDS DISCHARGE AND REENTRY FLOWCHART



Chapter 3: Item-by-Item Guide to the Swing Bed Minimum Data Set Assessment

3.1 Overview and Standard Format of the Item-by-Item Guide

The SB-MDS is a subset of the MDS 2.0 used by skilled nursing facilities. All clinical items are coded in exactly the same way by swing bed and skilled nursing facility staff. The MDS 2.0 item numbers are printed on the SB-MDS form to allow you to cross-reference to the complete Revised Long-Term Care Resident Assessment Instrument User's Manual.

Information contained in this chapter should facilitate completion of the SB-MDS assessment through item-by-item instructions that focus on:

- The intent of items included on the SB-MDS assessment.
- Supplemental definitions and instructions for completing SB-MDS items.
- SB-MDS items that require observation of the patient for other than the standard 7-day observation period.
- Sources of information to be consulted in completing specific SB-MDS items.

CMS recognizes that the publication of this revised manual will not preclude future questions or the need for more clarification about SB-MDS items. Therefore, CMS has developed a procedure to review, respond and distribute clarifications for the SB-MDS coding process.

STEP 1: If clinicians have a question about a particular SB-MDS item, they should first review the manual and then contact their State RAI Coordinator for a clarification. If necessary, the State RAI Coordinator will contact the appropriate CMS staff if he/she is not able to answer a specific question.

STEP 2: CMS will determine if a clarification about an item is needed and will post new clarifications on the CMS web site. If a clarification is posted on the official CMS web site, then it can be considered policy. CMS will develop a process to periodically update the manual and incorporate additional clarifications. Clinicians should monitor the CMS web site at:

http:://www.cms.hhs.gov/providers/snfpps/snfpps_swingbed.asp.

To ensure consistent interpretation, the item-by-item instructions are organized in the following standard format. Descriptions of each SB-MDS item in this chapter will include some or all of these information categories:

Intent: Reasons(s) for including the item (or set of items) in the SB-MDS and discussions about how the information will be used by clinical staff to document the services and treatments provided to the patient.

Definition: Explanation of key terms.

Process: Methods for determining the correct response for an item and sources of information, including:

- Discussion with facility staff, both licensed and non-licensed
- Patient interview and observation
- Clinical records, facility records, transmittal records (at admission), physician orders, laboratory data, medication records, treatment sheets, flow sheets (e.g., vital signs, weights, intake and output), and other documents in the facility record system
- Discussion with the patient's family
- Discussion with attending physician

Coding: Explanations of individual response categories and the proper method of recording each response.

Clarifications: ◆ Clarifications for SB-MDS items provided by CMS.

3.2 How to Use This Chapter

Use this chapter alongside the SB-MDS assessment, keeping the form in front of you at all times. The SB-MDS information in this chapter should facilitate successful completion of the SB-MDS assessment. The items from the SB-MDS assessment are presented in the same order as on the form.

Becoming Familiar with the SB-MDS

(A) Review the SB-MDS assessment.

- Notice how items are organized and where information is to be recorded.
- Work through each item.
- Examine item definitions and response categories.
- Review procedural instructions, time frames, and general coding conventions.

(B) Complete an SB-MDS assessment for a patient in your facility using only your knowledge of this individual. Enter the appropriate codes on the SB-MDS assessment. Note items that would benefit from additional information and where you might secure the information.

(C) Complete an initial pass through this chapter after reviewing the SB-MDS assessment and completing all items for a patient who is well known to you.

- Read the instructions that apply to a single item of the SB-MDS assessment. Make sure you understand this information before going on to another item. It will take time to review all this material. Do it slowly, working through the manual one item at a time.
- Review the test case you completed. Clarify questions you had as you completed the SB-MDS assessment for the first time.

(continued on next page)

Becoming Familiar with the SB-MDS
(continued)

- *Are you surprised by any SB-MDS definitions, instructions, or case examples? Do you understand how to code ADLs? Or Mood?*
- *Do any definitions or instructions differ from what you thought you learned when you reviewed the SB-MDS assessment?*
- *Would you now complete your test case differently?*
- *Are there definitions or instructions that differ from current practice patterns in your facility?*
- Make notations of any questions next to any section(s) of this manual. Be prepared to discuss these issues during any formal training program you attend, or contact your State SB-MDS resource person (see Appendix B).

(D) Make a second pass through this chapter, focusing on difficult issues or ones that were problematic in the first pass.

- Make notes of any issues on the SB-MDS assessment.
- Further familiarize yourself with definitions and procedures that differ from current practice patterns or seem to raise questions.
- Reread each of the case examples presented throughout this chapter.

(E) A third pass through this chapter may occur during formal SB-MDS training and will provide you with another opportunity to review the material in this chapter. If you have questions, raise them during the training session.

(F) Future use of information in this chapter:

- Keep this manual at hand during the assessment process.
- Where necessary, review the intent of each item in question.
- Use it to increase the accuracy of your assessments.

SB-MDS CODING CONVENTIONS

Use the following coding conventions to enter information on the SB-MDS form:

- Darkly shaded areas remain blank; they are on the form to set off boxes visually.

- **The convention of entering "0"**: In assigning values for items that have an ordered set of responses (e.g., from independent to dependent), zero ("0") is used universally to indicate the lack of a problem or that the patient is self-sufficient. For example, a patient whose ADL codes are almost all coded "0" is a self-sufficient patient; the patient whose ADLs have no "0" codes indicates a patient receives help from others.

- **When completing hard copy forms to be used for data entry, capital letters may be easiest to read**. Print legibly.

- **Dates -** Where recording month, day, and year, enter two digits for the month and the day, but four digits for the year. For example, the third day of January in the year 2003 is recorded as:

0	1		0	3		2	0	0	3
Month			Day			Year			

- **The standard no-information code is a dash (-).** This code indicates that all available sources of information have been exhausted; that is the information is **<u>not available</u>**, and despite exhaustive probing, it remains unavailable. The no-information code entered on the form manually or electronically may be any of the alternatives: circled dash,"NA", or plain dash.

- **"Skip" Patterns - There are a few instances where scoring on one item will govern how scoring is completed for one or more additional items.** The instructions direct the assessor to "skip" over the next item (or several items) and go on to another (e.g., **Item 17**, Comatose, directs the assessor to "skip" to **Item 23** if **Item 17** is answered "1" –"yes". **The intervening items would not be scored.** If **Item 17** was recorded as "0" - "no", then the assessor would continue with **Item 18**.).

  A useful technique for visually checking the proper use of the "skip" pattern instructions is to circle the "skip" instructions before going to the next appropriate item.

3.3 Item-by-Item Instructions for the SB-MDS Assessment

This section of item-by-item instructions follows the sequence of items on the CMS SB-MDS assessment.

1. Resident Name (Key Field Item)

Definition: Legal name in medical record.

Coding: Use printed letters. Enter in the following order:

a. First Name
b. Middle Initial - If the patient has no middle initial, leave blank.
c. Last Name
d. Jr./Sr.

If the patient has no middle initial, leave **Item (b)** blank.

2. Gender (Key Field Item)

Coding: Enter "1" for Male or "2" for Female.

3. Birth Date (Key Field Item)

Coding: Fill in the boxes with the appropriate date. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box with a "0". Use four digits for the year. For example: January 2, 1918, should be entered as:

0	1		0	2		1	9	1	8
Month			Day			Year			

4. Marital Status

Coding: Choose the answer that describes the current marital status of the patient.

1. Never Married
2. Married
3. Widowed
4. Separated
5. Divorced

5. Race/Ethnicity

Process: Enter the race or ethnic category the patient uses to identify himself/herself. Consult the patient, as necessary. For example, if parents are of two different races, consult with patient to determine how he or she wishes to be classified. Patients should be offered the option of selecting one or more racial designations.

Definition:

a. American Indian or Alaska Native - A person having origins in any of the original peoples of North, Central, and South America, and who maintains tribal affiliation or community attachment.

b. Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

c. Black or African American - A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

d. Hispanic or Latino - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin" can be used in addition to "Hispanic or Latino."

e. Native Hawaiian or Other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

f. White - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Coding: Check all that apply.

6. Zip Code

Definition: **Pre-Hospital Residence**. The community address where the patient last resided prior to swing bed admission. A primary residence includes a primary home, apartment, board and care home, assisted living, or group home. If the patient was admitted to your facility from another nursing facility or institutional setting, the prior primary residence is the address of the patient's primary home before entering the other nursing facility or institutional setting.

Process: Review patient's admission records and transmittal records as necessary. Ask patient and family members as appropriate. Check with your admissions office.

Examples

- Mr. T was admitted to the swing bed hospital from an acute hospital stay. Prior to the hospital admission, he lived with his wife in a mobile home in Jensen Beach, Florida. **Enter the zip code for Jensen Beach.**

- Mrs. F was admitted to the swing bed hospital after spending 3 years living with her daughter's family in Newton, MA. Prior to moving in with her daughter, Mrs. F lived in Boston, MA for 50 years with her husband until he died. **Enter the Newton, MA zip code. Rationale:** Her daughter's home was Mrs. F's primary residence prior to swing bed hospital admission.

- Ms. J was admitted to the Missouri Valley swing bed hospital following an acute stay in the hospital. Before coming to the hospital, she had been a patient at the Green Acres Nursing Facility in Chicago, Illinois. Prior to the nursing facility, she had lived in her own home in Aurora, Illinois. **Enter the Aurora, Illinois zip code. Rationale:** Her home in Aurora, Illinois was her prior primary residence before entering the nursing facility.

7. Social Security Number and Medicare Numbers

Intent: To record patient identifier numbers.

Process: Review the patient's record. If these numbers are missing, consult with your swing bed hospital's admission office.

Coding: Enter one number per box starting with the left most box. Recheck the number to be sure you have entered the digits correctly.

Social Security Number (Key Field Item) - If no Social Security number is available for the patient (e.g., if the patient is a recent immigrant or a child), leave it blank or enter the standard "no information" code (-).

Medicare Number (or comparable railroad insurance number) - Enter a Medicare number or railroad number exactly as it appears on the beneficiary documents. A Medicare number always starts with a number and the first 9 characters must be digits (0-9). It is important to remember that the Medicare Health Insurance number may be different from the patient's social security number (SSN). For example, many patients may be receiving Medicare benefits based on a spouse's Medicare eligibility.

In rare instances, the patient will have neither a Medicare number nor a social security number. When this occurs, another type of basic identification number (e.g., railroad retirement insurance number) may be substituted. Railroad retirement numbers contain 12 characters. Enter the number itself, one digit per box beginning with the left-most box.

8. Medicaid Number (if applicable)

Coding: Record this number if the patient is a Medicaid recipient. Enter one number per box beginning in the left-most box. Recheck the number to make sure you have entered the digits correctly. Enter a "+" in the left-most box if the number is pending. If you get notified later that the patient does have a Medicaid number, just include it on the next assessment. It is not necessary to process an SB-MDS correction to add the Medicaid number on a prior assessment. If not applicable because the patient is not a Medicaid recipient, enter "N" in the left-most box.

Clarification:

- The Medicaid number is a unique identifier assigned by the State Medicaid office. Questions regarding the Medicaid number can be referred to the State Medicaid office.

9. Facility Provider Numbers

Intent: To record the facility identifier numbers.

Definition: The identification numbers assigned to the swing bed hospital by the Medicare and Medicaid programs. Some facilities will have only a Federal (Medicare) identification number; i.e., Medicare-only facilities. Dually eligible facilities (i.e., facilities participating in both the Medicare and Medicaid programs) will have Federal (Medicare) and State (Medicaid) identification numbers.

Process: You can obtain the swing bed's Medicare and Medicaid numbers from the admission office. Once you have these numbers, they apply to all patients in the swing bed facility.

Coding: The Medicare provider number is a 6-digit number. For Medicare and Medicaid dually-certified facilities, the first two digits are the state identifier followed by a numeric character that is either a "5" or "6" followed by three numeric characters. For Medicaid-only facilities, the Federal ID number consists of a two-digit state identifier followed by one alpha character and three numeric characters. Start with the left-most box. Enter one character per box. Do not enter imbedded dashes. Recheck the number to be sure you have entered the digits correctly. There must always be a Federal provider number. The State Medicaid number is optional. Each state establishes the structure of its Medicaid provider numbers.

10. Assessment Reference Date (Key Field Item)

a. Last Day of SB-MDS Observation Period

Intent: To establish a common reference point for all staff participating in the patient's assessment. As staff members may work on a patient's SB-MDS assessment on different days, establishing the Assessment Reference Date (ARD) ensures a common assessment period. In other words, the ARD designates the end of the observation period so that all assessment items refer to the patient's objective performance and health status during the same period of time. See Chapter 2 for completion timing requirements for each assessment type.

Definition: **Assessment Reference Date -** This date refers to a specific end-point for a common observation period in the SB-MDS assessment process. Almost all SB-MDS items refer to the patient's status over a designated time period referring back in time from the Assessment Reference Date. The observation period ends on this date. Most observation periods are 7 days, while others are 14 or 30.

Clarifications:

- The ARD is the common date on which all SB-MDS observation periods end. The observation period is also referred to as the look-back period. It is the time period during which data is captured for inclusion on the SB-MDS assessment. The ARD is the last day of the observation period and controls what care and services are captured on the SB-MDS assessment. Anything that happens after the ARD will not be captured on that SB-MDS. For example, for an SB-MDS item with a 7-day period of observation, assessment information is collected for a 7 day period ending on **and** <u>including</u> the ARD, which is the 7th day of this observation period. For an item with a 14-day observation period, the information is collected for a 14-day period ending on **and** <u>including</u> the ARD.

  NOTE: Medicare Fiscal Intermediaries have often used the term "completion date" differently when applied to SNF payment. For Part A billing, the RUG-III payment rate may be adjusted on the ARD of a non-scheduled assessment; e.g., Clinical Change or OMRA. In these situations, the ARD of the non-scheduled assessment has sometimes been referred to as the completion date, and is used to indicate a change in the RUG-III group used for payment.

- When the patient dies or is discharged prior to the end of the observation period for a required assessment, the ARD must be adjusted to equal the discharge date. Generally, facilities are required to complete the assessment after the patient's discharge in order to bill for Medicare payment. Facilities have 2 options to choose from when adjusting the ARD to the date of discharge. In the first situation, changing the ARD shortens the observation period. Since some facilities prefer to use data for a full observation period, even if it means collecting more information on the patient's condition prior

to admission to the swing bed, CMS has established a second option that allows the swing bed to establish a full observation period.

Option 1 - Change the ARD to the date of discharge, but complete the SB-MDS using less than a full observation period. In this case, the Assessment Reference Date had been set at Day 5, and the patient was discharged after 4 days of the observation period. For items with a 7-day observation period, the SB-MDS would be completed using the data collected for the 4-day period in the swing bed and the 2-day period prior to admission. *NOTE:* **Item 38b**, Therapies, includes **only** medically necessary therapies furnished **after** admission or readmission to the swing bed. Therapies received in the acute care setting are **not** included in **Item 38b – a, b, c, and d**.

Option 2 - Change the ARD to the date of discharge, but extend the observation period prior to the date of admission, and collect additional data to complete the assessment. Generally, this expanded observation period would require additional data from the prior hospital stay. In this example, if the patient was discharged after 4 days, the SB-MDS would be completed using the data collected for the 4-day period in the swing bed. For a 7-day assessment item, hospital data could be used for the 3-day period prior to the swing bed admission. *NOTE:* **Item 38b**, Therapies, includes **only** medically necessary therapies furnished **after** admission or readmission to the swing bed. Therapies received in the acute care setting are **not** included in **Item 38b – a, b, c, and d**.

Swing bed providers must select one of these options and apply it consistently in all cases where the patient is discharged prior to the end of the observation period. It is not appropriate to change options on a case-by-case basis in order to increase reimbursement.

- The observation period may not be extended simply because a patient was out of the facility during a portion of the observation period; e.g., a home visit or therapeutic leave. For example, if the ARD is set at Day 14, and there is a 2-day temporary leave during the observation period, the two leave days are still considered part of the observation period. This procedure applies to all assessments.

Coding: Complete the boxes with the appropriate date. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box with a "0". Use four digits for the year. For example, August 2, 2002 should be entered as:

0	8		0	2		2	0	0	2
Month			Day			Year			

b. Original (00) or Correction (enter number of correction)

Intent: To be used in the correction process. Assessments can be corrected once they have been submitted to the national database. Errors can be corrected following the correction process detailed in Chapter 4.

Definition: **Original Record** - The initial assessment submitted to the national database.

Correction Record - This is a new version of an existing assessment that has already been accepted into the national database. The correction record must have the same "key fields" as the existing active record. Key fields are defined in Chapter 4, Section 4.6.

Coding: **Original Record** - Code "00" in the correction counter.

Correction Record - Code a value exactly one greater than the existing record. If this is the first correction following the submission of the original record, it would be coded "01". There is no penalty for submitting too many corrections. However, providers exhibiting a pattern for multiple corrections may be subject to stringent SB-MDS review during survey. If the surveyor identifies an error pattern impacting Medicare reimbursement, we would expect the survey agency to alert the FI of the problem.

11. Reasons for Assessment

a. Primary Reasons for Assessment (Key Field Item)

Intent: To document the reason for completing the assessment using the various categories of assessment types mandated by Federal regulation. For detailed information on the scheduling and timing of the assessments, see Chapter 2, Section 2.2.

Definition:

00. PPS Assessment for Medicare Payment - A code used to report an SB-MDS assessment completed for any PPS requirement: 5-Day, 14-Day, 30-Day, 60-Day, 90-Day, Readmission/Return, OMRA, or Clinical Change assessment.

06. Discharged-Return Not Anticipated - A code used to report a discharge from the swing bed when a patient is not expected to return. This is a means of closing the record of any patient from the facility without an anticipated return. Also completed when Part A SNF-level services are no longer provided.

07. Discharged-Return Anticipated - A code used to report a discharge when the patient is expected to return to the swing bed facility, such as a temporary discharge to a hospital.

09. **Reentry** - A code used when a patient is readmitted to the swing bed from a temporary discharge (Discharged-Return Anticipated).

11. **Assessment-Not for Medicare Payment** - A code used when the SB-MDS assessment is being completed for any reason other than a Medicare PPS assessment, discharge or reentry, such as State-Required Assessment (**Item 11e)** or Assessment Needed for Other Reasons (**Item 11f**).

Coding: A response is required in this subsection. Choose the one answer that applies. There may be situations when a swing bed patient is admitted as a hospital patient and stays in the same bed. Even though the patient has not physically moved from the bed, discharge tracking must be completed.

b. Assessment Codes Used for the Medicare Prospective Payment System

Intent: To document which SB-MDS assessment is being completed: 5-Day, 30-Day, 60-Day, 90-Day, Readmission/Return, 14-Day or Other.

Definition:

1. **5-Day** - The first Medicare PPS assessment completed upon admission to the swing bed hospital for Part A SNF-level services; i.e. swing bed services. The 5-Day Medicare PPS assessment will usually have an ARD (**Item 10a**) established between days 1-5 of the swing bed stay. The ARD (**Item 10a**) can be extended to day 8 if using the designated "Grace Days." The 5-Day Medicare PPS assessment must be completed (**Item 45b**) within 14 days of the ARD (**Item 10a**). The 14-day calculation is based on calendar days and includes weekends. The 5-Day assessment authorizes payment from days 1 through 14 of the stay, as long as the patient remains eligible for Part A SNF-level services. The SB-MDS records must be submitted electronically to the national database and will be considered timely if submitted and accepted into the database within 14 days of completion (**Item 45b**).

2. **30-Day** - Medicare PPS assessment that will usually have an ARD (**Item 10a**) established between days 21-29 of the swing bed stay. The ARD (**Item 10a**) can be extended to day 34 if using the designated "Grace Days." The 30-Day Medicare PPS assessment must be completed (**Item 45b**) within 14 days of the ARD (**Item 10a**). The 30-Day assessment authorizes payment from days 31 through 60 of the stay as long as the patient remains eligible for Part A SNF-level services. The SB-MDS records must be submitted electronically to the national database and will be considered timely if submitted and accepted into the database within 14 days of completion (**Item 45b**).

3. **60-Day** - Medicare PPS assessment that will usually have an established ARD (**Item 10a**) between days 50-59 of the swing bed stay. The ARD (**Item 10a**) can be extended to day 64 if using the designated "Grace

Days." The 60-Day Medicare PPS assessment must be completed (**Item 45b**) within 14 days of the ARD (**Item 10a**). The 60-Day assessment authorizes payment from days 61 through 90 of the stay as long as the patient remains eligible for Part A SNF-level services. The SB-MDS records must be submitted electronically to the national database and will be considered timely if submitted and accepted into the database within 14 days of completion (**Item 45b**).

4. **90-Day** - Medicare PPS assessment that will usually have an ARD (**Item 10a**) established between days 80-89 of the swing bed stay. The ARD (**Item 10a**) can be extended to day 94 if using the designated "Grace Days." The 90-Day Medicare PPS assessment must be completed (**Item 45b**) within 14 days of the ARD (**Item 10a**). The 90-Day assessment authorizes payment from days 91 through 100 of the stay as long as the patient remains eligible for Part A SNF-level services. The SB-MDS records must be submitted electronically to the national database and will be considered timely if submitted and accepted into the database within 14 days of completion (**Item 45b**).

5. **Readmission/Return** - Medicare PPS assessment that is completed when a patient whose stay was being reimbursed by SNF PPS, was hospitalized for more than 24 hours and was discharged return anticipated, then later readmitted to the swing bed from the hospital. The Readmission/Return assessment, like the 5-Day assessment, must have an ARD (**Item 10a**) established between days 1-8 of the return. The Readmission/Return assessment must be completed (**Item 45b**) within 14 days of the ARD (**Item 10a**). The Readmission/Return assessment restarts the Medicare PPS schedule and the next required assessment would be the Medicare 14-Day assessment. The SB-MDS records must be submitted electronically to the national database and will be considered timely if submitted and accepted into the database within 14 days of completion (**Item 45b**).

7. **14-Day** - Medicare PPS assessment that will usually have an ARD (**Item 10a**) established between days 11-14 of the swing bed stay. The ARD (**Item 10a**) can be extended to day 19 if using the designated "Grace Days." The 14-Day assessment must be completed (**Item 45b**) within 14 days of the ARD (**Item 10a**). The 14-Day assessment authorizes payment from days 15 through 30 of the stay as long as the patient remains eligible for Part A SNF-level services. The SB-MDS records must be submitted electronically to the national database and will be considered timely if submitted and accepted into the database within 14 days of completion (**Item 45b**).

9. **Other** - This code is used **<u>only</u>** when an OMRA (**Item 11c**) or a CCA (**Item 11d**) is completed.

Coding: Choose the one answer that applies. If you are completing an OMRA on a Medicare patient, you will enter a "9" indicating other and also code "1" to **Item-11c** (**OMRA assessment**). If you are completing a Clinical Change assessment on a Medicare patient, you will enter a "9" indicating other, and also code a "1" in **Item 11d** (Clinical Change assessment). If you are completing a State Required Assessment (**Item 11e**) or an Assessment Needed for Other Reason (**Item 11f**), leave this item blank.

c. OMRA Assessment

Definition: **Other Medicare Required Assessment (OMRA)** - Assessment that must be completed only when the patient was in a RUG-III Rehabilitation Plus Extensive Services or Rehabilitation classification and will continue to need Part A SNF-level services after the discontinuation of therapy. The OMRA ARD (**Item 10a**) must be set on day eight, nine, or ten after the last day that all rehabilitation therapies have been discontinued.

The OMRA must be completed (**Item 45b**) within 14 days of the ARD (**Item 10a**). The OMRA will establish a new non-therapy payment rate. The SB-MDS records must be submitted electronically to the national database and will be considered timely if submitted and accepted into the database within 14 days of completion (**Item 45b**).

Coding: A response is required in this subsection. Code "1" if the assessment is an OMRA.

d. Clinical Change Assessment

Definition: **Clinical Change Assessment (CCA) –** An assessment performed when a decline or improvement in a patient's status that: 1) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, 2) impacts on more than one area of the patient's health status and, 3) requires interdisciplinary review and/or revision of the plan of care. (See Chapter 2, Section 2.2 for guidelines.)

Coding: A response is required in this subsection. Code "1" if the assessment is a Clinical Change Assessment.

Clarification:

- Adding therapy services to the treatments furnished to a patient in a Part A SNF-level stay does not automatically require a new assessment. However, if the therapy was added because the beneficiary experienced a clinical change, a CCA must be completed.

e. State-Required Assessment

Definition: **State Required Assessment -** An assessment required by your State Medicaid swing bed program.

Coding: A response is required in this subsection. Code "1" if your state requires the SB-MDS assessment for the Medicaid program.

f. Assessment Needed for Other Reasons

Definition: **Assessment Needed for Other Reasons –** An assessment that is completed for other payers, such as a Health Maintenance Organization (HMO) or other Medicare Secondary Payer (MSP).

Coding: A response is required in this subsection. Code "1" if you are required to complete the SB-MDS assessment by an HMO or MSP or because of a sanction situation.

12. Prior Acute Care Stay

Intent: To document the admission date of the qualifying 3-day hospital stay that occurred before admission to the swing bed for Part A SNF-level services.

Definition: Date the patient was admitted as an inpatient for hospital acute care services.

Coding: Fill in the boxes with the appropriate date. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box with a "0". Use four digits for the year. For example, February 7, 2003 should be entered as:

0	2		0	7		2	0	0	3
Month			Day			Year			

13. Admission Date

Intent: To document the date of the initial admission for swing bed services.

Definition: **Admission Date -** The initial date of admission for Part A SNF-level services. This date will not change on subsequent assessments until the patient is discharged with a return not anticipated. If the patient is discharged as a return not anticipated and is admitted again at a later date, the patient will be considered a new admission and a new admission date will be entered on the 5-Day assessment.

Coding: Fill in the boxes with the appropriate date. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box with a "0". Use four digits for the year. For example, February 7, 2003 should be entered as:

0	2		0	7		2	0	0	3
Month			Day			Year			

Examples

Mr. Jones was first admitted to Green Oaks for swing bed services on March 3, 2002 for a Medicare Part A covered stay. On the 5-Day assessment, the admission date of 03/03/2002 was recorded as the admission date. On March 9, 2002 he became unstable and required acute care services at Green Oaks Hospital for 2 days. The RN assessment coordinator completed a discharge return anticipated on March 11, 2002. Mr. Jones returned to the swing bed on March 12, 2002. The nurse completed a reentry document on March 12, 2002. A Return/Readmission assessment is required because he will continue to be eligible for Medicare. The admission date would be coded 03/03/2002, because Mr. Jones was discharged as a return anticipated and you would reflect the initial admission date.

Mrs. Smith was admitted to the Missouri Valley Hospital as a swing bed patient on December 10, 2002. The admission date of 12/10/2002 was recorded on the 5-Day and 14-Day assessments. On day 18 of her stay, she was discharged to her home. A discharged-return not anticipated document was completed and submitted to the national database. On December 31st, Mrs. Smith was admitted to the hospital for a fractured hip and was transferred back to the swing bed for rehabilitation on January 6, 2003. The January 6, 2003 swing bed admission is a new stay and the admission date will be 01/06/2003.

14. Admission/Discharge Status Code

Definition:

01. Private Home/Apt With No Home Health Care - Any house, condominium or apartment in the community, whether owned by the patient or another person (may be a child, friend, sibling). Also included in this category are retirement communities and independent housing for the elderly. No health care services were provided to the resident.

02. Private Home/Apt With Home Health Care - Services including skilled nursing, therapy (e.g., physical, occupational, speech), nutritional, medical, psychiatric and home health aide services delivered in the home. Does not include the following services unless provided in conjunction with home health services: homemaker/personal care services, home delivered meals, telephone reassurance, transportation, respite services, or adult day care.

03. Board and Care/Assisted Living/Group Home - A non-institutional community residential setting that may include services of the following types: home health services, homemaker/personal care services, or meal services.

04. Another Nursing Facility - An institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services of injured, disabled, or sick persons. Include admissions from hospital swing beds here.

05. Acute Unit at Own Hospital - An institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons in the hospital where the swing bed services are currently being provided.

06. Acute Unit at Another Hospital - An institution where acute care was provided other than the hospital where the Part A SNF-level services are currently being provided.

07. Psychiatric Hospital - An institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients.

08. Rehabilitation Hospital - An institution that is engaged in providing, under the supervision of physicians, rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

09. MR/DD Facility - An institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who are mentally retarded or who have developmental disabilities.

