

**Centers for Medicare &
Medicaid Services**



**Long-Term Care
Facility Resident
Assessment
Instrument
User's Manual**

Version 3.0

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Questions regarding information presented in this Manual should be directed to your State's RAI Coordinator. Please continue to check our web site for more information at:

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS30Appendix_B.pdf

three components of the RAI yields information about a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified. Each component flows naturally into the next as follows:

- **Minimum Data Set.** A core set of screening, clinical, and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within nursing homes, between nursing homes, and between nursing homes and outside agencies. The required subsets of data items for each MDS assessment and tracking document (e.g., admission, quarterly, annual, significant change, significant correction, discharge, entry tracking, PPS assessments, etc.) can be found in Appendix H.
- **Care Area Assessment (CAA) Process.** This process is designed to assist the assessor to systematically interpret the information recorded on the MDS. Once a care area has been triggered, nursing home providers use current, evidence-based clinical resources to conduct an assessment of the potential problem and determine whether or not to care plan for it. The CAA process helps the clinician to focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the resident. The CAA process is explained in detail in Chapter 4. Specific components of the CAA process include:
 - **Care Area Triggers (CATs)** are specific resident responses for one or a combination of MDS elements. The triggers identify residents who have or are at risk for developing specific functional problems and require further assessment.
 - **Care Area Assessment** is the further investigation of triggered areas, to determine if the care area triggers require interventions and care planning. The **CAA** resources are provided as a courtesy to facilities in Appendix C. These resources include a compilation of checklists and Web links that may be helpful in performing the assessment of a triggered care area. The use of these resources are not mandatory and represent neither an all-inclusive list nor government endorsement.
 - **CAA Summary (Section V of the MDS 3.0)** provides a location for documentation of the care area(s) that have triggered from the MDS and the decisions made during the CAA process regarding whether or not to proceed to care planning.
- **Utilization Guidelines.** The Utilization Guidelines provide instructions for when and how to use the RAI. These include instructions for completion of the RAI as well as structured frameworks for synthesizing MDS and other clinical information (available from http://cms.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf).

1.3 Completion of the RAI

Over time, the various uses of the MDS have expanded. While its primary purpose is an assessment tool is used to identify resident care problems that are addressed in an individualized care plan, data collected from MDS assessments is also used for the SNF PPS Medicare reimbursement system, many State Medicaid reimbursement systems, and monitoring the quality of care provided to nursing home residents. The MDS instrument has also been adapted for use

by non-critical access hospitals with a swing bed agreement. They are required to complete the MDS for reimbursement under the Skilled Nursing Facility Prospective Payment System (SNF PPS).

- **Medicare and Medicaid Payment Systems.** The MDS contains items that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status. The MDS is used as a data collection tool to classify Medicare residents into RUGs (Resource Utilization Groups). The RUG classification system is used in SNF PPS for skilled nursing facilities, non-critical access hospital swing bed programs, and in many State Medicaid case mix payment systems to group residents into similar resource usage categories for the purposes of reimbursement. More detailed information on the SNF PPS is provided in Chapters 2 and 6. Please refer to the Medicare Internet-Only Manuals, including the Medicare Benefit Policy Manual, located at www.cms.gov/Manuals/IOM/list.asp for comprehensive information on SNF PPS, including but not limited to SNF coverage, SNF policies, and claims processing.
- **Monitoring the Quality of Care.** MDS assessment data are also used to monitor the quality of care in the nation's nursing homes. MDS-based quality measures (QMs) were developed by researchers to assist: (1) State Survey and Certification staff in identifying potential care problems in a nursing home; (2) nursing home providers with quality improvement activities/efforts; (3) nursing home consumers in understanding the quality of care provided by a nursing home; and (4) CMS with long-term quality monitoring and program planning. CMS continuously evaluates the usefulness of the QMs, which may be modified in the future to enhance their effectiveness.
- **Consumer Access to Nursing Home Information.** Consumers are also able to access information about every Medicare- and/or Medicaid-certified nursing home in the country. The Nursing Home Compare tool (<http://www.medicare.gov/NHCompare>) provides public access to nursing home characteristics, staffing and quality of care measures for certified nursing homes.

The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that

- (1) the assessment accurately reflects the resident's status
- (2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals
- (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts.

Nursing homes are left to determine

- (1) who should participate in the assessment process
- (2) how the assessment process is completed

- (3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual.

Given the requirements of participation of appropriate health professionals and direct care staff, completion of the RAI is best accomplished by an interdisciplinary team (IDT) that includes nursing home staff with varied clinical backgrounds, including nursing staff and the resident's physician. Such a team brings their combined experience and knowledge to the table in providing an understanding of the strengths, needs and preferences of a resident to ensure the best possible quality of care and quality of life. It is important to note that even nursing homes that have been granted a RN waiver under 42 CFR 483.30 (c) or (d) must provide a RN to conduct or coordinate the assessment and sign off the assessment as complete.

In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician, and family, guardian, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.

While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's 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 an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS.

1.4 Problem Identification Using the RAI

Clinicians are generally taught a problem identification process as part of their professional education. For example, the nursing profession's problem identification model is called the nursing process, which consists of assessment, diagnosis, outcome identification, planning, implementation, and evaluation. All good problem identification models have similar steps to those of the nursing process.

The RAI simply provides a structured, standardized approach for applying a problem identification process in nursing homes. The RAI should not be, nor was it ever meant to be, an additional burden for nursing home staff.

The completion of the RAI can be conceptualized using the nursing process as follows:

Section	Title	Intent
A	Identification Information	Obtain key information to uniquely identify each resident, nursing home, type of record, and reasons for assessment.
B	Hearing, Speech, and Vision	Document the resident's ability to hear, understand, and communicate with others and whether the resident experiences visual, hearing or speech limitations and/or difficulties.
C	Cognitive Patterns	Determine the resident's attention, orientation, and ability to register and recall information.
D	Mood	Identify signs and symptoms of mood distress.
E	Behavior	Identify behavioral symptoms that may cause distress or are potentially harmful to the resident, or may be distressing or disruptive to facility residents, staff members or the environment.
F	Preferences for Customary Routine and Activities	Obtain information regarding the resident's preferences for his or her daily routine and activities.
G	Functional Status	Assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion.
H	Bladder and Bowel	Gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.
I	Active Disease Diagnosis	Code diseases that have a relationship to the resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death.
J	Health Conditions	Document health conditions that impact the resident's functional status and quality of life.
K	Swallowing/Nutritional Status	Assess conditions that could affect the resident's ability to maintain adequate nutrition and hydration.
L	Oral/Dental Status	Record any oral or dental problems present.
M	Skin Conditions	Document the risk, presence, appearance, and change of pressure ulcers as well as other skin ulcers, wounds or lesions. Also includes treatment categories related to skin injury or avoiding injury.
N	Medications	Record the number of days that any type of injection, insulin, and/or select medications was received by the resident.
O	Special Treatments and Procedures	Identify any special treatments, procedures, and programs that the resident received during the specified time periods.
P	Restraints	Record the frequency that the resident was restrained by any of the listed devices at any time during the day or night.
Q	Participation in Assessment and Goal Setting	Record the participation of the resident, family and/or significant others in the assessment, and to understand the resident's overall goals.
V	Care Area Assessment (CAA) Summary	Document triggered care areas, whether or not a care plan has been developed for each triggered area, and the location of care area assessment documentation.
X	Correction Request	Request to modify or inactivate a record already present in the QIES ASAP database.
Z	Assessment Administration	Provide billing information and signatures of persons completing the assessment.

1.8 Protecting the Privacy of the MDS Data

MDS assessment data is personal information about nursing facility residents that facilities are required to collect and keep confidential in accordance with federal law. The 42 CFR Part 483.20 requires Medicare and Medicaid certified nursing facility providers to collect the resident assessment data that comprises the MDS. This data is considered part of the resident's medical record and is protected from improper disclosure by Medicare and Medicaid certified facilities by regulation at CFR 483.75(1)(2)(3) and 483.75(1)(2)(4)(i)(ii)(iii), release of information from the resident'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 resident.

Otherwise, providers cannot release MDS data in individual level format or in the aggregate. Nursing facility providers are also required under CFR 483.20 to transmit 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. Information regarding The Privacy Act can be found at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/PrivacyActof1974.html>.

The Privacy Act requires by regulation that all individuals whose data are collected and maintained in a federal database must receive notice. Therefore, residents in nursing facilities must be informed that the MDS data is being collected and submitted to the national system, Quality Improvement Evaluation System Assessment Submission and Processing System (QIES ASAP) and the State MDS database. The notice shown on page 1-14 of this section meets the requirements of the Privacy Act of 1974 for nursing facilities. The form is a notice and not a consent to release or use MDS data for health care information. Each resident or family member must be given the notice containing submission information at the time of admission. It is important to remember that resident consent is not required to complete and submit MDS assessments that are required under Omnibus Budget Reconciliation Act of 1987 (OBRA '87) or for Medicare payment purposes.

Contractual Agreements

Providers, who are part of a multi-facility corporation, may release data to their corporate office or parent company but not to other providers within the multi-facility corporation. The parent company is required to "act" in the same manner as the facility and is permitted to use data only to the extent the facility is permitted to do so (as described in the 42 CFR at 483.10(e)(3)).

In the case where a facility submits 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 facility does under the Federal and State regulations with respect to maintaining resident 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 facility. Moreover, the fact that there may have been a change of ownership of a facility 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 MDS information. All contractual agreements, regardless of their type, involving the 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.

PRIVACY ACT STATEMENT – HEALTH CARE RECORDS (7/14/2005)	
<i>THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.</i>	
1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)	Sections 1819(f), 1919(f), 1819(b)(3)(A), 1919(b)(3)(A), and 1864 of the Social Security Act.
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 evaluating and assuring the quality of care provided by nursing homes that participate in Medicare or Medicaid.
3. ROUTINE USES	The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long-term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, 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 Long-Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1517. Information from this system may be disclosed, under specific circumstances (routine uses), which include: 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 of 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. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION	For Nursing Home residents residing in a certified Medicare/Medicaid nursing facility the requested information is mandatory because of the need to assess the effectiveness and quality of care given in certified facilities and to assess the appropriateness of provided services. If the requested information is not furnished the determination of beneficiary services and resultant reimbursement may not be possible. Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.
_____	_____
Signature of Resident or Sponsor	Date

NOTE: Providers may request to have the Resident or his or her Representative sign a copy of this notice as a means to document that notice was provided. Signature is NOT required. If the

Resident or his or her Representative agrees to sign the form it merely acknowledges that they have been advised of the foregoing information. Residents or their Representative must be supplied with a copy of the notice. This notice may be included in the admission packet for all new nursing home admissions.

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CHAPTER 2: ASSESSMENTS FOR THE RESIDENT ASSESSMENT INSTRUMENT (RAI)

This chapter presents the assessment types and instructions for the completion (including timing and scheduling) of the mandated OBRA and Medicare assessments in nursing homes and the mandated Medicare assessments in non-critical access hospitals with a swing bed agreement.

2.1 Introduction to the Requirements for the RAI

The statutory authority for the RAI is found in Section 1819(f)(6)(A-B) for Medicare, and 1919(f)(6)(A-B) for Medicaid, of the Social Security Act (SSA), as amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). These sections of the SSA require the Secretary of the Department of Health and Human Services (the Secretary) to specify a Minimum Data Set (MDS) of core elements for use in conducting assessments of nursing home residents. It furthermore requires the Secretary to designate one or more resident assessment instruments based on the MDS.

The OBRA regulations require nursing homes that are Medicare certified, Medicaid certified or both, to conduct initial and periodic assessments for all their residents. The Resident Assessment Instrument (RAI) process is the basis for the accurate assessment of each nursing home resident. The MDS 3.0 is part of that assessment process and is required by CMS. The OBRA required assessments will be described in detail in Section 2.6.

MDS assessments are also required for Medicare payment (Prospective Payment System [PPS]) purposes under Medicare Part A (described in detail in Section 2.9).

It is important to note that when the OBRA and Medicare PPS assessment time frames coincide, one assessment may be used to satisfy both requirements. In such cases, the most stringent requirement for MDS completion must be met. Therefore, it is imperative that nursing home staff fully understand the requirements for both types of assessments in order to avoid unnecessary duplication of effort and to remain in compliance with both OBRA and Medicare PPS requirements. (Refer to Sections 2.11 and 2.12 for combining OBRA and Medicare assessments).

2.2 State Designation of the RAI for Nursing Homes

Federal regulatory requirements at 42 CFR 483.20(b)(1) and 483.20(c) require facilities to use an RAI that has been specified by the State and approved by CMS. The Federal requirement also mandates facilities to encode and electronically transmit the MDS data. (Detailed submission requirements are located in Chapter 5.)

While states must use all Federally-required MDS 3.0 items, they have some flexibility in adding optional Section S items. As such, each State must have CMS approval of the State's Comprehensive and Quarterly assessments.

through cooperation of both the hospice and long-term care facility staff (including participation in completing the RAI and care planning) with the consent of the resident.

- **Short-term or respite residents:** An RAI must be completed for any individual residing more than 14 days on a unit of a facility that is certified as a long-term care facility for participation in the Medicare or Medicaid programs. If the respite resident is in a certified bed, the OBRA assessment schedule and tracking document requirements must be followed. If the respite resident is in the facility for fewer than 14 days, an OBRA Admission assessment is not required; however, a Discharge assessment is required:
 - Given the nature of a short-term or respite resident, staff members may not have access to all information required to complete some MDS items prior to the resident's discharge. In that case, the "not assessed/no information" coding convention should be used ("-") (See Chapter 3 for more information).
 - Regardless of the resident's length of stay, the facility must still have a process in place to identify the resident's needs, and must initiate a plan of care to meet those needs upon admission.
 - If the resident is eligible for Medicare Part A benefits, a Medicare assessment will still be required to support payment under the SNF PPS.
- **Special population residents (e.g. pediatric or residents with a psychiatric diagnosis):** Certified facilities are required to complete an RAI for all residents who reside in the facility, regardless of age or diagnosis.
- **Swing bed facility residents:** Swing beds of non-critical access hospitals that provide Part A skilled nursing facility-level services were phased into the SNF PPS on July 1, 2002 (referred to as swing beds in this manual). Swing bed providers must assess the clinical condition of beneficiaries by completing the MDS assessment for each Medicare resident receiving Part A SNF level of care in order to be reimbursed under the SNF PPS. CMS collects MDS data for quality monitoring purposes of swing bed facilities effective October 1, 2010. Therefore, swing bed providers must also complete the Entry record, Discharge assessments, and Death in Facility record. Requirements for the Medicare-required PPS assessments, Entry record, Discharge assessments and Death in Facility record outlined in this manual also apply to swing bed facilities, including but not limited to, completion date, encoding requirements, submission time frame, and RN signature. There is no longer a separate swing bed MDS assessment manual.

The RAI process must be used with residents in facilities with different certification situations, including:

- **Newly Certified Nursing Homes:**
 - Nursing homes must admit residents and operate in compliance with certification requirements before a certification survey can be conducted.
 - Nursing homes must meet specific requirements, 42 Code of Federal Regulations, Part 483 (Requirements for States and Long Term Care Facilities, Subpart B), in order to participate in the Medicare and/or Medicaid programs.

- The 15-month period for maintaining assessment data may not restart with each readmission to the facility:
 - When a resident is **discharged return anticipated** and the resident **returns to the facility within 30 days**, the facility must copy the previous RAI and transfer that copy to the new record. The 15-month requirement for maintenance of the RAI data must be adhered to.
 - When a resident is **discharged return anticipated and does not return within 30 days** or **discharged return not anticipated**, facilities may develop their own specific policies regarding how to handle return situations, whether or not to copy the previous RAI to the new record.
 - In cases where the resident returns to the facility after a long break in care (i.e., 15 months or longer), staff may want to review the older record and familiarize themselves with the resident history and care needs. However, the decision on retaining the prior stay record in the active clinical record is a matter of facility policy and is not a CMS requirement.
- After the 15-month period, RAI information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff, State agency surveyors, CMS, or others as authorized by law. The **exception** is that demographic information (Items A0500-A1600) from the most recent Admission assessment must be maintained in the active clinical record until the resident is discharged return not anticipated.
- Nursing homes may use electronic signatures for clinical record documentation, including the MDS, when permitted to do so by State and local law and when authorized by the long-term care facility's policy. Use of electronic signatures for the MDS does not require that the entire clinical record be maintained electronically. Facilities must have written policies in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.
- Nursing homes also have the option for a resident's clinical record to be maintained electronically rather than in hard copy. This also applies to portions of the clinical record such as the MDS. Maintenance of the MDS electronically does not require that the entire clinical record also be maintained electronically, nor does it require the use of electronic signatures.
- In cases where the MDS is maintained electronically without the use of electronic signatures, nursing homes must maintain, at a minimum, hard copies of signed and dated CAA(s) completion (Items V0200B-C), correction completion (Items X1100A-E), and assessment completion (Items Z0400-Z0500) data that is resident-identifiable in the resident's active clinical record.
- Nursing homes must ensure that proper security measures are implemented via facility policy to ensure the privacy and integrity of the record.
- Nursing homes must also ensure that clinical records, regardless of form, are maintained in a centralized location as deemed by facility policy and procedure (e.g., a facility with five units may maintain all records in one location or by unit or a facility may maintain the MDS assessments and care plans in a separate binder). Nursing homes must also

assessment requirements, such as Admission and Discharge assessment, or two PPS assessments, such as a 30-day assessment and an End of Therapy OMRA.

Assessment Completion refers to the date that all information needed has been collected and recorded for a particular assessment type and staff have signed and dated that the assessment is complete.

- For OBRA-required Comprehensive assessments, assessment completion is defined as completion of the CAA process in addition to the MDS items, meaning that the RN assessment coordinator has signed and dated both the MDS (Item Z0500) and CAA(s) (Item V0200B) completion attestations. Since a Comprehensive assessment includes completion of both the MDS and the CAA process, the assessment timing requirements for a comprehensive assessment apply to both the completion of the MDS and the CAA process.
- For non-comprehensive and Discharge assessments, assessment completion is defined as completion of the MDS only, meaning that the RN assessment coordinator has signed and dated the MDS (Item Z0500) completion attestation.

Completion requirements are dependent on the assessment type and timing requirements. Completion specifics by assessment type are discussed in Section 2.6 for OBRA assessments and Section 2.9 for Medicare assessments.

Assessment Reference Date (ARD) refers to the last day of the observation (or “look back”) period that the assessment covers for the resident. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. The facility is required to set the ARD on the MDS Item Set or in the facility software within the required timeframe of the assessment type being completed. This concept of setting the ARD is used for all assessment types (OBRA and Medicare-required PPS) and varies by assessment type and facility determination.