10. Hospice - A program that provides palliative and supportive care for the terminally ill patients and their families.

11. Deceased

12. Other - Includes chronic disease hospitals. Also includes when a patient has exhausted Part A SNF days or no longer meets criteria for Part A SNF level services.

a. Admitted From

Intent: To document the patient's living arrangement prior to admission and the presence or absence of home health services.

Process: Review admission records. Consult the patient and the patient's family.

Coding: Choose only one answer.

b. Discharge Status

Intent: To document the type of living arrangement to which the patient is discharged or to report the death of a patient.

Coding: Choose only one answer.

Clarification: ◆ Complete when **Item 11a** is coded as 06 or 07. Must also complete **Item 15**.

c. Reentered From

Intent: To document the patient's living arrangements prior to reentry for swing bed services.

Process: Review admission records. Consult the patient and the patient's family.

Coding: Choose only one answer. Complete only if previously discharged with return anticipated.

Clarification: ◆ Complete when **Item 11a** is coded as 09. Must also complete **Item 16**.

15. Discharge Date **(Key Field Item)**

Intent: To track the date that the patient was discharged from the swing bed or has died. This includes when a patient has exhausted Part A SNF benefits or no longer meets the criteria for Part A SNF services.

Coding: Complete if **Item 11a** = **06** (Discharged-Return not Anticipated) or **07** (Discharged-Return Anticipated). Fill in the boxes with the appropriate date. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box with a "0". Use four digits for the year. For example, February 7, 2003 should be entered as:

0	2		0	7		2	0	0	3
Month			Day			Year			

16. Reentry Date (Key Field Item)

Intent: To document the date the patient returns to the swing bed program from a discharged-return anticipated status.

Coding: Complete if **Item 11a** = 09 (Reentry). Fill in the boxes with the appropriate date. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box with a "0". Use four digits for the year. For example, February 7, 2003 should be entered as:

0	2		0	7		2	0	0	3
Month			Day			Year			

CLINICAL DATA

17. Comatose (7-day look back)

Intent: To record whether the patient's clinical record includes a documented neurological diagnosis of coma or persistent vegetative state.

Coding: Enter the appropriate number in the box. If the patient has been diagnosed as comatose or in a persistent vegetative state, code "1" and ***Skip to Item 23*** (Activities of Daily Living). If the patient is not comatose or not in a persistent vegetative state, code "0" and ***proceed to the next item (Item 18)***.

Clarification:

- Comatose (coma) is a pathological state in which neither arousal (wakefulness, alertness) nor awareness (cognition of self and environment) is present. The comatose person is unresponsive and cannot be aroused; he/she does not open his/her eyes, does not speak and does not move his/her extremities on command or in response to noxious stimuli (e.g., pain).

  Sometimes patients who were comatose for a period of time after an anoxic-ischemic injury (i.e., not enough oxygen to the brain), from a cardiac arrest, head trauma or massive stroke, regain wakefulness but have no evidence of any purposeful behavior or cognition. Their eyes are open and they seem to be awake. They may grunt, yawn, pick with their fingers and have random movements of their heads and extremities. A neurological exam shows that they have extensive damage to both cerebral hemispheres. This state is different from coma, and if it continues, is called a persistent vegetative state. Both coma and vegetative state have serious consequences in terms of long-term clinical outcomes and care needs.

Many other patients have severe impairments in cognition that are associated with late stages of progressive neurological disorders such as Alzheimer's disease. Although such patients may be non-communicative, totally dependent on others for care and nourishment, and sleep a great deal of time, they are usually not comatose or in a persistent vegetative state as described above.

To prevent any patient from being mislabeled, it is imperative that coding of comatose reflects physician documentation of a diagnosis of either coma or persistent vegetative state.

18. Short-Term Memory (7-day look back)

Intent: To determine the patient's functional capacity to remember recent or short-term events.

Process: Ask the patient to describe a recent event that both of you had the opportunity to remember. Or, you could use a more structured short-term memory test. For patients with limited communication skills, ask staff and family about the patient's memory status. Remember, if there is no positive indication of memory ability, (e.g., remembering multiple items over time or following through on a direction given five minutes earlier) the correct response is "1", Memory Problem.

If the test cannot be conducted (patient will not cooperate, is non-responsive, etc.) and the staff were unable to make a determination based on observation of the patient, use the "-" response to indicate that the information is not available because it could not be assessed.

Examples

Ask the patient to describe the breakfast meal or an activity just completed.

Ask the patient to remember three items (e.g., book, watch, table) for a few minutes. After you have stated all three items, ask the patient to repeat them (to verify that you were heard and understood). Then proceed to talk about something else - do not be silent, do not leave the room. In five minutes, ask the patient to repeat the name of each item. If the patient is unable to recall all three items, code "1." For persons with verbal communication deficits, non-verbal responses are acceptable (e.g., when asked how many children they have, they can tap out a response of the appropriate number).

Coding: Enter the number that corresponds to the observed response. Remember, if there is no positive indication of memory ability, (e.g., remembering multiple items over time or following through on a direction given five minutes earlier) the correct response is "1", Memory Problem.

Clarifications:

- Many persons with memory problems can learn to function successfully in a structured, routine environment. Observing patient function in multiple daily activities is only one aspect of evaluating short-term memory function. For example, a patient may remember to come to lunch, but may not remember what he/she ate. The short-term memory test described above is still an important component of the overall evaluation.

- When coding short-term memory, identify the most representative level of function, not the highest. Therefore, a patient with short-term memory problems 6 of the 7 days should be coded as "1". For many patients, performance varies. Staff must use clinical judgment to decide whether a single observation provides sufficient information on the patient's typical level of function.

19. Cognitive Skills (7-day look back)

Intent: To record the patient's actual performance in making everyday decisions about tasks or activities of daily living.

Examples

Choosing items of clothing; knowing when to go to scheduled meals; using environmental cues to organize and plan (e.g., clocks, calendars, posted listings of upcoming events); in the absence of environmental cues, seeking information appropriately (i.e., not repetitively) from others in order to plan the day; using awareness of one's own strengths and limitations in regulating the day's events (e.g., asks for help when necessary); making the correct decision concerning how to get to the dining room; acknowledging need to use a walker, and using it faithfully.

Process: Review the clinical record. Consult family and nurse assistants. Observe the patient. The inquiry should focus on whether the patient is actively making these decisions, and not whether staff believe the patient might be capable of doing so or not. Remember, the intent of this item is to record what the patient is doing (performance). Where a staff member takes decision-making responsibility away from the patient regarding tasks of everyday living or the patient does not participate in decision making, whatever his or her level of capability may be, the patient should be considered to have impaired performance in decision-making.

This item is especially important for further assessment. It can alert staff to a mismatch between a patient's abilities and his or her current level of performance or to an inadvertent fostering of the patient's dependence.

Coding: Enter one number that corresponds to the most correct response.

0. Independent - The patient's decisions in organizing daily routine and making decisions were consistent, reasonable, and organized reflecting lifestyle, culture, values.

1. Modified Independence - The patient organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision-making when faced with new tasks or situations.

2. Moderately Impaired - The patient's decisions were poor; the patient required reminders, cues, and supervision in planning, organizing, and correcting daily routines.

3. Severely Impaired - The patient never (or rarely) made decisions.

Clarifications:

- If the patient "rarely or never" made decisions, despite being provided with opportunities and appropriate cues, code as "3" for **Severely Impaired**. If the patient attempts to make decisions, although poorly, code "2" for **Moderately Impaired**.

- Coding the following examples for "Cognitive Skills for Daily Decision-Making:"

  (1) If a patient seems to have severe cognitive impairment and is non-verbal, but usually clamps his mouth shut when offered a bite of food, would the patient be considered moderately or severely impaired?

  (2) If a patient does not generally make conversation or make his needs known, but replies "yes" when asked if he would like to take a nap, would the patient be considered moderately or severely impaired?

  These examples are similar in that the patients are primarily non-verbal and do not make their needs known, but they do make basic verbal or non-verbal responses to simple gestures or questions regarding care routines (e.g., comfort). More information about how the patient functions in his environment is needed to definitively answer the questions. From the limited information provided about these patients, one would gather that their communication is only focused on very particular circumstances, in which case it would be regarded as "rarely/never" in the relative number of decisions a person could make during the course of a week code as "3", **Severely Impaired**. The assessor should determine if the patient would respond in a similar fashion to other requests made during the 7-day

observation period. If such "decisions" are more frequent, the patient may be only moderately impaired or better.

20. Making Self Understood (7-day look back)

Intent: To document the patient's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, gestures, sounds, communication board or a combination of these.

Process: Interact with the patient. Observe and listen to the patient's efforts to communicate with you. Observe his or her interactions with others in different settings (e.g., one-on-one, groups) and different circumstances (e.g., when calm, when agitated). Consult with the primary nurse assistant (over all shifts), family members (if available), and the speech-language pathologist.

Coding: Enter the number corresponding to the most correct response.

0. Understood - The patient expresses ideas clearly.

1. Usually Understood - The patient has difficulty finding the right words or finishing thoughts, resulting in delayed responses; or the patient requires some prompting to make self understood.

2. Sometimes Understood - The patient has limited ability, but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, toilet).

3. Rarely/Never Understood - At best, understanding is limited to staff interpretation of highly individual, patient-specific sounds or body language (e.g., indicated presence of pain or need to toilet).

Clarification:

- A patient assessed as "3" (Rarely/Never Understood), should not necessarily be coded as severely impaired in daily decision making (**Item 19**, Cognitive Skills). The two areas of function are not always associated. The ability to be understood may not be a functional problem, but a different language spoken by the patient. For example, a person who is rarely/never understood may speak a language other than that spoken by caregivers, or he/she may be profoundly hearing or vision impaired. A more thorough assessment must be done to determine the actual level of cognitive function.

21. Indicators of Depression (30-day look back)

It is important to note that coding the presence of indicators does not automatically mean that the patient has a diagnosis of depression or anxiety. Assessors do not make or assign a diagnosis in this section; they simply record the presence or absence of specific indicators and behaviors. It is

important that facility staff recognizes these clinical indicators and consider them when developing the patient's plan of care.

Intent: To record the frequency of indicators observed in the last 30 days, irrespective of the assumed cause of the indicator (behavior).

Definition: Feelings of distress may be expressed directly by the patient who is depressed, anxious, or sad. Distress may also be expressed non-verbally and identified through observation of the patient during usual daily routines. Statements such as "I'm so depressed" are rare in the elderly. Rather, distress is more commonly expressed in the following ways:

VERBAL EXPRESSIONS OF DISTRESS

a. Negative Statements - e.g., "Nothing matters"; "Would rather be dead"; "What's the use"; "Regrets having lived so long"; "Let me die."

b. Repetitive Questions - e.g., "Where do I go?"; "What do I do?"

c. Repetitive Verbalizations - e.g., Calling out for help, "God help me".

d. Persistent Anger with Self/Others - e.g., easily annoyed, anger at placement in swing bed; anger at care received.

e. Self Deprecation - e.g., "I am nothing"; "I am of no use to anyone".

f. Expression of Unrealistic Fears - e.g., fear of being abandoned, left alone, being with others.

g. Recurrent Statements that Something Terrible is About to Happen - e.g., believes he or she is about to die, have a heart attack.

h. Repetitive Health Complaints - e.g., persistently seeks medical attention, obsessive concern with body functions.

i. Repetitive Anxious Complaints/Concerns (non-health related**)** - e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues.

NON-VERBAL EXPRESSIONS OF DISTRESS

<u>Sleep Cycle Patterns</u>:

j. Unpleasant Mood in Morning – e.g., angry, irritable.

k. **Insomnia/Change in Usual Sleep Pattern** - e.g., difficulty falling asleep, fewer or more hours of sleep than usual, waking up too early and unable to fall back to sleep.

Sad, Apathetic, Anxious Appearance:

l. **Sad, Pained, Worried Facial Expressions** - e.g., furrowed brows.

m. **Crying, Tearfulness**

n. **Repetitive Physical Movements** - e.g., pacing, hand wringing, restlessness, fidgeting, picking.

Loss Of Interest:

o. **Withdrawal from Activities of Interest** - e.g., no interest in long standing activities or being with family/friends. If the patient's withdrawal from activities of interest persists over time, it should continue to be coded, regardless of the amount of time the patient has withdrawn from activities of interest or has shown no interest in being with family/friends.

p. **Reduced Social Interaction** - e.g., less talkative, more isolated.

Process: Initiate a conversation with the patient. Some patients are more verbal about their feelings than others and will either tell someone about their distress, or tell someone only when directly asked how they feel. Other patients may be unable to articulate their feelings (i.e., cannot find the words to describe how they feel, or lack insight or cognitive capacity). Observe patients carefully for any indicator. Consult with direct care staff over all shifts, and family members, if available, who have direct knowledge of the patient's behavior. Relevant information may also be found in the clinical record.

Coding: For each indicator apply one of the following codes based on interactions with and observations of the patient in the last 30 days. Remember, code regardless of what you believe the cause to be.

0. **Indicator not exhibited in last 30 days**
1. **Indicator of this type exhibited up to 5 days a week** -exhibited at least once during the last 30 days but less than 6 days a week
2. **Indicator of this type exhibited daily or almost daily** – exhibited 6, 7 days a week

Clarifications:

- The keys to obtaining, tracking and recording accurate information are 1) interviews with and observations of the patient, and 2) communication between licensed and non-licensed staff and other caregivers.

- Daily communication between nurses, nurse assistants and other direct care providers is crucial for patient monitoring and care giving.

- Educate all caregivers (including direct care staff and staff who routinely come into contact with the patient, such as housekeepers, maintenance, and dietary personnel) about the patient's status in this area, and how to observe mood and behavior patterns that are captured in this item. These mood and behavior patterns are not part of normal aging. They are often indicative of depression, anxiety, and other mental disorders. These conditions are often under-identified and under-treated or untreated in Part A SNF-level care. Part of the reason may be that staff tend to perceive these conditions as the patient's "normal" or "usual" behaviors.

- Documentation of signs and symptoms of depression, anxiety and sad mood, and of behavioral symptoms, is a matter of good clinical practice. This information facilitates accurate diagnosis and identification of new or worsening problems. This information facilitates communication to the entire treatment team, across shifts, and is necessary in order to monitor on an on-going basis, the patient's status and response to treatment. It is up to the facility to determine the form and format of such documentation.

◆ These items specify a 30-day observation period. Try a rule-out process to make coding easier. For each indicator listed, think about whether it occurred at all. If not, use code "0". If the patient exhibited the behavior almost daily (6 or 7 days a week), or multiple times daily, code "2". If codes "0" or "2" do not reflect the patient's status, but the behavior occurred at least once, use code "1".

◆ If an indicator of depression occurs twice in the last 30 days (not 2 times each week), it should be coded as "1" to indicate that the indicator of depression was exhibited up to five days a week (but less than 6 days a week). It does not need to occur in each week to be coded. If an indicator of depression occurs only in the beginning of the 30-day period, it should be coded as an indicator of depression occurring up to 5 days a week (but less than 6 days a week) in the last 30 days.

Example

Mr. F is a new admission that becomes upset and angry when his daughter visits (3 times a week). He complains to her and staff caregivers that "she put me in this terrible dump." He chastises her "for not taking him into her home," and berates her "for being an ungrateful daughter." After she leaves, he becomes remorseful, sad looking, tearful, and says, "What's the use. I'm no good. I wish I died when my wife did." **Code a. (Negative statements), d. (Persistent anger with self/others), e. (Self deprecation), m. (Crying, tearfulness) as "1"; remaining Mood items would be coded "0".**

22. Behavioral Symptoms (7-day look back)

Intent: To identify the frequency of behavioral symptoms in the last seven days that cause distress to the patient, or are distressing or disruptive to facility patients or staff members. Such behaviors include those that are potentially harmful to the patient himself or herself or disruptive in the environment, even if staff and other patients appear to have adjusted to them (e.g., "Mrs. R's calling out isn't much different than others on the unit. There are many noisy patients;" or "Mrs. L doesn't mean to hit me. She does it because she's confused.").

Acknowledging and documenting the patient's behavioral symptom patterns on the SB-MDS provide a basis for further evaluation, planning care, and delivery of consistent, appropriate care towards ameliorating the behavioral symptoms. Documentation in the clinical record of the patient's current status may not initially be detailed (and in some cases will not pinpoint the patient's actual problems) and it is not intended to be the one and only source of information (see Process below). However, once the frequency of behavioral symptoms is accurately determined, subsequent documentation should more accurately reflect the patient's status and response to interventions.

Definition:

a. Wandering - Locomotion with no discernible, rational purpose. A wandering patient may be oblivious to his or her physical or safety needs. Wandering behavior should be differentiated from purposeful movement (e.g., a hungry person moving about the unit in search of food). Wandering may be manifested by walking or by wheelchair.

Do not include pacing as wandering behavior. Pacing back and forth is not considered wandering, and if it occurs, it should be documented in **Item 21n**, "Repetitive physical movements".

b. Verbally Abusive Behavioral Symptoms - Other patients or staff were threatened, screamed at, or cursed at.

c. **Physically Abusive Behavioral Symptoms** - Other patients or staff were hit, shoved, scratched, or sexually abused.

d. **Socially Inappropriate/Disruptive Behavioral Symptoms** - Includes disruptive sounds, excessive noise, screams, self-abusive acts, sexual behavior or disrobing in public, smearing or throwing food or feces, hoarding, rummaging through others' belongings.

e. **Resists Care** - Resists taking medications/injections, ADL assistance or help with eating. This category does not include instances where the patient has made an informed choice not to follow a course of care (e.g., patient has exercised his or her right to refuse treatment, and reacts negatively as staff try to reinstitute treatment).

   Signs of resistance may be verbal and/or physical (e.g., verbally refusing care, pushing caregiver away, scratching caregiver). These behaviors are not necessarily positive or negative, but are intended to provide information about the patient's responses to nursing interventions and to prompt further investigation of causes (e.g., fear of pain, fear of falling, poor comprehension, anger, poor relationships, eagerness for greater participation in care decisions, past experience with medication errors and unacceptable care, desire to modify care being provided).

Process: Take an objective view of the patient's behavioral symptoms. The coding for this item focuses on the patient's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. Therefore, it is important to start the assessment by recording any behavioral symptoms. The fact that staff have become used to the behavior and minimize the patient's presumed intent ("He doesn't really mean to hurt anyone. He's just frightened.") is not pertinent to this coding. Does the patient manifest the behavioral symptom or not? Is the patient combative during personal care? Does the patient strike out at staff or not?

Observe the patient. Observe how the patient responds to staff members' attempts to deliver care to him or her. Consult with staff that provide direct care on all shifts. A symptomatic behavior could be present only at specific times through out the day, e.g., during evening care. Therefore, it is especially important to solicit from all nurse assistants having contact with the patient.

Also, be alert to the possibility that staff might not think to report a behavioral symptom if it is part of the unit norm (e.g., staff are working with cognitively severe and functionally impaired patients and are used to patients' wandering, noisiness, etc.). Focus staff attention on what has been the individual patient's actual behavior over the last seven days. Finally, although it may not be complete, review the clinical record for documentation.

Coding: **0. Behavior NOT Exhibited in Last 7 Days** - Code "0" if the patient did not exhibit that type of symptom in the last seven days. This code applies to patients who have never exhibited the behavioral symptom or those who have previously exhibited the symptom but now no longer exhibit it, including those whose behavioral symptoms are fully managed by psychotropic drugs, restraints, or a behavior-management program. For example: A "wandering" patient who did not wander in the last seven days because he was restricted to a geri-chair would be coded "0" - Behavioral symptom not exhibited in last seven days.

1. Behavior Occurred 1 to 3 Days in Last 7 Days

2. Behavior Occurred 4 to 6 Days, but Less Than Daily

3. Behavior Occurred Daily - behavior symptom occurred daily or multiple times each day.

Examples for Wandering	Frequency
Ms. T has dementia and is severely impaired in making decisions about daily life on her unit. She is dependent on others to guide her through each day. When she is not involved in some type of activity (leisure, dining, ADLs, etc.) she wanders about the unit on a daily basis.	3
Mr. W has dementia and is severely impaired in making daily decisions. He wanders all around the unit throughout each day. He is extremely hard of hearing and refuses to wear his hearing aid. He is easily frightened by others and cannot stay still for activities programs.	3

23. Activities of Daily Living (ADLs) (7-day look back)

Most swing bed patients are at risk of physical decline. Most long-term and many short-term patients also have multiple chronic illnesses and are subject to a variety of other factors that can severely impact self-sufficiency. For example, cognitive deficits can limit ability or willingness to initiate or participate in self-care or constrict understanding of the tasks required to complete ADLs. A wide range of physical and neurological illnesses can adversely affect physical factors important to self-care such as stamina, muscle tone, balance, and bone strength. Side effects of medications and other treatments can also contribute to needless loss of self-sufficiency.

Due to these many, possibly adverse influences, a patient's potential for maximum functionality is often greatly underestimated by family, staff, and the patient himself or herself.

Thus, all patients are candidates for nursing-based rehabilitative care that focuses on maintaining and expanding self-involvement in ADLs. Individualized plans of care can be successfully developed only when the patient's self-performance has been accurately assessed and the amount and type of support being provided to the patient by others has been evaluated.

(A) ADL SELF-PERFORMANCE

Intent: To record the patient's self care performance in activities of daily living (i.e., what the patient actually did for himself or herself and/or how much verbal or physical help was required by staff members) during the **last seven days**.

Definition: **ADL Self-Performance -** Measures what the patient **actually did** (not what he or she might be capable of doing) within each ADL category over the last seven days according to a performance-based scale.

a. Bed Mobility - How the patient moves to and from a lying position, turns side to side, and positions body while in bed, in a recliner, or other type of furniture the patient sleeps in, rather than a bed.

b. Transfer - How the patient moves between surfaces - i.e., to/from bed, chair, wheelchair, standing position. Exclude from this definition movement to/from bath or toilet, which is covered under Toilet Use and Bathing.

c. Eating - How the patient eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).

Even a patient who receives tube feedings and no food or fluids by mouth is engaged in eating (receiving nourishment), and is not to be coded as an "8". The patient must be evaluated under the Eating ADL category for his/her level of assistance in the process. A patient who is highly involved in giving himself/herself a tube feeding is not totally dependent and should not be coded as a "4".

d. Toilet Use - How the patient uses the toilet room, commode, bedpan, or urinal, transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes. Do not limit assessment to bathroom use only. Elimination occurs in many settings and includes transferring on/off the toilet, cleansing, changing pads, managing an ostomy or catheter, and clothing adjustment.

Process: In order to be able to promote the highest level of functioning among patients, clinical staff must first identify what the patient actually does for himself or herself, noting when assistance is received and clarifying the types of assistance provided (verbal cueing, physical support, etc.).

A patient's ADL self-performance may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a nurse assistant he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the patient's ADL self-performance over the seven day period, 24 hours a day - i.e., not only how the evaluating clinician sees the patient, but how the patient performs on other shifts as well.

In order to accomplish this, it is necessary to gather information from multiple sources - i.e., interviews/discussion with the patient and direct care staff on all shifts including weekends, and review of documentation used to communicate with staff across shifts. Begin by reviewing the documentation in the clinical record. Observe the care being provided to the patient. Ask questions pertaining to all aspects of the ADL activity definitions. For example, when discussing Bed Mobility with a nurse assistant, be sure to inquire specifically how the patient moves to and from a lying position, how the patient turns from side to side, and how the patient positions himself or herself while in bed. A patient can be independent in one aspect of Bed Mobility yet, require extensive assistance in another aspect. Since accurate coding is important as a basis for making decisions on the type and amount of care to be provided, be sure to consider each activity definition fully.

The wording used in each ADL performance coding option is intended to reflect real-world situations where slight variations in performance are common. Where small variations occur, the coding ensures that the patient is not assigned to an excessively independent or dependent category. For example, by definition, codes 0, 1, 2, and 3 (Independent, Supervision, Limited Assistance, and Extensive Assistance) permit one or two exceptions or instances for the provision of heavier care within the assessment period. For example, in scoring a patient as independent in ADL Self-Performance, there can be one or two exceptions. As soon as there are three exceptions, another code must be considered. While it is not necessary to know the actual number of times the activity occurred, it is necessary to know whether or not the activity occurred three or more times within the last 7 days.

Because this section involves a two-part evaluation (**Item 23A**, ADL Self-Performance, and **Item 23B**, ADL Support), each using its own scale, it is recommended that you complete the Self-Performance evaluation for all ADL activities before beginning the ADL Support evaluation.

Talk with clinical staff from each shift to ascertain what the patient does for himself or herself in each ADL activity as well as the type and level of staff assistance being provided. As previously noted, be alert to differences in patient performance from shift to shift, and apply the ADL codes that capture these differences. For example, a patient may be independent in Toilet Use during daylight hours but receive non weight-bearing physical assistance every evening. In this case, the patient would be coded as "2" (Limited assistance) in **Toilet Use**.

Guidelines for Assessing ADL Self-Performance and ADL Support Provided

- The scales for ADL Self-Performance and ADL Support Provided are used to record the patient's actual level of involvement in self-care and the type and amount of support actually received during the last seven days.
- Do not record your assessment of the patient's capacity for involvement in self-care - i.e., what you believe the patient might be able to do for himself or herself based on demonstrated skills or physical attributes.
- Do not record the type and level of assistance that the patient "should" be receiving according to the written plan of care. The type and level of assistance actually provided might be quite different from what is indicated in the plan. Record what is actually happening.
- Engage direct care staff from all shifts that have cared for the patient over the last seven days in discussions regarding the patient's ADL functional performance. Remind staff that the focus is on the last seven days only. To clarify your own understanding and observations about each ADL activity (bed mobility, transfer, eating and toilet use), ask probing questions, beginning with the general and proceeding to the more specific.

Here is a typical conversation between the RN and a nurse assistant regarding a patient's Bed Mobility assessment:

R.N. "Describe to me how Mrs. L positions herself in bed. By that I mean once she is in bed, how does she move from sitting up to lying down, lying down to sitting up, turning side to side, and positioning herself?"

N.A. "She can lay down and sit up by herself, but I help her turn on her side."

R.N. "She lays down and sits up without any verbal instructions or physical help?"

N.A. "No, I have to remind her to use her trapeze every time. But once I tell her how to do things, she can do it herself."

R.N. "How do you help her turn side to side?"

N.A. "She can help turn herself by grabbing onto her side rail. I tell her what to do. But she needs me to lift her bottom and guide her legs into a good position."

R.N. "Do you lift her by yourself or does someone help you?"

N.A. "I do it by myself."

R.N. "How many days during the last week did you give this type of help?"

N.A. "Every day."

Provided that ADL function in Bed Mobility was similar on all shifts, Mrs. L would receive an ADL Self-Performance Code of "3" (Extensive Assistance) and an ADL Support Provided Code of "2" (One Person Physical Assist).

Now review the first two exchanges in the conversation between the RN and nurse assistant. If the RN did not probe further, he or she would not have received enough information to make an accurate assessment of either the patient's skills or the nurse assistant's actual workload, or whether or not the current plan of care was being implemented.

Coding: For each ADL category, code the appropriate response for the patient's actual performance during the past seven days. Enter the code in column (A). Consider the patient's performance during all shifts, as functionality may vary. In the pages that follow, two types of supplemental instructional material are presented to assist you in learning how to use this code: a series of case examples for each ADL and a schematic flow chart for scoring ADL Self-Performance.

In your evaluations, you will also need to consider the type of assistance known as "set-up help" (e.g., the nurse assistant positions wheelchair next to bed and locks wheels). Set-up help is recorded under ADL Support Provided (**Item 23B**). But in evaluating the patient's ADL Self-Performance, include set-up help within the context of the "0" (Independent) code. For example: If a patient transfers independently once wheelchair is set up for him, code "0" (Independent) in Transfer.

0. Independent - No help or staff oversight -OR- staff help/oversight provided only one or two times during the last seven days.

1. Supervision - Oversight, encouragement, or cueing provided three or more times during last seven days -OR- supervision (3 or more times) plus physical assistance provided, but only one or two times during last seven days.

2. Limited Assistance – Patient highly involved in activity, received physical help in guided maneuvering of limbs or other non weight-bearing assistance on three or more occasions -OR- limited assistance (3 or more times), plus more weight-bearing support provided, but for only one or two times during the last 7 days.

3. Extensive Assistance - While the patient performed part of activity over last seven days, help of following type(s) was provided three or more times:

-- Weight-bearing support provided three or more times;
-- Full staff performance of activity (3 or more times) during part (but not all) of last seven days.

4. **Total Dependence** - Full staff performance of the activity during entire 7-day period. There is complete non-participation by the patient in all aspects of the ADL definition task. If staff performed an activity for the patient during the entire observation period, but the patient performed part of the activity himself/herself, it would not be coded as a "4" (Total Dependence).

   Example: Eating is coded based on the patient's ability to eat and drink, regardless of skill, and includes intake of nourishment by other means (e.g., tube feeding, or total parenteral nutrition). For a patient to be coded as totally dependent in Eating, he or she would be fed all food and liquids at all meals and snacks (including tube feeding delivered totally by staff), and never initiate any subtask of eating (e.g., picking up finger foods, giving self tube feeding or assisting with procedure) at any meal.

8. **Activity Did Not Occur During the Entire 7-Day Period** - Over the last seven days, the ADL activity was not performed by the patient or staff. In other words, the particular activity did not occur at all.

   - A patient who was restricted to bed for the entire 7-day period and was never transferred from bed would be coded for both Self-Performance and Staff Support as "8", since the activity (transfer) did not occur.

   - To code Eating as an "8", consider if in the past 7 days the patient truly did not receive any nourishment. It should go without saying that this is a serious issue. Be careful not to confuse total dependence in eating (coded "4") with the activity itself (receiving nourishment and fluids). Keep in mind that as a patient who receives nourishment via tube feeding and manages the tube feeding independently is coded as "0" (Independent). In addition, the definition for Eating includes IV fluids. Therefore, code this item "4" (Total Dependence) rather than "8" for a patient who is receiving IV fluids or TPN.

     However, do not confuse a patient who is totally dependent in an ADL activity (code 4 - Total Dependence) with the activity itself not occurring. For example: Even a patient who receives tube feedings and no food or fluids by mouth is engaged in eating (receiving nourishment), and must be evaluated under the Eating category for his or her level of assistance in the process. A patient who is highly involved in giving himself a tube feeding is not totally dependent and should not be coded as "4".

Clarification:

- Each of these ADL Self-Performance codes is exclusive; there is no overlap between categories. Changing from one Self-Performance category to another demands an increase or decrease in the number of times that help is provided. Thus, to move from Independent to Supervision to Limited assistance, non weight-bearing supervision, or physical assistance must increase from one or two times to three or more times during the last seven days.

  There will be times when no one type or level of assistance is provided to the patient 3 or more times during a 7-day period. However, the sum total of support of various types will be provided 3 or more times. In this case, code for the least dependent Self-Performance category where the patient received that level or more dependent support 3 or more times during the 7-day period.

Examples

The patient received supervision for transferring on two occasions and non weight-bearing assistance on two occasions. **Code "1" for Supervision in Transferring. Rationale:** Supervision is the least dependent category.

The patient received supervision in toileting on one occasion, non weight-bearing assistance (i.e., transferring to commode) on two occasions, and weight-bearing assistance (i.e., transferring on commode) on one occasion during the last 7 days. **Code "2" for Limited assistance in Toileting. Rationale:** There were 3 episodes of physical assistance in the last 7 days: 2 non weight-bearing episodes, and 1 weight-bearing episode. Limited assistance is the correct code because it reflects the least dependent support category that encompasses 3 or more activities that were at least at that level of support.

Additional clarification and coding examples have been developed for this Manual update and are presented below.

Self-Performance - INDEPENDENT

ADLs - SELF-PERFORMANCE	INDEPENDENT
Bed Mobility	Mrs. D can easily turn and position herself in bed and is able to sit up and lie down without any staff assistance. She requires use of a single side rail that staff place in the up position when she is in bed. *Self-Performance = 0 Support Provided = 1* *Coding rationale: Patient is independent in task.*
Transfer	When transferring to her chair, the patient is able to stand up from a seated position (without requiring any physical or verbal help) and walk over to her reclining chair. *Self-Performance = 0 Support Provided = 0* *Coding rationale: Patient is independent.*
Eating	After staff delivered a lunch tray to Mr. K, he is able to consume all food and fluids without any cueing or physical help from staff. *Self-Performance = 0 Support Provided = 0* *Coding rationale: Patient is independent.*
Toilet Use	Mrs. L was able to transfer herself to the toilet, adjust her clothing, and perform the necessary personal hygiene after using the toilet without any staff assistance. *Self-Performance = 0 Support Provided = 0* *Coding rationale: Patient is independent.*

Self-Performance – SUPERVISION

ADLs - SELF-PERFORMANCE	SUPERVISION
Bed Mobility	Patient favors laying on right side. Since she has had a history of skin breakdown, staff must verbally remind her to reposition. *Self-Performance = 1 Support Provided = 0* *Coding rationale: Patient requires staff supervision, cueing and reminders.*
Transfer	Staff must supervise the patient as she transfers from her bed to wheelchair. Staff must bring the chair next to the bed and then remind her to hold on to the chair and position her body slowly. *Self-Performance = 1 Support Provided = 1* *Coding rationale: Patient requires staff supervision, cueing and reminders.*
Eating	One staff member had to verbally cue patient to eat slowly, and drink throughout the meal. *Self-Performance = 1 Support Provided = 0* *Coding rationale: Patient requires staff supervision, cueing and reminders for safe meal completion.*
Toilet Use	Staff member must remind patient to unzip pants and to wash his hands after using the toilet. *Self-Performance = 1 Support Provided = 0* *Coding rationale: Patient requires staff supervision, cueing and reminders.*

Self-Performance - Limited Assistance

ADLs - SELF-PERFORMANCE	LIMITED ASSISTANCE
Bed Mobility	Patient favors laying on right side. Since she has had a history of skin breakdown, staff must sometimes help the patient place her hands on the side rail and encourage her to change her position when in bed. *Self-Performance = 2 Support Provided = 2* *Coding rationale*: *Patient requires cueing and encouragement with set up or minor physical help.*
Transfer	Mrs. H is able to transfer from the bed to chair when she uses her walker. Staff place the walker near her bed and then help to steady the patient as she transfers. *Self-Performance = 2 Support Provided = 2* *Coding rationale: Patient requires staff to set up her walker and provide help when she is ready to transfer.*
Eating	Mr. V is able to feed himself. Staff must set up the tray, cut the meat, open containers and hand him the utensils. Mr. V requires more help during dinner with guiding of utensils as he is tired and less interested in completing his meals. In addition to encouraging him to continue eating and frequently handing him his utensils and cups to complete the meal, at these times a staff member also must assist guiding his hand in order to get the utensil to his mouth. *Self-Performance = 2 Support Provided = 1* *Coding rationale: Patient is unable to complete the meal without staff providing him non-weight bearing assistance (3 or more times in the observation period).*
Toilet Use	Staff must assist Mr. P to zip pants, hand him a washcloth and remind him to wash his hands after using the toilet. *Self-Performance = 2 Support Provided = 2* *Coding rationale: Patient requires staff to perform non-weight bearing activities to complete the task.*

Self-Performance – EXTENSIVE ASSISTANCE

ADLs - SELF-PERFORMANCE	EXTENSIVE ASSISTANCE
Bed Mobility	Mr. Q has slid to the foot of the bed. Two staff members must physically lift and reposition him toward the head of the bed. Mr. Q was able to assist by bending his knees and push with legs when reminded by staff. *Self-Performance = 3 Support Provided = 3* *Coding rationale: Patient partially participates in the task. 2 staff members are required.*
Transfer	Patient always had a difficult time standing from her chair. One staff member had to partially physically lift and support the patient as she stands up. *Self-Performance = 3 Support Provided = 2* *Coding rationale: Patient partially participates in the task. 1 staff member is required.*
Eating	Mr. F begins eating a meal by himself. After he has only eaten the bread, he states he is tired and is unable to complete the meal. One staff member physically supports his hand and provides verbal cues to swallow the food in his mouth. The patient is able to complete the meal. *Self-Performance = 3 Support Provided = 2* *Coding rationale: Patient partially participates in the task. 1 staff member is required.*
Toilet Use	Mrs. M has had recent bouts of vertigo. One staff member must assist and support her as she transfers to the bedside commode. *Self-Performance = 3 Support Provided = 2* *Coding rationale: Patient partially participates in the task. 1 staff member is required.*

Self-Performance - Total Dependence

ADLs - SELF-PERFORMANCE	TOTAL DEPENDENCE
Bed Mobility	Mrs. S is unable to physically turn, sit up or lay down in bed. Two staff members must physically turn her every 2 hours. She must be physically supported to a seated position in bed when reading. *Self-Performance = 4 Support Provided =3* *Coding rationale: Patient did not participate and required 2 staff to position her in bed.*
Transfer	Mr. T is in a physically debilitated state due to surgery. Two staff members must physically lift and transfer him to a reclining chair daily. Mr. T. is unable to assist or participate in any way. *Self-Performance = 4 Support Provided =3* *Coding rationale: Patient did not participate and required 2 staff to transfer him out of his bed.*
Eating	Mrs. U is severely cognitively impaired. She is unable to consume any of her meals or liquids served to her. One staff member is responsible to feed her all food and fluids. *Self-Performance = 4 Support Provided =2* *Coding rationale: Patient did not participate and required 1 staff person to feed her all of her meal.* Mr. B recently had a stroke. He is currently receiving 100% of his nutrition via a G-tube due to dysphagia. He does not assist in any part of the tube feeding process. *Self-Performance = 4 Support Provided =2* *Coding rationale: Patient did not participate and required 1 staff person to provide total nutritional support.*
Toilet Use	Miss W is cognitively and physically impaired; she is on strict bed rest. Staff are unable to physically transfer patient to toilet at this time. Miss W is incontinent of both bowel and bladder. One staff member must provide all care for her elimination and personal hygiene needs every 2 hours. *Self-Performance = 4 Support Provided =2* *Coding rationale: Patient did not participate and required 1 staff person to provide total care for toileting and personal hygiene.*

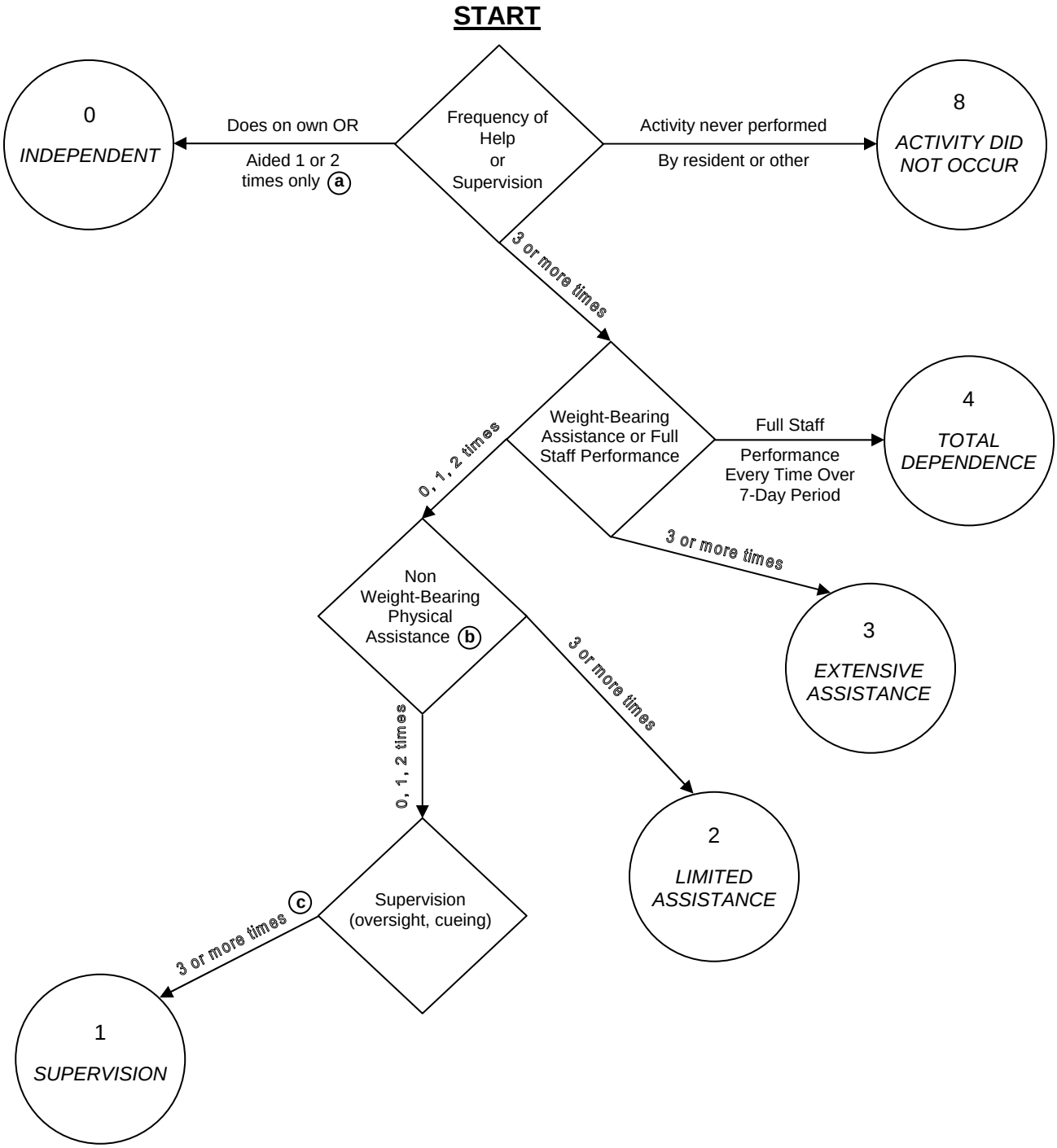
Examples – ADL ACTIVITY DID NOT OCCUR

ADLs - SELF-PERFORMANCE	8/8 - ADL ACTIVITY DID NOT OCCUR
Transfer	Mrs. D is post-operative for extensive surgical procedures. Due to her ventilator dependent status in addition to multiple surgical sites, her physician has determined that she must remain on total bed rest and not be moved from the bed. *Self-Performance = 8 Support Provided = 8* *Coding rationale: Activity did not occur.*

Examples - WHEN NOT TO CODE 8/8-ACTIVITY DID NOT OCCUR

ADLs - SELF-PERFORMANCE	WHEN NOT TO CODE 8/8 – ADL ACTIVITY DID NOT OCCUR
Bed Mobility	Mrs. P is unable to physically turn, sit up or lay down in bed for the past week. Two staff members must physically turn her every 2 hrs. She must be physically supported to a seated position in bed. *Self-Performance = 4 Support Provided =3* *Coding rationale: Although the patient did not move herself, staff performed the activity for her. Self-Performance code for the patient is total/did not participate; required 2 staff to position her in bed.*
Eating	Mrs. D is fed by feeding tube. No food or fluids are consumed thru her mouth. She does not assist with her tube feedings. *Self-Performance = 4 Support Provided =2* *Coding rationale: Patient does not participate in eating and receives nutrition and hydration thru a tube.*
Toileting	Mr. J has a catheter for urine. Adult briefs are utilized, checked, and changed every 3 hours. *Self-Performance = 4 Support Provided =2* *Coding rationale: Patient requires total care and staff support in toileting.*

SCORING ADL SELF-PERFORMANCE



a. Can include one or two events where received supervision, non weight-bearing assistance, or weight-bearing assistance.

b. Can include one or two episodes of weight-bearing assistance, e.g., two events with non weight-bearing assistance plus two of weight-bearing assistance would be coded as a "2".

c. Can include one or two episodes where physical help received, e.g., two episodes of supervision, one of weight-bearing assistance and one of non weight-bearing assistance would be coded as a "1".

(B) ADL Support Provided

Intent: To record the type and highest level of support the patient received in each ADL activity over the last seven days.

Definition: **ADL Support Provided** - Measures the highest level of support provided by staff over the last seven days, even if that level of support only occurred once. This is a different scale and is entirely separate from the ADL Self-Performance assessment.

Set-Up Help: The type of help characterized by providing the patient with articles, devices, or preparation necessary for greater patient self-performance in an activity. This can include giving or holding out an item that the patient takes from the caregiver.

Process: For each ADL category, code the maximum amount of support the patient received over the last seven days, irrespective of frequency, and enter in the "SUPPORT" column. Be sure your evaluation considers all nursing shifts, 24 hours per day, including weekends. Code independently of the patient's Self-Performance evaluation. For example, a patient could have been Independent in ADL Self-Performance in Transfer but received a one-person physical assist one or two times during the 7-day period. Therefore, the ADL Self-Performance Coding for Transfer would be "0" (Independent), and the ADL Support coding "2" (One person physical assist).

Coding: *NOTE:* The highest code of physical assistance in this category (other than the "8" code) is a code of "**3**", not "4" as in Self-Performance.

0. No Setup or Physical Help From Staff

1. Setup Help Only - The patient is provided with materials or devices necessary to perform the activity of daily living independently.

Examples of Setup Help

- **For bed mobility** - handing the patient the bar or a trapeze, staff applies ½ rails and then provides no further help.
- **For transfer** - giving the patient a transfer board or locking the wheels on a wheelchair for safe transfer.
- **For eating** - cutting meat and opening containers at meals; giving one food category at a time.
- **For toilet use** - handing the patient a bedpan or placing articles necessary for changing ostomy appliance within reach.

2. **One Person Physical Assist**

3. **Two+ Persons Physical Assist**

8. **ADL Activity Itself Did Not Occur During the Entire 7 Days** - When an "8" code is entered for an ADL Support Provided category, enter an "8" code for ADL Self-Performance in the same category.

Clarifications:

- General supervision of a dining room is not the same as individual supervision of a patient. If the patient ate independently, then code as "0" (Independent). If the individual patient needed oversight, encouragement, or cueing during the last 7 days, the item is coded as a "1" (Supervision). For a patient who has received oversight, encouragement, or cueing and also received more help, such as physical assistance provided one or two times during the 7-Day assessment period, the patient would still be coded as a "1" (Supervision). Patients who are in "feeding" or "eating" groups and who are individually supervised during the meal would be coded as "1" (Supervision) for Self-Performance in Eating.

- The key to the differentiation between guided maneuvering and weight-bearing assistance is determining *who* is supporting the weight of the patient's hand. If the staff member supports some of the weight of the patient's hand while helping the patient to eat (e.g., lifting a spoon or a cup to mouth), this is "weight-bearing" assistance for this activity. If the patient can lift the utensil or cup, but staff assistance is needed to guide the patient's hand to his/her mouth, this is guided maneuvering.

- If therapists are involved with the patient, their input should be included either by way of an interview or by the assessor reviewing the therapy documentation. The patient may perform differently in therapy than on the unit. Also focus on occurrences of exceptions in the patient's performance. When discussing a patient's ADL performance with a therapist, make sure the therapist's information can be expressed in SB-MDS terminology.

<u>CLARIFICATIONS USING THE CODE "8" (ACTIVITY DID NOT OCCUR)</u>:

- The Eating item is a little more complex. If in the past seven days the patient truly did not receive any nourishment, the item would be coded 8. It should go without saying that this is a serious issue. Be careful not to confuse total dependence with eating (code 4) with the activity itself (in this case, receiving nourishment and fluids). Keep in mind that a patient who is fed via tube, and manages the tube feeding independently is coded as independent (code 0). G1h includes receiving IV fluids. For a patient who is receiving fluids for hydration, and is totally dependent, this is coded as "4", rather than "8".

- Toilet use focuses on whether or not elimination occurs, rather than the process. The elimination may be in the toilet room, commode, in the bedroom on a bedpan or urinal. It includes transferring on/off the toilet, cleansing, changing pads, managing an ostomy or catheter, and clothing adjustment. The "8" code is rarely used in this section, as it would indicate that elimination did not occur.

The examples that follow clarify coding for both Self-Performance and Support. The answers appear to the right of the patient descriptions. Cover the answers, read and score the example, then compare your answers with those provided. For the purpose of this exercise, the clinician should assume that the patient has performed at the same level for the last 7 days.

Examples: ADL Self-Performance and Support	Self-Perf.	Support
Bed Mobility		
Patient was physically able to reposition self in bed but had a tendency to favor and remain on his left side. He received frequent reminders and monitoring to reposition self while in bed.	1	0
Patient received supervision and verbal cueing for using a trapeze for all bed mobility. On two occasions when arms were fatigued, he received heavier physical assistance of two persons.	1	3
Patient usually repositioned himself in bed. However, because he sleeps with the head of the bed raised 30 degrees, he occasionally slides down towards the foot of the bed. On 3 occasions the night nurse assistant helped him to reposition by providing weight-bearing support as he bent his knees and pushed up off the footboard.	3	2
To turn over, the patient always began by reaching for a side rail for support. He received physical assistance of one person to guide his legs into position and complete the turn by guiding him with a turn sheet (using weight-bearing assistance).	3	2
Patient independently turned on his left side whenever he wanted. Because of left-sided weakness he received physical weight bearing help of 1-2 persons to turn to his right side or sit up in bed.	3	3
Because of severe, painful joint deformities, patient was totally dependent on two persons for all bed mobility. Although unable to contribute physically to positioning process, she was able to cue staff for the position she wanted to assume and at what point she felt comfortable.	4	3

Examples: ADL Self-Performance and Support	Self-Perf.	Support
Transfer		
Despite bilateral above-the-knee amputations, patient almost always moved independently from bed to wheelchair (and back to bed) using a transfer board he retrieves independently from his bedside table. On one occasion in the past week, staff had to remind patient to retrieve the transfer board. On one other occasion, the patient was lifted by a staff member from the wheelchair back into the bed.	0	2
Patient was physically independent for all transfers. However, he would not get up in the morning until the nurse assistant rearranged his bed covers and released the half side rail on his bed.	0	1
Once someone correctly positioned the wheelchair in place and locked the wheels, the patient transferred independently to and from the bed.	0	1
Patient moved independently in and out of armchairs but always received light physical guidance of one person to get in and out of bed safely.	2	2
Transferring ability varied throughout each day. Patient received no assistance at some times and heavy weight-bearing assistance of one person at other times.	3	2

Examples: ADL Self-Performance and Support	Self-Perf.	Support
Eating		
Patient arose daily after 9:00 am, preferring to skip breakfast and just munch on fresh fruit later in the morning. She ate lunch and dinner independently in the facility's main dining room.	0	0
Patient on long standing tube feedings via gastrostomy tube was completely independent in self-administration including self-medication via the tube once set up by staff.	0	1
Patient with a history of dysphagia and choking, ate independently as long as a staff member sat with him during every meal (stand-by assistance if necessary).	1	0
Patient is blind and confused. He ate independently once staff oriented him to types and whereabouts of food on his tray and instructed him to eat.	1	1
Cognitively impaired patient ate independently when given one food item at a time and monitored to assure adequate intake of each item.	1	1
Patient fed self solid foods independently at all meals and snacks. Self-administered all fluids and medications via G-tube with supervision once set up appropriately.	1	1
Patient, with difficulty initiating activity, always ate independently after someone guided her hand with the first few bites and then offered encouragement to continue.	3	2
Patient with fine motor tremors fed self finger foods (e.g., sandwiches, raw vegetables and fruit slices, crackers) but always received supervision and total physical assistance with liquids and foods requiring utensils.	3	2
Patient fed self with staff monitoring at breakfast and lunch but tired later in day. She was fed totally by nursing assistant at supper meal.	3	2
Patient who was being weaned from gastrostomy tube feedings continued to receive total care for twice daily tube feedings. Additionally, she ate small amounts of food by mouth with staff supervision.	3	2
Patient received tube feedings via a jejunostomy for all nutritional intake. Feedings were given by a nurse.	4	2

Examples: ADL Self-Performance and Support	Self-Perf.	Support
Toilet Use		
Patient used bathroom independently once up in a wheelchair; used bedpan independently at night after it was set up on bedside table.	0	1
In the toilet room patient is independent. As a safety measure, the nurse assistant stays just outside the door, checking with her periodically.	1	0
Patient uses the toilet independently but occasionally required minor physical assistance for hygiene and straightening clothes afterwards. She received such help twice during the last week.	0	2
When awake, patient was toileted every two hours with minor assistance of one person for all toileting activities (e.g., contact guard for transfers to/from toilet, drying hands, zipping/buttoning pants). She required total care of one person several times each night after incontinence episodes.	3	2
Patient received heavy assistance of two persons to transfer on/off toilet. He was able to bear weight partially, and required only standby assistance with hygiene (e.g., being handed toilet tissue or incontinence pads).	3	3
Obese, severely physically and cognitively impaired patient receives a hoyer lift for all transfers to and from her bed. It is impossible to toilet her and she is incontinent. Complete personal hygiene is provided at least every two hours by two persons.	4	3

24. Toileting Programs (14-day look back)

Intent: To record if the patient is participating in a bladder program.

Definition: **Any Scheduled Toileting Plan** - A plan whereby staff members at scheduled times each day either take the patient to the toilet room, or give the patient a urinal, or remind the patient to go to the toilet. Includes habit training and/or prompted voiding.

Bladder Retraining Program - A retraining program where the patient is taught to consciously delay urinating (voiding) or resist the urgency to void. Patients are encouraged to void on a schedule rather than according to their urge to void. This form of training is used to manage urinary incontinence due to bladder instability.

Process: Check the clinical record. Consult with the nurse assistant and the patient. Be sure to ask about any items that are hidden from view because they are worn under clothing (e.g., pads or briefs).

Coding: Check all that apply.

Clarifications:

- A bladder retraining program is different from a toileting plan and should not be checked in **Item 24a** but should be checked in **Item 24b**.

- There are 3 key ideas captured in **Item 24a**: 1) scheduled, 2) toileting, and 3) program. The word "scheduled" refers to performing the activity according to a specific, routine time that has been clearly communicated to the patient (as appropriate) and caregivers. The concept of "toileting" refers to voiding in a bathroom or commode, or voiding into another appropriate receptacle (i.e., urinal, bedpan). A "program" refers to a specific approach that is organized, planned, documented, monitored and evaluated. A scheduled toileting program could include taking the patient to the toilet, providing a bedpan at scheduled times, or verbally prompting to void. Changing wet garments is not included in this concept.

  If the scheduled plan is recorded in the plan of care and staff are actually toileting the patient according to the multiple specified times, check **Item 24a**. If the patient also experiences breakthrough incontinence, this would be a good time to reevaluate the effectiveness of the current plan by assessing if the patient has a new, reversible condition causing a decline in continence (e.g., UTI, mobility problem, etc.), and treating the underlying cause. Also determine whether or not there is a pattern to the extra times the patient is incontinent and consider adjusting the scheduled toileting plan accordingly.

  For patients on a scheduled toileting plan, the plan of care should at least note that the patient is on a routine toileting schedule. A patient's specific toileting schedule must be in a place where it is clearly communicated and available and easily accessible to all direct care staff. Facility staff may list a patient's toileting schedule by specific hours of the day or by timing of specific routines, as long as those routines occur around the same time each day. If the timing of such routines is not fairly standardized, specific times should then be noted. Documentation in the clinical record should evaluate the patient's response to the toileting program.

25. Diseases (7-day look back)

Intent: To code those diseases or conditions which have a relationship to the patient's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. Nursing monitoring includes

clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluation, medication management, etc.).

- The disease and conditions in this section **require a physician-documented diagnosis in the clinical record**. It is good clinical practice to have the patient's physician provide supporting documentation for any diagnosis.

- **Do not include conditions that have been resolved or no longer affect the patient's functioning or plan of care**. In many facilities, clinical staff and physicians neglect to update the list of patient's "active" diagnoses. There may also be a tendency to continue old diagnoses that are either resolved or no longer relevant to the patient's plan of care.

Definition:

a. Diabetes Mellitus - Includes insulin-dependent diabetes mellitus (IDDM) and diet-controlled diabetes mellitus (NIDDM or AODM).

b. Aphasia - A speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts (i.e., speaking, writing), or understanding spoken or written language. Include aphasia due to CVA.

c. Cerebral Palsy - Paralysis related to developmental brain defects or birth trauma.

d. Hemiplegia/Hemiparesis - Paralysis/partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism, or tumor.

e. Multiple Sclerosis - Chronic disease affecting the central nervous system with remissions and relapses of weakness, incoordination, paresthesis, speech disturbances and visual disturbances.

f. Quadriplegia - Paralysis (temporary or permanent impairment of sensation, function, motion) of all four limbs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury. (Spastic quadriplegia, secondary to cerebral palsy, should not be coded as quadriplegia.) Do not code quadriparesis here.

Process: Consult transfer documentation and the patient's clinical record (including current physician treatment orders and nursing plans of care). If the patient was admitted from an acute care or rehabilitation hospital, the discharge forms often list diagnoses and corresponding ICD-9-CM codes that were current during the hospital stay. If these diagnoses are still active, record them on the SB-MDS assessment. Also, accept statements by the patient that seem to have clinical validity. Consult with the physician for confirmation. A physician diagnosis is required to code the MDS.