Most of the MDS 3.0 items have a 7 day look back period. If a resident has an ARD of July 1, 2011 then all pertinent information starting at 12 AM on June 25th and ending on July 1st at 11:59PM should be included for MDS 3.0 coding.

Assessment Scheduling refers to the period of time during which assessments take place, setting the ARD, timing, completion, submission, and the observation periods required to complete the MDS items.

Assessment Submission refers to electronic MDS data being in record and file formats that conform to standard record layouts and data dictionaries, and passes standardized edits defined by CMS and the State. Chapter 5, CFR 483.20(f)(2), and the MDS 3.0 Data Submission Specifications on the CMS MDS 3.0 web site provide more detailed information.

Assessment Timing refers to when and how often assessments must be conducted, based upon the resident’s length of stay and the length of time between ARDs. The table in Section 2.6 describes the assessment timing schedule for OBRA-required assessments, while information on the Medicare-required PPS assessment timing schedule is provided in Section 2.8.

- Start of Therapy (SOT) Other Medicare Required (OMRA)
- End of Therapy (EOT) OMRA
- Both Start and End of Therapy OMRA
- Change of Therapy (COT) OMRA

Non-Comprehensive MDS assessments include a select number of items from the MDS used to track the resident's status between comprehensive assessments and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status. They do not include completion of the CAA process and care planning. Non-comprehensive assessments include Quarterly and Significant Correction to Prior Quarterly (SCQA) assessments.

Observation (Look Back) Period is the time period over which the resident's condition or status is captured by the MDS assessment. When the resident is first admitted to the nursing home, the RN assessment coordinator and the IDT will set the ARD. For subsequent assessments, the observation period for a particular assessment for a particular resident will be chosen based upon the regulatory requirements concerning timing and the ARDs of previous assessments. Most MDS items themselves require an observation period, such as 7 or 14 days, depending on the item. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the observation period must also cover this time period. When completing the MDS, only those occurrences during the look back period will be captured. In other words, if it did not occur during the look back period, it is not coded on the MDS.

OBRA-Required Tracking Records and Assessments are federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. These assessments are coded on the MDS 3.0 in Items A0310A (Federal OBRA Reason for Assessment) and A0310F (Entry/discharge reporting). They include:

Tracking records

- Entry
- Death in facility

Assessments

- Admission (comprehensive)
- Quarterly
- Annual (comprehensive)
- SCSA (comprehensive)
- SCPA (comprehensive)
- SCQA
- Discharge (return not anticipated or return anticipated)

Reentry refers to the situation when a resident was previously in this nursing home **and** had an OBRA Admission assessment completed **and** was discharged return anticipated **and** returned within 30 days of discharge. Upon the resident's return to the facility, the facility is required to complete an Entry tracking record. In determining if the resident returned to facility within 30 days, the day of discharge from the facility is not counted in the 30 days. For example, a resident

who is discharged return anticipated on December 1 would need to return to the facility by December 31 to meet the “within 30 day” requirement.

Respite refers to short-term, temporary care provided to a resident to allow family members to take a break from the daily routine of care giving. The nursing home is required to complete an Entry tracking record and a Discharge assessment for all respite residents. If the respite stay is 14 days or longer, the facility must have completed an OBRA Admission.

2.6 Required OBRA Assessments for the MDS

If the assessment is being used for OBRA requirements, the OBRA reason for assessment must be coded in Items A0310A and A0310F (Discharge Assessment). Medicare reasons for assessment are described later in this chapter (Section 2.9) while the OBRA reasons for assessment are described below.

The table provides a summary of the assessment types and requirements for the OBRA-required assessments, the details of which will be discussed throughout the remainder of this chapter.

Comprehensive Assessments

OBRA-required comprehensive assessments include the completion of both the MDS and the CAA process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of:

- Admission Assessment
- Annual Assessment
- Significant Change in Status Assessment
- Significant Correction to Prior Comprehensive Assessment

Each of these assessment types will be discussed in detail in this section. They are **not** required for residents in swing bed facilities.

Assessment Management Requirements and Tips for Comprehensive Assessments:

- The ARD (Item A2300) is the last day of the observation/look back period, and day 1 for purposes of counting back to determine the beginning of observation/look back periods. For example, if the ARD is set for day 14 of a resident's admission, then the beginning of the observation period for MDS items requiring a 7-day observation period would be day 8 of admission (ARD + 6 previous calendar days), while the beginning of the observation period for MDS items requiring a 14-day observation period would be day 1 of admission (ARD + 13 previous calendar days).
- If a resident goes to the hospital **prior** to completion of the OBRA Admission assessment, when the resident returns, the nursing home must consider the resident as a new admission. The nursing home may not complete a Significant Change in Status Assessment until after an OBRA Admission assessment has been completed.
- If a resident had an OBRA Admission assessment completed and then goes to the hospital (discharge return anticipated and returns within 30 days) and returns during an assessment period and most of the assessment was completed prior to the hospitalization, then the nursing home may wish to continue with the original assessment, provided the resident does not meet the criteria for a SCSA. In this case, the ARD remains the same and the assessment must be completed by the completion dates required of the assessment type based on the timeframe in which the assessment was started. Otherwise, the assessment should be reinitiated with a new ARD and completed within 14 days after re-entry from the hospital. The portion of the resident's assessment that was previously completed should be stored on the resident's record with a notation that the assessment was reinitiated because the resident was hospitalized.
- If a resident is discharged prior to the completion deadline for the assessment, completion of the assessment is not required. Whatever portions of the RAI that have been completed

will provide an opportunity for staff to consider illness, medication reactions, environmental stress, and other possible sources of Mr. T's disruptive behavior.

2. Mrs. T required minimal assistance with ADLs. She fractured her hip and upon return to the facility requires extensive assistance with all ADLs. Rehab has started and staff is hopeful she will return to her prior level of function in 4-6 weeks.
 - **Improvement in two or more of the following:**
 - Any improvement in an ADL physical functioning area where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment;
 - Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases;
 - Resident's decision making changes for the better;
 - Resident's incontinence pattern changes for the better;
 - Overall improvement of resident's condition.
3. Mrs. G has been in the nursing home for 5 weeks following an 8-week acute hospitalization. On admission she was very frail, had trouble thinking, was confused, and had many behavioral complications. The course of treatment led to steady improvement and she is now stable. She is no longer confused or exhibiting inappropriate behaviors. The resident, her family, and staff agree that she has made remarkable progress. A SCSA is required at this time. The resident is not the person she was at admission - her initial problems have resolved and she will be remaining in the facility. A SCSA will permit the interdisciplinary team to review her needs and plan a new course of care for the future.

Guidelines for When a Change in Resident Status is not Significant:

Note: this is not an exhaustive list

- Discrete and easily reversible cause(s) documented in the resident's record and for which the IDT can initiate corrective action (e.g., an anticipated side effect of introducing a psychoactive medication while attempting to establish a clinically effective dose level. Tapering and monitoring of dosage would not require a SCSA)
- Short-term acute illness, such as a mild fever secondary to a cold from which the IDT expects the resident to fully recover.
- Well-established, predictable cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions (e.g., depressive symptoms in a resident previously diagnosed with bipolar disease would not precipitate a Significant Change Assessment).
- Instances in which the resident continues to make steady progress under the current course of care. Reassessment is required only when the condition has stabilized.
- Instances in which the resident has stabilized but is expected to be discharged in the immediate future. The facility has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning.

2.7 The Care Area Assessment (CAA) Process and Care Plan Completion

Federal statute and regulations require nursing homes to conduct initial and periodic assessments for all their residents. The assessment information is used to develop, review, and revise the resident's plans of care that will be used to provide services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

The RAI process, which includes the Federally-mandated MDS, is the basis for an accurate assessment of nursing home residents. The MDS information and the CAA process provide the foundation upon which the care plan is formulated. There are 20 problem-oriented CAAs, each of which includes MDS-based "trigger" conditions that signal the need for additional assessment and review of the triggered care area. Detailed information regarding each care area and the CAA process, including definitions and triggers, appear in Chapter 4 of this manual. Chapter 4 also contains detailed information on care planning development utilizing the RAI and CAA process.

CAA(s) Completion

- Is required for OBRA-required comprehensive assessments. They are not required for non-comprehensive assessments, PPS assessments, Discharge assessments, or Tracking records.
- After completing the MDS portion of the comprehensive assessment, the next step is to further identify and evaluate the resident's strengths, problems, and needs through use of the CAA process (described in detail in Chapter 3, Section V, and Chapter 4 of this manual) and through further investigation of any resident-specific issues not addressed in the RAI/CAA process.
- The CAA(s) completion date (Item V0200B2) must be either later than or the same date as the MDS completion date (Item Z0500B). In no event can either date be later than the established timeframes as described in Section 2.6.
- It is important to note that for an Admission assessment, the resident enters the nursing home with a set of physician-based treatment orders. Nursing home staff should review these orders and begin to assess the resident and to identify potential care issues/problems. In many cases, interventions will already have been implemented to address priority issues prior to completion of the final care plan. At this time, many of the resident's problems in the 20 care areas will have been identified, causes will have been considered, and a preliminary care plan initiated. However, a final CAA(s) review and associated documentation are still required no later than the 14th calendar day of admission (admission date plus 13 calendar days).
- Detailed information regarding each CAA and the CAA process appears in Chapter 4 of this manual.

Care Plan Completion

- Care plan completion based on the CAA process is required for OBRA-required comprehensive assessments. It is not required for non-comprehensive assessments, PPS assessments, Discharge assessments, or Tracking records.
- After completing the MDS and CAA portions of the comprehensive assessment, the next step is to evaluate the information gained through both assessment processes in order to identify problems, causes, contributing factors, and risk factors related to the problems. Subsequently, the IDT must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's strengths, problems, and needs (described in detail in Chapter 4 of this manual).
- The care plan completion date (Item V0200C2) must be either later than or the same date as the CAA completion date (Item V0200B2), but no later than 7 calendar days after the CAA completion date. The MDS completion date (Item Z0500B) must be earlier than or the same date as the care plan completion date. In no event can either date be later than the established timeframes as described in Section 2.6.
- For Annual assessments, SCSAs, and SCPAs, the process is basically the same as that described with an Admission assessment. In these cases, however, the care plan will already be in place. Review of the CAA(s) when the MDS is complete for these assessment types should raise questions about the need to modify or continue services and result in either the continuance or revision of the existing care plan. A new care plan does not need to be developed after each Annual assessment, SCSA, or SCPA.
- Nursing homes should also evaluate the appropriateness of the care plan after each Quarterly assessment and modify the care plan on an ongoing basis, if appropriate.
- Detailed information regarding the care planning process appears in Chapter 4 of this manual.

2.8 The Skilled Nursing Facility Medicare Prospective Payment System Assessment Schedule

Skilled nursing facilities (SNFs) must assess the clinical condition of beneficiaries by completing the MDS assessment for each Medicare resident receiving Part A SNF-level care for reimbursement under the SNF PPS. In addition to the Medicare-required assessments, the SNF must also complete the OBRA assessments. All requirements for the OBRA assessments apply to the Medicare-required assessments, such as completion and submission time frames.

Assessment Window

Each of the Medicare-required scheduled assessments has defined days within which the Assessment Reference Date (ARD) must be set. The facility is required to set the ARD on the MDS form itself or in the facility software within the appropriate timeframe of the assessment type being completed. For example, the ARD for the Medicare-required 5-day scheduled assessment must be set on days 1 through 8. Timeliness of the PPS assessment is defined by selecting an ARD within the prescribed ARD window. See Scheduled Medicare PPS

Assessments chart below for the allowed ARDs for each of the Medicare-required assessments and other assessment information.

When coding a standalone Change of Therapy OMRA (COT), a standalone End of Therapy OMRA (EOT), or a standalone Start of Therapy OMRA (SOT), facilities must set the ARD for the assessment for a day within the allowable ARD window for that assessment type, but may do so no more than two days after the window has passed.

The first day of Medicare Part A coverage for the current stay is considered day 1 for PPS assessment scheduling purposes. In most cases, the first day of Medicare Part A coverage is the date of admission or reentry. However, there are situations in which the Medicare beneficiary may qualify for Part A services at a later date. See Chapter 6, Section 6.7, for more detailed information.

Grace Days

There may be situations when an assessment might be delayed (e.g., illness of RN assessor, a high volume of assessments due at approximately the same time) or additional days are needed to more fully capture therapy or other treatments. Therefore, CMS has allowed for these situations by defining a number of grace days for each Medicare assessment. For example, the Medicare-required 5-Day ARD can be extended 1 to 3 grace days (i.e., days 6 to 8). The use of grace days allows clinical flexibility in setting ARDs. See chart below for the allowed grace days for each of the scheduled Medicare-required assessments. Grace days are not applied to unscheduled Medicare PPS Assessments.

Scheduled Medicare PPS Assessments

The Medicare-required standard assessment schedule includes 5-day, 14-day, 30-day, 60-day, and 90-day scheduled assessments, each with a predetermined time period for setting the ARD for that assessment. The Readmission/Return assessment is also a scheduled assessment.

The SNF provider must complete the Medicare-required assessments according to the following schedule to assure compliance with the SNF PPS requirements.

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

+Grace Days: a specific number of days that can be added to the ARD window without penalty.

^Applicable Standard Medicare Payment Days may vary when assessment types are combined. For example, when a provider combines an unscheduled assessment, such as a Significant Change in Status Assessment (SCSA), with a scheduled assessment, such as a 30-day Medicare-required assessment, the new resource utilization group (RUG) would take effect on the ARD of the assessment. If the ARD of this assessment was day 28, the new RUG would take effect on day 28 of the stay. The exception would be if the ARD fell within the grace days. In that case, the new RUG would be effective on the first day of the regular payment period. For example, if the ARD of an unscheduled assessment combined with the 60-day assessment, was day 62, the new RUG would take effect on day 61.

Unscheduled Medicare PPS Assessments

There are situations when a SNF provider must complete an assessment outside of the standard scheduled Medicare-required assessments. These assessments are known as unscheduled assessments. When indicated, a provider must complete the following unscheduled assessments:

1. *Significant Change in Status Assessment* (for swing bed providers this unscheduled assessment is called the *Swing Bed Clinical Change Assessment*): Complete when the SNF interdisciplinary team has determined that a resident meets the significant change guidelines for either improvement or decline (see section 2.6).
2. *Significant Correction to Prior Comprehensive Assessment*: Complete because a significant error was made in the prior comprehensive assessment (see section 2.6).
3. *Start of Therapy Other Medicare Required Assessment (SOT-OMRA)*: Complete to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. This is an optional assessment (see section 2.9).
4. *End of Therapy Other Medicare Required Assessment (EOT- OMRA)*: Complete in two circumstances: (a) When the beneficiary who was receiving rehabilitation services (occupational therapy [OT], and/or physical therapy [PT], and/or speech-language pathology services [SLP]), was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group, all therapies have ended and the beneficiary continues to receive skilled services. (b) When the beneficiary who was receiving rehabilitation services (occupational therapy [OT], and/or physical therapy [PT], and/or speech-language pathology services [SLP]), was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and did not receive any therapy services for three or more consecutive calendar days. The EOT would be completed to classify the beneficiary into a non-therapy RUG group beginning on the day after the last day of therapy provided.
5. *Change of Therapy Other Medicare Required Assessment (COT-OMRA)*: Complete when the intensity of therapy, which includes the total reimbursable therapy minutes (RTM), and other therapy qualifiers such as number of therapy days and disciplines providing therapy, changes to such a degree that the beneficiary would classify into a different RUG-IV category than the RUG-IV category for which the resident is currently being billed for the 7-day COT observation period following the ARD of the most recent assessment used for Medicare payment(see section 2.9). The requirement to complete a change of therapy is reevaluated with additional 7-day COT observation periods ending on the 14th, 21st, and 28th days after the most recent Medicare payment assessment ARD and a COT OMRA is to be completed if the RUG-IV category changes. If a new assessment used for Medicare payment has occurred, the COT observation period will restart beginning on the day following the ARD of the most recent assessment used for Medicare payment.

A Medicare unscheduled assessment in a scheduled assessment window cannot be followed by the scheduled assessment later in that window—the two assessments must be combined with an ARD appropriate to the unscheduled assessment. If a scheduled assessment has been completed and an unscheduled assessment falls in that assessment window, the unscheduled assessment may supersede the scheduled assessment and the payment may be modified until the next unscheduled or scheduled assessment. See Chapter 6 (Section 6.4) for complete details.

PPS Scheduled Assessments for a Medicare Part A Stay

01. Medicare-required 5-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 1 through 5 of the Part A SNF covered stay.
- ARD may be extended up to day 8 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 1 through 14 of the stay, as long as the resident meets all criteria for Part A SNF-level services.
- Must be submitted electronically and accepted into the QIES Assessment Submission and Processing (ASAP) system within 14 days after completion (Item Z0500B) (completion + 14 days).
- If combined with the OBRA Admission assessment, the assessment must be completed by the end of day 14 of admission (admission date plus 13 calendar days).
- Is the first Medicare-required assessment to be completed when the resident is first admitted for SNF Part A stay.
- Is the first Medicare-required assessment to be completed when the Part A resident is re-admitted to the facility following a discharge assessment – return not anticipated or if the resident returns more than 30 days after a discharge assessment-return anticipated.
- If a resident goes from Medicare Advantage to Medicare Part A, the Medicare PPS schedule must start over with a 5 -day PPS assessment as the resident is now beginning a Medicare Part A stay.

02. Medicare-required 14-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 13 through 14 of the Part A SNF covered stay.
- ARD may be extended up to day 18 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 15 through 30 of the stay, as long as all the coverage criteria for Part A SNF-level services continue to be met.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).
- If combined with the OBRA Admission assessment, the assessment must be completed by the end of day 14 of admission and grace days may not be used when setting the ARD.