Check a disease item only if the disease has a relationship to current ADL status, cognitive status, behavior status, medical treatment, nursing monitoring, or risk of death. For example, it is not necessary to check "diabetes mellitus" if the patient was diagnosed with latent diabetes mellitus during a pregnancy several years ago and is no longer being treated for the illness. However, if the patient later developed overt diabetes mellitus and the diabetes is currently being controlled by medications, diet, exercise, etc., then check the disease.

Physician involvement in this part of the assessment process is crucial. The physician should be asked to review the items in this section at the time of the visit closest to the scheduled SB-MDS assessment. Use this scheduled visit as an opportunity to ensure that active diagnoses are noted and "inactive" diagnoses are designated as resolved. This is also an important opportunity to share the entire SB-MDS assessment with the physician. In many facilities, physicians are not brought into the SB-MDS review and assessment process. It is the responsibility of facility staff to aggressively solicit physician input.

Full physician review of the most recent SB-MDS assessment or ongoing input into the assessment currently being completed can be very useful. For the physician, the SB-MDS assessment completed by facility staff can provide insights that would have otherwise not been possible. For staff, the informed comments of the physician may suggest new avenues of inquiry, or help to confirm existing observations, or suggest the need for additional follow-up.

Coding: Check all that apply. Do not record any conditions that have been resolved and no longer affect the patient's status.

Consult the patient's transfer documentation (in the case of new admissions or re-admissions) and current medical record including current nursing plans of care. There will be times when a particular diagnosis will not be documented in the medical record. If that is the case, as indicated above, accept statements by the patient that seem to have clinical validity, consult with the physician for confirmation, and initiate necessary physician documentation.

Clarification:

- Patients with communication problems as a result of Alzheimer's, Parkinson's or multi-infarct dementia need to be carefully assessed. These diagnoses may result in impairment in the ability to comprehend or express language that may affect some or all channels of communication, including listening, reading, speaking, writing and gesturing.

26. Infections (7-day look back)

Intent: To code those infections which have a relationship to the patient's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. Nursing monitoring includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluation, medication management, etc.).

Definition: **a. Pneumonia -** Inflammation of the lungs; most commonly of bacterial or viral origin.

b. Septicemia - Morbid condition associated with bacterial growth in the blood. Septicemia can be indicated once a blood culture has been ordered and drawn. A physician's working diagnosis of septicemia can be accepted, provided the physician has documented the septicemia diagnosis in the patient's clinical record.

Process: Consult transfer documentation and the patient's clinical record (including current physician treatment orders and nursing plans of care). Accept statements by the patient that seem to have clinical validity. Consult with physician for confirmation. A physician diagnosis is required to code the MDS.

Physician involvement in this part of the assessment process is crucial.

Coding: Check all that apply.

Check an infection item only if the infection has a relationship to current ADL status, cognitive status, mood and behavior status, medical treatment, nursing monitoring, or risk of death. Do not record any conditions that have been resolved and no longer affect the patient's functional status or plan of care.

27. Problem Conditions (7-day look back)

Intent: To record specific problems or symptoms which affect or could affect the patient's health or functional status and to identify risk factors for illness, accident, and functional decline.

Definition: **a. Dehydrated, Output Exceeds Intake** – Check this item if the patient has 2 or more of the following indicators.

1. Patient usually takes in less than the recommended 1500 ml of fluids daily (water or liquids in beverages, and water in high fluid content foods such as gelatin and soups). *NOTE:* The recommended intake level has been changed from 2500 ml to 1500 ml to reflect current practice standards.

2. Patient has one or more clinical signs of dehydration, including but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium albumin, blood urea nitrogen, or urine specific gravity).

3. Patient's fluid loss exceeds the amount of fluids he or she takes in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement).

b. Delusions - Fixed, false beliefs not shared by others that the patient holds even when there is obvious proof or evidence to the contrary (e.g., belief he or she is terminally ill; belief that spouse is having an affair; belief that food served by the facility is poisoned).

c. Fever - A fever is present when the patient's temperature (°F) is 2.4 degrees greater than the baseline temperature. The baseline temperature may have been established prior to the Assessment Reference Date.

d. Hallucinations - False sensory perceptions that occur in the absence of any real stimuli. A hallucination may be auditory (e.g., hearing voices), visual (e.g., seeing people, animals), tactile (e.g., feeling bugs crawling over skin), olfactory (e.g., smelling poisonous fumes), or gustatory (e.g., having strange tastes).

e. Internal Bleeding - Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools). Clinical indicators include black, tarry stools, vomiting "coffee grounds", hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed) that requires packing. However, nose bleeds that are easily controlled should not be coded as internal bleeding.

f. Vomiting - Regurgitation of stomach contents; may be caused by any etiology (e.g., drug toxicity; influenza; psychogenic).

Process: It is often difficult to recognize when a frail, chronically ill elder is experiencing dehydration or alternatively fluid overload that could precipitate congestive heart failure. Ways to monitor the problem, particularly in patients who are unable to recognize or report the common symptoms of fluid variation, are as follows: Ask the patient if he or she has experienced any of the listed symptoms in the last seven days. Review the clinical records (including current nursing care plan) and consult with facility staff members and the patient's family if the patient is unable to respond. A patient may not complain to staff members or others, attributing such symptoms to "old age." Therefore, it is important to ask and observe the patient directly, if possible, since the health problems being experienced by the patient can often be remedied.

Coding: Check all conditions that occurred within the past seven days.

28. Weight Loss (30-day and 180-day look back)

Intent: To record variations in the patient's weight over time.

Definition: **Weight Loss in Percentages** – Decline in weight of 5% or more in last 30 days, or 10% or more in last 180 days.

Process: **New Admission** - Ask the patient or family about weight changes over the last 30 and 180 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight loss in percentages during the specified time periods.

Current Patient - Review the clinical records and compare current weight with weights of 30 and 180 days ago. Calculate weight loss in percentages during the specified time periods.

Coding: Code "0" for No or "1" for Yes. **If there is no weight to compare to, enter the unknown code (-).**

Clarifications:

- The first step in calculating percent weight loss is to obtain the actual weights for the 30-day and 180-day time periods from the patient's clinical record. Calculate percentage for weight loss based on the patient's actual weights. Do not round the weights. The calculation is as follows:

  1. Start with the patient's weight from 30 days ago and multiply it by the proportion (0.05). If the patient has lost this amount or more, then code a "1" for Yes.

  2. Start with the patient's weight from 180 days ago and multiply it by the proportion (0.10). If the patient has lost this amount or more, then code a "1" for Yes.

- Patients experiencing a 7½ percent weight change 90 days ago must be evaluated to determine how much of the 7½ percent weight change occurred over the last 30 days.

29. Nutritional Approaches (7-day look back)

Intent: To record when the patient receives nutrition through alternative means.

Definition: **a. Parenteral/IV** - Include only fluids administered for **nutrition or hydration**, such as:

- IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently
- IV fluids running at KVO (Keep Vein Open)
- IV fluids administered via heparin lock
- IV fluids contained in IV piggybacks
- IV fluids used to reconstitute medications for IV administration

Do NOT include:

- IV medications (code in **38A**)
- IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay
- IV fluids administered solely as flushes
- Parenteral/IV fluids administered during chemotherapy or dialysis

b. Feeding Tube - Presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, and percutaneous endoscopic gastrostomy (PEG) tubes.

Coding: Check all that apply.

Clarification: ◆ If the patient receives fluids by hypodermoclysis and subcutaneous ports in hydration therapy, code these nutritional approaches as Parenteral/IV. The term parenteral therapy means "introduction of a substance (especially nutritive material) into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous)." If the patient receives fluids via these modalities also code **Items 30a and 30b**, which refer to the caloric and fluid intake the patient received in the last 7 days. Additives such as electrolytes and insulin, which are added to the patient's TPN or IV fluids, should be documented in **Item 38ac** (IV medications).

Skip to Item 31 if neither 29a nor 29b is coded.

30. Parenteral or Enteral Intake (7-day look back)

Intent: To record the proportion of calories received and the average fluid intake through parenteral or tube feeding in the last seven days.

a. PROPORTION OF TOTAL CALORIES

Definition: **Proportion of Total Calories Received -** The proportion of all calories ingested during the last seven days that the patient actually received (not ordered) by parenteral or tube feedings. Determined by calorie count.

Process: Review Intake record. If the patient took no food or fluids by mouth, or took just sips of fluid, stop here and code "4" (76%-100%). If the patient had more substantial oral intake than this, consult with the dietitian who can derive a calorie count received from parenteral or tube feedings.

Coding: Code for the correct response:

0. None
1. 1% to 25%
2. 26% to 50%
3. 51% to 75%
4. 76% to 100%

Example of Calculation for Proportion of Total Calories from IV or Tube Feeding

Mr. H has had a feeding tube since his surgery. He is currently more alert and feeling much better. He is very motivated to have the tube removed. He has been taking soft solids by mouth, but only in small to medium amounts. For the past week he has been receiving tube feedings for nutritional supplementation. As his oral intake improves, the amount received by tube will decrease. The dietitian has totaled his calories per day as follows:

Step #1:

	Oral		**Tube**
Sun.	500	+	2000
Mon.	250	+	2250
Tues.	250	+	2250
Wed.	350	+	2250
Thurs.	500	+	2000
Fri.	800	+	800
Sat.	800	+	1800
TOTAL	**3450**	**+**	**14350**

Step #2: Total calories = 3450 + 14350 = 17800

Step #3: Calculate percentage of total calories by tube feeding.

14350/17800 = .806 X 100 = 80.6%

Step #4: Code "4" for 76% to 100%

b. AVERAGE FLUID INTAKE

Definition: **Average fluid intake** per day by IV or tube feeding in last seven days refers to the actual amount of fluid the patient received by these modes (not the amount ordered).

Process: Review the Intake and Output record from the last seven days. Add up the total amount of fluid received each day by IV and/or tube feedings only. Also include the water used to flush, as well as the "free water" in the tube feeding (based

upon the percent of water in the specific enteral formula). The amount of heparinized saline solution used to flush a heparin lock **is not** included in the average fluid intake calculation, while the amount of fluid in an IV piggyback solution **is** included in the calculation. Divide the week's total fluid intake by 7. This will give you the average of fluid intake per day.

Coding: Code for the average number of cc's of fluid the patient received per day by IV or tube feeding. Record what was actually received by the patient, not what was ordered.

Codes: Code the correct response.

0. None
1. 1 to 500 cc/day
2. 501 to 1000 cc/day
3. 1001 to 1500 cc/day
4. 1501 to 2000 cc/day
5. 2001 to or more cc/day

Example of Calculation for Average Daily Fluid Intake

Ms. A has swallowing difficulties secondary to Huntington's disease. She is able to take oral fluids by mouth with supervision, but not enough to maintain hydration. She received the following daily fluid totals by supplemental tube feedings (including water, prepared nutritional supplements, juices) during the last 7 days.

Step #1:

Sun.	1250 cc
Mon.	775 cc
Tues.	925 cc
Wed.	1200 cc
Thurs.	1200 cc
Fri.	1200 cc
Sat.	1000 cc
TOTAL	**7550 cc**

Step #2: 7550 divided by 7 = 1078.6 cc

Step #3: Code "3" for 1001 to 1500 cc/day

Clarifications:

- The basic TPN solution itself (that is, the protein/carbohydrate mixture or a fat emulsion) is not counted as a medication. The use of TPN is coded here. When medications such as electrolytes, vitamins, or insulin have been added to the TPN solution, they are considered medications.

- The amount of heparinized saline solution used to flush a heparin lock is not included in the average fluid intake calculation.

31. Ulcers (7-day look back)

Intent: To record the number of skin ulcers at each ulcer stage, on any part of the body.

Definition: **Skin ulcer** - A local loss of epidermis and variable levels of dermis and subcutaneous tissue, or in the case of Stage 1 pressure ulcers, persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. Skin ulcers that develop because of circulatory problems or pressure are coded here. Rashes without open areas, burns, desensitized skin ulcers related to diseases, such as syphilis and cancer, and surgical wounds are **NOT** coded here. Surgical wounds are coded in **Item 34f**. Skin tears/shears **NOT** caused by pressure are **NOT** coded here.

a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.

b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, scab, or shallow crater.

c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

Process: Review the patient's record and consult with the nurse assistant about the presence of any skin ulcers. Examine the patient and determine the stage and number of any ulcers present. Without a full body check, a skin ulcer can be missed.

Assessing a Stage 1 skin ulcer requires a specially focused assessment for patients with darker skin tones to take into account variations in ebony-colored skin. To recognize Stage 1 ulcers in ebony complexions, look for: (1) any change in the feel of the tissue in a high-risk area; (2) any change in the appearance of the skin in high-risk areas, such as the "orange-peel" look; (3) a subtle purplish hue; and (4) extremely dry, crust-like areas that, upon closer examination, are found to cover a tissue break.

Coding: Record the number of skin ulcers at each stage on the patient's body in the last 7 days. If necrotic eschar is present, prohibiting accurate staging, code the skin

ulcer as Stage "4". If there are no skin ulcers at a particular stage, record "0" (zero) in the box provided. If there are more than 9 skin ulcers at any one stage, enter "9" in the appropriate box.

Clarifications:

- All skin ulcers present during the current observation period should be documented on the SB-MDS assessment. These items refer to the objective presence of skin ulcers as observed during the assessment period.

- For the SB-MDS assessment, pressure ulcers should be coded in terms of what is seen (i.e., visible tissue) during the look-back period. For example, a healing Stage 3 pressure ulcer that has the appearance (i.e., presence of granulation tissue, size, depth, and color) of a Stage 2 pressure ulcer must be coded as a "2" for purposes of the SB-MDS assessment. Facilities certainly may adopt the National Pressure Ulcer Advisory Panel (NPUAP) standards in their clinical practice. However, the NPUAP standards cannot be used for coding on the SB-MDS.

- Debridement of an ulcer merely removes necrotic and decayed tissue to promote healing. The skin ulcer still exists and may or may not be at the same stage as it was prior to debridement. Good clinical practice dictates that the ulcer be re-examined and re-staged after debridement. Also code treatments as appropriate in **Item 34** (Skin Treatments). Do not code the debrided skin ulcer as a surgical wound.

- If a skin ulcer is repaired with a flap graft, it should be coded as a surgical wound and not as a skin ulcer. If the graft fails, continue to code it as a surgical wound until healed.

Example

Mrs. L has end-stage metastatic cancer and weighs 75 pounds. She has a Stage 3 ulcer over her sacrum and two Stage 1 pressure ulcers over her heels.

Item 31, Ulcers	**Stage**	**Code**
	a. 1	2
	b. 2	0
	c. 3	1
	d. 4	0

Mr. A has five open wounds as a result of frostbite that are not pressure or venous stasis ulcers. Upon examination, these wounds do not meet the criteria provided in **Item 31** (Ulcers) coding definitions. Code the patient's condition as follows:

Item 31, Ulcers	**Stage**	**Code**
	a. 1	0
	b. 2	0
	c. 3	0
	d. 4	0

Item 32, Type of Ulcer:

Code "0" (highest stage ulcer is not a pressure ulcer).

Include coding for treatments provided in **Items 34** and **35**, (Foot Problems and Care) as appropriate.

32. Pressure Ulcers (7-day look back)

Intent: To record the highest stage for pressure ulcers that were present in the last 7 days.

Definition: **Pressure Ulcer** - Any skin ulcer caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include bedsores and decubitus ulcers.

Process: Review the patient's record. Examine the patient. Consult with the physician regarding the cause of the ulcer(s).

Coding: Using the ulcer staging scale in **Item 31**, record the highest ulcer stage for pressure ulcers present in the last 7 days.

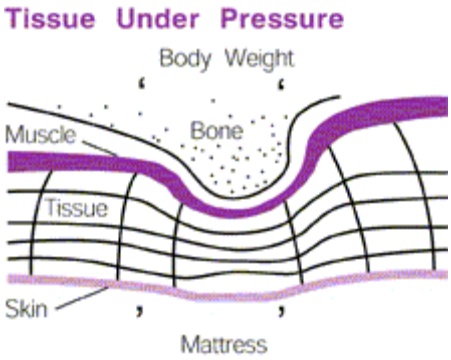
More definitive information concerning pressure ulcers is provided in the AHRQ Guidelines for pressure ulcers in adults at: **http://www.ahrq.gov/consumer/bodysys/edbody6.htm**.

What are Pressure Ulcers?

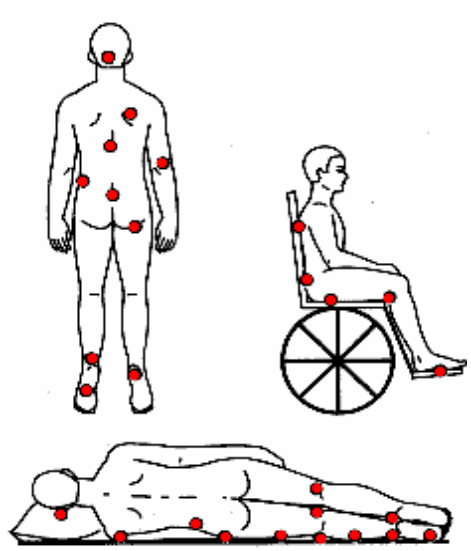
A pressure ulcer is an injury usually caused by unrelieved pressure that damages the skin and underlying tissue. Pressure ulcers are also called decubitus ulcers or bedsores and range in severity from mild (minor skin reddening) to severe (deep craters down to muscle and bone).

Unrelieved pressure on the skin squeezes tiny blood vessels, which supply the skin with nutrients and oxygen. When skin is starved of nutrients and oxygen for too long, the tissue dies and a pressure ulcer forms. The affected area may feel warmer than surrounding tissue. Skin reddening that disappears after pressure is removed is normal and not a pressure ulcer.

Other factors cause pressure ulcers, too. If a person slides down in the bed or chair, blood vessels can stretch or bend and cause pressure ulcers. Even slight rubbing or friction on the skin may cause minor pressure ulcers.



Where Pressure Ulcers Form



Pressure ulcers form where bone causes the greatest force on the skin and tissue, and squeezes them against an outside surface. This may be where bony parts of the body press against other body parts, a mattress, or a chair. In persons who must stay in bed, most pressure ulcers form on the lower back below the waist (sacrum), the hip bone (trochanter), and on the heels. In people in chairs or wheelchairs, the exact spot where pressure ulcers form depends on the sitting position. Pressure ulcers can also form on the knees, ankles, shoulder blades, back of the head, and spine.

Nerves normally tell the body when to move to relieve pressure on the skin. Persons in bed who are unable to move may get pressure ulcers after as little as 1-2 hours. Persons who sit in chairs and who cannot move can get pressure ulcers in even less time because the force on the skin is greater.

NOTE: It is also common for pressure ulcers to form on the ears and scrotum.

The full AHCRP guideline for clinicians can be found at:

http://www.ahcpr.gov/clinic/cpgonline.htm.

Clarification:

- In order to code Pressure Ulcers in the case of a blister, the key is to determine if there was a source of pressure that caused the blister. In the presence of moisture, less pressure may be required to develop a pressure ulcer. If, for example, a blister was found in the area of the incontinence brief waist or leg band, pressure from the band may be a likely cause of the blister and the assessor would record the blister as a pressure ulcer. If no source of pressure could be identified, the blister may be evidence of perineal dermatitis caused by excessive urine or stool eroding the epidermis. No pressure is required for perineal dermatitis to occur. If this is the case, the blister would not be recorded as a pressure ulcer, but would be considered a rash. For additional information, refer to: Lyder, C. (1997). Perineal dermatitis in the elderly: A critical review of the literature. Journal of Gerontological Nursing 23(12), 5-10.

Example

Mr. C has diabetes and poor circulation to his lower extremities. Last month Mr. C spent 2 weeks in the hospital where he had a left below the knee amputation (BKA) for treatment of a gangrenous foot. He was readmitted to the swing bed 3 days ago with a Stage II pressure ulcer over his sacrum and a Stage I pressure ulcer over his right heel and both elbows. No other ulcers were present.

Item 31, Ulcers	**Code (# at stage)**
a. Stage 1	3
b. Stage 2	1
c. Stage 3	0
d. Stage 4	0

Item 32, Type of Ulcer	**Code (highest stage)**
a. Pressure Ulcer	2

***Rationale for coding*:** Mr. C has 4 pressure ulcers, the highest stage of which is Stage 2.

Mrs. B has a blockage in the arteries of her right leg causing impaired arterial circulation to her right foot (ischemia). She has 1 ulcer, a Stage 3 ulcer on the dorsal surface (top) of her right foot.

Item 31, Ulcer	**Code (# at Stage)**
a. Stage 1	0
b. Stage 2	0
c. Stage 3	1
d. Stage 4	0

Items 32, Type of Ulcer	**Code (highest stage)**
a. Pressure ulcer	0

***Rationale for coding*:** Mrs. B's ulcer is an ischemic ulcer rather than caused by pressure.

33. Other Skin Problems or Lesions (7-day look back)

Intent: To document the presence of skin problems other than pressure or circulatory ulcers, and conditions that are risk factors for more serious problems.

Definition:

a. **Burns (second or third degree)** - Includes burns from any cause (e.g., heat, chemicals) in any stage of healing. This category does not include first degree burns (changes in skin color only).

b. **Open Lesions/Sores (e.g., cancer lesions)** – Include skin ulcers that developed as a result of diseases and conditions such as syphilis and cancer. Do NOT code skin tears or cuts, abrasions or bruises, burns (from any cause), and rashes here.

c. **Surgical Wounds** - Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. This category does not include healed surgical sites or stomas, or lacerations that require suturing or butterfly closures.

Process: Ask the patient if he or she has any problem areas. Examine the patient. Ask the nurse assistant. Review the patient's record.

Coding: Check all that apply.

Clarification:

- PICC sites, central line sites, and peripheral sites are not coded as surgical wounds.

34. Skin Treatments (7-day look back)

Intent: To document any specific or generic skin treatments the patient has received in the past seven days.

Definition:

a. **Pressure Relieving Device(s) for Chair** - Includes gel, air (e.g., Roho), or other cushioning placed on a chair or wheelchair. Include pressure relieving, pressure reducing, and pressure redistributing devices. Do not include egg crate cushions in this category.

b. **Pressure Relieving Device(s) for Bed** - Includes air fluidized, low air loss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Include pressure relieving, pressure reducing, and pressure redistributing devices. Do not include egg crate mattresses in this category.

c. **Turning/Repositioning Program** - Includes a continuous, consistent program for changing the patient's position and realigning the body. "Program" is defined as "a specific approach that is organized, planned, documented, monitored and evaluated."

d. **Nutrition or Hydration Intervention to Manage Skin Problems** - Dietary measures received by the patient for the purpose of preventing or treating specific skin conditions - e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplements to prevent skin breakdown, high

protein supplements for wound healing. Vitamins and minerals, such as Vitamin C and Zinc, which are used to manage a potential or active skin problem, should be coded here.

e. **Ulcer Care** - Includes any intervention for treating skin problems coded in **Items 31**, **32**, and **33b**. Examples include: use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.

f. **Surgical Wound Care** - Includes any intervention for treating or protecting any type of surgical wound. Examples of care include: topical cleansing, wound irrigation, application of antimicrobial ointments, dressings of any type, suture removal, and warm soaks or heat application.

g. **Application of Dressings (with or without topical medications) Other Than to Feet** - Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

h. **Application of Ointments/Medications (other than to feet)** - Includes ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents, etc.). This definition does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain).

Process: Review the patient's records. Ask the patient and the nurse assistant. Examine the patient.

Coding: Check all that apply.

Clarifications:

- Good clinical practice dictates that staff should document treatments provided. Flow sheets could be useful for this purpose, but the form and format of such documentation is determined by the facility.
- Do not code an egg crate cushion or mattress as pressure relieving devices. These are specifically excluded from coding.
- Dressings do not have to be applied daily in order to be coded. If any dressing was applied even once during the 7-day period, the assessor would check the appropriate item.

35. Foot Care Problems (7-day look back)

Intent: To document the presence of foot problems and care to the feet during the last seven days.

Definition:

a. Infection of the foot - e.g., cellulitis, purulent drainage

b. Open lesions on the foot - Includes cuts, ulcers, and fissures.

c. Application of dressings (with or without topical medications) - Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

Process: Ask the patient and the nurse assistant. Inspect the patient's feet. Review the patient's clinical records.

Coding: Check all that apply.

Clarifications:

- For SB-MDS coding, ankle problems are not considered foot problems and should be coded in **Item 34**.
- Good clinical practice dictates that staff should document treatments provided. Flow sheets could be useful for this purpose, but the form and format of such documentation is determined by the facility.

36. Time Awake (7-day look back)

Intent: To identify those periods of a typical day (over the last seven days) when the patient was awake all or most of the time (i.e., no more than one hour nap during any such period).

Definition:

a. Morning – From 7 a.m. (or when the patient wakes up) until noon.

b. Afternoon – From noon until 5 p.m.

c. Evening – From 5 p.m. until 10 p.m. (or bedtime, if earlier).

Process: Consult with direct care staff, the patient, and the patient's family. Review the chart. Observe patient.

Coding: Check all periods when patient was awake all or most of the time.

Clarifications:

- When coding this item, check each time period, as defined for that patient, during which he or she did not nap for more than one hour. Some examples of coding are as follows:
  - A patient wakes up every morning at 7 a.m. He typically eats breakfast, has a shower, gets dressed and goes back to bed for a late morning nap from 10 a.m. until 11:30 a.m. Morning should NOT be checked, since this patient typically naps for more than 1 hour during the morning.

- A patient typically wakes up at 6 a.m. She is busy with therapy and activities most of the day, and does not take naps. She goes to bed by 7 p.m. every evening. Morning, Afternoon and Evening should all be checked, since this patient does not take naps.

- A patient who is bedfast and has end-stage Alzheimer's disease wakes up at 6 a.m. daily. She typically dozes off throughout day, napping for more than 1 hour before noon, and again from 3:30 pm to 5:30 pm every afternoon. She is typically awake from 5:30 until 9 p.m. After that, she's asleep for the night. Morning and Afternoon should NOT be checked, since this patient naps for more than one hour during each of these periods. Evening should be checked as time awake. Although this patient sleeps until 5:30 pm, that is only a 30-minute naptime in the evening period (5 p.m. until 5:30 p.m.).

◆ Accurate coding relies on the use of appropriate information-gathering techniques. Coding based on only the assessor's personal knowledge of a patient's typical day may result in an inaccurate response to this item. Documentation review is important. However, we would generally not expect facility staff to maintain flowcharts for information such as sleep and awake times.

◆ It is important to observe the patient across all shifts. In addition, the same individual staff member is generally not on duty and available to observe a patient across a 24-hour period. It's important to supplement observation with interviews of the patient, his/her family members, other staff across shifts, and in particular, the nursing assistants caring for the patient.

37. Injections (7-day look back)

Intent: To determine the number of days during the past seven days that the patient received any type of medication, antigen, vaccine, by subcutaneous, intramuscular or intradermal injection. Although antigens and vaccines are considered "biologicals" and not medication per se, it is important to track when they are given to monitor for localized or systemic reactions.

Coding: Record the number of DAYS in the answer box.

Clarifications:

◆ Subcutaneous pumps would be coded for **only** the number of days that the patient actually required a subcutaneous injection to restart the pump.

◆ This category does not include intravenous (IV) fluids or medications. If the patient received IV fluids, record in **Item 29a** (Parenteral/IV). If IV medications were given, record in **Item 38ac** (IV Medication).

- If a test or vaccination is provided on one day and another vaccine provided on the next day, code "2" for the number of days where the patient received injections. If both injections were administered on the same day, code "1".

Example

During the last seven days, Mr. T received a flu shot on Monday, a PPD test (for tuberculosis) on Tuesday, and a Vitamin B_{12} injection on Wednesday. **Code "3" as the patient received injections on three days during the last seven days**.

During the last 7 days, Miss C received a flu shot and her Vitamin B_{12} injection on Thursday. **Code "1" for patient received 2 injections on the same day in the last 7 days**.

38. Special Treatments and Procedures

Intent: To identify any special treatments, therapies, or programs that the patient received in the specified time period. **Do not code services that were provided solely in conjunction with a surgical or diagnostic procedure and the immediate post-operative or post-procedure recovery period.**

a. SPECIAL CARE (14-day look back)

TREATMENTS - The following treatments may be received by a swing bed patient either at the facility, as a hospital outpatient, or as an inpatient, etc.