03. Medicare-required 30-Day Scheduled Assessment

- ARD (Item A2300) must be set on days 27 through 29 of the Part A SNF covered stay.
- ARD may be extended up to day 33 if using the designated grace days.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment from days 31 through 60 of the stay, as long as all the coverage criteria for Part A SNF-level services continue to be met.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

Start of Therapy (SOT) OMRA

- Optional.
- Completed only to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a Rehabilitation Plus Extensive Services or a Rehabilitation (therapy) group, the assessment will not be accepted by CMS and cannot be used for Medicare billing.
- Completed only if the resident is not already classified into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group.
- ARD (Item A2300) must be set on days 5-7 after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date) with the exception of the Short Stay Assessment (see Chapter 6, Section 6.4). The date of the earliest therapy evaluation is counted as day 1 when determining the ARD for the Start of Therapy OMRA, regardless if treatment is provided or not on that day.
- May be combined with scheduled PPS assessments.
- An SOT OMRA is not necessary if rehabilitation services start within the ARD window (including grace days) of the 5-day assessment, since the therapy rate will be paid starting Day 1 of the SNF stay.
- The ARD may not precede the ARD of first scheduled PPS assessment of the Medicare stay (5-day or readmission/return assessment).
 - For example if the 5-day assessment is performed on Day 8 and an SOT is performed in that window, the ARD for the SOT would be Day 8 as well.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Establishes a RUG-IV classification and Medicare payment (see Chapter 6, Section 6.4 for policies on determining RUG-IV payment), which begins on the day therapy started.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

End of Therapy (EOT) OMRA

- Required when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the planned or unplanned discontinuation of all rehabilitation therapies for three or more consecutive days.
- ARD (Item A2300) must be set on day 1, 2, or 3 after all rehabilitation therapies have been discontinued for any reason (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest). The last day on which therapy treatment was furnished is considered day 0 when determining the ARD for the End of Therapy OMRA. Day 1 is the first day after the last therapy treatment was provided whether therapy was scheduled or not scheduled for that day. For example:
 - If the resident was discharged from all therapy services on Tuesday, day 1 is Wednesday.
 - If the resident was discharged from all therapy services on Friday, Day 1 would be Saturday.

- Mr. G. who had been classified into RVX did not receive therapy on Saturday and Sunday. He also missed therapy on Monday because his family came to visit, on Tuesday he missed therapy due to a doctor's appointment and refused therapy on Wednesday. An EOT OMRA was performed on Monday classifying him into the ES2 non-therapy RUG. He missed 5 consecutive calendar days of therapy. A new therapy evaluation was completed and he resumed therapy services on Thursday. An SOT OMRA was then completed and Mr. G. was placed back into the RVX therapy RUG category.
 - Mrs. B., who had been classified into RHC did not receive therapy on Monday, Tuesday, and Wednesday because of an infection, and it was determined that she would be able to start therapy again on Thursday. An EOT OMRA was completed to pay for the three days she did not have therapy with a non-therapy RUG classification of HC2. It was determined that Mrs. B. would not be able to resume therapy at the same RUG-IV therapy classification, and an SOT OMRA was completed to place her into the RMB RUG-IV therapy category. A new therapy evaluation was required.
3. In cases where therapy resumes after the EOT OMRA is performed and the resumption of therapy date is no more than 5 consecutive calendar days after the last day of therapy provided, and the therapy services have resumed at the same RUG-IV classification level, and with the same therapy plan of care that had been in effect prior to the EOT OMRA, an End of Therapy OMRA with Resumption (EOT-R) may be completed. For Example:
- Mrs. A. who was in RVL did not receive therapy on Saturday and Sunday because the facility did not provide weekend services and she missed therapy on Monday because of a doctor's appointment, but resumed therapy Tuesday. The IDT determined that her RUG-IV therapy classification level did not change as she had not had any significant clinical changes during the lapsed therapy days. An EOT-R was completed and Mrs. A. was placed into ES3 for the three days she did not receive therapy. On Tuesday, Mrs. A. was placed back into RVL, which was the same therapy RUG group she was in prior to the discontinuation of therapy. A new therapy evaluation was not required.

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

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

4. In cases when the therapy end date is in one payment period and the resumption date is in the next payment period, the facility should bill the non-therapy RUG given on the EOT OMRA beginning the day after the last day of therapy treatment and begin billing the therapy RUG that was in effect prior to the EOT OMRA beginning on the day that

Swing Bed Clinical Change Assessment

- Is a required assessment for swing bed providers. Staff is responsible for determining whether a change (either an improvement or decline) in a patient's condition constitutes a "clinical change" in the patient's status.
- Is similar to the OBRA Significant Change in Status Assessment with the exceptions of the CAA process and the timing related to the OBRA Admission assessment. See Section 2.6 of this chapter.
- May establish a new RUG-IV classification. See previous Significant Change in Status subsection for ARD implications on the payment schedule.

Significant Correction to Prior Comprehensive Assessment

- Is an OBRA required assessment. See Section 2.6 of this chapter for definition, guidelines in completion, and scheduling.
- May establish a new RUG-IV classification. See previous Significant Change in Status subsection for ARD implications on the payment schedule.

Coding Tips and Special Populations

- When coding a standalone Change of Therapy OMRA (COT), a standalone End of Therapy OMRA (EOT), or a standalone Start of Therapy OMRA (SOT), the interview items may be coded using the responses provided by the resident on a previous assessment **only** if the DATE of the interview responses from the previous assessment (as documented in item Z0400) were obtained no more than 14 days prior to the DATE of completion for the interview items on the unscheduled assessment (as documented in item Z0400) for which those responses will be used.
- When coding a standalone Change of Therapy OMRA (COT), a standalone End of Therapy OMRA (EOT), or a standalone Start of Therapy OMRA (SOT), facilities must set the ARD for the assessment for a day within the allowable ARD window for that assessment type, but may only do so no more than two days after the window has passed. For example, if Day 7 of the COT observation period is May 23rd and the COT is required, then the ARD for this COT must be set for May 23rd and this must be done by May 25th. Facilities may still exercise the use of this flexibility period in cases where the resident discharges from the facility during that period.

2.10 Combining Medicare Scheduled and Unscheduled Assessments

There may be instances when more than one Medicare-required assessment is due in the same time period. To reduce provider burden, CMS allows the combining of assessments. Two Medicare-required Scheduled Assessments may **never** be combined since these assessments have specific ARD windows that do not occur at the same time. However, it is possible that a Medicare-required Scheduled Assessment and a Medicare Unscheduled Assessment may be combined or that two Medicare Unscheduled assessments may be combined.

2.11 Combining Medicare Assessments and OBRA Assessments⁷

SNF providers are required to meet two assessment standards in a Medicare certified nursing facility:

- The OBRA standards are designated by the reason selected in Item A0310A, **Federal OBRA Reason for Assessment**, and Item A0130F, **Entry/Discharge Reporting** and are required for all residents.
- The Medicare standards are designated by the reason selected in Item A0310B, **PPS Assessment**, and Item A0310C, **PPS Other Medicare Required Assessment - OMRA** and are required for resident's whose stay is covered by Medicare Part A.
- When the OBRA and Medicare assessment time frames coincide, one assessment may be used to satisfy both requirements. PPS and OBRA assessments may be combined when the ARD windows overlap allowing for a common assessment reference date. When combining the OBRA and Medicare assessments, the most stringent requirements for ARD, item set, and CAA completion requirements must be met. For example, the skilled nursing facility staff must be very careful in selecting the ARD for an OBRA Admission assessment combined with a 14-day Medicare assessment. For the OBRA Admission standard, the ARD must be set between days 1 and 14 counting the date of admission as day 1. For Medicare, the ARD must be set for days 13 or 14, but the regulation allows grace days up to day 18. However, when combining a 14-day Medicare assessment with the Admission assessment, the use of grace days for the PPS assessment would result in a late OBRA Admission assessment. To assure the assessment meets both standards, an ARD of day 13 or 14 would have to be chosen in this situation. In addition, the completion standards must be met. While a PPS assessment can be completed within 14 days after the ARD when it is not combined with an OBRA assessment, the CAA completion date for the OBRA Admission assessment (Item V0200B2) must be day 14 or earlier. With the combined OBRA Admission/Medicare 14-day assessment, completion by day 14 would be required. Finally, when combining a Medicare assessment with an OBRA assessment, the SNF staff must ensure that all required items are completed. For example, when combining the Medicare-required 30-day assessment with a Significant Change in Status Assessment, the provider would need to complete a comprehensive item set, including CAAs.

Some states require providers to complete additional state-specific items (Section S) for selected assessments. States may also add comprehensive items to the Quarterly and/or PPS item sets. Providers must ensure that they follow their state requirements in addition to any OBRA and/or Medicare requirements.

The following tables provide the item set for each type of assessment or tracking record. When two or more assessments are combined then the appropriate item set contains all items that would be necessary if each of the combined assessments were being completed individually.

⁷ OBRA-required comprehensive and Quarterly assessments do not apply to Swing Bed Providers. However, Swing Bed Providers are required to complete the Entry Record, Discharge Assessments, and Death in Facility Record.

- ARD (Item A2300) must be set for the day of discharge (Item A2000) **and** the date of discharge must fall within the allowed window of the Medicare scheduled assessment as described earlier in Section 2.9.
- Must be completed (Item Z0500B) within 14 days after the ARD.

Start of Therapy OMRA and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier of the stay and 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date).
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will not be accepted by CMS and cannot be used for Medicare billing.
- Must be completed (Item Z0500B) by day 14 of the stay (admission date plus 13 calendar days).
- See Section 2.7 for requirements for CAA process and care plan completion

Start of Therapy OMRA and OBRA Quarterly Assessment

- Quarterly item set as required by the State.
- ARD (Item A2300) must be set 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date) and meet the requirements for an OBRA Quarterly assessment as described in Section 2.6.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will not be accepted by CMS and cannot be used for Medicare billing.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

Start of Therapy OMRA and Annual Assessment

- Comprehensive item set
- ARD (Item A2300) must be set 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5) **and** meet the requirements for an OBRA Annual assessment as described in Section 2.6.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will not be accepted by CMS and cannot be used for Medicare billing.
- See Section 2.7 for requirements for CAA process and care plan completion.

Start of Therapy OMRA and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that criteria are met for a Significant Change in Status assessment **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date).

- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that the criteria are met for a Significant Change in Status assessment.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- See Section 2.7 for requirements for CAA process and care plan completion.

Start of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after determination that an uncorrected significant error in a comprehensive assessment has occurred **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected significant error in a comprehensive assessment has occurred.
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- See Section 2.7 for requirements for CAA process and care plan completion.

Start of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See SOT OMRA and OBRA Quarterly Assessment

Start of Therapy OMRA and Discharge Assessment

- Start of Therapy OMRA and Discharge item set.
- ARD (Item A2300) must be set for the day of discharge (Item A2000) **and** the date of discharge must fall within 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date). The ARD must be set by no more than two days after the date of discharge. (See Section 2.8 for further clarification.)
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group. If the RUG-IV classification is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing.
- Must be completed (Item Z0500B) within 14 days after the ARD.

End of Therapy OMRA and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier of the stay **and** 1-3 days after the last day therapy was furnished (difference is 3 or less for Item A2300 minus Item O0400A6 or O0400B6 or O0400C6, whichever is the latest).

- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.7 for requirements for CAA process and care plan completion.

End of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that an uncorrected significant error in the prior comprehensive assessment has occurred **and** 1-3 days after the end of therapy (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest date).
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that an uncorrected significant error in prior comprehensive assessment has occurred.
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- See Section 2.7 for requirements for CAA process and care plan completion.

End of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See EOT OMRA and OBRA Quarterly Assessment.

End of Therapy OMRA and Discharge Assessment

- OMRA and Discharge item set.
- ARD (Item A2300) must be set for the day of discharge (Item A2000) **and** the date of discharge must fall within 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest). The ARD must be set by no more than two days after the date of discharge. (See Section 2.8 for further clarification).
- Completed only when the resident was classified in a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group and continues to need Part A SNF-level services after the discontinuation of all therapies.
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- Must be completed (Item Z0500B) within 14 days after the ARD.

Start and End of Therapy OMRA and OBRA Admission Assessment

- Comprehensive item set.

Start and End of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See Start and End of Therapy OMRA and OBRA Quarterly Assessment.

Start and End of Therapy OMRA and Discharge Assessment

- OMRA-Start of Therapy and Discharge item set.
- ARD (Item A2300) must be set for the day of discharge (Item A2000) and the date of discharge must fall within 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) and 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6). The ARD must be set by no more than two days after the date of discharge. (See Section 2.8 for further clarification).
- Completed to classify a resident into a RUG-IV Rehabilitation Plus Extensive Services or Rehabilitation group (Item Z0100A) **and** into a non-therapy group (Item Z0150A) when the resident continues to need Part A SNF-level services after the discontinuation of all therapies. If the RUG-IV classification (Item Z0100A) is not a therapy group, the assessment will **not** be accepted by CMS and cannot be used for Medicare billing..
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment.
- Must be completed (Item Z0500B) within 14 days after the ARD.

Change of Therapy OMRA and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on day 14 or earlier after admission **and** be on the last day of a COT 7-day observation period. Must be completed (Item Z0500B) by day 14 after admission (admission date plus 13 calendar days).
- Completed when the patient received skilled therapy services and a change of therapy evaluation determines that a COT OMRA is necessary, based on a determination that the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) delivered and other therapy qualifiers such as number of therapy days and disciplines providing therapy), in the COT observation window differed from the therapy intensity on the last PPS assessment to such an extent that the RUG IV category would change).
- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0100A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
- See Section 2.7 for requirements for CAA process and care plan completion.

Change of Therapy OMRA and OBRA Quarterly Assessment

- Quarterly item set as required by the State.
- ARD (Item A2300) must meet the requirements for an OBRA Quarterly assessment as described in Section 2.6 **and** be on the last day of a COT 7-day observation period.

- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0150A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
- See Section 2.7 for requirements for CAA process and care plan completion.

Change of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within 14 days after the determination that an uncorrected error in the prior comprehensive assessment has occurred **and** be on the last day of a COT 7-day observation period.
- Must be completed (Item Z0500B) within 14 days after the ARD and within 14 days after the determination that the criteria are met for a Significant Correction assessment.
- Completed when the patient received skilled therapy services and a change of therapy evaluation determines that a COT OMRA is necessary, based on a determination that the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) and other therapy qualifiers such as the number of therapy days and disciplines providing therapy), in the COT observation window differed from the therapy intensity on the last PPS assessment to such an extent that the RUG IV category would change.
- Establishes a new RUG-IV classification and Medicare payment rate (Item Z0150A), which begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other unscheduled PPS assessment.
- See Section 2.7 for requirements for CAA process and care plan completion.

Change of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See COT OMRA and OBRA Quarterly Assessment.

Change of Therapy OMRA and Discharge Assessment

- COT OMRA and Discharge item set.
- ARD (Item A2300) must be set for the day of discharge (Item A2000) **and** be on the last day of a COT 7-day observation period. The ARD must be set by no more than two days after the date of discharge. (See Section 2.8 for further clarification.)
- Completed when the patient received skilled therapy services and a change of therapy evaluation determines that a COT OMRA is necessary, based on a determination that the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) and other therapy qualifiers such as the number of therapy days and disciplines providing therapy), in the COT observation window differed from the therapy intensity on the last PPS assessment to such an extent that the RUG IV category would change.

for at least 5 days. NOTE: In such cases where a late assessment is completed and no intervening assessments occur, the late assessment is used to establish the COT calendar.

If the ARD of the late assessment is set **after the end of the period during which the late assessment would have controlled payment**, had the assessment been completed timely, or in cases where **an intervening assessment** has occurred and the resident is still on Part A, the provider must still complete the assessment. The ARD can be no earlier than the day the error was identified. **The SNF must bill all covered days during which the late assessment would have controlled payment had the ARD been set timely at the default rate regardless of the HIPPS code calculated from the late assessment.** For example, a Medicare-required 14-day assessment with an ARD of Day 32 would be paid at the default rate for Days 15 through 30. A late assessment cannot be used to replace a different Medicare-required assessment. In the example above, the SNF would also need to complete the 30-day Medicare-required assessment within Days 27-33, which includes grace days. The 30-day assessment would cover Days 31 through 60 as long as the beneficiary has SNF days remaining and is eligible for SNF Part A services. In this example, the late 14-day assessment would not be considered an assessment used for payment and would not impact the COT calendar, as only an assessment used for payment can affect the COT calendar (see section 2.8).

A second example involving an unscheduled assessment would be the following. A 30-day assessment is completed with an ARD of Day 30. Day 7 of the COT observation period is Day 37. An EOT OMRA is performed timely for this resident with an ARD set for Day 42 and the resident's last day of therapy was Day 39. Upon further review of the resident's record on Day 52, the facility determines that a COT should have been completed with an ARD of Day 37 but was not. The ARD for the COT OMRA is set for day 52. The late COT OMRA should have controlled payment from Day 31 until the next assessment used for payment. Because there was an intervening assessment (in this case the EOT OMRA) prior to the ARD of the late COT OMRA, the facility would bill the default rate for 9 days (the period during which the COT OMRA would have controlled payment). The facility would bill the RUG from the EOT OMRA as per normal beginning the first non-therapy day, in this case Day 40, until the next scheduled or unscheduled assessment used for payment.

Missed PPS Assessment

If the SNF fails to set the ARD of a scheduled PPS assessment prior to the end of the last day of the ARD window, including grace days, and the resident was already discharged from Medicare Part A when this error is discovered, the provider cannot complete an assessment for SNF PPS purposes and the days cannot be billed to Part A. An existing OBRA assessment (except a stand-alone discharge assessment) in the QIES ASAP system may be used to bill for some Part A days when specific circumstances are met. See Chapter 6, Section 6.8 for greater detail.

In the case of an unscheduled PPS assessment, if the SNF fails to set the ARD for an unscheduled PPS assessment within the defined ARD window for that assessment, and the resident has been discharged from Part A, the assessment is missed and cannot be completed. All days that would have been paid by the missed assessment (had it been completed timely) are considered provider-liable. However, as with the late unscheduled assessment policy, the provider-liable period only lasts until the point when an intervening assessment controls the payment.

Expected Order of MDS Records

Next Record	Prior Record												
	Entry	OBRA Admission	OBRA annual	OBRA quarterly	PPS 5-day or readmission/return	PPS 14-day	PPS 30-day	PPS 60-day	PPS 90-day	PPS unscheduled	Discharge	Death in facility	No prior record
Entry	no	no	no	no	no	no	no	no	no	no		no	
OBRA Admission		no	no	no			no	no	no		no	no	no
OBRA Annual		no	no								no	no	no
OBRA Quarterly, sign. change, sign correction											no	no	no
PPS 5-day or readmission/return					no	no	no	no	no		no	no	no
PPS 14-day	no					no	no	no	no		no	no	no
PPS 30-day	no				no		no	no	no		no	no	no
PPS 60-day	no	no			no	no		no	no		no	no	no
PPS 90-day	no	no			no	no	no		no		no	no	no
PPS unscheduled											no	no	no
Discharge											no	no	no
Death in facility											no	no	no

Note: “no” indicates that the record sequence is not expected; record order warnings will be issued for these combinations. Blank cells indicate expected record sequences; no record order warning will be issued for these combinations.

if Item A0310F is changed to 10 (admission assessment combined with a return not anticipated discharge assessment). The item set is again an OBRA comprehensive assessment (NC). If Items A0310A = 99, A0310B = 99, A0310C= 0 and Item A0310F = 12 (a death in facility tracking record), then these values are matched in the last row and the item set is a tracking record (NT). Finally, if Items A0310A = 99, A0310B = 99, A0310C= 0 and A0310F = 99, then no row matches these entries, and the record is invalid and would be rejected.

There is one additional item set for inactivation request records. This is the set of items active on a request to inactivate a record in the national MDS QIES ASAP system. An inactivation request is indicated by A0050 = 3. The item set for this type of record is “Inactivation” with an ISC code of XX.

The next lookup table is for swing bed records. The first 5 columns are entries for the reason for assessment (RFA) Items A0310A, A0310B, A0310C, A0310D, and A0310F. To determine the item set for a record, locate the row that includes the values of Items A0310A, A0310B, A0310C, A0310D, and A0310F for that record. When the row is located, then the item set is identified in the ISC and Description columns for that row. If the combination of A0310A, A0310B, A0310C, A0310D, and A0310F values for the record cannot be located in any row, then that combination of RFAs is not allowed and any record with that combination will be rejected by the QIES ASAP system.

Swing Bed Item Set Code (ISC) Reference Table

OBRA RFA (A0310A)	PPS RFA (A0310B)	OMRA (A0310C)	SB Clinical Change (A0310D)	Entry/ Discharge (A0310F)	ISC	Description
99	01 thru 06	0,1,2,3	0	10,11,99	SP	PPS
99	01 thru 07	0,1,2,3	1	10,11,99	SP	PPS
99	02 thru 05	4	0	10,11,99	SP	PPS
99	02 thru 05,07	4	1	10,11,99	SP	PPS
99	07	1	0	99	SS	SOT OMRA
99	07	1	0	10,11	SSD	SOT OMRA and Discharge
99	07	2,3,4	0	99	SO	EOT , EOT-R or COT OMRA
99	07	2,3,4	0	10,11	SOD	EOT , EOT-R or COT OMRA and Discharge
99	99	0	0	10,11	SD	Discharge
99	99	0	0	01,12	ST	Tracking

The “Inactivation” (XX) item set is also used for swing beds when Item A0050 = 3.

3.2 Becoming Familiar with the MDS-recommended Approach

1. First, reading the Manual is essential.

- The CMS Long-Term Care Facility Resident Assessment Instrument User's Manual is the **primary** source of information for completing an MDS assessment.
- Notice how the manual is organized.
- Using it correctly will increase the accuracy of your assessments.
- While it is important to understand and apply the information in Chapter 3, facilities should also become familiar with Chapters 1, 2, 4, 5 and 6. These Chapters provide the framework and supporting information for data collected on the item set as well as the process for further assessment and care planning.
- It is important to understand the entire process of the RAI in conjunction with the intent and rationale for coding items on the MDS 3.0 item set.
- Check the MDS 3.0 Web site regularly for updates at:
http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp
- If you require further assistance, submit your question to your State RAI Coordinator listed in **Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts** available on CMS' website:
http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp

2. Second, review the MDS item sets.

- Notice how sections are organized and where information should be recorded.
- Work through one section at a time.
- Examine item definitions and response categories as provided on the item sets, realizing that more detailed definitions and coding information is found in each Section of Chapter 3.
- There are several item sets, and depending on which item set you are completing, the skip patterns and items active for each item set may be different.

3. Complete a thorough review of Chapter 3.

- Review procedural instructions, time frames, and general coding conventions.
- Become familiar with the intent of each item, rationale and steps for assessment.
- Become familiar with the item itself with its coding choices and responses, keeping in mind the clarifications, issues of note, and other pertinent information needed to understand how to code the item.
- Do the definitions and instructions differ from current practice at your facility?
- Does your facility processes require updating to comply with MDS requirements?
- Complete a test MDS assessment for a resident at your facility. Enter the appropriate codes on the MDS.

- Make a note where your review could benefit from additional information, training, and using the varying skill sets of the interdisciplinary team. Be certain to explore resources available to you.
- As you are completing this test case, read through the instructions that apply to each section as you are completing the MDS. Work through the Manual and item set one section at a time until you are comfortable coding items. Make sure you understand this information before going on to another section.
- Review the test case you completed. Would you still code it the same way? Are you surprised by any definitions, instructions, or case examples? For example, do you understand how to code ADLs?
- As you review the coding choices in your test case against the manual, make notations corresponding to the section(s) of this Manual where you need further clarification, or where questions arose. Note sections of the manual that help to clarify these coding and procedural questions.
- Would you now complete your initial case differently?
- It will take time to go through all this material. Do it slowly and carefully without rushing. Discuss any clarifications, questions or issues with your State RAI Coordinator (see **Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts** available on CMS' website: http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp)

4. Use of information in this chapter:

- Keep this chapter with you during the assessment process.
- Where clarification is needed, review the intent, rationale and specific coding instructions for each item in question.

3.3 Coding Conventions

There are several standard conventions to be used when completing the MDS assessment, as follows.

- Unlike the MDS 2.0, the standard look-back period for the MDS 3.0 is **7 days**, unless otherwise stated.
- **With the exception of certain items (e.g., some items in Sections K and O), the look-back period generally does not include hospital stay.**
- There are a few instances in which scoring on one item will govern how scoring is completed for one or more additional items. This is called a skip pattern. The instructions direct the assessor to “skip” over the next item (or several items) and go on to another. When you encounter a skip pattern, leave the item blank and move on to the next item as directed (e.g., item B0100, **Comatose**, directs the assessor to skip to item G0110, **Activities of Daily Living Assistance**, if B0100 is answered **code 1, yes**. The intervening items from B0200-F0800 would not be coded (i.e. left blank). If B0100 was recorded as **code 0, no**, then the assessor would continue to code the MDS at the next item, B0200).
- Use a check mark for boxes with where the instructions state to “check all that apply,” if specified condition is met; otherwise these boxes remain blank (e.g., F0800, **Staff Assessment of Daily and Activity Preferences**, boxes A-Z).

- Use a numeric response (a number or pre-assigned value) for blank boxes (e.g., D0350, **Safety Notification**).
- When completing hard copy forms to be used for data entry, capital letters may be easiest to read. Print legibly.
- When recording month, day, and year for dates, enter two digits for the month and the day and four digits for the year. For example, the third day of January in the year 2011 is recorded as:

0	1	0	3	2	0	1	1
Month		Day		Year			

- Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to the MDS QIES ASAP system.
 - A dash value indicates that an item was not assessed. This most often occurs when a resident is discharged before the item could be assessed.
 - Dash values allow a partial assessment to be submitted when an assessment is required for payment purposes.
 - There are four date items (A2400C, O0400A6, O0400B6, and O0400C6) that use a dash-filled value to indicate that the event has not yet occurred. For example, if there is an ongoing Medicare stay, then the end date for that Medicare stay (A2400C) has not occurred, therefore, this item would be dash-filled.
 - The few items that do not allow dash values include identification items in Section A [e.g., Legal Name of Resident (Item A0500), Assessment Reference Date (Item A2300), Type of Assessment (Item A0310), and Gender (Item A0800)] and ICD-9 diagnosis codes (Item I8000). All items for which a dash is not an acceptable value can be found on the CMS MDS 3.0 Technical Information web page at the following link: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html>
- When the term “physician” is used in this manual, it should be interpreted as including nurse practitioners, physician assistants, or clinical nurse specialists, if allowable under state licensure laws and Medicare.
- Residents should be the primary source of information for resident assessment items. Should the resident not be able to participate in the assessment, the resident’s family, significant other, and guardian or legally authorized representative should be consulted.
- Several times throughout the manual the word “significant” is used. The term may have different connotations depending on the circumstance in which it is used. For the MDS 3.0, the term “significant” when discussing clinical, medical, or laboratory findings refers to measures of supporting evidence that are considered when developing or assigning a diagnosis, and therefore reflects clinical judgment. When the term “significant” is used in discussing relationships between people, as in “significant other,” it means a person, who may be a family member or a close friend that is important or influential in the life of the resident.
- When completing the MDS 3.0, there are some items that require a count or measurement, however, there are instances where the actual results of the count or

measurement are greater than the number of available boxes. For example, number of pressure ulcers, or weight. When the result of a count or measurement is greater than the number of available boxes, facilities are instructed to maximize the count/measurement by placing a "9" in each box (e.g. k0200B if the weight was 1010 lbs you would enter 999 in the available boxes). Even though the number is not exact, the facility should document the correct number in the resident's medical record and ensure that an appropriate plan of care is completed that addresses the additional counts/measurements.

Section	Title	Intent
A	Identification Information	Obtain key information to uniquely identify each resident, nursing home, type of record, and reasons for assessment.
B	Hearing, Speech, and Vision	Document the resident's ability to hear, understand, and communicate with others and whether the resident experiences visual, hearing or speech limitations and/or difficulties.
C	Cognitive Patterns	Determine the resident's attention, orientation, and ability to register and recall information.
D	Mood	Identify signs and symptoms of mood distress.
E	Behavior	Identify behavioral symptoms that may cause distress or are potentially harmful to the resident, or may be distressing or disruptive to facility residents, staff members or the environment.
F	Preferences for Customary Routine and Activities	Obtain information regarding the resident's preferences for his or her daily routine and activities.
G	Functional Status	Assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion.
H	Bladder and Bowel	Gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.
I	Active Disease Diagnosis	Code diseases that have a relationship to the resident's current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death.
J	Health Conditions	Document health conditions that impact the resident's functional status and quality of life.
K	Swallowing/Nutritional Status	Assess conditions that could affect the resident's ability to maintain adequate nutrition and hydration.
L	Oral/Dental Status	Record any oral or dental problems present.
M	Skin Conditions	Document the risk, presence, appearance, and change of pressure ulcers as well as other skin ulcers, wounds or lesions. Also includes treatment categories related to skin injury or avoiding injury.
N	Medications	Record the number of days that any type of injection, insulin, and/or select medications was received by the resident.
O	Special Treatments and Procedures	Identify any special treatments, procedures, and programs that the resident received during the specified time periods.
P	Restraints	Record the frequency that the resident was restrained by any of the listed devices at any time during the day or night.
Q	Participation in Assessment and Goal Setting	Record the participation of the resident, family and/or significant others in the assessment, and to understand the resident's overall goals.
V	Care Area Assessment (CAA) Summary	Document triggered care areas, whether or not a care plan has been developed for each triggered area, and the location of care area assessment documentation.
X	Correction Request	Request to modify or inactivate a record already present in the QIES ASAP database.
Z	Assessment Administration	Provide billing information and signatures of persons completing the assessment.

A0050: Type of Record (cont.)

- Code 3, Inactivate existing record: if this is a **request to inactivate** a record that already has been submitted and accepted in the QIES ASAP system.

If this item is **coded as 3**, skip to X0150, Type of Provider.

When an inactivation request is submitted, the QIES ASAP system will take the following steps:

1. The system will attempt to locate the existing record in the QIES ASAP system for this facility with the resident, reasons for assessment/tracking, and date (assessment reference date, entry date, or discharge date) indicated in subsequent Section X items.
2. If the existing record is not found in the QIES ASAP database, the submitted inactivation request will be rejected and a “fatal” error will be reported to the facility on the Final Validation Report.
3. All items in Section X of the submitted record will be edited. If there are any fatal errors, the current inactivation request will be rejected and no record will be inactivated in the QIES ASAP system.
4. If the existing record is found, it will be removed from the active records in the QIES ASAP database and moved to a history file.

Identification of Record to be Modified/Inactivated

The Section X items from X0200 through X0700 identify the existing QIES ASAP database assessment or tracking record that is in error. In this section, reproduce the information **EXACTLY** as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the database.

Example: A MDS assessment for Joan L. Smith is submitted and accepted by the QIES ASAP system. A data entry error is then identified on the previously submitted and accepted record: The encoder mistakenly entered “John” instead of “Joan” when entering a prior assessment for Joan L. Smith. To correct this data entry error, the facility will modify the erroneous record and complete the items in Section X including items under Identification of Record to be Modified/Inactivated. When completing X0200A, the Resident First Name, “John” will be entered in this item. This will permit the MDS system to locate the previously submitted assessment that is being corrected. If the correct name “Joan” were entered, the QIES ASAP system would not locate the prior assessment.

The correction to the name from “John” to “Joan” will be made by recording “Joan” in the “normal” A0500A, Resident First Name in the modification record. The modification record must include all items appropriate for that assessment, not just the corrected name. This modification record will then be submitted and accepted into the QIES ASAP system which causes the desired correction to be made.

A0310: Type of Assessment (cont.)

Coding Instructions for A0310A, Federal OBRA Reason for Assessment

- Document the reason for completing the assessment, using the categories of assessment types. For detailed information on the requirements for scheduling and timing of the assessments, see Chapter 2 on assessment schedules.
- Enter the number corresponding to the OBRA reason for assessment. This item contains 2 digits. For codes 01-06, enter “0” in the first box and place the correct number in the second box. If the assessment is not coded 01-06, enter code “99”.
 01. Admission assessment (required by day 14)
 02. Quarterly review assessment
 03. Annual assessment
 04. Significant change in status assessment
 05. Significant correction to prior comprehensive assessment
 06. Significant correction to prior quarterly assessment
 99. None of the above

Coding Tips and Special Populations

- If a nursing home resident elects the hospice benefit, the nursing home is required to complete an MDS significant change in status assessment (SCSA). The nursing home is required to complete a SCSA when they come off the hospice benefit (revoke). See Chapter 2 for details on this requirement.
- It is a CMS requirement to have a SCSA completed EVERY time the hospice benefit has been elected, even if a recent MDS was done and the only change is the election of the hospice benefit.

Coding Instructions for A0310B, PPS Assessment

- Enter the number corresponding to the PPS reason for completing this assessment. This item contains 2 digits. For codes 01-07, enter “0” in the first box and place the correct number in the second box. If the assessment is not coded as 01-07, enter code “99”.
- See Chapter 2 on assessment schedules for detailed information on the scheduling and timing of the assessments.

PPS Scheduled Assessments for a Medicare Part A Stay

01. 5-day scheduled assessment
02. 14-day scheduled assessment
03. 30-day scheduled assessment
04. 60-day scheduled assessment
05. 90-day scheduled assessment
06. Readmission/return assessment

DEFINITION

PROSPECTIVE PAYMENT SYSTEM (PPS)

Method of reimbursement in which Medicare payment is made based on the classification system of that service (e.g., resource utilization groups, RUGs, for skilled nursing facilities).

A0310: Type of Assessment (cont.)

PPS Unscheduled Assessments for Medicare Part A Stay

- 07. Unscheduled assessment used for PPS (OMRA, significant change, or significant correction assessment)
- 99. None of the above

Coding Instructions for A0310C, PPS Other Medicare Required Assessment—OMRA

- Code 0, no: if this assessment is not an OMRA.
- Code 1, Start of therapy assessment (OPTIONAL): with an assessment reference date (ARD) that is 5 to 7 days after the first day therapy services are provided (except when the assessment is used as a Short Stay assessment, see Chapter 6). No need to combine with the 5-day assessment except for short stay. Only complete if therapy RUG (index maximized), otherwise the assessment will be rejected.
- Code 2, End of therapy assessment: with an ARD that is 1 to 3 days after the last day therapy services were provided.
- Code 3, both the Start and End of therapy assessment: with an ARD that is both 5 to 7 days after the first day therapy services were provided and that is 1 to 3 days after the last day therapy services were provided (except when the assessment is used as a Short Stay assessment, see Chapter 6).
- Code 4, Change of therapy assessment: with an ARD that is Day 7 of the COT observation period.

Coding Instructions for A0310D, Is This a Swing Bed Clinical Change Assessment?

- Code 0, no: if this assessment is not a Swing Bed Clinical Change assessment.
- Code 1, yes: if this assessment is a swing bed clinical change assessment.

Coding Instructions for A0310E, Is This Assessment the First Assessment (OBRA, PPS, or Discharge) since the Most Recent Admission/Entry or Reentry?

- Code 0, no: if this assessment is not the first assessment since the most recent admission/entry or reentry.
- Code 1, yes: if this assessment is the first assessment since the most recent admission/entry or reentry.

Coding Tips and Special Populations

- A0310E = 0 for any tracking record (Entry or Death in Facility) because tracking records are not considered assessments.

A1500: Preadmission Screening and Resident Review (PASRR) (cont.)

- Each State Medicaid agency might have specific processes and guidelines for referral, and which types of significant changes should be referred. Therefore, facilities should become acquainted with their own State requirements.
- Please see https://www.cms.gov/PASRR/01_Overview.asp for CMS information on PASRR.

Planning for Care

- The Level II PASRR determination and the evaluation report specify services to be provided by the nursing home and/or specialized services defined by the State.
- The State is responsible for providing specialized services to individuals with MI or ID/DD. In some States specialized services are provided to residents in Medicaid-certified facilities (in other States specialized services are only provided in other facility types such as a psychiatric hospital). The nursing home is required to provide all other care and services appropriate to the resident's condition.
- The services to be provided by the nursing home and/or specialized services provided by the State that are specified in the Level II PASRR determination and the evaluation report should be addressed in the plan of care.
- Identifies individuals who are subject to Resident Review upon change in condition.

Steps for Assessment

1. Complete if A0310A = 01, 03, 04 or 05 (Admission assessment, Annual assessment, Significant Change in Status Assessment, Significant Correction to Prior Comprehensive Assessment).
2. Review the Level I PASRR form to determine whether a Level II PASRR was required.
3. Review the PASRR report provided by the State if Level II screening was required.

Coding Instructions

- Code 0, no: and skip to A1550, Conditions Related to ID/DD Status, if any of the following apply:
 - PASRR Level I screening did not result in a referral for Level II screening, or
 - Level II screening determined that the resident does not have a serious mental illness and/or intellectual/developmental disability or related condition, or
 - PASRR screening is not required because the resident was admitted from a hospital after requiring acute inpatient care, is receiving services for the condition for which he or she received care in the hospital, and the attending physician has certified before admission that the resident is likely to require less than 30 days of nursing home care.