Definition:

a. Chemotherapy - Includes any type of chemotherapy (anticancer drug) given by any route. The drugs coded here are those actually used for cancer treatment. For example, Megace (megestrol ascetate) is classified in the Physician's Desk Reference (PDR) as an anti-neoplastic drug. One of its side effects is appetite stimulation and weight gain. If Megace is being given only for appetite stimulation, do not code it as chemotherapy in this item. The patient is not receiving chemotherapy in these situations. Each drug should be evaluated to determine its reason for use before coding it here. IVs, IV medications and blood transfusions provided only during chemotherapy are not coded under the respective **Items 29a** (Parentral/IV), **38c** (IV Medications), and **38h** (Transfusions).

b. Dialysis - Includes peritoneal or renal dialysis that occurs at the swing bed facility or at another facility. Record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH) and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medications, and blood transfusions administered only during dialysis are not coded under the respective **Items 29a** (Parenteral/IV), **38c** (IV Medications) and **38h** (Transfusions).

c. **IV Medication** - Includes any drug or biological (e.g., contrast material) given by intravenous push or drip through a central or peripheral port. Does not include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medication. Record the use of an epidural pump in this item. Epidurals, intrathecal, and baclofen pumps may be coded, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Do **not** include IV medications that were administered only during dialysis or chemotherapy when treatment was rendered only off-site.

d. **Oxygen Therapy** - Includes continuous or intermittent oxygen via mask, cannula, etc. (does not include hyperbaric oxygen for wound therapy).

e. **Radiation** - Includes radiation therapy or having a radiation implant.

f. **Suctioning** - Includes nasopharyngeal or tracheal aspiration **only**. Oral suctioning should **not** be coded here.

g. **Tracheostomy Care** - Includes cleansing of tracheostomy and cannula.

h. **Transfusions** - Includes transfusions of blood or any blood products (e.g., platelets), which are administered directly into the bloodstream. Do not include transfusions that were administered only during dialysis or chemotherapy when treatment was rendered only off-site.

i. **Ventilator or Respirator** - Assures adequate ventilation in patients who are, or who may become, unable to support their own respiration. Includes any type of electrically or pneumatically powered closed system mechanical ventilatory support devices. Any patient who was in the process of being weaned off of the ventilator or respirator in the last 14 days should be coded under this definition. Does not include Continuous Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BIPAP) devices.

Coding: Check all treatments received during the last 14 days.

Clarifications:

- Patients with sleep apnea may undergo treatments with a mask-like device that is used to keep the airway open during sleep. This service cannot be coded as a ventilator or a respirator. According to the American Academy of Otolaryngology-Head and Neck Surgery, Inc., a CPAP (Continuous Positive Airway Pressure) device delivers air into your airway through a specially designed mask or pillows. The mask does not breathe for you; the flow of air creates enough pressure when you inhale to keep your airway open. Ventilators are sometimes used to deliver this type of non-invasive ventilation when CPAP or BIPAP machines are not available. In these cases, the ventilator is merely providing air, not traditional life support via invasive measures and does not require the same level of intensity of care that life support ventilation demands.

- Do not code services that were provided solely in conjunction with a surgical procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.

b. THERAPIES (7-day look back)

Therapies that occurred after admission/readmission to the swing bed, were ordered by a physician, and were performed by a qualified therapist (i.e., one who meets State credentialing requirements or in some instances, under such a person's direct supervision).

The licensed 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 patients. Includes **only** medically necessary therapies furnished **after** admission to the swing bed. Also includes **only** therapies ordered by a physician, based on a therapist's assessment and treatment plan that is documented in the patient's clinical record. The therapy treatment may occur either inside or outside the facility. Therapies received in the acute care setting are not included.

Intent: To record the **(A) number of days**, and **(B) total number of minutes** each of the following therapies was administered to the patient in the last 7 days.

Definition:

a. **Speech-Language Pathology and Audiology** - Services that are provided by a licensed speech-language pathologist.

b. **Occupational Therapy** - Therapy services that are provided or directly supervised by a licensed occupational therapist. A qualified occupational therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include services provided by a qualified occupational therapy assistant who is employed by (or under contract to) the swing bed only if he or she is under the direction of a licensed occupational therapist.

c. **Physical Therapy** - Therapy services that are provided or directly supervised by a licensed physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include services provided by a qualified physical therapy assistant who is employed by (or under contract to) the swing bed only if he or she is under the direction of a licensed physical therapist.

d. **Respiratory Therapy** – Therapy services that are provided by a qualified professional (respiratory therapists, trained nurse). Included treatments are coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds, and mechanical ventilation, etc., which must be provided by a qualified professional (i.e., trained nurse, respiratory therapist). Does not include hand held medication dispensers. Count only the time that the

qualified professional spends with the patient. (See clarification below defining "trained nurse.") A trained nurse may perform the assessment and the treatments when permitted by the state nurse practice act.

Process: Review the patient's clinical record and consult with each of the licensed therapists.

Coding: **Box A:** In the first column, enter the number (#) of days therapy was administered for 15 minutes or more in the last seven calendar days. Enter "0" if none.

Box B: In the second column, enter the total number (#) of minutes the particular therapy was provided in the last seven days, even if you entered "0" in Box A. The time should include only the actual treatment time (not time waiting or writing reports or performing initial evaluation). Enter "0" if none.

Clarifications: **Coding Minutes of Therapy:**

- Includes only therapies that were provided once the individual is actually living/being cared for at the swing bed. Do **NOT** include therapies that occurred while the person was an inpatient at a hospital or recuperative/rehabilitation center or other nursing facility, or a recipient of home care or community-based services. If a patient returns from a hospital stay and a readmission assessment is done, count only those therapies that occurred since readmission to the swing bed.

- If a whirlpool treatment is specifically ordered by a physician to be performed by or under the supervision of a physical therapist, it may be coded as therapy.

- Transdermal Wound Stimulation (TEWS) treatment for wounds can be coded when complex wound care procedures, requiring the specialized skills of a licensed therapist, are ordered by a physician. However, routine wound care, such as applying/changing dressings, should not be coded as therapy, even when performed by therapists.

- Qualified professionals for the delivery of respiratory services include "**trained nurses**." A trained nurse refers to a nurse who received specific training on the administration of respiratory treatments and procedures. This training may have been provided at the swing bed, during a previous work experience or as part of an academic program. Nurses do not necessarily learn these procedures as part of their formal nurse training programs.

- The SB-MDS instructions require reporting the actual minutes of therapy received by the patient.

  - The patient's treatment time starts when he/she begins the first treatment activity or task and ends when he/she finishes with the last apparatus and the treatment is ended.

  - The time required to adjust equipment or otherwise prepare for the individualized therapy of a particular patient, is the set-up time and may be included in the count of minutes of therapy delivered to the patient.

  - The therapist's time spent on documentation or on initial evaluation may not be included.

  - Time spent on periodic reevaluations conducted during the course of a therapy treatment may be included.

  - Services provided at the request of the patient or family that are not medically necessary (sometimes referred to as a family-funded services) may not be counted, even when performed by a licensed therapist.

- Historically, units of therapy time have been used for billing and have been derived from the actual therapy minutes. Conversion from units to minutes is not appropriate and the actual minutes are the only appropriate measures that can be counted for completion. Please note that therapy logs are not a 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 SB-MDS assessment.

- Swing beds may elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In these situations, the services may not be coded as therapy since the specific interventions would be considered restorative nursing services when performed by nurses or aides.

- A licensed therapist starts work directly with one patient beginning a specific task. Once the patient can proceed with supervision, the licensed therapist works directly with a second patient to get him/her started on a different task, while continuing to supervise the first patient. The treatment ends for each patient 30 minutes after it begins. For each patient, record 30 minutes therapy time for each patient. This delivery of therapy is often referred to as supervisory treatment, dovetailing, or concurrent therapy.

- In some cases, the patient will be able to perform part of the treatment tasks with supervision, once set up appropriately. Time supervising the patient is a part of total treatment time. For example, as the last treatment task of the day, a patient uses an exercise bicycle for 10 minutes. It may take the therapist 2 minutes to set the patient up on the apparatus. The therapist, or assistant under the supervision of a PT, may then leave the patient to help another patient in the same exercise room. However, the therapist still has eye contact with the patient and is providing supervision, verbal encouragement and direction to the patient on the bicycle. Therefore, if it took 2 minutes to set the patient up with the cycling apparatus, the patient was supervised during two 5-minute cycling periods; one 2-minute rest between the exercise periods; and took 1 minute to get out of the apparatus, the total cycling activity is 15 minutes. Include in this example that the patient did three additional treatment activities totaling 45 minutes before beginning to cycle. The total time reported on the assessment is 60 minutes. The key is that the patient was receiving treatment the entire time and had the physical presence of a therapist in the room, supervising the entire treatment process.

- Two licensed therapists, each from a different discipline, begin treating one patient at the same time. The treatment ends 30 minutes after it starts. Split the time between the two disciplines as appropriate. For example, PT = 20 minutes, OT = 10 minutes; or PT = 15 minutes, OT = 15 minutes, etc. In the first example, where the beneficiary received 20 minutes of PT and only 10 minutes of OT, for each session code 1 day of PT and 20 minutes of PT. Also code the 10 minutes of OT. In this example, no days may be coded for OT because the session only lasted 10 minutes.

Group Therapy (for Speech-Language Pathology and Occupational and Physical Therapies):

- For groups of four or fewer patients per supervising therapist (or assistant), each patient is coded as having received the full time in the therapy session. For example, if a therapist worked with three patients for 45 minutes on training to return to the community, each patient received 45 minutes of therapy so long as that does not exceed 25% of his/her therapy time per therapy discipline, during the 7-day observation period. Remember, code for the patient's time, not for the therapist's time.

Supervision:

- Aides cannot independently provide a skilled service. The services of aides performing therapy treatments may only be coded when the services are performed under line of sight supervision by a licensed therapist. This type of coordination between the licensed therapist and therapy aide under the direct, personal (e.g., line of sight) supervision of the therapist is considered individual therapy for counting minutes. When the therapist starts the session and delegates the performance of the therapy treatment to a therapy aide, while maintaining direct line of sight supervision, the total number of minutes of the therapy session may be coded as therapy minutes.

- Therapy students are recognized as skilled providers under Medicare A only. They must be "in line of sight" supervision (**Federal Register** November 4, 1999).

Maintenance Therapy/Nursing Rehabilitation:

- Once the licensed therapist has designed a maintenance program and discharged the patient from the rehabilitation (i.e., skilled) therapy program, the services performed by the therapist and the aide should no longer be reported as skilled therapy. The services of the aide may be reported on the SB-MDS assessment as restorative nursing at **Item 39**, provided they meet the requirements for restorative therapy.

Example

Following a stroke Mrs. F was admitted to the swing bed in stable condition for rehabilitation therapies. Since admission she has been receiving speech therapy twice weekly for 30-minute sessions, occupational therapy twice weekly for 30-minute sessions, and physical therapy twice a day (30 minute sessions) for 5 days and respiratory therapy for 10 minutes per day on each of the last 7 days. During the last seven days Mrs. F has participated in all of her scheduled sessions.

Coding	A	B
a. Speech-language pathology, audiology services	2	60
b. Occupational therapy	2	60
c. Physical therapy	5	300
d. Respiratory therapy	0	70
e. Psychological therapy	0	0

39. Nursing Rehabilitation/Restorative Care (7-day look back)

Intent: To determine the extent to which the patient receives nursing rehabilitation or restorative services from other than specialized therapy staff (e.g., occupational therapist, physical therapist, etc.). Rehabilitative or restorative care refers to nursing interventions that promote the patient's ability to adapt and adjust to living as independently and safely as is possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. Generally, restorative nursing programs are initiated when a patient is discharged from formalized physical, occupational, or speech rehabilitation therapy. A patient may also be started on a restorative program when he/she is admitted to the swing bed with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when a restorative need arises during the course of a custodial stay. Restorative nursing does not require a physician's order.

Skill practice in such activities as walking and mobility, dressing and grooming, eating and swallowing, transferring, amputation care, and communication can improve or maintain function in physical abilities and ADLs and prevent further impairment.

Definition: **Rehabilitation/Restorative Care -** Included are nursing interventions that assist or promote the patient's ability to attain his or her maximum functional potential. This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in **Item 38b**. In addition, **to be included in this section, rehabilitation or restorative care must meet all of the following additional criteria:**

- Measurable objectives and interventions must be documented in the plan of care and in the clinical record.
- Evidence of periodic evaluation by a licensed nurse must be present in the clinical record.
- Nurse assistants/aides must be trained in the techniques that promote patient involvement in the activity.
- These activities are carried out or supervised by members of the nursing staff. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific patients.
- This category does not include groups with more than four patients per supervising helper or caregiver.

a. Range of Motion (Passive) - The extent to which, or the limits between which, a part of the body can be moved around a fixed point or joint. A

program of passive movements to maintain flexibility and useful motion in the joints of the body. The caregiver moves the body part around a fixed point or joint through the patient's available range of motion. The patient provides no assistance. These exercises must be planned, scheduled and documented in the clinical record. Helping a patient get dressed does not, in and of itself, constitute a range of motion exercise session.

b. Range of Motion (Active) - Exercises performed by a patient, with cueing, supervision, or physical assist by staff, that are planned, scheduled, and documented in the clinical record. Include active ROM and active assisted ROM. Any participation by the resident in the ROM activity should be coded here.

c. Splint or Brace Assistance - Assistance can be of 2 types: 1) where staff provide verbal and physical guidance and direction that teaches the patient how to apply, manipulate, and care for a brace or splint, or 2) where staff have a scheduled program of applying and removing a splint or brace, assess the patient's skin and circulation under the device, and reposition the limb in correct alignment. These sessions are planned, scheduled, and documented in the clinical record.

TRAINING AND SKILL PRACTICE IN: - Activities including repetition, physical or verbal cueing, and task segmentation provided by any staff member or volunteer under the supervision of a licensed nurse.

d. Bed Mobility - Activities used to improve or maintain the patient's self-performance in moving to and from a lying position, turning side to side, and positioning him or herself in bed.

e. Transfer - Activities used to improve or maintain the patient's self-performance in moving between surfaces or planes either with or without assistive devices.

f. Walking - Activities used to improve or maintain the patient's self-performance in walking, with or without assistive devices.

g. Dressing or Grooming - Activities used to improve or maintain the patient's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.

h. Eating or Swallowing - Activities used to improve or maintain the patient's self-performance in feeding one's self food and fluids, or activities used to improve or maintain the patient's ability to ingest nutrition and hydration by mouth.

i. **Amputation/Prosthesis Care** - Activities used to improve or maintain the patient'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.

j. **Communication** - Activities used to improve or maintain the patient's self-performance in using newly acquired functional communication skills or assisting the patient in using residual communication skills and adaptive devices.

Process: Review the clinical record. Consult with staff. Review rehabilitation/restorative care schedule and implementation record sheet.

Coding: For the last seven days, enter the number of days on which the technique, procedure, or activity was practiced for a total of at least 15 minutes during the 24-hour period. The time provided must be coded separately in time blocks of 15 minutes or more. For example, to check **Item 39a**, 15 or more minutes of 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 **Items 39a, b and c**. Remember that persons with dementia learn skills best through repetition that occurs multiple times per day. Review for each activity throughout the 24-hour period. Enter zero "0" if none.

Clarifications:

- If a restorative nursing program is in place when a plan of care is being revised, it is appropriate to reassess progress, goals and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this "reassessment" should be documented in the record.

- 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.

- Facilities may elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In these situations, the services **may not** be coded as therapy in **Item 38b**, since the specific interventions are considered restorative nursing services when performed by nurses or aides. 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.

- Active or passive movement by a patient that is incidental to dressing, bathing, etc. does not count as part of a formal restorative care program. For inclusion in this section, active or passive range of motion must be a component of an individualized program with measurable objectives and periodic evaluation delivered by staff specifically trained in the procedures.

- The use of Continuous Passive Motion (CPM) devices as Rehabilitation/Restorative Nursing is coded when the following criteria are met: 1) ordered by a physician, 2) nursing staff have been trained in technique (e.g., properly aligning patient's limb in device, adjusting available range of motion), and 3) nursing staff monitor the device. Nursing staff should document the application of the device and the effects on the patient. Do not include the time the patient is receiving treatment in the device. Include only the actual time staff required to apply the device and monitor.

- Grooming programs, including programs to help patients 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 have goals, objectives and documentation of progress included in the clinical record.

Examples of Nursing Rehabilitation/Restoration

Mr. V has lost range of motion (ROM) in his right arm, wrist and hand due to a 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 3 times per day. The nursing assistants and Mr. V's wife have been instructed on how and when to apply and remove the hand splint and how to do the passive ROM exercises. The total amount of time involved each day in removing and applying the hand splint and completing the ROM exercises is 30 minutes. The nursing assistants report that there is less resistance in Mr. V's affected extremity when bathing and dressing him. For both Splint or Brace assistance and Range of Motion (passive), **enter "7" as the number of days these nursing rehabilitative techniques were provided.**

Mrs. K was admitted to the swing bed 7 days ago following repair of 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 bedrails, and a transfer board. The plan was documented in Mrs. K's clinical record and communicated to all staff at the change of shift. The charge nurse documented in the nurses notes that in the five days Mrs. K has been receiving training and skill practice for bed mobility and transferring, her endurance and strength are improving, and she requires only extensive assistance for transferring. Each day the amount of time to provide this nursing rehabilitation intervention has been decreasing so that for the past five days, the average time is 45 minutes. **Enter "5" as the number of days training and skill practice for bed mobility and transfer was provided.**

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 goal is to maximize her independence in ADL's. A plan, documented on the medical record, has been developed to teach Mrs. J how 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. It takes approximately 20 minutes per day for Mrs. J to complete this task (dressing and undressing). **Enter "7" as the number of days training and skill practice for dressing and grooming was provided.**

(continued on next page)

Examples of Nursing Rehabilitation/Restoration
(continued)

Using a quad cane and a short leg brace, Mrs. D is receiving training and skill practice in walking. 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 apply her short leg brace followed by walking. Each teaching and practice episode for brace application and walking, supervised by a nursing assistant, takes approximately 15 minutes. **Enter "7" as the number of days for splint and brace assistance and training and skill practice in walking were provided**.

Experiencing a slow recovery from Guillain Barre syndrome, Mr. B is receiving daily training and skill practice in swallowing. Along with specially designed cups and appropriate food consistency, the documented plan of care to improve his ability to swallow involves proper body positioning, consistent verbal instructions, and jaw control techniques. Mr. B requires close monitoring when given food and fluids as he is at risk for choking and aspiration. Therefore, only licensed nurses provide this nursing rehabilitative intervention. It takes approximately 35 minutes each meal for Mr. B to finish his food and liquids. He receives supplements via a gastrostomy tube if he does not achieve the prescribed fluid and caloric intake by mouth. **Enter "7" as the number of days training and skill practice in swallowing was provided.**

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. Because Mr. W did not receive nursing rehabilitation/restoration for eating in the last 7 days, **enter "0" as the number of days training and skill practice for eating was provided.**

Mrs. E has amyotrophic lateral sclerosis. She no longer has the ability to speak or even to nod her head "yes" and "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 proven very successful and 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 medical record. Because the teaching and practice in using the communication board had been completed two weeks ago and Mrs. E is able to use the board to communicate successfully, she no longer receives skill and practice training in communication. **Enter "0" as the number of days training and skill practice in communication was provided.**

40. Physician Visits (14-day look back)

Intent: To record the **number of days** during the last 14-day period a physician has **examined** the patient (or since admission/readmission if less than 14 days ago). Examination can occur in the facility or in the physician's office. In some cases the frequency of physician's visits is indicative of clinical complexity.

Definition: **Physician -** Includes MD, DO (osteopath), podiatrist, or dentist who is either the primary physician or consultant. Also include an authorized physician assistant, nurse practitioner, or clinical nurse specialist working in collaboration with the physician. Does not include visits made by Medicine Men nor licensed psychologists (PhD).

Physician Exam - May be a partial or full exam at the facility or in the physician's office. This does not include exams conducted in an emergency room.

Coding: Enter the number of days the physician examined the patient. If none, enter "0".

Clarifications:

- If a patient is evaluated by a physician off-site (e.g., while undergoing dialysis or radiation therapy), it can be coded as a physician visit. Documentation of the physician's evaluation should be included in the clinical record. The physician's evaluation can include partial or complete examination of the patient, monitoring the patient for response to the treatment, or adjusting the treatment as a result of the examination.

- Do not count physician visits that occurred during the patient's acute care stay.

41. Physician Orders (14-day look back)

Intent: To record the **number of days** during the last 14-day period (or since admission/readmission if less than 14 days ago) in which a physician has changed the patient's orders. In some cases the frequency of physician's order changes is indicative of clinical complexity.

Definition: **Physician -** Includes MD, DO (osteopath), podiatrist, or dentist who is either the primary physician or a consultant. Also includes authorized physician assistant, nurse practitioner, or clinical nurse specialist working in collaboration with the physician.

Physician Orders - Includes written, telephone, fax, or consultation orders for new or altered treatment. Does **NOT** include standard admission orders, return admission orders, renewal orders, or clarification orders without changes. Orders written on the day of admission as a result of an unexpected deterioration in

condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.

Coding: Enter the number of days on which physician orders were changed. Do not include order renewals without change. If no order changes, enter "0".

Clarifications:

- 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.

- Do not count orders prior to the date of admission or reentry. Do not count return admission orders or renewal orders without changes. Do not count orders written by a pharmacist. The prohibition against counting standard admission or readmission orders applies, regardless of whether the orders are given at one time or are received at different times on the date of admission or readmission.

- A monthly Medicare Certification is a renewal of an existing order and should not be included when coding this item.

- If a patient has multiple physicians; e.g., surgeon, cardiologist, internal medicine, etc., and they all visit and write orders on the same day, the SB-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 SB-MDS observation period for a consultation planned 3-6 months in the future should be carefully reviewed. Orders written to increase the patient's RUG-III classification and swing bed payment are not acceptable.

- When a PRN 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.

- Orders for transfer of care to another physician may not be counted.

42. Ordered Therapies (first 14 days)

Skip these items unless this is a Medicare 5-Day assessment or a Medicare Readmission/Return assessment.

Intent: To recognize ordered and scheduled therapy services [physical therapy (PT), occupational therapy (OT) and speech pathology services (SP)] during the early days of the patient's stay. Often therapies are not initiated until after the end of the observation assessment period. For the Medicare 5-Day or Readmission/Return assessment, this section provides an overall picture of the amount of therapy that a patient will likely receive through the fifteenth day from admission.

Process: Review the patient's clinical record to determine if the physician has ordered one or more of the medically necessary therapies to begin in the first 14 days of stay. Therapies include PT, OT, and/or SP. If orders exist, consult with the therapist(s) involved to determine if the initial evaluation is completed and therapy treatment(s) has (have) been scheduled.

If the patient is scheduled to receive at least one of the therapies, have the therapist(s) calculate the total number of days through the patient's fifteenth day since admission to Medicare Part A when at least one therapy service will be delivered. Then have the therapist(s) estimate the total PT, OT, and SP treatment minutes that will be delivered through the fifteenth day of admission.

Coding: **a. Ordered Therapies** – Code "1", Yes, if the physician has ordered any of the following therapy services to begin in the first 14 days of the stay – physical therapy, occupational therapy, or speech pathology services. Consult with the therapist to complete **Item 42b** and **42c**. If the physician has not ordered therapy, enter "0" in **Item 42a** and skip to **Item 43** (Case Mix Group).

b. Estimate of Number of Days - Enter the number of days at least one therapy service can be expected to have been delivered through the patient's fifteenth day of admission. Count the days of therapy <u>already</u> delivered. Calculate the expected number of days through day 15. If orders are received for more than one therapy discipline, enter the number of days at least one therapy service is performed. For example, if PT is provided on MWF, and OT is provided on MWF, the SB-MDS should be coded as 3 days, not 6 days.

c. Estimate of Number of Minutes - Enter the estimated **total** number of therapy minutes (across all therapies) it is expected the patient will receive through day 15. Include the number of minutes already provided. Calculate the expected number of minutes through day 15.

Clarifications:

- Do not include evaluation minutes in the estimate of number of minutes.

- Do not count the evaluation day in the estimate for number of days unless treatment is rendered.

- When the physician orders a limited number of days of therapy, then the projection is based on the actual number of days of therapy ordered. For example, if the physician orders therapy for 7 days, the projected number of days in **Item 42b** will be 7.

Example of Ordered Therapies on Medicare 5-Day Assessments

Mr. Z was admitted to the swing bed late Thursday afternoon. The physician's orders for both physical therapy and speech language pathology evaluation were obtained on Friday. Both therapy evaluations were completed on Monday and physical and speech therapy were scheduled to begin on Tuesday. Physical therapy was scheduled 5 days a week for 60 minutes each day. Speech therapy was scheduled for 3 days a week for 60 minutes each day. The RN Assessment Coordinator identified Monday as the end of the observation assessment period for this Medicare 5-day assessment. Within the 15 days from the patient's admission date (Thursday), the patient will receive 8 days of physical therapy (480 minutes) and 4 days of speech therapy (240 minutes) for a total of 720 minutes in the fifteen days.

Enter "8" in Item 42b for the number of days that at least one therapy service is expected to be delivered.

Enter "720" in Item 42c for the estimated total number of minutes that both physical therapy and speech therapy are expected to be delivered.

Mrs. C was admitted to the facility Tuesday with an evaluation order for all three therapies. The physical therapist completed the evaluation for physical therapy on Wednesday and scheduled treatment to begin on Thursday, five days a week for 30 minutes each day. The occupational therapist completed the evaluation on Friday and scheduled therapy to begin on Monday, 3 days a week for one hour each day. The speech language pathologist's evaluation did not recommend speech therapy for the patient so speech therapy was not scheduled. The RN Assessment Coordinator identified Monday as the end of the observation assessment period. Within the observation assessment period, the patient received 3 days of physical therapy for a total of 90 minutes. The patient received one occupational therapy treatment for a total of 60 minutes. It was expected that Mrs. C would receive 6 more days of physical therapy within the 15 days after the patient's admission for a total of 180 minutes and 3 more days of occupational therapy within the 15 days after the patient's admission for a total of 180 minutes.

Enter "9" in Item 42b for the number of days that at least one therapy service is expected to be delivered.

Enter "510" in Item 42c for the estimated total number of minutes that both physical therapy and occupational therapy is expected to be delivered.

43. Case Mix Group

Intent: Records the RUG-III Classification calculated from the RAVEN-SB software.

a. <u>Medicare</u>
The software calculated RUG-III Classification for the Medicare program using the 53 Group Version 5.20. The first three characters entered in the boxes represent one of the 53 RUG-III groups. The last two numbers are an indicator of the version of the RUG-III Classification system. Currently, this version is **07**. This **07** comes directly from the software and will appear on every assessment.

b. <u>State</u>
The software calculated RUG-III Classification for the State case mix field using the State-specified RUG-III Classification system. For states using the RUG-III Classification system for case mix reimbursement, this item may be required. States have the option of using either the 34 or 44 RUG-III Classification systems, or a different version of the RUG-III Classification system. The first three characters entered in the boxes represent one of the RUG-III groups. This could vary from the Medicare case mix field if the state is using the 34 RUG-III Classification system. The last two numbers may vary depending on the version of the RUG-III Classification system specified in the state. Please contact your State representatives for your State requirements.

44. HIPPS Code

Definition: **Health Insurance Prospective Payment System (HIPPS) Code -** 5-character codes used solely for billing the Medicare Part A stay under the SNF PPS. The codes reflect the 3-character RUG-III group into which the patient is classified, and a 2-character assessment indicator. The assessment indicator is calculated based on the answers to **Items 11a-d**, Reason for Assessment.

Process: The RAVEN-SB software program calculates the HIPPS code for you. The HIPPS codes must appear when billing a Part A SNF-level stay under the SNF PPS. The computer software program will calculate the appropriate HIPPS code that will be used in the billing process, except for the 5 special payment codes. Chapter 5, Section 5.4 contains more detailed information on the HIPPS codes.

Example of HIPPS Code

A 5-Day Medicare assessment that is classified into the High Rehabilitation RUG-III classification would be coded as RHB01. The "R" indicates Rehabilitation, the "H" indicates the High Rehabilitation group, the "B" indicates an ADL score of 8-12, and the "01" indicates a 5-Day Medicare assessment.

R	H	B	0	1

45. Signature

Intent: Federal regulations at 42 CFR 483.20 (i) (1) require that a registered nurse must sign, date, and certify that the assessment is complete.