A1550: Conditions Related to Intellectual Disability/Developmental Disability (ID/DD) Status

A1550. Conditions Related to ID/DD Status	
If the resident is 22 years of age or older, complete only if A0310A = 01	
If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05	
↓ Check all conditions that are related to ID/DD status that were manifested before age 22, and are likely to continue indefinitely	
	ID/DD With Organic Condition
<input type="checkbox"/>	A. Down syndrome
<input type="checkbox"/>	B. Autism
<input type="checkbox"/>	C. Epilepsy
<input type="checkbox"/>	D. Other organic condition related to ID/DD
	ID/DD Without Organic Condition
<input type="checkbox"/>	E. ID/DD with no organic condition
	No ID/DD
<input type="checkbox"/>	Z. None of the above

Item Rationale

- To document conditions associated with intellectual or developmental disabilities.

Steps for Assessment

- If resident is 22 years of age or older on the assessment reference date, complete only if A0310A = 01 (Admission assessment).
- If resident is 21 years of age or younger on the assessment reference date, complete if A0310A = 01, 03, 04, or 05 (Admission assessment, Annual assessment, Significant Change in Status Assessment, Significant Correction to Prior Comprehensive Assessment).

Coding Instructions

- Check all conditions related to ID/DD status that were present before age 22.
- When age of onset is not specified, assume that the condition meets this criterion AND is likely to continue indefinitely.
- Code A: if Down syndrome is present.
- Code B: if autism is present.
- Code C: if epilepsy is present.
- Code D: if other organic condition related to ID/DD is present.

DEFINITIONS

DOWN SYNDROME

A common genetic disorder in which a child is born with 47 rather than 46 chromosomes, resulting in developmental delays, intellectual disability, low muscle tone, and other possible effects.

AUTISM

A developmental disorder that is characterized by impaired social interaction, problems with verbal and nonverbal communication, and unusual, repetitive, or severely limited activities and interests.

EPILEPSY

A common chronic neurological disorder that is characterized by recurrent unprovoked seizures.

A1700: Type of Entry (cont.)

1. resident has never been admitted to this facility before; OR
 2. resident has been in this facility previously and was discharged prior to completion of the OBRA Admission assessment; OR
 3. resident has been in this facility previously and was discharged return not anticipated; OR
 4. resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge.
- Code 2, reentry: when all 3 of the following occurred prior to the this entry, the resident was:
 1. admitted to this nursing home (i.e., OBRA Admission assessment was completed), AND
 2. discharged return anticipated, AND
 3. returned to facility within 30 days of discharge.

Coding Tips and Special Populations

- Swing bed facilities will always code the resident’s entry as an admission, ‘1’, since an OBRA Admission assessment must have been completed to code as a reentry. OBRA Admission assessments are not completed for swing bed residents.
- In determining if a resident returns to the facility within 30 days, the day of discharge from the facility is not counted in the 30 days. For example, a resident is discharged return anticipated on December 1 would need to return to the facility by December 31 to meet the “within 30 day” requirement.

A1800: Entered From

A1800. Entered From	
Enter Code <input type="text"/>	01. Community (private home/apt., board/care, assisted living, group home) 02. Another nursing home or swing bed 03. Acute hospital 04. Psychiatric hospital 05. Inpatient rehabilitation facility 06. ID/DD facility 07. Hospice 09. Long Term Care Hospital (LTCH) 99. Other

Item Rationale

- Understanding the setting that the individual was in immediately prior to nursing home admission informs care planning and may also inform discharge planning and discussions.
- Demographic information.

Steps for Assessment

1. Review transfer and admission records.
2. Ask the resident and/or family or significant others.

A2100: Discharge Status (cont.)

been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under §1886(d)((1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.

- Code 99, other: if discharge location is none of the above.

A2200: Previous Assessment Reference Date for Significant Correction

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

Item Rationale

- To identify the ARD of a previous comprehensive or Quarterly assessment (A0310A = 05 or 06) in which a significant error is discovered.

Coding Instructions

- Complete only if A0310A = 05 (Significant Correction to Prior Comprehensive Assessment) or A0310A = 06 (Significant Correction to Prior Quarterly Assessment).
- Enter the ARD of the prior comprehensive or Quarterly assessment in which a significant error has been identified and a correction is required.

A2300: Assessment Reference Date

A2300. Assessment Reference Date		
Observation end date:		
	<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
	Month Day Year	

Item Rationale

- Designates the end of the look-back period so that all assessment items refer to the resident's status during the same period of time.

As the last day of the look-back period, the ARD serves as the reference point for determining the care and services captured on the MDS assessment. Anything that happens after the ARD will not be captured on that MDS. For example, for a MDS item with a 7-day look-back period, assessment information is collected for a 7-day period ending on and including the ARD which is the 7th day of this look-back period. For an item with a 14-day look-back period, the information is collected for a 14-day period ending on and including the ARD. The look-back period includes observations and events through the end of the day (midnight) of the ARD.

A2400: Medicare Stay (cont.)

Coding Tips and Special Populations

- When a resident on Medicare Part A returns following a therapeutic leave of absence or a hospital observation stay of less than 24 hours (without hospital admission), this is a continuation of the Medicare Part A stay, not a new Medicare Part A stay.
- The end date of the Medicare stay may be earlier than actual discharge date from the facility (Item A2000).

Examples

1. Mrs. G. began receiving services under Medicare Part A on October 14, 2010. Due to her stable condition and ability to manage her medications and dressing changes, the facility determined that she no longer qualified for Part A SNF coverage and issued an Advanced Beneficiary Notice (ABN) and a Generic Notice with the last day of coverage as November 23, 2010. Mrs. G. was discharged from the facility on November 24, 2010. Code the following on her Discharge assessment:
 - A2000 = 11-24-2010
 - A2400A = 1
 - A2400B = 10-14-2010
 - A2400C = 11-23-2010
2. Mr. N began receiving services under Medicare Part A on December 11, 2010. He was sent to the ER on December 19, 2010 at 8:30pm and was not admitted to the hospital. He returned to the facility on December 20, 2010, at 11:00 am. The facility completed his 14-day PPS assessment with an ARD of December 23, 2010. Code the following on his 14-day PPS assessment:
 - A2400A = 1
 - A2400B = 12-11-2010
 - A2400C = -----
3. Mr. R. began receiving services under Medicare Part A on October 15, 2010. He was discharged return anticipated on October 20, 2010, to the hospital. Code the following on his Discharge assessment:
 - A2000 = 10-20-2010
 - A2400A = 1
 - A2400B = 10-15-2010
 - A2400C = 10-20-2010

B0200: Hearing (cont.)

- Consider other communication strategies for persons with hearing loss that is not reversible or is not completely corrected with hearing devices.
- Adjust environment by reducing background noise by lowering the sound volume on televisions or radios, because a noisy environment can inhibit opportunities for effective communication.

Steps for Assessment

1. Ensure that the resident is using his or her normal hearing appliance if they have one. Hearing devices may not be as conventional as a hearing aid. Some residents by choice may use hearing amplifiers or a microphone and headphones as an alternative to hearing aids. Ensure the hearing appliance is operational.
2. Interview the resident and ask about hearing function in different situations (e.g. hearing staff members, talking to visitors, using telephone, watching TV, attending activities).
3. Observe the resident during your verbal interactions and when he or she interacts with others throughout the day.
4. Think through how you can best communicate with the resident. For example, you may need to speak more clearly, use a louder tone, speak more slowly or use gestures. The resident may need to see your face to understand what you are saying, or you may need to take the resident to a quieter area for them to hear you. All of these are cues that there is a hearing problem.
5. Review the medical record.
6. Consult the resident's family, direct care staff, activities personnel, and speech or hearing specialists.

Coding Instructions

- Code 0, adequate: No difficulty in normal conversation, social interaction, or listening to TV. The resident hears all normal conversational speech and telephone conversation and announcements in group activities.
- Code 1, minimal difficulty: Difficulty in some environments (e.g., when a person speaks softly or the setting is noisy). The resident hears speech at conversational levels but has difficulty hearing when not in quiet listening conditions or when not in one-on-one situations. The resident's hearing is adequate after environmental adjustments are made, such as reducing background noise by moving to a quiet room or by lowering the volume on television or radio.
- Code 2, moderate difficulty: Speaker has to increase volume and speak distinctly. Although hearing-deficient, the resident compensates when the speaker adjusts tonal quality and speaks distinctly; or the resident can hear only when the speaker's face is clearly visible.

B0200: Hearing (cont.)

- Code 3, highly impaired: Absence of useful hearing. The resident hears only some sounds and frequently fails to respond even when the speaker adjusts tonal quality, speaks distinctly, or is positioned face-to-face. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

Coding Tips for Special Populations

- Residents who are unable to respond to a standard hearing assessment due to cognitive impairment will require alternate assessment methods. The resident can be observed in their normal environment. Does he or she respond (e.g., turn his or her head) when a noise is made at a normal level? Does the resident seem to respond only to specific noise in a quiet environment? Assess whether the resident responds only to loud noise or do they not respond at all.

B0300: Hearing Aid

B0300. Hearing Aid	
Enter Code	Hearing aid or other hearing appliance used in completing B0200, Hearing
<input type="checkbox"/>	0. No
	1. Yes

Item Rationale

Health-related Quality of Life

- Problems with hearing can contribute to social isolation and mood and behavior disorders.
- Many residents with impaired hearing could benefit from hearing aids or other hearing appliances.
- Many residents who own hearing aids do not have the hearing aids with them or have nonfunctioning hearing aids upon arrival.

Planning for Care

- Knowing if a hearing aid was used when determining hearing ability allows better identification of evaluation and management needs.
- For residents with hearing aids, use and maintenance should be included in care planning.
- Residents who do not have adequate hearing without a hearing aid should be asked about history of hearing aid use.
- Residents who do not have adequate hearing despite wearing a hearing aid might benefit from a re-evaluation of the device or assessment for new causes of hearing impairment.

Steps for Assessment

1. Prior to beginning the hearing assessment, ask the resident if he or she owns a hearing aid or other hearing appliance and, if so, whether it is at the nursing home.
2. If the resident cannot respond, write the question down and allow the resident to read it.

SECTION C: COGNITIVE PATTERNS

Intent: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions.

C0100: Should Brief Interview for Mental Status Be Conducted?

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?	
Attempt to conduct interview with all residents	
Enter Code <input type="checkbox"/>	0. No (resident is rarely/never understood) → Skip to and complete C0700-C1000, Staff Assessment for Mental Status 1. Yes → Continue to C0200, Repetition of Three Words

Item Rationale

Health-related Quality of Life

- This information identifies if the interview will be attempted.
- Most residents are able to attempt the Brief Interview for Mental Status (BIMS).
- A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance.
 - Without an attempted structured cognitive interview, a resident might be mislabeled based on his or her appearance or assumed diagnosis.
 - Structured interviews will efficiently provide insight into the resident's current condition that will enhance good care.

Planning for Care

- Structured cognitive interviews assist in identifying needed supports.
- The structured cognitive interview is helpful for identifying possible delirium behaviors (C1300).

Steps for Assessment

1. Determine if the resident is rarely/never understood verbally or in writing. If rarely/never understood, skip to C0700 – C1000, Staff Assessment of Mental Status.
2. Review **Language** item (A1100), to determine if the resident needs or wants an interpreter.
 - If the resident needs or wants an interpreter, complete the interview with an interpreter.

Coding Instructions

Record whether the cognitive interview should be attempted with the resident.

- Code 0, no: if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status.
- Code 1, yes: if the interview should be attempted because the resident is at least sometimes understood verbally or in writing, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words.

C0100: Should Brief Interview for Mental Status Be Conducted? (cont.)

Coding Tips

- If the resident needs an interpreter, every effort should be made to have an interpreter present for the BIMS. If it is not possible for a needed interpreter to participate on the day of the interview, code C0100 = 0 to indicate interview not attempted and complete C0700-C1000, **Staff Assessment of Mental Status**, instead of C0200-C0500, **Brief Interview for Mental Status**.
- Includes residents who use American Sign Language (ASL).



C0200-C0500: Brief Interview for Mental Status (BIMS)

Brief Interview for Mental Status (BIMS)	
C0200. Repetition of Three Words	
Enter Code <input type="checkbox"/>	Ask resident: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed . Now tell me the three words." Number of words repeated after first attempt 0. None 1. One 2. Two 3. Three After the resident's first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.
C0300. Temporal Orientation (orientation to year, month, and day)	
Enter Code <input type="checkbox"/>	Ask resident: "Please tell me what year it is right now." A. Able to report correct year 0. Missed by > 5 years or no answer 1. Missed by 2-5 years 2. Missed by 1 year 3. Correct
Enter Code <input type="checkbox"/>	Ask resident: "What month are we in right now?" B. Able to report correct month 0. Missed by > 1 month or no answer 1. Missed by 6 days to 1 month 2. Accurate within 5 days
Enter Code <input type="checkbox"/>	Ask resident: "What day of the week is today?" C. Able to report correct day of the week 0. Incorrect or no answer 1. Correct
C0400. Recall	
Enter Code <input type="checkbox"/>	Ask resident: "Let's go back to an earlier question. What were those three words that I asked you to repeat?" If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word. A. Able to recall "sock" 0. No - could not recall 1. Yes, after cueing ("something to wear") 2. Yes, no cue required
Enter Code <input type="checkbox"/>	B. Able to recall "blue" 0. No - could not recall 1. Yes, after cueing ("a color") 2. Yes, no cue required
Enter Code <input type="checkbox"/>	C. Able to recall "bed" 0. No - could not recall 1. Yes, after cueing ("a piece of furniture") 2. Yes, no cue required
C0500. Summary Score	
Enter Score <input type="text"/>	Add scores for questions C0200-C0400 and fill in total score (00-15) Enter 99 if unable to complete one or more questions of the interview

C0200-C0500: Brief Interview for Mental Status (BIMS) (cont.)



Item Rationale

Health-related Quality of Life

- Direct or performance-based testing of cognitive function decreases the chance of incorrect labeling of cognitive ability and improves detection of delirium.
- Cognitively intact residents may appear to be cognitively impaired because of extreme frailty, hearing impairment or lack of interaction.
- Some residents may appear to be more cognitively intact than they actually are.
- When cognitive impairment is incorrectly diagnosed or missed, appropriate communication, worthwhile activities and therapies may not be offered.
- A resident's performance on cognitive tests can be compared over time.
 - If performance worsens, then an assessment for delirium and or depression should be considered.
- The BIMS is an opportunity to observe residents for signs and symptoms of delirium (C1300).

Planning for Care

- Assessment of a resident's mental state provides a direct understanding of resident function that may:
 - enhance future communication and assistance and
 - direct nursing interventions to facilitate greater independence such as posting or providing reminders for self-care activities.
- A resident's performance on cognitive tests can be compared over time.
 - An abrupt change in cognitive status may indicate delirium and may be the only indication of a potentially life threatening illness.
 - A decline in mental status may also be associated with a mood disorder.
- Awareness of possible impairment may be important for maintaining a safe environment and providing safe discharge planning.

Steps for Assessment: Basic Interview Instructions for BIMS (C0200-C0500)

1. Refer to Appendix D for a review of basic approaches to effective interviewing techniques.
2. Interview any resident not screened out by **Should Brief Interview for Mental Status Be Conducted?** (Item C0100).
3. Conduct the interview in a private setting.
4. Be sure the resident can hear you.
 - Residents with hearing impairment should be tested using their usual communication devices/techniques, as applicable.

D0300: Total Severity Score (cont.)

Steps for Assessment

After completing D0200 A-I:

1. Add the numeric scores across all frequency items in **Resident Mood Interview** (D0200) Column 2.
2. Do not add up the score while you are interviewing the resident. Instead, focus your full attention on the interview.
3. The maximum resident score is 27 (3 x 9).

Coding Instructions

- The interview is successfully completed if the resident answered the frequency responses of at least 7 of the 9 items on the PHQ-9[®].
- If symptom frequency is blank for 3 or more items, the interview is deemed **NOT** complete. **Total Severity Score** should be coded as “99” and the **Staff Assessment of Mood** should be conducted.
- Enter the total score as a two-digit number. The **Total Severity Score** will be between **00** and **27** (or “99” if symptom frequency is blank for 3 or more items).
- The software will calculate the Total Severity Score. For detailed instructions on manual calculations and examples, see Appendix E: PHQ-9[®] Total Severity Score Scoring Rules.

Coding Tips and Special Populations

- Responses to PHQ-9[®] can indicate possible depression. Responses can be interpreted as follows:
 - Major Depressive Syndrome is suggested if—of the 9 items—5 or more items are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days) during the look-back period.
 - Minor Depressive Syndrome is suggested if, of the 9 items, (1) feeling down, depressed or hopeless, (2) trouble falling or staying asleep, or sleeping too much, or (3) feeling tired or having little energy are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days).
 - In addition, PHQ-9[®] **Total Severity Score** can be used to track changes in severity over time. **Total Severity Score** can be interpreted as follows:
 - 1-4: minimal depression
 - 5-9: mild depression
 - 10-14: moderate depression
 - 15-19: moderately severe depression
 - 20-27: severe depression

D0600: Total Severity Score (cont.)

Steps for Assessment

After completing items D0500 A-J:

1. Add the numeric scores across all frequency items for **Staff Assessment of Mood, Symptom Frequency** (D0500) Column 2.
2. Maximum score is 30 (3×10).

Coding Instructions

The interview is successfully completed if the staff members were able to answer the frequency responses of at least 8 out of 10 items on the PHQ-9-OV[®].

- The software will calculate the Total Severity Score. For detailed instructions on manual calculations and examples, see Appendix E: PHQ-9-OV[®] Total Severity Score Scoring Rules.

Coding Tips and Special Populations

- Responses to PHQ-9-OV[®] can indicate possible depression. Responses can be interpreted as follows:
 - Major Depressive Syndrome is suggested if—of the 10 items, 5 or more items are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days) during the look-back period.
 - Minor Depressive Syndrome is suggested if—of the 10 items, (1) feeling down, depressed or hopeless, (2) trouble falling or staying asleep, or sleeping too much, or (3) feeling tired or having little energy are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these, (1) little interest or pleasure in doing things, or (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days).
 - In addition, PHQ-9[®] **Total Severity Score** can be used to track changes in severity over time. **Total Severity Score** can be interpreted as follows:

1-4:	minimal depression
5-9:	mild depression
10-14:	moderate depression
15-19:	moderately severe depression
20-30:	severe depression

E0500: Impact on Resident (cont.)

- During the last 7 days, a resident with vascular dementia and severe hypertension, hits staff during incontinent care making it very difficult to change her. Six out of the last seven days the resident refuses all her medication including her antihypertensive. The resident closes her mouth and shakes her head and will not take it even if re-approached multiple times.

Coding: E0500A and E0500B would both be coded 1, yes.