Coding: The registered nurse who is certifying the completion of the SB-MDS must sign and date the assessment. Use the actual date the SB-MDS was completed, reviewed, and signed, even if it is after the patient's date of discharge. If, for some technical reason, such as computer or printer breakdown, the SB-MDS cannot be signed on the date it is completed, it is appropriate to use the actual date that it is signed. It is recommended that the nurse document the reason for the discrepancy in the clinical record. Backdating **Item 45** on the printed copy to the date the handwritten copy was completed and/or signed is not acceptable.

Clarification:

- The use of a signature stamp is allowed. The facility must have policies in place to ensure proper use and secured storage of the stamps. The State may have additional regulations that apply.

Chapter 4: Submission and Correction of the Swing Bed Minimum Data Set Assessment

4.1 Legal and Submission Authority

According to Section 4432(a) of the Balanced Budget Act (BBA) of 1997, swing bed hospitals are to be incorporated into the SNF PPS system effective with cost reporting periods beginning on or after July 1, 2002. To accomplish this, a unique 2-page SB-MDS assessment has been developed and must be completed, encoded, and submitted to a national database. Directions for this process are included in Program Memorandum Transmittal Number A-02-016 dated February 15, 2002. The SB-MDS must be completed in compliance with the Medicare PPS schedule found in Chapter 2 of this manual.

Swing bed providers must complete the SB-MDS assessment within 14 days of the Assessment Reference Date. An SB-MDS is considered complete on the day that the registered nurse (RN) responsible for coordinating the SB-MDS assessment process signs and dates the assessment. The SB-MDS records must be submitted electronically to the national database and will be considered timely if submitted and accepted into the database within 14 days of completion.

The Swing Bed facility is required to submit SB-MDS records for patients in a Medicare Part A SNF-level stay. The swing bed facility may also choose to submit assessments for other patients, but only when the SB-MDS assessments are for patients in a Medicare or Medicaid certified swing bed. Submission of assessments for other patients is a violation of patient privacy rights. Appropriate authority to submit records is denoted in the submission record in the SUB_REQ field. The SUB_REQ field is explained in more detail later in this chapter.

4.2 Computer Requirements

Hardware - Specifications are available detailing the hardware that is needed at the Swing Bed facility to support this data submission program. They may be found at **http://www.qtso.com/download/swingbed/readme.txt**.

Software - The Swing Bed facility must use software that will allow accurate encoding of the SB-MDS data and assure that the records pass the standardized edits defined by CMS. The Resident Assessment and Verification Entry Software for Swing Beds (RAVEN-SB) is available free to the Swing Bed facility at **http://www.cms.hhs.gov/providers/snfpps/raven-sb.asp** or **http://www.qtso.com/ravensbdownload.html**. It meets all of the CMS standardized edits and creates the files needed to submit the SB-MDS data to the national database and download reports.

Commercial software may be purchased that incorporates more features than RAVEN-SB. If the facility chooses to purchase such a system, it must be certain that it conforms to the data specifications required by CMS. The vendor can access these specifications at **http://www.cms.hhs.gov/providers/snfpps/swingbed_specs.asp**.

4.3 Submission Rules

Timing Rules - There are currently two timing rules in the SB-MDS data specifications:

1. Completion Timing: **Item 45b**, Completion Date, can be no more that 14 days later than **Item 10a**, Assessment Reference Date. Although the record will be accepted into the national database, failure to follow this rule will result in a warning message. ***NOTE:*** Discharge and Reentry tracking information must be completed within 7 days of the event (**Items 15** and **16** respectively).

2. Submission Timing: All assessments must be submitted within 14 days of **Item 45b**, Completion Date. Although the record will be accepted into the national database, failure to follow this rule will result in a warning message.

Date Sequencing Rules - There is a logical sequence of dates on the SB-MDS. For example, it would be illogical for the patient's birth date to be later than the admission date or for any date on the SB-MDS to be later than the current date. If there are date inconsistencies within a record when submitted to the national database, the record will receive a fatal error and will be rejected.

The following table lists each date field from the SB-MDS and the related date fields that must be either later or the same as that date field.

Date Field (MDS Crosswalk)/Description	Date Fields that Must Be Later or the Same
Item 3 Birth Date	10a Assessment Reference Date 12 Prior Acute Care Stay 13 Admission Date 15 Discharge Date 16 Reentry Date 45b Completion Date Current Date
Item 10a Assessment Reference Date	15 Discharge Date 16 Reentry Date 45b Completion Date Current Date
Item 13 Admission Date	10a Assessment Reference Date 15 Discharge Date 16 Reentry Date 45b Completion Date Current Date
Item 15 Discharge Date	Current Date
Item 16 Reentry	Current Date
Item 45b Completion Date	Current Date

Item 12, Prior Acute Care Stay captures the admission date of the qualifying 3-day hospital stay that occurred before admission to the swing bed for Part A SNF-level care. It should always be earlier than **Item 13**, Admission Date (to the swing bed), **Item 10a**, Assessment Reference Date, **Item 45b**, Completion Date and the current date.

Another fatal date edit requires that **Item 3**, Birth Date, be no more than 140 years prior to the current date.

4.4 Submission File Structure

Each submission file consists of a **Header Record**, one or more **Body Records** and a **Trailer Record.** The RAVEN-SB software will create the files, including header and trailer records needed to submit the SB-MDS data to the national database. Commercial software vendors can access record specifications at **http://www.cms.hhs.gov/providers/snfpps/swingbed_specs.asp**.

The **Header Record** contains basic identifying information for the swing bed hospital submitting SB-MDS data, the contact persons, and telephone numbers to use in the event that the file is in error. Each **Body Record** contains information for a single SB-MDS assessment. These assessments include original SB-MDS forms, corrected SB-MDS forms, and discharge and reentry information. The **Trailer Record** indicates the end of the submission file and includes a count of the total records in the file including the header and trailer records.

Each **Body Record** will contain a SUB_REQ field. This field indicates whether the submission of the record is authorized. **There is CMS authority to submit an assessment if the patient is in a Medicare or Medicaid certified swing bed.** If the assessment submitted is AUTHORIZED, the SUB_REQ should be "1".

A SUB_REQ code of "0" identifies an assessment with no authority for submission. If the patient is not in a Medicare or Medicaid certified swing bed, the record must not be submitted. If a swing bed provider inadvertently transmits an SB-MDS with a SUB_REQ of 0, it will be rejected.

4.5 Prospective Payment System (PPS) Requirements

Every Medicare assessment that is submitted to the national database must include a RUG-III case mix code and a Health Insurance Prospective Payment System (HIPPS) Code.

RUG-III Code - The first three characters are the RUG-III group code and the last two characters are a valid RUG-III version code. The RAVEN-SB software determines the correct code for you and inserts the code on each patient's SB-MDS record.

HIPPS Code - The first three characters are the RUG-III group code and the last two characters are a valid assessment indicator. The RAVEN-SB software determines the correct code for you and inserts the code on each patient's SB-MDS record.

When a Medicare SB-MDS assessment record is received by the national database, both the RUG-III case mix code and HIPPS Code are recalculated and verified. Once the patient's SB-MDS record has been accepted into the national database, clinical staff should give the HIPPS code to the billing office. The HIPPS code must appear on the claim, and the claim cannot be filed until the patient's SB-MDS record has been accepted into the national database.

It is important to remember that the record will be accepted into the database even if the calculated RUG-III code or HIPPS code differ from the submitted values. The error will be flagged on the final validation report by issuing a warning message and listing the correct RUG-III or HIPPS code. When such discrepancies occur, the RUG-III and/or HIPPS code reported on the validation report should always be used for billing.

4.6 Definitions for Correction Procedures

There are several definitions relevant to correction procedures:

Test Batch - The national database system allows a swing bed hospital to submit test SB-MDS batches. This allows the hospital to test the submission process and to verify that it is submitting valid data. A Test/Production field in the header record identifies that the data to follow is for test purposes only and should be edited but not accepted into the database.

Production Batch - A Test/Production field in the header record identifies that the data to follow is production data and should be edited and accepted into the database.

Unauthorized Record - The hospital has no "submission authority" to submit the record to CMS.

Submission Authority - The hospital has authority to submit SB-MDS assessments to CMS for patients in a Medicare or Medicaid certified swing bed. States may also establish additional submission requirements. Submission authority and the SUB_REQ have been discussed earlier in this chapter.

Key Fields - Key fields are used by the national database to uniquely identify an assessment. The following table lists the key fields in an assessment record.

Key Field Name (MDS 2.0 Crosswalk)	Description
FAC_ID	Unique Hospital ID code
Item 1a (AA1a)	Patient First Name
Item 1c (AA1c)	Patient Last Name
Item 2 (AA2)	Gender
Item 3 (AA3)	Birth Date
Item 7a (AA5a)	Social Security Number
Item 10a (A3a)	Assessment Reference Date
Item 11a (AA8b)	Primary Reason for Assessment
Item 11b (AA8b)	PPS Scheduled Assessment
Item 15 (R4)	Discharge Date
Item 16 (A4a)	Reentry Date

Non-Key Fields – Includes all SB-MDS fields, except SUB_REQ and the key fields, which are listed above.

Active Record – An SB-MDS record that has been submitted and accepted into the national database.

Original Record – The initial version of an active record. An original record must have a unique combination of key fields. For an assessment to be coded as an original record the correction counter field **Item 10b** must be 00.

Correction Record - A new version of the assessment submitted to correct an existing active record. A correction record must have the same key fields as the active record in error. Code the correction record in **Item 10b** with a value one greater than **Item 10b** on the record being corrected. If you were correcting an original record, the counter in **Item 10b** on the correction record would be 01. You can correct any record in error, including active correction records. If you were correcting an already existing correction record with an **Item 10b** value of 01, then **Item 10b** on the new correction record would be 02.

Inactivation Record - A special SB-MDS record containing the key fields needed to identify and inactivate an active record in the national database. An inactivation record must have key fields exactly matching the active record.

Correction Counter - Item 10b, Original or Correction, on the SB-MDS is used to identify the version of a record. Entering 00 in this field indicates an original record. A correction record will always have an entry greater than zero. **Item 10b** must be incremented to 01 (zero, one) for the first corrected version accepted in the national database, to 02 (zero, two) for the second corrected version accepted in the national database, etc.

4.7 Timing and Types of Corrections

After an assessment has been completed and submitted to the national database, no further changes should be made to the assessment record. Corrections are allowed if an assessment, data entry or software error has been made. Corrections must be completed within 14 days of detecting the error or errors, and then submitted within 14 days of completion of the correction.

There are different correction procedures for different types of errors.

I. Records in Error Not Accepted Into the National Database:

This includes records that have been submitted and rejected, production records that were inadvertently submitted as test records, or records that have not been submitted at all. Since none of these records have been accepted into the national database, corrections can be made, and these records can simply be submitted without any special procedures.

II. Records in Error Accepted Into the National Database:

This includes test records submitted and accepted as production, unauthorized records submitted with incorrect submission authority, records with errors in key fields (see Page 4-5 for more information on key fields), and records with errors in non-key field items. Each requires special correction procedures.

A. Test batch is inadvertently submitted as a production batch.
These assessments must be deleted from the national database. When such a deletion is necessary, the swing bed facility must submit a written deletion request to the support office for the national database.

The following is an example of the deletion request worksheet:

Example Swing Bed Test File Deletion Request Worksheet

1. Complete a copy of this form for each Test File to be deleted.

2. Submit to: Iowa Foundation For Medical Care, QTSO Support
6000 Westown Parkway Suite 350E
West Des Moines, IA 50266-7771
(This information must not be sent via e-mail due to confidentiality of the information)

SB Facility information	
Name	
ID (FAC_ID)	
Requester information	
Name	
Title	
Phone #	
Submission information	
Date and time	
Batch #	
Reason For Deletion Request	
This test file was inadvertently submitted as a production file. Please delete all of the assessments from the national database.	

_____
Assessment Coordinator Name

_____
Assessment Coordinator Signature

_____
Date

B. Unauthorized record is accepted.

Only assessments for Medicare or Medicaid certified swing beds are authorized for submission to the national database. These assessment(s) must be deleted from the database. When such a deletion is necessary, the swing bed facility must submit a written deletion request to the support office for the national database.

The following is an example of the unauthorized record deletion request worksheet:

Example SB-MDS Unauthorized Record Deletion Request Worksheet

Instructions:

1. Complete a copy of this form for each unauthorized record to be deleted.

2. Submit to: Iowa Foundation For Medical Care, QTSO Support
6000 Westown Parkway Suite 350E
West Des Moines, IA 50266-7771
(This information must not be sent via e-mail due to confidentiality of the information)

Facility information	
Name	
ID (FAC_ID)	
Requester information	
Name	
Title	
Phone #	
Resident information	
First Name	
Last Name	
SSN	
Birth date	
Gender	
Record information	
Item 11a	
Item 11b	
Event Date[1]	
Submission information	
Date and time	
Batch #	
Assessment Internal ID	
Reason for Deletion Request	
This record was inadvertently submitted indicating it had submission authority, when it did not have authority. Please delete this record from the national database.	

Assessment Coordinator Name

Assessment Coordinator Signature

Date

[1]Event Date:
SB-MDS Item 10a, reference date, for an assessment record.
SB-MDS Item 15, discharge date, for a discharge record.
SB-MDS Item 16, reentry date, for a reentry record.

C. Authorized record is accepted with incorrect key fields.
An authorized record with incorrect key fields identifies the wrong swing bed facility, patient, type of assessment, or event date, such as birth date, discharge date, reentry date or ARD. If an authorized record is accepted into the national database with incorrect key fields, the record must be inactivated and, if appropriate, a new original record with all information correct (both key and non-key fields) must be submitted. To inactivate a record, the authorized facility staff member must inactivate the record according to the SB-MDS software procedure, which moves the erroneous record from the active part of the database to a history file maintained as an audit trail of corrections. Once the erroneous assessment has been inactivated, a replacement assessment may be submitted as an original record with **Item 10b** entered as 00.

The key fields of the inactivation must match all the key fields of the existing active record. If all key fields do not match the active record existing in the database (i.e., the record with the error), the inactivation record will be rejected. Once the record is properly inactivated, if appropriate, complete a replacement assessment. For submission purposes, both the inactivation record and the replacement assessment record may be included in the same submission batch.

For example, if an assessment was submitted with an incorrect patient birth date (**Item 3**), an inactivation record would be submitted and a replacement assessment with the correct birth date would also be submitted. The replacement assessment would be an original record with **Item 10b** equal to 00. It is important to submit inactivation records when mistakes are identified, since the system will not recognize assessments with different information in the key fields as belonging to the same patient.

D. Authorized record is accepted with incorrect non-key fields.
If an active authorized assessment is determined to have errors only in non-key fields, a correction record must be submitted. The non-key errors should be corrected in a copy of the assessment. The correction field **Item 10b** should be increased by 1, from 00 to 01 etc. The correction record must be submitted to CMS.

When a correction record is accepted, the existing active record is moved to an inactive history file as an audit trail and the new corrected record will be placed in the active database. Standard system reports and procedures are limited to active records.

A correction record will be rejected if the national database does not already contain an existing active version of the record with exactly the same key fields, and the correction field **Item 10b** having a value exactly one greater than the **Item 10b** value in the existing version of the record.

Correction Policy Examples

Your swing bed hospital just submitted the first production batch of assessments after successfully testing the submission process. After reviewing the validation reports, you realize that the test indicator had not been switched to production. To correct this, change the Test/Production indicator and resubmit the batch. Do not increment **Item 10b** (Original and Correction field). You are resubmitting the **Original Record** and it should still be coded 00.

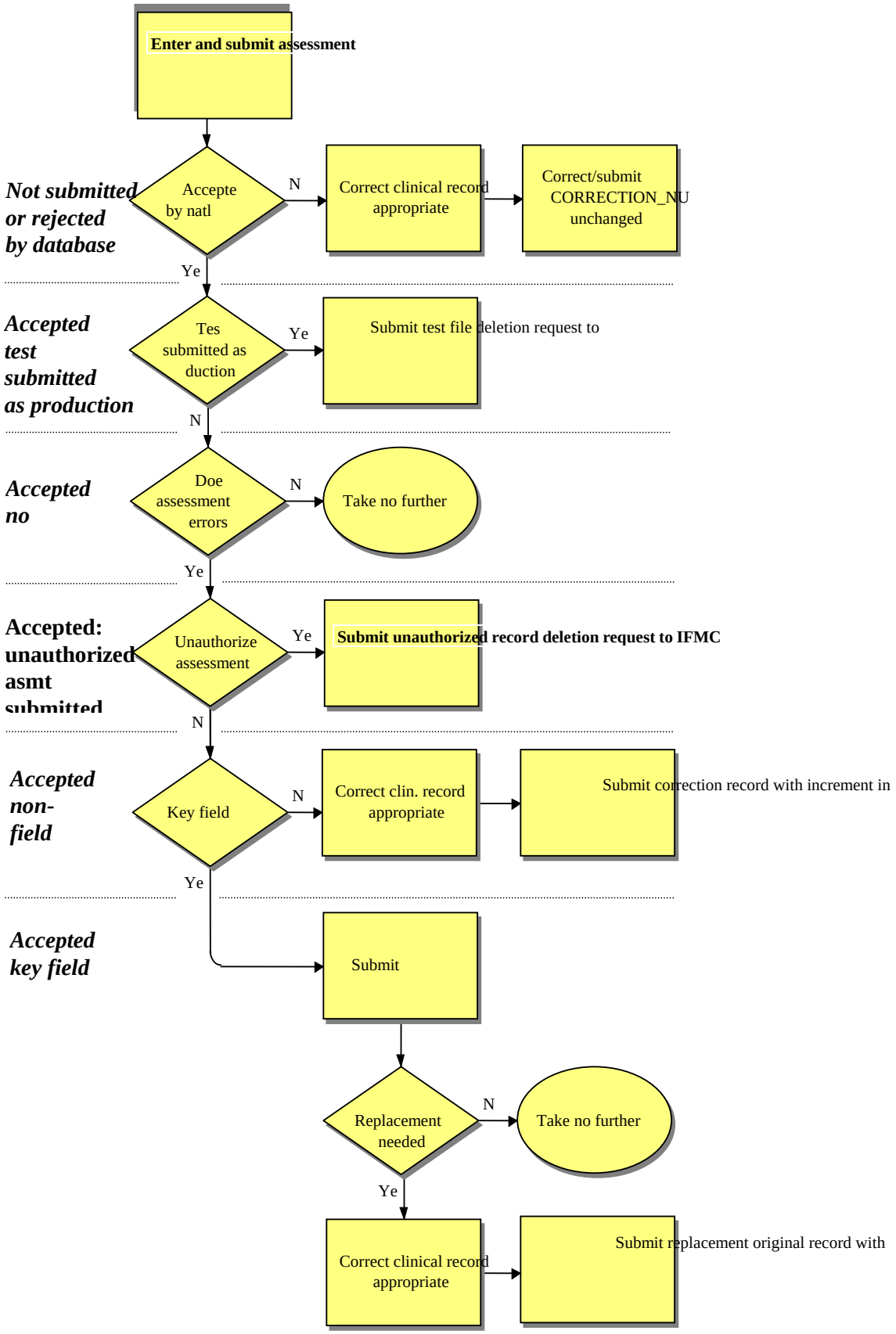
Today is July 3, 2002 and you have just submitted an SB-MDS batch and received the validation report. After reviewing the report you notice the assessment submitted for Mr. J has been rejected. The birth date submitted was invalid because it is after the current date. After a review of the assessment, you see that rather than 10 07 1922, his birth date was entered as 10 07 2002. You should reopen the assessment, correct the birth date, and submit the assessment. Do not increment **Item 10b** (Original and Correction field). You are resubmitting the **Original Record** and it should still be coded 00.

Your swing bed hospital is anxious to test the submission process. You enter several fictitious assessments into the software using silly names and made-up data. You submit the batch but forget to set the Test/Production indicator to test. The validation report shows that the data has been accepted into the database. You must submit a written **Test File Deletion Request** to the Support office for the national database. The request should include the swing bed hospital name, the name, title and phone number of the person making the request, the Hospital ID (FAC_ID), the submission data and time, and the submission batch ID number. (A sample request form is included on Page 4-7.)

When entering the 30-Day assessment for Mr. G, you notice that his social security number is incorrect in the system. Both the 5-Day and the 14-Day assessment have been submitted with this incorrect number. **Item 7a** (Social Security Number) is a key field. To correct this error, you would need to submit an **Inactivation Record** for both the 5-Day and 14-Day assessments. Then create new original records for both assessments with the correct social security numbers. Submit the new original for the 5-Day and 14-Day assessments with **Item 10b** (Original and Correction field) coded 00. Also, submit the 30-Day assessment with the correct social security number. Both the inactivation records and the replacement assessment records may be included in the same submission batch.

When reviewing a 5-Day assessment on Mrs. Y, you realize that **Item 38aa** (Chemotherapy) had been incorrectly marked and **Item 38ab** (Dialysis) should have been marked but was not. This error is in a non-key field and can be corrected with a correction record. Using RAVEN-SB software, make a correction copy of the assessment. Revise **Items 38aa and 38ab** with the correct answers. Increment **Item 10b** (Original and Correction field). Since the 5-Day was an original record coded 00, you would now code it 01. Submit the corrected assessment.

SB-MDS Correction Policy Flowchart



Chapter 5: Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS)

5.1 SNF PPS Coverage Guidelines

Under SNF PPS, beneficiaries must continue to meet the established eligibility requirements for a Part A SNF-level stay; i.e., the beneficiary must have received acute care as a hospital inpatient for a medically necessary stay of at least 3 consecutive calendar days. In addition, the beneficiary must have started receiving extended care swing bed services within 30 days after discharge as an acute care patient from the swing bed facility or other hospital, unless the exception in §3131.3b of the Medicare Intermediary Manual (MIM) applies. To be covered, the extended care services must be needed for a condition which was treated during the beneficiary's qualifying hospital stay or for a condition which arose while receiving extended care services for a condition for which the beneficiary was previously treated during the acute care stay.

Swing bed providers will assess the clinical condition of beneficiaries by completing the SB-MDS assessment for each Medicare beneficiary receiving Part A SNF-level care. The SB-MDS assessment data is used to calculate the RUG-III Classification necessary for payment. The SB-MDS contains extensive information on the patient's nursing needs, ADL impairments, cognitive status, behavioral problems, and medical diagnoses. This information is used to define RUG-III groups that form a hierarchy from the greatest to the least resources used. Patients with more specialized nursing requirements, licensed therapies, greater ADL dependency or other conditions will be assigned to higher groups in the RUG-III hierarchy. Providing care to these patients is more costly and is reimbursed on a higher level. The table below shows the applicable assessment days and grace days for each PPS assessment, as well as the applicable payment days.

Medicare Assessment Schedule for Swing Bed Hospitals

Medicare SB-MDS Assessment Type	Reason for Assessment (SB-MDS Item 11b code)	Assessment Reference Date * (based on start of Part A stay)	Assessment Reference Date Grace Days	Number of Days Authorized for Coverage and Payment	Applicable Medicare Payment Days
5-Day	1	1-5**	6-8**	14	1-14
14-Day	7	11-14	15-19	16	15-30
30-Day	2	21-29	30-34	30	31-60
60-Day	3	50-59	60-64	30	61-90
90-Day	4	80-89	90-94	10	91-100

***The assessment reference date is the last date of the observation period for the clinical assessment. The timeliness requirements are calculated using the first day of the Medicare Part A-covered stay as "day 1".

****If a beneficiary expires or transfers to another facility before the 5-Day assessment has been completed, the facility will still need to prepare an SB-MDS as completely as possible for the RUG-III classification and Medicare payment purposes. Otherwise the days will be paid at the default rate. The assessment reference date must also be adjusted to no later than the date of discharge.

5.2 Payment Provisions Under SNF PPS

Federal Rate

Swing bed services reimbursed under the SNF PPS will be paid at the full Federal rate. The Federal payment rates were developed by CMS using allowable costs from hospital-based and freestanding Part A SNF-level cost reports from reporting periods beginning in fiscal year 1995. The data used in developing the Federal rates also incorporated an estimate of the amount payable under Part B for covered SNF-level services furnished during fiscal year 1995 to individuals who were patients of the facility and receiving Part A covered services.

In accordance with the formula prescribed in the BBA, the Federal rates were set at a level equal to the weighted mean of freestanding costs plus 50 percent of the difference between the freestanding mean and the mean of all SNF costs (hospital-based and freestanding) combined. In addition, the portion of the Federal rate attributable to wage-related costs is adjusted by an appropriate wage index. Payment rates are computed and applied separately for facilities located in urban and rural areas. All swing bed hospitals are classified as rural providers, and will be paid at the rural rate for their geographic locations.

The Federal rate incorporates adjustments to account for facility case mix from the RUG-III patient classification system used under the national PPS. RUG-III is a 53-group patient classification system that provides the basis for the case-mix payment indices (or relative payment weights) used to standardize the Federal rates and subsequently to establish case mix adjustments to the rates for patients with different service use. Information from the SB-MDS is used to classify patients into one of 53 RUG-III groups. Like other providers subject to the SNF PPS, swing bed providers must complete these assessments according to an assessment schedule specifically designed for Medicare payment.

When assessments are performed late (i.e., the ARD is a later date than the allowed ARD window), the swing bed facility will be paid at a default rate equal to the payment made for the lowest RUG III group. The default rate will be in effect from the first day of the coverage period to the ARD of the late assessment.

When assessments are performed early (i.e., the ARD is an earlier date than the allowed ARD window), the swing bed facility will be paid at the default rate for the number of days the assessment was out of compliance. For example, a Medicare-required 14-Day assessment with an ARD of day 10 (1 day early) would be paid at the default rate for the first day of the payment period that begins on day 15.

Under the SNF PPS, covered swing bed services will include Part A SNF-level services for which benefits are provided under Part A (the hospital insurance program). In addition, the SNF PPS rate includes all items and services for which, prior to July 1, 1998, payment had been made under Part B (the supplementary medical insurance program) but furnished to SNF patients during a Part A covered stay.

Services that are not reimbursed through the SNF PPS per diem rate include physician services, physician assistant services, nurse practitioner and clinical nurse specialist services, certified midwife services, qualified psychologist services, certified registered nurse anesthetist services and anesthesiologist assistant services. Services of nurses and physician assistants are not separately billable when they are employees of the swing bed facility.

5.3 Resource Utilization Groups Version III

Beginning on the first day of each provider's next fiscal year on or after July 2002, swing bed programs are required to conduct assessments that are used to determine reimbursement for their Medicare patients. The SB-MDS assessment contains items that reflect the acuity level of the patient, including diagnoses, treatments, and an evaluation of the patient's functional status. Patient acuity information is used to calculate a RUG-III classification for each patient. The RUG-III system predicts levels of resources that are required to care for a mixture of different patient needs. The RUG-III patient classification system measures both nursing and therapy staff resource use.

The RUG-III Classification system has eight major patient classification groups, Rehabilitation Plus Extensive Services, Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Functions. The eight groups are further divided by the intensity of the patient's activities of daily living (ADL) needs.

- In the Extensive Services category, an extensive services count is completed to determine if the assessment also classifies in other categories such as Special Care, Clinically Complex, and Impaired Cognition.

- In the Clinically Complex category, assessments are differentiated by the absence or presence of depression.

- In the Impaired Cognition, Behavior Problems and Reduced Physical Functioning categories, two or more nursing rehabilitation services are recognized.

One very important calculation in the classification process is the scoring of Activities of Daily Living (ADL). An ADL Score is calculated for all assessment classifications and is one of the determining factors regarding placement in all RUG-III categories. The ADL Score calculation includes **Item 23a** (Bed Mobility), **Item 23b** (Transfer), **Item 23d** (Toilet Use), and a calculation using **Items 23c** (Eating) **and 29** (Nutritional Approaches), **and 30** (Parenteral/Enteral Intake). The ADL Scores range between 4 and 18. An ADL Score of 4 represents the most independent patient while a score of 18 represents the most dependent patient.

EIGHT MAJOR RUG-III CLASSIFICATION GROUPS	
MAJOR RUG-III GROUP	**CHARACTERISTICS ASSOCIATED WITH MAJOR RUG-III GROUP**
Rehabilitation Plus Extensive Services	Patients receiving physical, speech or occupational therapy AND receiving IV feeding or medication, suctioning, tracheostomy care, or ventilator/respirator.
Rehabilitation	Patients receiving physical, speech or occupational therapy.
Extensive Services	Patients receiving complex clinical care or with complex clinical needs such as IV feeding or medications, suctioning, tracheostomy care, ventilator/respirator and comorbidities that make the patient eligible for other RUG categories.
Special Care	Patients with complex clinical care or with serious medical conditions such as multiple sclerosis, quadriplegia, cerebral palsy, respiratory therapy, ulcers, stage III or IV pressure ulcers, radiation, surgical wounds or open lesions, tube feeding and aphasia, fever with dehydration, pneumonia, vomiting, weight loss or tube feeding.
Clinically Complex	Patients receiving complex clinical care or with conditions requiring skilled nursing management and interventions for conditions and treatments such as burns, coma, septicemia, pneumonia, foot wounds, foot infections, diabetes mellitus and injections with physician order changes, internal bleeding, dehydration, tube feeding, oxygen, transfusions, hemiplegia, chemotherapy, dialysis, and physician visits/order changes.
Impaired Cognition	Patients having cognitive impairment in decision making, recall and short-term memory. (Score on SB-MDS cognitive performance scale >=3).
Behavior Problems	Patients displaying behavior such as wandering, verbally or physically abusive or socially inappropriate, or who experience hallucinations or delusions.

Reduced Physical Functions	Patients whose needs are primarily for activities of daily living and general supervision.

5.4 Relationship Between the SB-MDS and the Claim

The SNF PPS establishes a schedule of Medicare assessments. Each required Medicare assessment is used to support Medicare PPS reimbursement for a predetermined **maximum** number of Medicare Part A days. To verify that the Medicare bill accurately reflects the assessment information, three data items derived from the SB-MDS assessment must be included on the Medicare claim:

1. Assessment Reference Date (ARD)

The ARD must be reported on the Medicare claim. If a SB-MDS assessment was not completed, the ARD is not used and the claim must be billed at the default rate. CMS has developed mechanisms to link the assessment and billing records.

2. The RUG-III Group

The RUG-III group is calculated from the SB-MDS assessment data. The software used to encode and transmit the SB-MDS assessment data calculates the RUG-III group. CMS edits and validates the RUG-III code of transmitted SB-MDS assessments. Facilities cannot submit Medicare Part A claims until the assessment has been accepted into the CMS database, and they must use the RUG-III code as validated by CMS when bills are filed. The following abbreviated RUG-III codes are used in the billing process:

RUX, RUL, RVX, RVL, RHX, RHL, RMX, RML, RLX
RUA, RUB, RUC, RVA, RVB, RVC, RHA, RHB, RHC, RMA, RMB, RMC, RLA, RLB
SE1, SE2, SE3
SSA, SSB, SSC
CA1, CA2, CB1, CB2, CC1, CC2
IA1, IA2, IB1, IB2
BA1, BA2, BB1, BB2
PA1, PA2, PB1, PB2, PC1, PC2, PD1, PD2, PE1, PE2
AAA (the default code)

3. Health Insurance PPS (HIPPS) Codes

Each Medicare PPS assessment is used to support Medicare Part A payment for a maximum number of days. The HIPPS modifier code must be entered on each claim, and must accurately reflect which assessment is being used to bill the RUG-III group for Medicare reimbursement.

The CMS HIPPS modifier codes contain a 3-position code to represent the RUG-III of the SNF patient, plus a 2-position assessment indicator to indicate which assessment was completed. Together they make up the 5-position HIPPS modifier code for the purpose of billing Part A covered days to the Fiscal Intermediary.

HIPPS modifier codes have been established for each type of assessment used to support Medicare payment. For example, the Medicare reason for assessment on a Medicare 5-Day assessment is "1", and the HIPPS modifier code is "01". The chart shown below lists the HIPPS codes used by swing beds.

HIPPS MODIFIERS/ASSESSMENT TYPE INDICATORS

Basic Assessments:

- 01 5-Day Medicare-required assessment
- 02 30-Day Medicare-required assessment
- 03 60-Day Medicare-required assessment
- 04 90-Day Medicare-required assessment
- 05 Readmission/Return Medicare-required assessment
- 07 14-Day Medicare-required assessment
- 08 Off-cycle other Medicare-required assessment (OMRA)
- 30 Off-cycle swing bed change in clinical status (outside assessment window)

Replacement Assessments - OMRAs:

- 18 OMRA replacing 5-Day Medicare-required assessment or 5-Day Readmission/Return Assessment
- 28 OMRA replacing 30-Day Medicare-required assessment
- 38 OMRA replacing 60-Day Medicare-required assessment
- 48 OMRA replacing 90-Day Medicare-required assessment
- 78 OMRA replacing 14-Day Medicare-required assessment

Replacement Assessments -Change in Clinical Status:

- 32 Swing bed change in clinical status replaces 30-Day Medicare-required assessment
- 33 Swing bed change in clinical status replaces 60-Day Medicare-required assessment
- 34 Swing bed change in clinical status replaces 90-Day Medicare-required assessment
- 35 Swing bed change in clinical status replaces a Readmission/Return Medicare-required assessment
- 37 Swing bed change in clinical status replaces 14-Day Medicare-required assessment

NOTE: A code for a Change in Clinical Status replacing the initial 5-Day Medicare-required assessment is not provided. If the change in clinical status occurs after the initial 5-Day assessment has been completed (i.e., between days 1-8), and before the assessment window for the 14-Day assessment, it will be considered an off-cycle change in clinical status and the HIPPS code will be coded as 30.

HIPPS MODIFIERS/ASSESSMENT TYPE INDICATORS
(continued)

Special Payment Situations - **New Assessment Indicator Codes Effective July 1, 2002**:
In some situations, beneficiaries may change payer source after admission to the swing bed, but fail to notify the provider in a timely manner; e.g., disenrollment from an HMO, disenrollment from a hospice, change in Medicare payer status from secondary to primary, etc. In those situations, the provider may not have completed the SB-MDS assessments needed for Medicare billing. New assessment indicator codes have been established for these special payment situations. Claims processing instructions are being developed and will be issued separately.

Since these codes are used to indicate unusual situations, they must be assigned manually.

- 19 Special payment situation 5-Day assessment
- 29 Special payment situation 30-Day assessment
- 39 Special payment situation 60-Day assessment
- 49 Special payment situation 90-Day assessment
- 79 Special payment situation 14-Day assessment

Default Code - No Assessment Completed:
- 00 Default code (No assessment completed)

5.5 RUG-III 53 Group Model Calculation Worksheet for Swing Beds

This RUG-III Version 5.20 calculation worksheet is a step-by-step walk through to manually determine the appropriate RUG-III classification based on the data from an SB-MDS assessment. The worksheet takes the grouper logic and puts it into words. We have carefully reviewed the worksheet to insure that it represents the standard logic.

This worksheet is for the 53-group RUG-III Version 5.20 model. In the 53-group model, there are 23 different Rehabilitation Plus Extensive Services and Rehabilitation groups representing 10 different levels of rehabilitation services. In the 53-group model, the patients in the Rehabilitation Plus Extensive Services groups have the highest level of combined nursing and rehabilitation need, while patients in the Rehabilitation groups have the next highest level of need. Therefore, the 53-group model has the Rehabilitation Plus Extensive services groups first, followed by the Rehabilitation groups, the Extensive Services groups, the Special Care groups, the Clinically Complex groups, the Impaired Cognition groups, the Behavior Problems groups, and finally the Reduced Physical Function groups.

There are two basic approaches to RUG-III classification: (1) hierarchical classification and (2) index maximizing classification. The present worksheet is focused on the hierarchical approach but can be adapted to the index maximizing approach.

Hierarchical Classification - The present worksheet employs the hierarchical classification method. Hierarchical classification is used in some payment systems, in staffing analysis, and in many research projects. In the hierarchical approach, you start at the top and work down through the RUG-III model, and the classification is the first group for which the patient qualifies. In other words, start with the Rehabilitation Plus Extensive Services groups at the top of the RUG-III model. Then you work your way down through the groups in hierarchical order: Rehabilitation Plus Extensive Services, Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Functions. When you find the first of the 53 individual RUG-III groups for which the patient qualifies, assign that group as the RUG-III classification and you are finished.

If the patient qualifies in the Extensive Services group and also in a Special Care group, always choose the Extensive Services classification, since it is higher in the hierarchy. Likewise, if the patient qualifies for Special Care and Clinically Complex, always choose Special Care. In hierarchical classification, always pick the group nearest the top of the model.

Index Maximizing Classification - Index maximizing classification is used in Medicare PPS and most Medicaid payment systems. There is a designated Case Mix Index (CMI) for each RUG-III category. The first step in index maximizing is to determine all of the RUG-III groups for which the patient qualifies. Then from the qualifying groups you choose the RUG-III group that has the highest case mix index. The index maximizing method uses the case mix indices effective with RUG-III changes on January 1, 2006.

While the present worksheet illustrates the hierarchical classification method, it can be adapted for index maximizing. To index maximize, you would evaluate all classification groups rather than assigning the patient to the first qualifying group. In the index maximizing approach, you again start at the beginning of the worksheet. You then work down through all of the 53 RUG-III classification groups, ignoring instructions to skip groups and noting each group for which the patient qualifies. When you finish, record the CMI for each of these groups. Select the group with the highest CMI. This group is the index-maximized classification for the patient.

If the patient qualifies in an Extensive Services group and a Special Care group, choose the RUG-III classification with the higher CMI. Likewise, if the patient qualifies for Special Care and Clinically Complex, again choose the RUG-III classification with the higher CMI. Always select the classification with the highest CMI.

CALCULATION OF TOTAL "ADL" SCORE
RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION

The ADL score is used in all determinations of a patient's placement in a RUG-III category. It is a very important component of the classification process.

► *STEP # 1*

To calculate the ADL score use the following chart for **Item 23a** (Bed Mobility), **Item 23b** (Transfer), and **Item 23d** (Toilet Use). **Enter the ADL scores to the right.**

Column A =		***Column B =***	***ADL score =***	***SCORE***
-, 0 or 1	**and**	(any number)	= 1	23a = _____
2	**and**	(any number)	= 3	23b = _____
3, 4, or 8	**and**	-, 0, 1 or 2	= 4	23d = _____
3, 4, or 8	**and**	3 or 8	= 5	

► *STEP # 2*

If **Item 29a** (Parenteral/IV) is checked, the eating ADL score is 3. If **Item 29b** (Feeding Tube) is checked and EITHER (1) **Item 30a** is 51 % or more calories OR (2) **Item 30a** is 26% to 50% calories and **Item 30b** is 501cc or more per day fluid enteral intake, then the eating ADL score is 3**. Enter the ADL eating score (23c) below and total the ADL score. If not*, go to Step #3.***

► *STEP # 3*

If neither **Item 29a** nor **Item 29b** (with appropriate intake) are checked, evaluate the chart below for **Item 23cA** (Eating Self-performance). *Enter the score to the right* and total the ADL score. This is the RUG-III **TOTAL ADL SCORE.** (The total ADL score range possibilities are 4 through 18.)

Column A (23c) =	***ADL score =***	***EATING SCORE***
-, 0 or 1	= 1	23c = _____
2	= 2	
3, 4, or 8	= 3	

TOTAL RUG-III ADL SCORE _____

CATEGORY I: REHABILITATION PLUS EXTENSIVE SERVICES

RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION

You start the classification process beginning at the Rehabilitation Plus Extensive Services level. In order for a patient to qualify for this category, he/she must meet 3 requirements, which are 1) have an ADL score of 7 or more, 2) meet one of the criteria for Extensive Services category, and 3) meet the criteria for one of the Rehabilitation categories.

► *STEP # 1*

Determine the patient's ADL score. **If the patient's ADL score is 7 or higher go to step 2.**

If the ADL score is less than 7, *skip to Category II* now.

► *STEP # 2*

Is the patient coded for receiving **one** or more of the following extensive services?

Item 29a	Parenteral / IV
Item 38ac	IV Medication
Item 38af	Suctioning
Item 38ag	Tracheostomy care
Item 38ai	Ventilator or respirator

If the patient does not receive one of the above, *skip to Category II* now.

► *STEP # 3*

Determine if the patient's rehabilitation therapy services satisfy the criteria for one of the RUG-III Rehabilitation groups. **If the patient does not meet all of the criteria for one Rehabilitation group (e.g., Ultra High Intensity), then move to the next group (e.g., Very High Intensity).**

A. **Ultra High Intensity Criteria**

In the last 7 days **(Item 38b [a, b, c]):**

720 minutes or more (total) of therapy per week **AND**
At least two disciplines, 1 for at least 5 days, **AND**
2nd for at least 3 days

RUG-III ADL Score	***RUG-III Class***
16 - 18	RUX
7 - 15	RUL

B. **Very High Intensity Criteria**

In the last 7 days **(Item 38b [a, b, c,]):**

500 minutes or more (total) of therapy per week **AND**
At least 1 discipline for at least 5 days

RUG-III ADL Score	***RUG-III Class***
16 - 18	RVX
7 - 15	RVL

C. **High Intensity Criteria** (either (1) or (2) below may qualify)

(1) In the last 7 days **(Item 38b [a, b, c])**:

325 minutes or more (total) of therapy per week **AND**
At least 1 discipline for at least 5 days

(2) **If this is a Medicare 5-day or a Medicare Readmission/Return Assessment, then the following apply (Item 42a, Item 42b, Item 42c and Item 38b [a, b, c]):**

Ordered Therapies, **Item 42a** is checked **AND**
In the last 7 days:

Received 65 or more minutes, **Item 38b [a, b, c]** **AND**

In the first 15 days from admission:

520 or more minutes expected, **Item 42c** **AND**
rehabilitation services expected on 8 or more days, **Item 42b**.

RUG-III ADL Score	***RUG-III Class***
13 - 18	RHX
7 - 12	RHL

D. **Medium Intensity Criteria** (either (1) or (2) below may qualify)

(1) In the last 7 days: **(Item 38b [a, b, c])**

150 minutes or more (total) of therapy per week **AND**
At least 5 days of any combination of the 3 disciplines

(2) **If this is a Medicare 5-day or a Medicare Readmission/Return Assessment, then the following apply: (Item 42a, Item 42b, Item 42c):**

Ordered Therapies, **Item 42a** is checked **AND**
In the first 15 days from admission:

240 or more minutes are expected, **Item 42c** **AND**
rehabilitation services expected on 8 or more days, **Item 42b**.

RUG-III ADL Score	***RUG-III Class***
15 - 18	RMX
7 - 14	RML

E. **Low Intensity Criteria** (either (1) or (2) below may qualify):

(1) In the last 7 days **(Item 38b [a, b, c] and Item 39):**

45 minutes or more (total) of therapy per week **AND**

At least 3 days of any combination of the 3 disciplines **AND**

2 or more nursing rehabilitation services* received for at least 15 minutes each with each administered for 6 or more days.

(2) **If this is a Medicare 5-day or a Medicare Readmission/Return Assessment, then the following apply (Item 39 and Item 42a, Item 42b, Item 42c):**

Ordered therapies **Item 42a** is checked **AND**

In the first 15 days from admission:

75 or more minutes are expected, **Item 42c** **AND**

rehabilitation services expected on 5 or more days, **Item 42b** **AND**

2 or more nursing rehabilitation services* received for at least 15 minutes each with each administered for 2 or more days, **Item 39.**

Nursing Rehabilitation Services

Items 24a,b*	***Any scheduled toileting program and/or bladder retraining program***
Items 39a,b*	***Passive and/or active ROM***
Item 39c	***Splint or brace assistance***
Items 39d,f*	***Bed mobility and/or walking training***
Item 39e	***Transfer training***
Item 39g	***Dressing or grooming training***
Item 39h	***Eating or swallowing training***
Item 39i	***Amputation/Prosthesis care***
Item 39j	***Communication training***

*****Count as one service even if both provided***

RUG-III ADL Score	***RUG-III Class***
7 - 18	RLX

RUG-III CLASSIFICATION _____

If the patient does not classify in the Rehabilitation Plus Extensive Services Category, *proceed to Category II*.

CATEGORY II: REHABILITATION
RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION

Rehabilitation therapy is any combination of the disciplines of physical, occupational, and speech therapy. This information is found in **Item 38b**. Nursing rehabilitation is also considered for the low intensity classification level. It consists of providing active or passive range of motion, splint/brace assistance, training in transfer, training in dressing/grooming, training in eating/swallowing, training in bed mobility or walking, training in communication, amputation/prosthesis care, any scheduled toileting program, and bladder retraining program. This information is found in **Item 39** and **Items 24a, b** of the SB-MDS.

► *STEP # 1*

Determine if the patient's rehabilitation therapy services satisfy the criteria for one of the RUG-III Rehabilitation groups. **If the patient does not meet all of the criteria for one Rehabilitation group (e.g., Ultra High Intensity), then move to the next group (e.g., Very High Intensity).**

A. **Ultra High Intensity Criteria**

In the last 7 days **(Item 38b [a, b, c]):**

720 minutes or more (total) of therapy per week **AND**
At least two disciplines, 1 for at least 5 days, **AND**
2nd for at least 3 days

RUG-III ADL Score	***RUG-III Class***
16 - 18	RUC
9 - 15	RUB
4 - 8	RUA

B. **Very High Intensity Criteria**

In the last 7 days **(Item 38b [a, b, c,]):**

500 minutes or more (total) of therapy per week **AND**
At least 1 discipline for at least 5 days

RUG-III ADL Score	***RUG-III Class***
16 - 18	RVC
9 - 15	RVB
4 - 8	RVA

C. **High Intensity Criteria** (either (1) or (2) below may qualify)

(1) In the last 7 days **(Item 38b [a, b, c])**:

325 minutes or more (total) of therapy per week **AND**
At least 1 discipline for at least 5 days

(2) **If this is a Medicare 5-day or a Medicare Readmission/Return Assessment, then the following apply (Item 42a, Item 42b, Item 42c and Item 38b [a, b, c]):**

Ordered Therapies, **Item 42a** is checked **AND**
In the last 7 days:
Received 65 or more minutes, **Item 38b [a, b, c]** **AND**
In the first 15 days from admission:
520 or more minutes expected, **Item 42c** **AND**
rehabilitation services expected on 8 or more days, **Item 42b**.

RUG-III ADL Score	***RUG-III Class***
13 - 18	RHC
8 - 12	RHB
4 - 7	RHA

D. **Medium Intensity Criteria** (either (1) or (2) below may qualify)

(1) In the last 7 days: **(Item 38b [a, b, c])**

150 minutes or more (total) of therapy per week **AND**
At least 5 days of any combination of the 3 disciplines

(2) **If this is a Medicare 5-day or a Medicare Readmission/Return Assessment, then the following apply: (Item 42a, Item 42b, Item 42c):**

Ordered Therapies, **Item 42a** is checked **AND**
In the first 15 days from admission:
240 or more minutes are expected, **Item 42c** **AND**
rehabilitation services expected on 8 or more days, **Item 42b**.

RUG-III ADL Score	***RUG-III Class***
15 - 18	RMC
8 - 14	RMB
4 - 7	RMA

E. **Low Intensity Criteria** (either (1) or (2) below may qualify):

(1) In the last 7 days **(Item 38b [a, b, c] and Item 39):**

45 minutes or more (total) of therapy per week **AND**
At least 3 days of any combination of the 3 disciplines **AND**
2 or more nursing rehabilitation services* received for at least 15 minutes each with each administered for 6 or more days.

(2) **If this is a Medicare 5-day or a Medicare Readmission/Return Assessment, then the following apply (Item 39 and Item 42a, Item 42b, Item 42c):**

Ordered therapies **Item 42a** is checked **AND**
In the first 15 days from admission:
75 or more minutes are expected, **Item 42c** **AND**
rehabilitation services expected on 5 or more days, **Item 42b** **AND**
2 or more nursing rehabilitation services* received for at least 15 minutes each with each administered for 2 or more days, **Item 39.**

Nursing Rehabilitation Services

Items 24a,b*	***Any scheduled toileting program and/or bladder retraining program***
Items 39a,b*	***Passive and/or active ROM***
Item 39c	***Splint or brace assistance***
Items 39d,f*	***Bed mobility and/or walking training***
Item 39e	***Transfer training***
Item 39g	***Dressing or grooming training***
Item 39h	***Eating or swallowing training***
Item 39i	***Amputation/Prosthesis care***
Item 39j	***Communication training***

*****Count as one service even if both provided***

RUG-III ADL Score	***RUG-III Class***
14 - 18	RLB
4 - 13	RLA

RUG-III CLASSIFICATION _____

If the patient does not classify in the Rehabilitation Category, *proceed to Category III*.

CATEGORY III: EXTENSIVE SERVICES
RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION

The classification groups in this hierarchy are based on various services provided. Use the following instructions to begin the calculation:

► *STEP # 1*

Is the patient coded for receiving **one** or more of the following extensive services?

Item 29a	Parenteral / IV
Item 38ac	IV Medication
Item 38af	Suctioning
Item 38ag	Tracheostomy care
Item 38ai	Ventilator or respirator

If the patient does not receive one of the above, *skip to Category IV* now.

► *STEP # 2*

If at least **one** of the above treatments is coded and the patient has a total RUG-III ADL score of 7 or more, he/she classifies as Extensive Services. ***Move to Step #3*. If the patient's ADL score is 6 or less, he/she classifies as Special Care (SSA*). *Skip to Category IV, Step #5* now and record the classification as SSA.**

► *STEP # 3*

The patient classifies in the Extensive Services category. To complete the scoring, however, an extensive count will need to be determined. If **Item 29a, Parenteral/IV** is checked, add 1 to the extensive count below. If **Item 38ac, IV Medication** is checked, add 1 to the extensive count below. To complete the extensive count, determine if the patient also meets the criteria for Special Care, Clinically Complex, and Impaired Cognition. The final split into either SE1, SE2, or SE3 will be completed after these criteria have been scored***. Go to Category IV, Step #1* now.**

Item 29a	Parenteral / IV
Item 38ac	IV Medication

Extensive Count _____

(Enter this count in Step #4 on Page 5-24.)

CATEGORY IV: SPECIAL CARE
RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION

The classification groups in this hierarchy are based on certain patient conditions or services. Use the following instructions:

► *STEP # 1*

Determine if the patient is coded for **one** of the following conditions or services:

Item 25c	Cerebral palsy, with ADL sum >=10
Item 25e	Multiple sclerosis, with ADL sum >=10
Item 25f	Quadriplegia, with ADL sum >=10
Item 27c	Fever and **one** of the following;
	Item 26a Pneumonia
	Item 27a Dehydration
	Item 27f Vomiting
	Item 28 Weight loss
	Item 29b Tube feeding*
Item 29b, Item 25b	Tube feeding* and aphasia
Items 31a,b,c,d	Ulcers 2+ sites over all stages with 2 or more skin treatments**
Item 32	Any stage 3 or 4 pressure ulcer with 2 or more skin treatments**
Items 33b,c	Surgical wounds or open lesions with 1 or more skin treatments***
Item 38ae	Radiation treatment
Item 38bdA	Respiratory therapy =7 days

Tube feeding classification requirements:

(1) Item* 30a *is 51% or more calories **OR**

(2) Item* 30a *is 26% to 50% calories and Item* 30b *is 501 cc or more per day fluid enteral intake in the last 7 days.

*****Skin treatments:***

Items 34a, b#	***Pressure relieving chair and/or bed***
Item 34c	***Turning/repositioning***
Item 34d	***Nutrition or hydration intervention***
Item 34e	***Ulcer care***
Item 34g	***Application of dressings (not to feet)***
Item 34h	***Application of ointments (not to feet)***

#Count as one treatment even if both provided

******Skin Treatments***

Item 34f	***Surgical wound care***
Item 34g	***Application of dressing (not to feet)***
Item 34h	***Application of ointments (not to feet)***

If the patient does not have one of the above conditions, *skip to Category V* now.

► *STEP # 2*

If at least one of the special care conditions above is met:

a. If the patient previously qualified for Extensive Services, proceed to Extensive Count Determination. ***Go to Step #3.*** **OR**

b. If the RUG-III ADL score is 7 or more, the patient classifies as Special Care. ***Go to Step #4.*** **OR**

c. If the RUG-III ADL score is 6 or less, the patient classifies as Clinically Complex. ***Skip to Category V, Step #4.***

► *STEP # 3 (Extensive Count Determination)*

If the patient previously met the criteria for the Extensive Services category and the evaluation of the Special Care category is done only to determine if the patient is an SE1, SE2, or SE3, **enter 1 for the extensive count below and *skip to Category V, Step #1.***

Extensive Count _____
(Enter this count in Step #4 on Page 5-24.)

► *STEP # 4*

If at least one of the special care conditions above is coded and the RUG-III ADL score is 7 or more, **the patient classifies in the Special Care category. Select the Special Care classification below based on the ADL score and *record this classification in Step #5:***

RUG-III ADL Score	***RUG-III Class***
17 - 18	SSC
15 - 16	SSB
7 - 14	SSA

► *STEP #5*

Record the appropriate Special Care classification:

RUG-III CLASSIFICATION _____

CATEGORY V: CLINICALLY COMPLEX
RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION

The classification groups in this category are based on certain patient conditions. Use the following instructions:

► *STEP # 1*

Determine if the patient is coded for **one** of the following conditions or services:

Item 17	Coma **(Item 17 =1)** and not awake **(Items 36a,b,c = 0)** and completely ADL-dependent **(Item 23aA, Item 23bA, Item 23cA, Item 23dA= 4 or 8)**
Item 25a, Item 37, Item 41	Diabetes mellitus and injection 7 days and Physician order changes >= 2 days
Item 25d	Hemiplegia with ADL sum >=10
Item 26a	Pneumonia
Item 26b	Septicemia
Item 27a	Dehydration
Item 27e	Internal bleeding
Item 29b	Tube feeding*
Item 33a	Burns
Items 35a,b,c	Infection of foot (**Item 35a or Item 35b**) with treatment in **Item 35c**
Item 38aa	Chemotherapy
Item 38ab	Dialysis
Item 38ad	Oxygen therapy
Item 38ah	Transfusions
Item 40, Item 41	Number of Days in last 14, Physician Visit/order changes: Visits >= 1 day and changes >= 4 days **OR** Visits >= 2 days and changes >= 2 days

Tube feeding classification requirements

(1) Item 30a is 51% or more calories OR

(2) Item 30a is 26% to 50% calories and Item 30b is 501 cc or more per day fluid enteral intake in the last 7 days.

If the patient does not have one of the above conditions, *skip to Category VI* now.

► *STEP # 2*

If at least one of the clinically complex conditions above is met:

a. Extensive Count Determination. ***Go to Step #3*** **OR**

b. Clinically Complex classification. The patient classifies as Clinically Complex. ***Go to Step #4.***

► *STEP # 3 (Extensive Count Determination)*

If the patient previously met the criteria for the Extensive Services category, and the evaluation of the Clinically Complex category is done only to determine if the patient is an SE1, SE2, or SE3, **enter 1 for the extensive count below and *skip to Category VI Step #1***.

Extensive Count _____
(Enter this count in Step #4 on Page 5-24.)

► *STEP # 4*

Evaluate for Depression. Signs and symptoms of a depressed or sad mood are used as a third level split for the Clinically Complex category. Patients with a depressed or sad mood are identified by the presence of a combination of symptoms, as follows:

Count the number of indicators of depression. The patient is considered depressed if he/she has at least 3 of the following:

(Indicator exhibited in last 30 days and coded "1" or "2")

Item 21a	Negative statements
Item 21b	Repetitive questions
Item 21c	Repetitive verbalization
Item 21d	Persistent anger with self and others
Item 21e	Self deprecation
Item 21f	Expressions of what appear to be unrealistic fears
Item 21g	Recurrent statements that something terrible is going to happen
Item 21h	Repetitive health complaints
Item 21i	Repetitive anxious complaints/concerns (Non-health related)
Item 21j	Unpleasant mood in morning
Item 21k	Insomnia/changes in usual sleep pattern
Item 21l	Sad, pained, worried facial expression
Item 21m	Crying, tearfulness
Item 21n	Repetitive physical movements
Item 21o	Withdrawal from activities of interest
Item 21p	Reduced social interaction

Does the patient have 3 or more indicators of depression? **YES**_____ **NO**_____

➤ *STEP # 5*

Assign the Clinically Complex category based on both the ADL score and the presence or absence of depression.