Rationale: The behavior interfered significantly with delivery of her medical and nursing care and put her at clinically significant risk for physical illness.

- A resident paces incessantly. When staff encourage him to sit at the dinner table, he returns to pacing after less than a minute, even after cueing and reminders. He is so restless that he cannot sit still long enough to feed himself or receive assistance in obtaining adequate nutrition.

Coding: E0500A and E0500B would both be coded 1, yes.

Rationale: This behavior significantly interfered with personal care (i.e., feeding) and put the resident at risk for malnutrition and physical illness.

- A resident repeatedly throws his markers and card on the floor during bingo.

Coding: E0500C would be coded 1, yes.

Rationale: This behavior interfered with his ability to participate in the activity.

- A resident with severe dementia has continuous outbursts while awake despite all efforts made by staff to address the issue, including trying to involve the resident in prior activities of choice.

Coding: E0500C would be coded 1, yes.

Rationale: The staff determined the resident's behavior interfered with the ability to participate in any activities.

E0600: Impact on Others

E0600. Impact on Others	
Enter Code <input type="checkbox"/>	Did any of the identified symptom(s): A. Put others at significant risk for physical injury? 0. No 1. Yes
Enter Code <input type="checkbox"/>	B. Significantly intrude on the privacy or activity of others? 0. No 1. Yes
Enter Code <input type="checkbox"/>	C. Significantly disrupt care or living environment? 0. No 1. Yes

E0600: Impact on Others (cont.)

3. A resident repeatedly enters the rooms of other residents and rummages through their personal belongings. The other residents do not express annoyance.

Coding: E0600A and E0600C would be coded 0, no; E0600B would be coded 1, yes.

Rationale: This is an intrusion and violates other residents' privacy regardless of whether they complain or communicate their distress.

4. When eating in the dining room, a resident frequently grabs food off the plates of other residents. Although the other resident's food is replaced, and the behavior does not compromise their nutrition, other residents become anxious in anticipation of this recurring behavior.

Coding: E0600A would be coded 0, no; E0600B and E0600C would be coded 1, yes.

Rationale: This behavior violates other residents' privacy as it is an intrusion on the personal space and property (food tray). In addition, the behavior is pervasive and disrupts the staff's ability to deliver nutritious meals in dining room (an organized activity).

5. A resident tries to seize the telephone out of the hand of another resident who is attempting to complete a private conversation. Despite being asked to stop, the resident persists in grabbing the telephone and insisting that he wants to use it.

Coding: E0600A and E0600C would be coded 0, no; E0600B would be coded 1, yes.

Rationale: This behavior is an intrusion on another resident's private telephone conversation.

6. A resident begins taunting two residents who are playing an informal card game, yelling that they will "burn in hell" if they don't stop "gambling."

Coding: E0600A and E0600C would be coded 0, no; E0600B would be coded 1, yes.

Rationale: The behavior is intruding on the other residents' game. The game is not an organized facility event and does not involve care. It is an activity in which the two residents wanted to engage.

7. A resident yells continuously during an exercise group, diverting staff attention so that others cannot participate in and enjoy the activity.

Coding: E0600A and E0600B would be coded 0, no; E0600C would be coded 1, yes.

Rationale: This behavior disrupts the delivery of physical care (exercise) to the group participants and creates an environment of excessive noise.

E0600: Impact on Others (cont.)

8. A resident becomes verbally threatening in a group discussion activity, frightening other residents. In response to this disruption, staff terminate the discussion group early to avoid eliciting the behavioral symptom.

Coding: E0600A and E0600B would be coded 0, no; E0600C would be coded 1, yes.

Rationale: This behavior does not put other residents at risk for significant injury. However, the behavior restricts full participation in the organized activity, and limits the enjoyment of other residents. It also causes fear, thereby disrupting the living environment.

E0800: Rejection of Care—Presence & Frequency

E0800. Rejection of Care - Presence & Frequency	
Enter Code <input type="checkbox"/>	<p>Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being? Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals.</p> <ol style="list-style-type: none"> 0. Behavior not exhibited 1. Behavior of this type occurred 1 to 3 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily

Item Rationale

Health-related Quality of Life

- Goals for health and well-being reflect the resident’s wishes and objectives for health, function, and life satisfaction that define an acceptable quality of life for that individual.
- The resident’s care preferences reflect desires, wishes, inclinations, or choices for care. Preferences do not have to appear logical or rational to the clinician. Similarly, preferences are not necessarily informed by facts or scientific knowledge and may not be consistent with “good judgment.”
- It is really a matter of resident choice. When rejection/decline of care is first identified, the team then investigates and determines the rejection/decline of care is really a matter of resident’s choice. Education is provided and the resident’s choices become part of the plan of care. On future assessments, this behavior would not be coded in this item.
- A resident might reject/decline care because the care conflicts with his or her preferences and goals. In such cases, care rejection behavior is not considered a problem that warrants treatment to modify or eliminate the behavior.
- Care rejection may be manifested by verbally declining, statements of refusal, or through physical behaviors that convey aversion to, result in avoidance of, or interfere with the receipt of care.

E0800: Rejection of Care—Presence & Frequency (cont.)

2. A resident informs the staff that he would rather receive care at home, and the next day he calls for a taxi and exits the nursing facility. When staff try to persuade him to return, he firmly states, "Leave me alone. I always swore I'd never go to a nursing home. I'll get by with my visiting nurse service at home again." He is not exhibiting signs of disorientation, confusion, or psychosis and has never been judged incompetent.

Coding: E0800 would be coded 0, behavior not exhibited.

Rationale: His departure is consistent with his stated preferences and goals for health care. Therefore, this is **not** coded as care rejection.

3. A resident goes to bed at night without changing out of the clothes he wore during the day. When a nursing assistant offers to help him get undressed, he declines, stating that he prefers to sleep in his clothes tonight. The clothes are wet with urine. This has happened 2 of the past 7 days. The resident was previously fastidious, recently has expressed embarrassment at being incontinent, and has care goals that include maintaining personal hygiene and skin integrity.

Coding: E0800 would be coded 1, behavior of this type occurred 1-3 days.

Rationale: The resident's care rejection behavior is not consistent with his values and goals for health and well-being. Therefore, this is classified as care rejection that occurred twice.

4. A resident chooses not to eat supper one day, stating that the food causes her diarrhea. She says she knows she needs to eat and does not wish to compromise her nutrition, but she is more distressed by the diarrhea than by the prospect of losing weight.

Coding: E0800 would be coded 1, behavior of this type occurred 1-3 days.

Rationale: Although choosing not to eat is consistent with the resident's desire to avoid diarrhea, it is also in conflict with her stated goal to maintain adequate nutrition.

5. A resident is given his antibiotic medication prescribed for treatment of pneumonia and immediately spits the pills out on the floor. This resident's assessment indicates that he does not have any swallowing problems. This happened on each of the last 4 days. The resident's advance directive indicates that he would choose to take antibiotics to treat a potentially life-threatening infection.

Coding: E0800 would be coded 2, behavior of this type occurred 4-6 days, but less than daily.

Rationale: The behavioral rejection of antibiotics prevents the resident from achieving his stated goals for health care listed in his advance directives. Therefore, the behavior is coded as care rejection.

E1100: Change in Behavioral or Other Symptoms (cont.)

Examples

1. On the prior assessment, the resident was reported to wander on 4 out of 7 days. Because of elopement, the behavior placed the resident at significant risk of getting to a dangerous place. On the current assessment, the resident was found to wander on 2 of the last 7 days. Because a door alarm system is now in use, the resident was not at risk for elopement and getting to a dangerous place. However, the resident is now wandering into the rooms of other residents, intruding on their privacy. This requires occasional redirection by staff.

Coding: E1100 would be coded 1, improved.

Rationale: Although one component of this resident's wandering behavior is worse because it has begun to intrude on the privacy of others, it is less frequent and less dangerous (without recent elopement) and is therefore improved overall since the last assessment. The fact that the behavior requires less intense surveillance or intervention by staff also supports the decision to rate the overall behavior as improved.

2. At the time of the last assessment, the resident was ambulatory and would threaten and hit other residents daily. He recently suffered a hip fracture and is not ambulatory. He is not approaching, threatening, or assaulting other residents. However, the resident is now combative when staff try to assist with dressing and bathing, and is hitting staff members daily.

Coding: E1100 would be coded 0, same.

Rationale: Although the resident is no longer assaulting other residents, he has begun to assault staff. Because the danger to others and the frequency of these behaviors is the same as before, the overall behavior is rated as unchanged.

3. On the prior assessment, a resident with Alzheimer's disease was reported to wander on 2 out of 7 days and has responded well to redirection. On the most recent assessment, it was noted that the resident has been wandering more frequently for 5 out of 7 days and has also attempted to elope from the building on two occasions.

This behavior places the resident at significant risk of personal harm. The resident has been placed on more frequent location checks and has required additional redirection from staff. He was also provided with an elopement bracelet so that staff will be alerted if the resident attempts to leave the building. The intensity required of staff surveillance because of the dangerousness and frequency of the wandering behavior has significantly increased.

Coding: E1100 would be coded 2, worse.

Rationale: Because the danger and the frequency of the resident's wandering behavior have increased and there were two elopement attempts, the overall behavior is rated as worse.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

- Most residents are candidates for nursing-based rehabilitative care that focuses on maintaining and expanding self-involvement in ADLs.
- Graduated prompting/task segmentation (helping the resident break tasks down into smaller components) and allowing the resident time to complete an activity can often increase functional independence.

DEFINITIONS

ADL SUPPORT PROVIDED

Measures the most support **provided by staff** over the last 7 days, even if that level of support only occurred once.

Steps for Assessment

1. Review the documentation in the medical record for the 7-day look-back period.
2. Talk with direct care staff from each shift that has cared for the resident to learn what the resident does for himself during each episode of each ADL activity definition as well as the type and level of staff assistance provided. Remind staff that the focus is on the 7-day look-back period only.
3. When reviewing records, interviewing staff, and observing the resident, be specific in evaluating each component as listed in the ADL activity definition. For example, when evaluating Bed Mobility, determine the level of assistance required for moving the resident to and from a lying position, for turning the resident from side to side, and/or for positioning the resident in bed.

To clarify your own understanding and observations about a resident's performance of an ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific. See page G-9 for an example of using probes when talking to staff.

Coding Instructions

For each ADL activity:

- To assist in coding ADL self-performance items, please use the algorithm on page G-6.
- Consider each episode of the activity that occurred during the 7-day look-back period.
- In order to be able to promote the highest level of functioning among residents, clinical staff must first identify what the resident actually does for himself or herself, noting when assistance is received and clarifying the types of assistance provided (verbal cueing, physical support, etc.).
- Code based on the resident's level of assistance when using special adaptive devices such as a walker, device to assist with donning socks, dressing stick, long-handle reacher, or adaptive eating utensils.
- For the purposes of completing Section G, "facility staff" pertains to direct employees and facility-contracted employees (e.g. rehabilitation staff, nursing agency staff). Thus, does not include individuals hired, compensated or not, by individuals outside of the

G0110: Activities of Daily Living (ADL) Assistance (cont.)

- o When there are three or more episodes of a combination of full staff performance, weight-bearing assistance, and/or non-weight-bearing assistance—code limited assistance (2).
- **If none of the above are met, code supervision.**

Coding Instructions for G0110, Column 1, ADL-Self Performance

- Code 0, independent: if resident completed activity with no help or oversight every time during the 7-day look-back period.
- Code 1, supervision: if oversight, encouragement, or cueing was provided **three** or more times during the last 7 days.
- Code 2, limited assistance: if resident was highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight-bearing assistance on **three** or more times during the last 7 days.
- Code 3, extensive assistance: if resident performed part of the activity over the last 7 days, help of the following type(s) was provided three or more times:
 - Weight-bearing support provided three or more times.
 - Full staff performance of activity during part but not all of the last 7 days.
- Code 4, total dependence: if there was full staff performance of an activity with no participation by resident for any aspect of the ADL activity. The resident must be unwilling or unable to perform any part of the activity over the entire 7-day look-back period.
- Code 7, activity occurred only once or twice: if the activity occurred but **not** three times or more.
- Code 8, activity did not occur: if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.

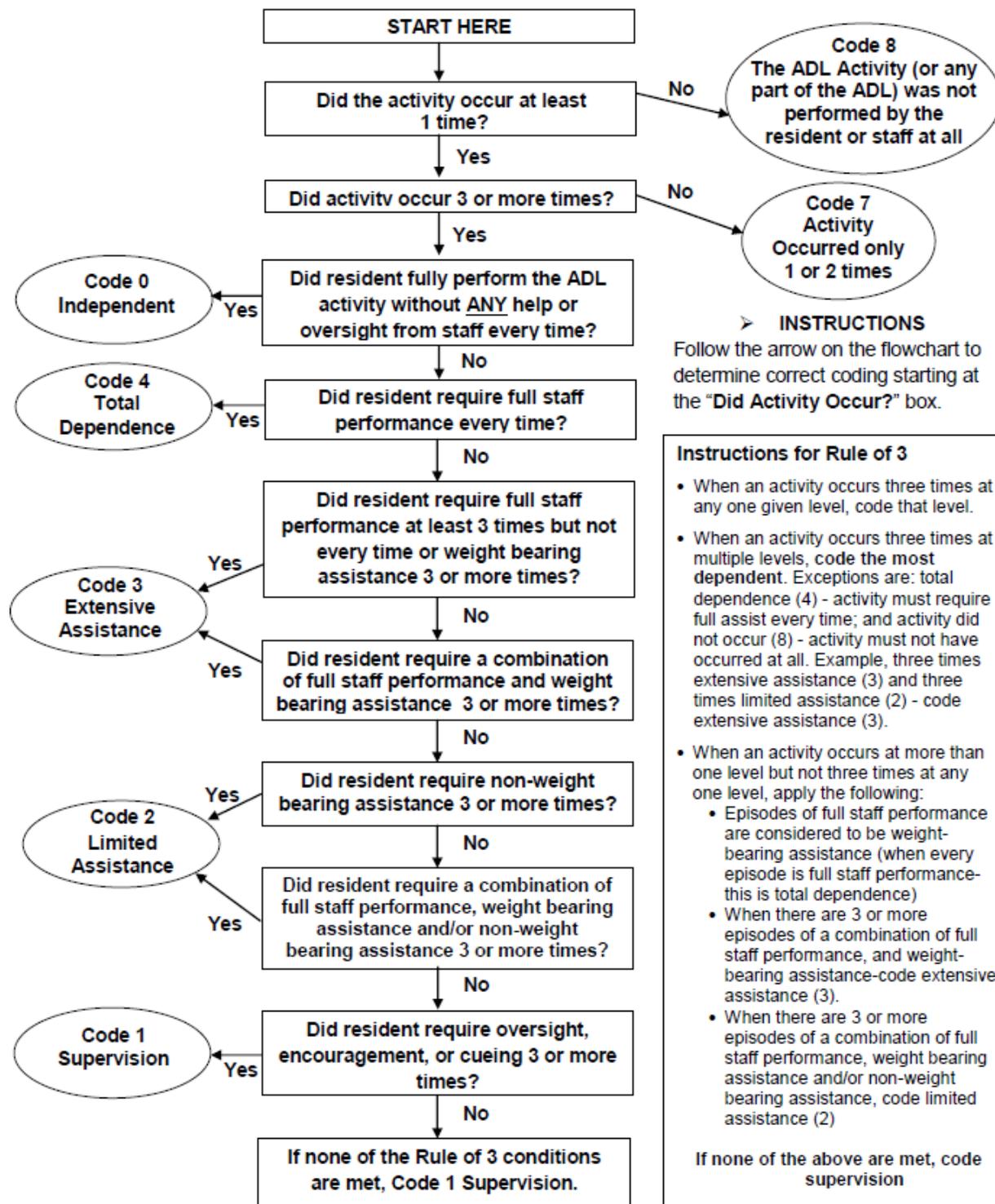
Coding Instructions for G0110, Column 2, ADL Support

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

- Code 0, no setup or physical help from staff: if resident completed activity with no help or oversight.
- Code 1, setup help only: if resident is provided with materials or devices necessary to perform the ADL independently. This can include giving or holding out an item that the resident takes from the caregiver.
- Code 2, one person physical assist: if the resident was assisted by one staff person.
- Code 3, two+ person physical assist: if the resident was assisted by two or more staff persons.
- Code 8, ADL activity itself did not occur during the entire period: if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

ADL Self Performance Algorithm



G0110: Activities of Daily Living (ADL) Assistance (cont.)

Examples for G0110F, Locomotion off Unit

1. Mr. R. does not like to go off his nursing unit. He prefers to stay in his room or the day room on his unit. He has visitors on a regular basis, and they visit with him in the day room on the unit. During the 7-day look-back period the resident did not leave the unit for any reason.

Coding: G0110F1 would be coded 8, activity did not occur.

G0110F2 would be coded 8, ADL activity itself did not occur during entire period.

Rationale: Activity did not occur at all.

2. Mr. Q. is a wheelchair-bound and is able to self-propel on the unit. On two occasions during the 7-day look-back period, he self-propelled off the unit into the courtyard.

Coding: G0110F1 would be coded 7, activity occurred only once or twice.

G0110F2 would be coded 0, no setup or physical help from staff.

Rationale: The activity of going off the unit happened only twice during the look-back period with no help or oversight from staff.

3. Mr. H. enjoyed walking in the nursing home garden when weather permitted. Due to inclement weather during the assessment period, he required various levels of assistance on the days he walked through the garden. On two occasions, he required limited assistance for balance of one staff person and on another occasion he only required supervision. On one day he was able to walk through the garden completely by himself.

Coding: G0110F1 would be coded 1, supervision.

G0110F2 would be coded 2, one person physical assist.

Rationale: Activity did not occur at any one level for three times and he did not require physical assistance for at least three times. The most support provided by staff was one person assist.

Examples for G0110G, Dressing

1. Mrs. C. did not feel well and chose to stay in her room. She requested to stay in night clothes and rest in bed for the entire 7-day look-back period. Each day, after washing up, Mrs. C. changed night clothes with staff assistance to guide her arms and assist in guiding her nightgown over her head and buttoning the front.

Coding: G0110G1 would be coded 2, limited assistance.

G0110G2 would be coded 2, one person physical assist.

Rationale: Resident was highly involved in the activity and changed clothing daily with non-weight-bearing assistance from one staff member during the 7-day look-back period.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

Examples for G0110H, Eating

1. After staff deliver Mr. K.'s meal tray, he consumes all food and fluids without any cueing or physical help during the entire 7-day look-back period.

Coding: G0110H1 would be coded 0, independent.

G0110H2 would be coded 0, no setup or physical help from staff.

Rationale: Resident is completely independent in eating during the entire 7-day look-back period.

2. One staff member had to verbally cue the resident to eat slowly and drink throughout each meal during the 7-day look-back period.

Coding: G0110H1 would be coded 1, supervision.

G0110H2 would be coded 0, no setup or physical help from staff.

Rationale: Resident required staff supervision, cueing, and reminders for safe meal completion daily during the 7-day look-back period.

3. Mr. V. is able to eat by himself. Staff must set up the tray, cut the meat, open containers, and hand him the utensils. Each day during the 7-day look-back period, Mr. V. required more help during the evening meal, as he was tired and less interested in completing his meal. In the evening, in addition to encouraging the resident to eat and handing him his utensils and cups, staff must also guide the resident's hand so he will get the utensil to his mouth.

Coding: G0110H1 would be coded 2, limited assistance.

G0110H2 would be coded 2, one person physical assist.

Rationale: Resident is unable to complete the evening meal without staff providing him non-weight-bearing assistance daily.

4. Mr. F. begins eating each meal daily by himself. During the 7-day look-back period, after he had eaten only his bread, he stated he was tired and unable to complete the meal. One staff member physically supported his hand to bring the food to his mouth and provided verbal cues to swallow the food. The resident was then able to complete the meal.

Coding: G0110H1 would be coded 3, extensive assistance.

G0110H2 would be coded 2, one person physical assist.

Rationale: Resident partially participated in the task daily at each meal, but one staff member provided weight-bearing assistance with some portion of each meal.

5. Mrs. U. is severely cognitively impaired. She is unable to feed herself. She relied on one staff member for all nourishment during the 7-day look-back period.

Coding: G0110H1 would be coded 4, total dependence.

G0110H2 would be coded 2, one person physical assist.

Rationale: Resident did not participate and required one staff person to feed her all of her meals during the 7-day look-back period.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

6. Mrs. D. receives all of her nourishment via a gastrostomy tube. She did not consume any food or fluid by mouth. During the 7-day look-back period, she did not participate in the gastrostomy nourishment process.

Coding: G0110H1 would be coded 4, total dependence.

G0110H2 would be coded 2, one person physical assist.

Rationale: During the 7-day look-back period, she did not participate in eating and/or receiving of her tube feed during the entire period. She required full staff performance of these functions.

Examples for G0110I, Toilet Use

1. Mrs. L. transferred herself to the toilet, adjusted her clothing, and performed the necessary personal hygiene after using the toilet without any staff assistance daily during the entire 7-day look-back period.

Coding: G0110I1 would be coded 0, independent.

G0110I2 would be coded 0, no setup or physical help from staff.

Rationale: Resident was independent in all her toileting tasks.

2. Staff member must remind resident to toilet frequently during the day and to unzip and zip pants and to wash his hands after using the toilet. This occurred multiple times each day during the 7-day look-back period.

Coding: G0110I1 would be coded 1, supervision.

G0110I2 would be coded 0, no setup or physical help from staff.

Rationale: Resident required staff supervision, cueing and reminders daily.

3. Staff must assist Mr. P. to zip his pants, hand him a washcloth, and remind him to wash his hands after using the toilet daily. This occurred multiple times each day during the 7-day look-back period.

Coding: G0110I1 would be coded 2, limited assistance.

G0110I2 would be coded 2, one person physical assist.

Rationale: Resident required staff to perform non-weight-bearing activities to complete the task multiple times each day during the 7-day look-back period.

4. Mrs. M. has had recent bouts of vertigo. During the 7-day look-back period, the resident required one staff member to assist and provide weight-bearing support to her as she transferred to the bedside commode four times.

Coding: G0110I1 would be coded 3, extensive assistance.

G0110I2 would be coded 2, one person physical assist.

Rationale: During the 7-day look-back period, the resident required weight-bearing assistance with the support of one staff member to use the commode four times.

G0110: Activities of Daily Living (ADL) Assistance (cont.)

- Miss W. is cognitively and physically impaired. During the 7-day look-back period, she was on strict bed rest. Staff were unable to physically transfer her to toilet during this time. Miss W. is incontinent of both bowel and bladder. One staff member was required to provide all the care for her elimination and hygiene needs several times each day.

Coding: G0110I1 would be coded 4, total dependence.

G0110I2 would be coded 2, one person physical assist.

Rationale: Resident did not participate and required one staff person to provide total care for toileting and hygiene each time during the entire 7-day look-back period.

Examples for G0110J, Personal Hygiene

- The nurse assistant takes Mr. L.'s comb, toothbrush, and toothpaste from the drawer and places them at the bathroom sink. Mr. L. combs his own hair and brushes his own teeth daily. During the 7-day look-back period, he required cueing to brush his teeth on three occasions.

Coding: G0110J1 would be coded 1, supervision.

G0110J2 would be coded 1, setup help only.

Rationale: Staff placed grooming devices at sink for his use, and during the 7-day look-back period staff provided cueing three times.

- Mrs. J. normally completes all hygiene tasks independently. Three mornings during the 7-day look-back period, however, she was unable to brush and style her hair because of elbow pain, so a staff member did it for her.

Coding: G0110J1 would be coded 3, extensive assistance.

G0110J2 would be coded 2, one person physical assist.

Rationale: A staff member had to complete part of the activity for the resident 3 days during the look-back period; the assistance was non-weight-bearing.

G0120: Bathing

G0120. Bathing	
How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (excludes washing of back and hair). Code for most dependent in self-performance and support	
Enter Code <input type="checkbox"/>	A. Self-performance 0. Independent - no help provided 1. Supervision - oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period
Enter Code <input type="checkbox"/>	B. Support provided (Bathing support codes are as defined in item G0110 column 2, ADL Support Provided , above)

G0120: Bathing (cont.)

Item Rationale

Health-related Quality of Life

- The resident's choices regarding his or her bathing schedule should be accommodated when possible so that facility routine does not conflict with resident's desired routine.

Planning for Care

- The care plan should include interventions to address the resident's unique needs for bathing. These interventions should be periodically evaluated and, if objectives were not met, alternative approaches developed to encourage maintenance of bathing abilities.

DEFINITIONS

BATHING

How the resident takes a full body bath, shower or sponge bath, including transfers in and out of the tub or shower. It does not include the washing of back or hair.

Coding Instructions for G0120A, Self Performance

Code for the maximum amount of assistance the resident received during the bathing episodes.

- Code 0, independent: if the resident required no help from staff.
- Code 1, supervision: if the resident required oversight help only.
- Code 2, physical help limited to transfer only: if the resident is able to perform the bathing activity, but required help with the transfer only.
- Code 3, physical help in part of bathing activity: if the resident required assistance with some aspect of bathing.
- Code 4, total dependence: if the resident is unable to participate in any of the bathing activity.
- Code 8, ADL activity itself did not occur during entire period: if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.

Coding Instructions for G0120B, Support Provided

- Bathing support codes are as defined **ADL Support Provided** item (G0110), Column 2.

Coding Tips

- Bathing is the only ADL activity for which the ADL Self-Performance codes in Item G0110, **Column 1 (Self-Performance)**, do not apply. A unique set of self-performance codes is used in the bathing assessment given that bathing may not occur as frequently as the other ADLs in the 7-day look-back period.
- If a nursing home has a policy that all residents are supervised when bathing (i.e., they are never left alone while in the bathroom for a bath or shower, regardless of resident capability), it is appropriate to code the resident self-performance as supervision, even if the supervision is precautionary because the resident is still being individually supervised. Support for bathing in this instance would be coded according to whether or not the staff had to actually assist the resident during the bathing activity.

G0300: Balance During Transitions and Walking (cont.)

- Code 1, not steady, but able to stabilize without staff assistance:
 - If any transfers during the look-back period are not steady, but the resident stabilizes without assistance from a staff.
 - If the resident is unstable with an assistive device but does not require staff assistance.
 - Residents coded in this category appear at increased risk for falling during transitions.
- Code 2, not steady, only able to stabilize with staff assistance:
 - If any transfers during the 7-day look-back period are not steady, and the resident can only stabilize with assistance from a staff.
 - If the resident fell during a surface-to-surface transfer during the look-back period.
 - Residents coded in this category appear at high risk for falling during transitions.
 - If a lift device (a mechanical device that is completely operated by another person) is used, and this mechanical device is being used because the resident requires staff assistance to stabilize, **code 2**.
- Code 8, activity did not occur:
 - If the resident did not transfer between bed and chair or wheelchair during the 7-day look-back period.

Examples for G0300E, Surface-to-Surface Transfer (Transfer Between Bed and Chair or Wheelchair)

1. A resident who uses her wheelchair for mobility stands up from the edge of her bed, pivots, and sits in her locked wheelchair in a steady fashion.

Coding: G0300E would be coded 0, steady at all times.
Rationale: The resident was steady when transferring from bed to wheelchair.
2. A resident who needs assistance ambulating transfers to his chair from the bed. He is observed to stand halfway up and then sit back down on the bed. On a second attempt, a nursing assistant helps him stand up straight, pivot, and sit down in his chair.

Coding: G0300E would be coded 2, not steady, only able to stabilize with staff assistance.
Rationale: The resident was unsteady when transferring from bed to chair and required staff assistance to make a steady transfer.
3. A resident with an above-the-knee amputation sits on the edge of the bed and, using his locked wheelchair due to unsteadiness and the nightstand for leverage, stands and transfers to his wheelchair rapidly and almost misses the seat. He is able to steady himself using the nightstand and sit down into the wheelchair without falling to the floor.

Coding: G0300E would be coded 1, not steady, but able to stabilize without staff assistance.

H0100: Appliances (cont.)

- Care planning should be based on an assessment and evaluation of the resident's history, physical examination, physician orders, progress notes, nurses' notes and flow sheets, pharmacy and lab reports, voiding history, resident's overall condition, risk factors and information about the resident's continence status, catheter status, environmental factors related to continence programs, and the resident's response to catheter/continence services.

Steps for Assessment

- Examine the resident to note the presence of any urinary or bowel appliances.
- Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances.

Coding Instructions

*Check next to each appliance that was used at any time in the past 7 days. Select **none of the above** if none of the appliances A-D were used in the past 7 days.*

- H0100A, indwelling catheter (including suprapubic catheter and nephrostomy tube)
- H0100B, external catheter
- H0100C, ostomy (including urostomy, ileostomy, and colostomy)
- H0100D, intermittent catheterization
- H0100Z, none of the above

Coding Tips and Special Populations

- Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter (H0100A) only and not as an ostomy (H0100C).
- Condom catheters (males) and external urinary pouches (females) are often used intermittently or at night only; these should be coded as external catheters.
- Do not code gastrostomies or other feeding ostomies in this section. Only appliances used for elimination are coded here.
- Do not include one time catheterization for urine specimen during look back period as intermittent catheterization.

DEFINITIONS

EXTERNAL CATHETER

Device attached to the shaft of the penis like a condom for males or a receptacle pouch that fits around the labia majora for females and connected to a drainage bag.

OSTOMY

Any type of surgically created opening of the gastrointestinal or genitourinary tract for discharge of body waste.

UROSTOMY

A stoma for the urinary system used in cases where long-term drainage of urine through the bladder and urethra is not possible, e.g., after extensive surgery or in case of obstruction.

ILEOSTOMY

A stoma that has been constructed by bringing the end or loop of small intestine (the ileum) out onto the surface of the skin.

COLOSTOMY

A stoma that has been constructed by connecting a part of the colon onto the anterior abdominal wall.

INTERMITTENT CATHETERIZATION

Sterile insertion and removal of a catheter through the urethra for bladder drainage.

H0200: Urinary Toileting Program (cont.)

Steps for Assessment: H0200A, Trial of a Toileting Program

The look-back period for this item is since the most recent admission/entry or reentry or since urinary incontinence was first noted within the facility.

1. Review the medical record for evidence of a trial of an individualized, resident-centered toileting program. A toileting trial should include observations of at least 3 days of toileting patterns with prompting to toilet and of recording results in a bladder record or voiding diary. Toileting programs may have different names, e.g., habit training/scheduled voiding, bladder rehabilitation/bladder retraining.
2. Review records of voiding patterns (such as frequency, volume, duration, nighttime or daytime, quality of stream) over several days for those who are experiencing incontinence.
3. Voiding records help detect urinary patterns or intervals between incontinence episodes and facilitate providing care to avoid or reduce the frequency of episodes.
4. Simply tracking continence status using a bladder record or voiding diary should not be considered a trial of an individualized, resident-centered toileting program.
5. Residents should be reevaluated whenever there is a change in cognition, physical ability, or urinary tract function. Nursing home staff must use clinical judgment to determine when it is appropriate to reevaluate a resident's ability to participate in a toileting trial or, if the toileting trial was unsuccessful, the need for a trial of a different toileting program.

Steps for Assessment: H0200B, Response to Trial Toileting Program

1. Review the resident's responses as recorded during the toileting trial, noting any change in the number of incontinence episodes or degree of wetness the resident experiences.

DEFINITIONS

BLADDER REHABILITATION/ BLADDER RETRAINING

A behavioral technique that requires the resident to resist or inhibit the sensation of urgency (the strong desire to urinate), to postpone or delay voiding, and to urinate according to a timetable rather than to the urge to void.

PROMPTED VOIDING

Prompted voiding includes (1) regular monitoring with encouragement to report continence status, (2) using a schedule and prompting the resident to toilet, and (3) praise and positive feedback when the resident is continent and attempts to toilet.

HABIT TRAINING/ SCHEDULED VOIDING

A behavior technique that calls for scheduled toileting at regular intervals on a planned basis to match the resident's voiding habits or needs.

CHECK AND CHANGE

Involves checking the resident's dry/wet status at regular intervals and using incontinence devices and products.

H0200: Urinary Toileting Program (cont.)

Steps for Assessment: H0200C, Current Toileting Program or Trial

1. Review the medical record for evidence of a toileting program being used to manage incontinence during the 7-day look-back period. Note the number of days during the look-back period that the toileting program was implemented or carried out.
2. Look for documentation in the medical record showing that the following three requirements have been met:
 - implementation of an individualized, resident-specific toileting program that was based on an assessment of the resident's unique voiding pattern
 - evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report
 - notations of the resident's response to the toileting program and subsequent evaluations, as needed
3. Guidance for developing a toileting program may be obtained from sources found in Appendix C.

Coding Instructions H0200A, Toileting Program Trial

- Code 0, no: if for any reason the resident did not undergo a toileting trial. This includes residents who are continent of urine with or without toileting assistance, or who use a permanent catheter or ostomy, as well as residents who prefer not to participate in a trial. Skip to **Urinary Continence** item (H0300).
- Code 1, yes: for residents who underwent a trial of an individualized, resident-centered toileting program at least once since admission/readmission, prior assessment, or when urinary incontinence was first noted.
- Code 9, unable to determine: if records cannot be obtained to determine if a trial toileting program has been attempted. If code 9, skip H0200B and go to H0200C, **Current Toileting Program or Trial**.

Coding Instructions H0200B, Toileting Program Trial Response

- Code 0, no improvement: if the frequency of resident's urinary incontinence did not decrease during the toileting trial.
- Code 1, decreased wetness: if the resident's urinary incontinence frequency decreased, but the resident remained incontinent. There is no quantitative definition of improvement. However, the improvement should be clinically meaningful—for example, having at least one less incontinent void per day than before the toileting program was implemented.
- Code 2, completely dry (continent): if the resident becomes completely continent of urine, with no episodes of urinary incontinence during the toileting trial. (For residents who have undergone more than one toileting program trial during their stay, use the most recent trial to complete this item.)
- Code 9, unable to determine or trial in progress: if the response to the toileting trial cannot be determined because information cannot be found or because the trial is still in progress.

H0200: Urinary Toileting Program (cont.)

2. Mr. M., who has a diagnosis of congestive heart failure (CHF) and a history of left-sided hemiplegia from a previous stroke, has had an increase in urinary incontinence. The team has assessed him for a reversible cause of the incontinence and has evaluated his voiding pattern using a voiding assessment/diary. After completing the assessment, it was determined that incontinence episodes could be reduced. A plan was developed and implemented that called for toileting every hour for 4 hours after receiving his 8 a.m. diuretic, then every 3 hours until bedtime at 9 p.m. The team has communicated this approach to the resident and the care team and has placed these interventions in the care plan. The team will reevaluate the resident's response to the plan after 1 month and adjust as needed.

Coding: H0200A would be coded as 1, yes.

H0200B would be coded as 9, unable to determine or trial in progress

H0200C would be coded as 1, current toileting program or trial.

Rationale: Based on this resident's voiding assessment/diary, it was determined that this resident could benefit from a toileting program. Therefore H0200A is coded as 1, yes. Based on the assessment it was determined that incontinence episodes could be reduced, therefore H0200B is coded as 9, unable to determine or trial in progress. An individualized plan has been developed, implemented, and communicated to the resident and staff, therefore H0200C is coded as 1, current toileting program or trial.

H0300: Urinary Continence

H0300. Urinary Continence	
Enter Code <input type="checkbox"/>	<p>Urinary continence - Select the one category that best describes the resident</p> <ol style="list-style-type: none"> 0. Always continent 1. Occasionally incontinent (less than 7 episodes of incontinence) 2. Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding) 3. Always incontinent (no episodes of continent voiding) 9. Not rated, resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days

Item Rationale

Health-related Quality of Life

- Incontinence can
 - interfere with participation in activities,
 - be socially embarrassing and lead to increased feelings of dependency,
 - increase risk of long-term institutionalization,
 - increase risk of skin rashes and breakdown,
 - increased risk of repeated urinary tract infections, and
 - increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.

DEFINITIONS

URINARY INCONTINENCE
The involuntary loss of urine.

CONTINENCE
Any void into a commode, urinal, or bedpan that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting.

H0500: Bowel Toileting Program (cont.)

Steps for Assessment

1. Review the medical record for evidence of a bowel toileting program being used to manage bowel incontinence during the 7-day look-back period.
2. Look for documentation in the medical record showing that the following three requirements have been met:
 - implementation of an individualized, resident-specific bowel toileting program based on an assessment of the resident's unique bowel pattern;
 - evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, verbal and a written report; and
 - notations of the resident's response to the toileting program and subsequent evaluations, as needed.

Coding Instructions

- Code 0, no: if the resident is not currently on a toileting program targeted specifically at managing bowel continence.
- Code 1, yes: if the resident is currently on a toileting program targeted specifically at managing bowel continence.