RUG-III ADL Score	***Depressed***	***RUG-III Class***
17 - 18	YES	CC2
17 - 18	NO	CC1
12 - 16	YES	CB2
12 - 16	NO	CB1
4 - 11	YES	CA2
4 - 11	NO	CA1

RUG-III CLASSIFICATION _____

CATEGORY VI: IMPAIRED COGNITION
RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION

► *STEP # 1*

Determine if the patient is cognitively impaired according to the RUG-III Cognitive Performance Scale (CPS). The patient is cognitively impaired if **one** of the three following conditions exists:

(1) **Item 17** Coma **(Item 17 = 1)** and not awake **(Item 36a, b, c = 0)** and completely ADL **dependent (Item 23aA, Item 23bA, Item 23cA, Item 23dA = 4 or 8)**

(2) **Item 19** Severely impaired cognitive skills **(Item 19 = 3)**

(3) **Item 18, Item 19, Item 20**

These three **Items (18, 19, and 20)** are all assessed with none being blank or unknown (value N/A or "-")

AND

Two or more of the following impairment indicators are present

Item 18 = 1	Short-term memory problem
Item 19 > 0	Cognitive skills problem
Item 20 > 0	Problem being understood

AND

One or more of the following severe impairment indicators are present:

Item 19 >= 2	Severe cognitive skills problem
Item 20 >= 2	Severe problem being understood

If the patient does not meet the criteria for cognitively impaired:

a. and the evaluation is being done to determine if the patient is in SE1, SE2, or SE3, ***skip to Step #4*** **on Page 5-24 "Category III: Extensive Services (cont.)." OR**

b. ***Skip to Category VII*** **now.**

► *STEP # 2*

If the patient meets the criteria for cognitive impairment:

a. Extensive Count Determination. ***Go to Step #3.*** **OR**

b. Impaired Cognition classification. The patient may classify as Impaired Cognition. ***Go to Step #4.***

► *STEP # 3 (Extensive Count Determination)*

If the patient previously met the criteria for the Extensive Services category, and the evaluation of the Impaired Cognition category is done to determine if the patient is in SE1, SE2, or SE3, **enter 1 for the extensive count below and *skip to Step #4* on Page 5-24, "Category III: Extensive Services (cont.)".**

Extensive Count _____
(Enter this count in Step #4 on Page 5-24.)

► *STEP # 4*

The patient's total RUG-III ADL score must be 10 or less to be classified in the RUG-III Impaired Cognition category. **If the ADL score is greater than 10, *skip to Category VIII* now. If the ADL score is 10 or less and one of the impaired cognition conditions above is present, then the patient classifies as Impaired Cognition. *Proceed with Step #5.***

► *STEP # 5*

Determine Nursing Rehabilitation Count

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

Enter the nursing rehabilitation count to the right.

Items 24a,b*	***Any scheduled toileting program and/or bladder retraining program***
Items 39a,b*	***Passive and/or active ROM***
Item 39c	***Splint or brace assistance***
Item 39d,f*	***Bed mobility and/or walking training***
Item 39e	***Transfer training***
Item 39g	***Dressing or grooming training***
Item 39h	***Eating or swallowing training***
Item 39i	***Amputation/Prosthesis care***
Item 39j	***Communication training***

****Count as one service even if both provided***

Nursing Rehabilitation Count _____

► *STEP # 6*

Select the final RUG-III classification by using the total RUG-III ADL score and the Nursing Rehabilitation Count.

RUG-III ADL Score	***Nursing Rehabilitation***	***RUG-III Class***
6 - 10	2 or more	IB2
6 - 10	0 or 1	IB1
4 - 5	2 or more	IA2
4 - 5	0 or 1	IA1

RUG-III CLASSIFICATION _____

CATEGORY III: EXTENSIVE SERVICES (cont.)
RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION

If the patient previously met the criteria for the Extensive Services category with an ADL score of 7 or more, complete the Extensive Services classification here.

► *STEP # 4 (Extensive Count Determination)*

Complete the scoring of the Extensive Services by summing the extensive count items:

Page 5-16	Extensive Count - Extensive Services	_____
Page 5-18	Extensive Count - Special Care	_____
Page 5-20	Extensive Count - Clinically Complex	_____
Page 5-23	Extensive Count - Impaired Cognition	_____
	Total Extensive Count	_____

Select the final Extensive Service classification using the Total Extensive Count.

Extensive Count	***RUG-III Class***
4 or 5	SE3
2 or 3	SE2
0 or 1	SE1

RUG-III CLASSIFICATION _____

CATEGORY VII: BEHAVIOR PROBLEMS
RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION

► *STEP # 1*

The patient's total RUG-III ADL score must be 10 or less. **If the score is greater than 10, *skip to Category VIII* now.**

► *STEP # 2*

One of the following must be met:

Item 22a	Wandering (2 or 3)
Item 22b	Verbal abuse (2 or 3)
Item 22c	Physical abuse (2 or 3)
Item 22d	Inappropriate behavior (2 or 3)
Item 22e	Resisted care (2 or 3)
Item 27b	Delusions
Item 27d	Hallucinations

If the patient does not meet one of the above*, skip to Category VIII* now.

► *STEP # 3*

Determine Nursing Rehabilitation

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

Enter the nursing rehabilitation count to the right.

Items 24a,b*	***Any scheduled toileting program and/or bladder retraining program***
Items 39a,b*	***Passive and/or active ROM***
Item 39c	***Splint or brace assistance***
Item 39d,f*	***Bed mobility and/or walking training***
Item 39e	***Transfer training***
Item 39g	***Dressing or grooming training***
Item 39h	***Eating or swallowing training***
Item 39i	***Amputation/Prosthesis care***
Item 39j	***Communication training***

****Count as one service even if both provided.***

Nursing Rehabilitation Count _____

➤ *STEP # 4*

Select the final RUG-III classification by using the total RUG-III ADL score and the Nursing Rehabilitation Count.

RUG-III ADL Score	***Nursing Rehabilitation***	***RUG-III Class***
6 - 10	2 or more	BB2
6 - 10	0 or 1	BB1
4 - 5	2 or more	BA2
4 - 5	0 or 1	BA1

RUG-III CLASSIFICATION _____

CATEGORY VIII: REDUCED PHYSICAL FUNCTION

RUG-III, 53 GROUP HIERARCHICAL CLASSIFICATION

► *STEP # 1*

Patients who do not meet the conditions of any of the previous categories, including those who would meet the criteria for the Impaired Cognition or Behavior Problems categories but have a RUG-III ADL score greater than 10, are placed in this category.

► *STEP # 2*

Determine Nursing Rehabilitation

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

Enter the nursing rehabilitation count to the right.

Items 24a,b*	***Any scheduled toileting program and/or bladder retraining program***
Items 39a,b*	***Passive and/or active ROM***
Item 39c	***Splint or brace assistance***
Items 39d,f*	***Bed mobility and/or walking training***
Item 39e	***Transfer training***
Item 39g	***Dressing or grooming training***
Item 39h	***Eating or swallowing training***
Item 39i	***Amputation/Prosthesis care***
Item 39j	***Communication training***

****Count as one service even if both provided***

Nursing Rehabilitation Count _____

► *STEP # 3*

Select the RUG-III classification by using the RUG-III ADL score and the Nursing Rehabilitation Count.

RUG-III ADL Score	***Nursing Rehabilitation***	***RUG-III Class***
16 - 18	2 or more	PE2
16 - 18	0 or 1	PE1
11 - 15	2 or more	PD2
11 - 15	0 or 1	PD1
9 - 10	2 or more	PC2
9 - 10	0 or 1	PC1
6 - 8	2 or more	PB2
6 - 8	0 or 1	PB1
4 - 5	2 or more	PA2
4 - 5	0 or 1	PA1

RUG-III CLASSIFICATION _____

APPENDIX A

GLOSSARY AND COMMON ACRONYMS

Glossary

Activities of **D**aily **L**iving	**ADL**	Activities of daily living are those needed for self-care: bathing, dressing, mobility, toileting, eating, and transferring. The late-loss ADLs (eating, toileting, bed mobility, and transferring) are used in classifying a patient into a RUG-III group.
Assessment Period		The time period during which the assessment coordinator starts the assessment until it is signed as complete.
Assessment **R**eference **D**ate	**ARD**	The last day of the observation period for the SB-MDS assessment. All SB-MDS items refer back in time from this common endpoint. May also be referred to as the "Target Date" in CMS system-generated reports. The SB-MDS field name is 10a.
Assessment Window		The period of time defined by Medicare regulations that specify when the Assessment Reference Date must be set. For example, the assessment window for a Medicare 5-Day assessment is between days 1-8, including grace days.
Browser		A program, such as Internet Explorer or Netscape, that allows access to the internet or a private intranet site. A browser with 128-bit encryption is necessary to access the CMS intranet for data submission or report retrieval.
Case **M**ix **I**ndex	**CMI**	Weight or numeric score assigned to each RUG-III group that reflects the relative resources predicted to provide care to a patient. The higher the case mix weight, the greater the resource requirements for the patient.
Case Mix Reimbursement System		A payment system that measures the intensity of care and services required for each patient, and translates these measures into the amount of reimbursement given to the facility for care of a patient. Payment is linked to the intensity of resource use.
Centers for **M**edicare and **M**edicaid **S**ervices	**CMS**	Formerly known as HCFA, the Federal agency that administers the Medicare, Medicaid, and Child Health Insurance Programs.

Clinical **C**hange **A**ssessment	**CCA**	An assessment required when there is a decline or improvement in a patient's status that a) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, b) impacts more than one area of the patient's health status, and c) requires interdisciplinary review and/or revision of the plan of care.
Code of **F**ederal **R**egulations	**CFR**	A codification of the general and permanent rules published in the *Federal Register* by the Executive departments and agencies of the Federal Government. The CFR is divided into 50 titles that represent broad areas subject to Federal regulation. Each title is divided into chapters that usually bear the name of the issuing agency. Each chapter is further subdivided into parts covering specific regulatory areas. Large parts may be subdivided into subparts. All parts are organized in sections, and most citations to the CFR will be provided at the section level.
Cognitive **P**erformance **S**cale	**CPS**	The measure of cognitive status used in the RUG-III Classification system.
Discharge		For the purposes of the SB-MDS, a discharge is reported when a patient leaves the facility for more than 24 hours for other than a temporary home visit or therapeutic leave, or is admitted to the hospital.
Dually Certified Facilities		Nursing facilities that participate in both the Medicare and Medicaid programs.
Facility **ID**	**FACID**	The facility identification number is assigned to each nursing facility by the State agency. The FACID must be placed in the header record in each SB-MDS file, and in the individual SB-MDS and tracking form records. This normally is completed as a function within the facility's SB-MDS data entry software.
Fatal File		An SB-MDS file that has an error in the format and causes the entire file to be rejected. The individual records are not validated or stored in the database. The facility must contact its software support to resolve the problem with the submission file.

Fatal Record		An SB-MDS record that has an error severe enough to result in record rejection. A fatal record is not saved in the CMS database. The facility must correct the error that caused the rejection and resubmit a corrected original record.
Federal Register		The official daily publication for rules, proposed rules and notices of Federal agencies and organizations, as well as Executive Orders and other Presidential Documents. It is a publication of the National Archives and Records Administration, and is available by subscription and on-line. The web site is http://www.gpoaccess.gov/fr/index.html.
Final **V**alidation **R**eports	**FVR**	A report generated after the successful submission of SB-MDS assessment data. This report lists all of the patients for whom assessments have been submitted in a particular submission batch, and displays all errors and/or warnings that occurred during the validation process. A FVR with a submission type of "production" is a facility's documentation for successful file submission. An individual record listed on the FVR marked as "accepted" is documentation for successful record submission.
Fiscal **I**ntermediary	**FI**	An organization designated by CMS to process Medicare claims for payment that are submitted by a swing bed facility.
F-Tag		Numerical designations for criteria reviewed during the facility survey.
Grace Days		Additional days that may be added to the assessment window for Medicare assessments without incurring financial penalty. These may be used in situations such as an absence/illness of the RN assessor, reassignment of the assessor to other duties for a short period of time, or an unusually large number of assessments due at approximately the same time. Grace days may also be used to more fully capture therapy minutes or other treatments.
Header		The first record in an SB-MDS file submitted to the CMS Data Collection System. This record contains facility and software vendor information for the subsequent records within the file.
Health **C**are **F**inance **A**dministration	**HCFA**	Former name for CMS, (see CMS).

Health **I**nsurance **P**ortability and **A**ccountability **A**ct of 1996	**HIPAA**	Federal law that gives the Department of Health and Human Services (DHHS) the authority to mandate regulations that govern privacy, security, and electronic transactions standards for health care information.
Health **I**nsurance **P**rospective **P**ayment **S**ystem	**HIPPS**	Billing codes used when submitting claims to the FI for Medicare payment.
Hierarchy		The ordering of groups within the RUG-III Classification system. A hierarchy begins with groups with the highest resource use and descends to those groups with the lowest resource use. The RUG-III Classification system has 8 hierarchical groups: Rehabilitation Plus Extensive Services, Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Functions.
Inactivation		A type of correction allowed under the SB-MDS Correction Policy. When an invalid record has been accepted into the database, a correction record is submitted with inactivation selected as the type of correction.
Index Maximizing		The process of RUG-III Classification where the RUG-III category with the highest case mix index (CMI) is selected from all of the possible groups in which a patient's assessment is classified.
Initial **F**eedback **R**eport	**IFR**	The first report generated by the CMS Data Collection System after an SB-MDS data file is electronically submitted. This report validates the file structure, provides the submission batch ID, and indicates whether the file has been accepted or rejected. If the file has been accepted, each record will go through the edit process and be reported on the final validation report. If the file is rejected, there will be no final validation report.
Internal Assessment ID		A sequential numeric identifier assigned to each record submitted to the CMS Data Collection System.

Invalid Record		As defined by the SB-MDS Correction Policy, a record that was accepted into the CMS Data Collection System that should not have been submitted. Invalid records are defined as: a test record submitted as production, a record for an event that did not occur, a record with the wrong patient identified, or the wrong reason for assessment, or submission of an inappropriate non-required record.
Login ID		A State-assigned facility identifier required to access the CMS Data Collection System. This may or may not be the same as the Facility ID.
Look Back Period		A period of time in the past 7, 14, or 30 days from the Assessment Reference Date that is used when completing certain sections of the SB-MDS.
Medicaid		A Federal and State program subject to the provisions of Title XIX of the Social Security Act that pays for specific kinds of medical care and treatment for low-income families.
Medicare		A health insurance program administered by CMS under provisions of Title XVIII of the Social Security Act for people aged 65 and over, for those who have permanent kidney failure, and for certain people with disabilities. **Medicare Part A:** The part of Medicare that covers inpatient hospital services and services furnished by other institutional health care providers, such as nursing facilities, swing bed programs, home health agencies, and hospices. **Medicare Part B:** The part of Medicare that covers services of doctors, suppliers of medical items and services, and various types of outpatient services.
Medicare **D**ata **C**ommunications **N**etwork	**MDCN**	A secure dial-up connection through the AT&T Global Network that is used to transmit SB-MDS data to the national repository. A user ID and password is issued and maintained by the MDCN Help Desk for each person who requires access to the CMS SB-MDS intranet through this network.
Minimum **D**ata **S**et	**MDS**	A core set of screening, clinical, and functional status elements, including common definitions and coding categories that forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare and Medicaid.

Nursing **F**acility	**NF**	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health related care services above the level of custodial care to other than mentally retarded individuals.
Observation Period		The time period, ending with the Assessment Reference Date, which is used by all staff for gathering information for an SB-MDS assessment.
Omnibus **B**udget **R**econciliation **A**ct of 1987	**OBRA '87**	Law that enacted reforms in nursing facility care and provides the statutory authority for the MDS. The goal is to ensure that residents of nursing facilities receive quality care that will help them to attain or maintain the highest practicable, physical, mental, and psychosocial well-being.
Other **M**edicare **R**equired **A**ssessment	**OMRA**	An assessment required when a Medicare Part A patient that was in a RUG-III Rehabilitation Plus Extensive Services or Rehabilitation Classification, continues to require skilled care after all therapy is discontinued. This assessment is to be done 8-10 days after the cessation of therapies in order to re-calculate the RUG Classification from a therapy RUG to a non-therapy group.
Other **S**tate **R**equired **A**ssessment	**OSRA**	A specific assessment required by a state in addition to assessments required by OBRA regulation or for Medicare. These assessments are defined by State regulations and are usually used for State Medicaid reimbursement systems.
Peer **R**eview **O**rganization	**PRO**	See QIO – Quality Improvement Organization
Post **A**cute **C**are	**PAC**	Refers to patients who are admitted to a facility following an acute care hospitalization. Their stay is usually of short duration, about 30 days or less.
Program Memorandums		Official agency transmittals used for communicating reminder items, request for action or information of a one time only, non-recurring nature. Program Memos can be found at the following web site: **http://www.cms.hhs.gov/manuals/memos/comm_date_dsc.asp**

Program Transmittals		Transmittal pages summarize the instructions to providers, emphasizing what has been changed, added or clarified. They provide background information that would be useful in implementing the instructions. Program Transmittals can be found at the following web site: **http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp**
Prospective **P**ayment **S**ystem	**PPS**	A payment system, developed for Medicare skilled nursing facilities and swing bed hospitals, that pays facilities an all-inclusive rate for all Medicare Part A beneficiary services. Payment is determined by a case mix classification system that categorizes patients by the type and intensity of resources used.
PPS Assessments		Those assessments required by Medicare Prospective Payment Regulations for patients in a Medicare Part A stay. Each Medicare assessment is classified into a RUG-III group based on the clinical resource needs as recorded on the SB-MDS assessment and is used to determine the Medicare reimbursement rate. PPS assessments are: 5-Day, 14-Day, 30-Day, 60-Day, 90-Day, OMRA and Return/Readmission.
Quality **I**mprovement and **E**valuation **S**ystem	**QIES**	The umbrella system that encompasses the MDS and SB-MDS system as well as other systems for survey and certification, and home health providers.
Quality **I**mprovement **O**rganization	**QIO**	A program administered by CMS that is designed to monitor and improve utilization and quality of care for Medicare beneficiaries. The program consists of a national network of 53 QIOs (formerly known as Peer Review Organizations or PRO) responsible for each U.S. territory and the District of Columbia. Their mission is to ensure the quality, effectiveness, efficiency, and economy of healthcare services provided to Medicare beneficiaries.
Record Type		A code submitted in the SB-MDS and tracking records used to identify certain combinations of reasons for assessment.
Reentry		When a patient returns to a facility following a temporary discharge (return anticipated).

Registered **N**urse **A**ssessment **C**oordinator	**RNAC**	An individual, licensed as a registered nurse by the State Board of Nursing and employed by a nursing facility, who is responsible for coordinating and certifying completion of the resident assessment.
Resident **A**ssessment **V**alidation and **EN**try System for **S**wing-**B**eds	**RAVEN-SB**	Data entry software supplied by CMS for swing-bed hospitals used to enter SB-MDS assessment data.
Resource Use		The measure of the number of minutes of care used to develop the classification system. Direct and indirect time is obtained from RNs, LPNs, nursing assistants, physical, occupational and speech therapists, social workers, and activity staff. An index score is created based on the amount of staff time, weighted by staff salary and benefits.
Resource **U**tilization **G**roup, Version III	**RUG-III**	A category-based classification system in which nursing facility residents and swing bed patients classify into one of 53 or 44 or 34 RUG-III groups. Patients in each group utilize similar quantities and patterns of resource. Assignment of a resident to a RUG-III group is based on certain item responses on the SB-MDS. Medicare uses the 53-group classification.
SB-MDS Completion Date		The date at which the RN assessment coordinator indicates that all portions of the SB-MDS have been completed. For SB-MDS, this is the date at Item 45b.
Skilled **N**ursing **F**acility	**SNF**	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or on a regular basis, health related care services above the level of custodial care to other than mentally retarded individuals.
Submission **Req**uirement	**SUB_REQ**	A field in the SB-MDS electronic record that identifies the authority for data collection. CMS has authority to collect assessments for all patients (regardless of their payer source) who reside in Medicare- and/or Medicaid- certified units. States may or may not have regulatory authority to collect assessments for patients in non-certified units.

Swing-**B**ed **MDS**	**SB-MDS**	MDS assessments completed by swing-bed hospitals for Medicare Prospective Payment.
System **O**f **R**ecords	**SOR**	Standards for collection and processing of personal information as defined by the Privacy Act of 1974.
Target Date		A term used in CMS system-generated reports. This date is the Assessment Reference Date for an assessment, date of discharge for a discharge, and date of reentry for a reentry.
Transfer		When a patient leaves a swing bed, either temporarily or permanently, and goes to another health care setting.
Validation Report		See FVR or Final Validation Report.

Common Acronyms

ADLs	Activities of Daily Living
AHEs	Average Hourly Earnings
ARD	Assessment Reference Date
BBA-97	Balanced Budget Act of 1997
BBRA	Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999
BEA	(U.S) Bureau of Economic Analysis
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000
BLS	(U.S.) Bureau of Labor Statistics
CBSA	Core-Based Statistical Area
CAH	Critical Access Hospital
CCA	Clinical Change Assessment
CFR	Code of Federal Regulations
CLIA	Clinical Laboratory Improvements Amendments (1998)
CMS	Centers for Medicare and Medicaid Services
COTA	Certified Occupational Therapist Assistant
CPI	Consumer Price Index
CPI-U	Consumer Price Index for All Urban Consumers
CPT	(Physicians) Current Procedural Terminology
CR	Change Request
CWF	Common Working File
DME	Durable Medical Equipment
DMERC	Durable Medical Equipment Regional Carrier
DOS	Dates of Service
ECI	Employment Cost Index
ESRD	End Stage Renal Disease
FI	Fiscal Intermediary
FMR	Focused Medial Review
FR	Final Rule
FY	Fiscal Year
GME	Graduate Medical Education
HCFA	Health Care Financing Administration
HCFA Pub. 10	Hospital Manual
HCFA Pub. 12	Skilled Nursing Facility Manual
HCFA Pub. 7	State Operations Manual
HCFA Pub.13-3	Medicare Intermediary Manual, Claims Process, Part 3
HCPCS	Healthcare Common Procedure Coding System
HIPPS	Health Insurance Prospective Payment System (Rate Codes)
ICD-9-CM	International Classification of Diseases, Ninth Edition, Clinical Modification Revision

IFC	Interim Final Rule with Comment
IOM	Internet-Only Manual
LOA	Leave of Absence
MDS	Minimum Data Set
MEDPAR	Medicare Provider Analysis and Review (File)
MIM	Medicare Intermediary Manual
MPAF	Medicare Prospective Payment System Assessment Form
MRI	Magnetic Resonance Imaging
MSA	Metropolitan Statistical Area
NCS	National Supplier Clearinghouse
NDM	National Data Mover
NECMA	New England Country Metropolitan Area
NSC	National Supplier Clearinghouse
OBRA '87	Omnibus Budget Reconciliation Act of 1987
OMB	Office of Management and Budget
OMRA	Other Medicare Required Assessment
OT	Occupational Therapy/Therapist
PCE	Personal Care Expenditures
PIM	Program Integrity Manual
PM	Program Memorandum
POS	Point of Service
PPI	Producer Price Index
PPS	Prospective Payment System
PRM	Provider Reimbursement Manual
PT	Physical Therapy/Therapist
PTA	Physical Therapist Assistant
Pub. 100-1	Medicare General Information, Eligibility, and Entitlement IOM
Pub. 100-2	Medicare Benefit IOM
Pub. 100-4	Medicare Claims Processing IOM
Pub. 100-7	Medicare State Operations IOM
Pub. 100-8	Medicare Program Integrity IOM
Pub. 100-12	State Medicaid IOM
QIO	Quality Improvement Organization
RAI	Resident Assessment Instrument
RUG	Resource Utilization Group
SB-MDS	Swing Bed Minimum Data Set
SB-PPS	Swing Bed Prospective Payment System
SNF	Skilled Nursing Facility
SNF PPS	Skilled Nursing Facility Prospective Payment System
SLP (or ST)	Speech Language Pathology Services
STM	Staff Time Measure

APPENDIX B

CONTACT INFORMATION

1. The following Centers for Medicare and Medicaid Services (CMS) website should be monitored for swing bed updates.

   www.cms.gov/providers/snfpps/snfpps_swingbed.asp

2. Iowa Foundation for Medical Care (IFMC) is the contractor responsible for SB-MDS data submission.

   Help Desk: **1-800-339-9313**

   Email Address: **swing_help@ifmc.org**

3. For SB-MDS Prospective Payment System questions or billing questions, contact your Fiscal Intermediary.

4. For questions on completion of MDS items, contact your State RAI Coordinator. Refer to Pages B-3 thru B-5.

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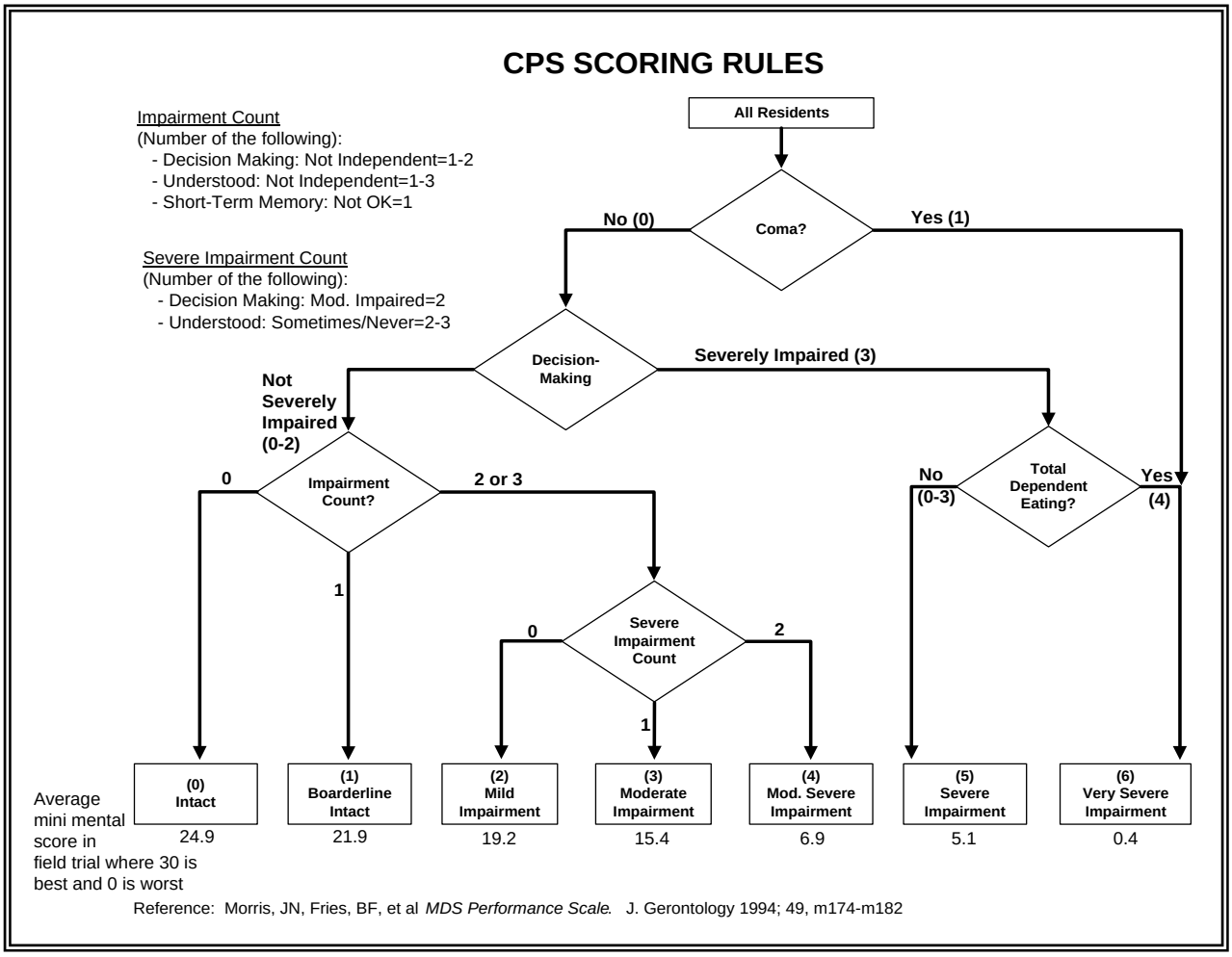
NOTE: Not included in this manual is a list of the State MDS Automation Coordinators and the State Medicaid MDS Coordinators. These lists will be posted on the CMS web site at: **http://www.cms.hhs.gov/medicaid/mds20**.

APPENDIX C

CPS SCORING RULES



The CPS scale is used in the RUG-III Classification system to measure a patient's cognitive performance. The RUG-III Classification system uses the CPS scale to identify patients who demonstrate moderate to severe cognitive impairment as a basis for classification in the Impaired Cognition RUG-III groups.

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