H0600: Bowel Patterns

H0600. Bowel Patterns	
Enter Code	Constipation present?
<input type="checkbox"/>	0. No
	1. Yes

Item Rationale

Health-related Quality of Life

- Severe constipation can cause abdominal pain, anorexia, vomiting, bowel incontinence, and delirium.
- If unaddressed, constipation can lead to fecal impaction.

Planning for Care

- This item identifies residents who may need further evaluation of and intervention on bowel habits.
- Constipation may be a manifestation of serious conditions such as
 - dehydration due to a medical condition or inadequate access to and intake of fluid, and
 - side effects of medications.

DEFINITIONS

CONSTIPATION

If the resident has two or fewer bowel movements during the 7-day look-back period or if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements).

I: Active Diagnoses in the Last 7 Days (cont.)

Item Rationale

Health-Related Quality of Life

- Disease processes can have a significant adverse affect on an individual's health status and quality of life.

Planning for Care

- This section identifies active diseases and infections that drive the current plan of care.

Steps for Assessment

There are two look-back periods for this section:

- Diagnosis identification (Step 1) is a 60-day look-back period.
- Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period (except for Item I2300 UTI, which does not use the active 7-day look-back period).

1. **Identify diagnoses:** The disease conditions in this section require a physician-documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the **last 60 days**.

Medical record sources for physician diagnoses include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available. If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered.

- Although open communication regarding diagnostic information between the physician and other members of the interdisciplinary team is important, it is also essential that diagnoses communicated verbally be documented in the medical record by the physician to ensure follow-up.
 - Diagnostic information, including past history obtained from family members and close contacts, must also be documented in the medical record by the physician to ensure validity and follow-up.
2. **Determine whether diagnoses are active:** Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a **direct relationship** to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses.

DEFINITIONS

ACTIVE DIAGNOSES

Physician-documented diagnoses in the last 60 days that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

FUNCTIONAL LIMITATIONS

Loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform, ADLs, paresis, or paralysis.

NURSING MONITORING

Nursing Monitoring includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management, etc.).

I: Active Diagnoses in the Last 7 Days (cont.)

- Item I2300 UTI, has specific coding criteria and does not use the active 7-day look-back. Please refer to Page I-8 for specific coding instructions for Item I2300 UTI.
- Check the following information sources in the medical record for the last 7 days to identify “active” diagnoses: transfer documents, physician progress notes, recent history and physical, recent discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor’s orders, consults and official diagnostic reports, and other sources as available.

Coding Instructions

Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident’s current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period (except Item I2300 UTI, which does not use the active diagnosis 7-day look-back. Please refer to Item I2300 UTI, Page I-8 for specific coding instructions).

- Document active diagnoses on the MDS as follows:
 - Diagnoses are listed by major disease category: Cancer; Heart/Circulation; Gastrointestinal; Genitourinary; Infections; Metabolic; Musculoskeletal; Neurological; Nutritional; Psychiatric/Mood Disorder; Pulmonary; and Vision.
 - Examples of diseases are included for some disease categories. Diseases to be coded in these categories are not meant to be limited to only those listed in the examples. For example, **I0200, Anemia**, includes anemia of any etiology, including those listed (e.g., aplastic, iron deficiency, pernicious, sickle cell).
- Check off each active disease. Check all that apply.
- If a disease or condition is **not** specifically listed, enter the diagnosis and ICD code in item I8000, Additional active diagnosis.
- Computer specifications are written such that the ICD code should be automatically justified. The important element is to ensure that the ICD code’s decimal point is in its own box and should be right justified (aligned with the right margin so that any unused boxes and on the left.)
- If a diagnosis is a V-code, another diagnosis for the related primary medical condition should be checked in items I0100-I7900 or entered in I8000.

Cancer

- I0100, cancer (with or without metastasis)

Heart/Circulation

- I0200, anemia (e.g., aplastic, iron deficiency, pernicious, sickle cell)
- I0300, atrial fibrillation or other dysrhythmias (e.g., bradycardias, tachycardias)
- I0400, coronary artery disease (CAD) (e.g., angina, myocardial infarction, atherosclerotic heart disease [ASHD])

I: Active Diagnoses in the Last 7 Days (cont.)

organism. An appropriate culture will help to ensure the diagnosis of infection is correct, and the appropriate antimicrobial is prescribed to treat the infection. The CDC does not recommend routine antimicrobial treatment for the purposes of attempting to eradicate colonization of MRSA or any other antimicrobial resistant organism.

The CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) has released infection prevention and control guidelines that contain recommendations that should be applied in all healthcare settings. At this site you will find information related to UTIs and many other issues related to infections in LTC.

http://www.cdc.gov/ncidod/dhqp/gl_longterm_care.html

Examples of Active Disease

1. A resident is prescribed hydrochlorothiazide for hypertension. The resident requires regular blood pressure monitoring to determine whether blood pressure goals are achieved by the current regimen. Physician progress note documents hypertension.

Coding: **Hypertension** item (I0700), would be checked.

Rationale: This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy.

2. Warfarin is prescribed for a resident with atrial fibrillation to decrease the risk of embolic stroke. The resident requires monitoring for change in heart rhythm, for bleeding, and for anticoagulation.

Coding: **Atrial fibrillation** item (I0300), would be checked.

Rationale: This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy as well as to monitor for side effects related to the medication.

3. A resident with a past history of healed peptic ulcer is prescribed a non-steroidal anti-inflammatory (NSAID) medication for arthritis. The physician also prescribes a proton-pump inhibitor to decrease the risk of peptic ulcer disease (PUD) from NSAID treatment.

Coding: **Arthritis** item (I3700), would be checked.

Rationale: Arthritis would be considered an active diagnosis because of the need for medical therapy. Given that the resident has a history of a healed peptic ulcer without current symptoms, the proton-pump inhibitor prescribed is preventive and therefore PUD would not be coded as an active disease.

4. The resident had a stroke 4 months ago and continues to have left-sided weakness, visual problems, and inappropriate behavior. The resident is on aspirin and has physical therapy and occupational therapy three times a week. The physician's note 25 days ago lists stroke.

Coding: **Cerebrovascular Vascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke** item (I4500), would be checked.

K0200: Height and Weight (cont.)

- If a resident cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code (-) and document rationale on the resident's medical record.

K0300: Weight Loss

K0300. Weight Loss	
Enter Code <input type="checkbox"/>	<p>Loss of 5% or more in the last month or loss of 10% or more in last 6 months</p> <p>0. No or unknown</p> <p>1. Yes, on physician-prescribed weight-loss regimen</p> <p>2. Yes, not on physician-prescribed weight-loss regimen</p>

Item Rationale

Health-related Quality of Life

- Weight loss can result in debility and adversely affect health, safety, and quality of life.
- For persons with morbid obesity, controlled and careful weight loss can improve mobility and health status.
- For persons with a large volume (fluid) overload, controlled and careful diuresis can improve health status.

Planning for Care

- Weight loss may be an important indicator of a change in the resident's health status or environment.
- If significant weight loss is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medication (e.g., diuretics), or changed fluid volume status.
- Weight loss should be monitored on a continuing basis; weight loss should be assessed and care planned at the time of detection and not delayed until the next MDS assessment.

DEFINITIONS

5% WEIGHT LOSS IN 30 DAYS

Start with the resident's weight closest to 30 days ago and multiply it by .95 (or 95%). The resulting figure represents a 5% loss from the weight 30 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost more than 5% body weight.

10% WEIGHT LOSS IN 180 DAYS

Start with the resident's weight closest to 180 days ago and multiply it by .90 (or 90%). The resulting figure represents a 10% loss from the weight 180 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost 10% or more body weight.

Steps for Assessment

This item compares the resident's weight in the current observation period with his or her weight at two snapshots in time:

- At a point closest to 30-days preceding the current weight.
- At a point closest to 180-days preceding the current weight.

K0300: Weight Loss (cont.)

This item does not consider weight fluctuation outside of these two time points, although the resident's weight should be monitored on a continual basis and weight loss assessed and addressed on the care plan as necessary.

For a New Admission

1. Ask the resident, family, or significant other about weight loss over the past 30 and 180 days.
2. Consult the resident's physician, review transfer documentation, and compare with admission weight.
3. If the admission weight is less than the previous weight, calculate the percentage of weight loss.
4. Complete the same process to determine and calculate weight loss comparing the admission weight to the weight 30 and 180 days ago.

For Subsequent Assessments

1. From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 30 days ago.
2. If the current weight is less than the weight in the observation period 30 days ago, calculate the percentage of weight loss.
3. From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 180 days ago.
4. If the current weight is less than the weight in the observation period 180 days ago, calculate the percentage of weight loss.

DEFINITIONS

PHYSICIAN-PRESCRIBED WEIGHT-LOSS REGIMEN

A weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. May employ a calorie-restricted diet or other weight loss diets and exercise. Also includes planned diuresis. It is important that weight loss is intentional.

BODY MASS INDEX (BMI)

Number calculated from a person's weight and height. BMI is used as a screening tool to identify possible weight problems for adults. Visit http://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/index.html.

Coding Instructions

Mathematically round weights as described in Section K0200B before completing the weight loss calculation.

- Code 0, no or unknown: if the resident has not experienced weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available.
- Code 1, yes on physician-prescribed weight-loss regimen: if the resident has experienced a weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight loss was planned and pursuant to a physician's order. In cases where a resident has a weight loss of 5% or more in 30 days or 10% or more in 180 days as a result of any physician ordered diet plan or expected weight loss due to loss of fluid with physician orders for diuretics, K0300 can be coded as **1**.

K0300: Weight Loss (cont.)

The most recent postoperative weight of 110 lbs (110 lbs, taking the amputated limb into account) is >10% weight loss (significant at 180 days).

Present weight of 110 lbs >10% weight loss (significant at 180 days).

Coding: K0300 would be coded 2, yes, weight change is significant; not on physician-prescribed weight-loss regimen.

Rationale: The resident had a significant weight loss of >5% in 30 days and did have a weight loss of >10% in 180 days, the item would be coded as 2, yes weight change is significant; not on physician-prescribed weight-loss regime, with one of the items being triggered. This item is coded for either a 5% 30-day weight loss or a 10% 180-day weight loss. In this example both items, the criteria are met but the coding does not change as long as one of them are met.

K0310: Weight Gain

K0310. Weight Gain	
Enter Code <input type="checkbox"/>	Gain of 5% or more in the last month or gain of 10% or more in last 6 months 0. No or unknown 1. Yes, on physician-prescribed weight-gain regimen 2. Yes, not on physician-prescribed weight-gain regimen

Item Rationale

Health-related Quality of Life

- Weight gain can result in debility and adversely affect health, safety, and quality of life.

Planning for Care

- Weight gain may be an important indicator of a change in the resident's health status or environment.
- If significant weight gain is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medication (e.g., steroidal), or changed fluid volume status.
- Weight gain should be monitored on a continuing basis; weight gain should be assessed and care planned at the time of detection and not delayed until the next MDS assessment.

Steps for Assessment

This item compares the resident's weight in the current observation period with his or her weight at two snapshots in time:

- At a point closest to 30-days preceding the current weight.
- At a point closest to 180-days preceding the current weight.

DEFINITIONS

5% WEIGHT GAIN IN 30 DAYS

Start with the resident's weight closest to 30 days ago and multiply it by 1.05 (or 105%). The resulting figure represents a 5% gain from the weight 30 days ago. If the resident's current weight is equal to or more than the resulting figure, the resident has gained more than 5% body weight.

10% WEIGHT GAIN IN 180 DAYS

Start with the resident's weight closest to 180 days ago and multiply it by 1.10 (or 110%). The resulting figure represents a 10% gain from the weight 180 days ago. If the resident's current weight is equal to or more than the resulting figure, the resident has gained more than 10% body weight.

K0310: Weight Gain (cont.)

This item does not consider weight fluctuation outside of these two time points, although the resident's weight should be monitored on a continual basis and weight gain assessed and addressed on the care plan as necessary.

For a New Admission

1. Ask the resident, family, or significant other about weight gain over the past 30 and 180 days.
2. Consult the resident's physician, review transfer documentation, and compare with admission weight.
3. If the admission weight is more than the previous weight, calculate the percentage of weight gain.
4. Complete the same process to determine and calculate weight gain comparing the admission weight to the weight 30 and 180 days ago.

For Subsequent Assessments

1. From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 30 days ago.
2. If the current weight is more than the weight in the observation period 30 days ago, calculate the percentage of weight gain.
3. From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 180 days ago.
4. If the current weight is more than the weight in the observation period 180 days ago, calculate the percentage of weight gain.

Coding Instructions

Mathematically round weights as described in Section K0200B before completing the weight gain calculation.

- Code 0, no or unknown: if the resident has not experienced weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days or if information about prior weight is not available.
- Code 1, yes on physician-prescribed weight-gain regimen: if the resident has experienced a weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight gain was planned and pursuant to a physician's order. In cases where a resident has a weight gain of 5% or more in 30 days or 10% or more in 180 days as a result of any physician ordered diet plan, K0310 can be coded as **1**.
- Code 2, yes, not on physician-prescribed weight-gain regimen: if the resident has experienced a weight gain of 5% or more in the past 30 days or 10% or more in the last 180 days, and the weight gain was not planned and prescribed by a physician.

Coding Tips

- A resident may experience weight variances in between the snapshot time periods. Although these require follow up at the time, they are not captured on the MDS.

K0700: Percent Intake by Artificial Route (cont.)

Coding Instructions

Code for the average number of cc per day of fluid the resident received via IV or tube feeding. Record what was actually received by the resident, not what was ordered.

- Code 1: 500 cc/day or less
- Code 2: 501 cc/day or more

Examples

1. 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.

IV Fluid Intake	
Sun.	1250 cc
Mon.	775 cc
Tues.	925 cc
Wed.	1200 cc
Thurs.	1200 cc
Fri.	500 cc
Sat.	450 cc
Total	6,300 cc

Coding: K0700B would be coded **2, 501cc/day or more**.

Rationale: The total fluid intake by supplemental tube feedings = 6,300 cc
 6,300 cc divided by 7 days = 900 cc/day
 900 cc is greater than 500 cc, therefore **code 2, 501 cc/day or more** is correct.

2. Calculation for Average Daily Fluid Intake

Mrs. G. received 1 liter of IV fluids during the 7-day assessment period. She received no other intake via IV or tube feeding during the assessment period.

IV Fluid Intake	
Sun.	0 cc
Mon.	0 cc
Tues.	1,000 cc
Wed.	0 cc
Thurs.	0 cc
Fri.	0 cc
Sat.	0 cc
Total	1,000 cc

K0700: Percent Intake by Artificial Route (cont.)

Coding: K0700b would be coded **1, 500 cc/day or less**.

Rationale: The total fluid intake by supplemental tube feedings = 1000 cc
1000 cc divided by 7 days = 142.9 cc/day
142.9 cc is less than 500 cc, therefore **code 1, 500 cc/day or less** is correct.

L0200: Dental (cont.)

Steps for Assessment

1. Ask the resident about the presence of chewing problems or mouth or facial pain/discomfort.
2. Ask the resident, family, or significant other whether the resident has or recently had dentures or partials. (If resident or family/significant other reports that the resident recently had dentures or partials, but they do not have them at the facility, ask for a reason.)
3. If the resident has dentures or partials, examine for loose fit. Ask him or her to remove, and examine for chips, cracks, and cleanliness. Removal of dentures and/or partials is necessary for adequate assessment.
4. Conduct exam of the resident's lips and oral cavity with dentures or partials removed, if applicable. Use a light source that is adequate to visualize the back of the mouth. Visually observe and feel all oral surfaces including lips, gums, tongue, palate, mouth floor, and cheek lining. Check for abnormal mouth tissue, abnormal teeth, or inflamed or bleeding gums. The assessor should use his or her gloved fingers to adequately feel for masses or loose teeth.
5. If the resident is unable to self-report, then observe him or her while eating with dentures or partials, if indicated, to determine if chewing problems or mouth pain are present.
6. Oral examination of residents who are uncooperative and do not allow for a thorough oral exam may result in medical conditions being missed. Referral for dental evaluation should be considered for these residents and any resident who exhibits dental or oral issues.

DEFINITIONS

ORAL MASS

A swollen or raised lump, bump, or nodule on any oral surface. May be hard or soft, and with or without pain.

ULCER

Mouth sore, blister or eroded area of tissue on any oral surface.

Coding Instructions

- Check L0200A, broken or loosely fitting full or partial denture: if the denture or partial is chipped, cracked, uncleanable, or loose. A denture is coded as loose if the resident complains that it is loose, the denture visibly moves when the resident opens his or her mouth, or the denture moves when the resident tries to talk.
- Check L0200B, no natural teeth or tooth fragment(s) (edentulous): if the resident is edentulous or lacks all natural teeth or parts of teeth.
- Check L0200C, abnormal mouth tissue (ulcers, masses, oral lesions): select if any ulcer, mass, or oral lesion is noted on any oral surface.
- Check L0200D, obvious or likely cavity or broken natural teeth: if any cavity or broken tooth is seen.
- Check L0200E, inflamed or bleeding gums or loose natural teeth: if gums appear irritated, red, swollen, or bleeding. Teeth are coded as loose if they readily move when light pressure is applied with a fingertip.
- Check L0200F, mouth or facial pain or discomfort with chewing: if the resident reports any pain in the mouth or face, or discomfort with chewing.
- Check L0200G, unable to examine: if the resident's mouth cannot be examined.
- Check L0200Z, none of the above: if none of conditions A through F is present.

L0200: Dental (cont.)

Coding Tips

- Mouth or facial pain coded for this item should also be coded in Section J, items J0100 through J0850, in any items in which the coding requirements of Section J are met.

M0100: Determination of Pressure Ulcer Risk (cont.)

Steps for Assessment

1. Review the medical record, including skin care flow sheets or other skin tracking forms, nurses' notes, and pressure ulcer risk assessments.
2. Speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident.
3. Examine the resident and determine whether any ulcers, scars, or non-removable dressings/devices are present. Assess key areas for pressure ulcer development (e.g., sacrum, coccyx, trochanters, ischial tuberosities, and heels). Also assess bony prominences (e.g., elbows and ankles) and skin that is under braces or subjected to pressure (e.g., ears from oxygen tubing).

Coding Instructions

For this item, ***check all that apply:***

- Check A if resident has a Stage 1 or greater pressure ulcer, a scar over bony prominence, or a non-removable dressing/device. Review descriptions of pressure ulcer stages and information obtained during physical examination and medical record review. Examples of non-removable dressings/devices include a primary surgical dressing, a cast, or a brace.
- Check B if a formal assessment has been completed. An example of an established pressure ulcer risk tool is the *Braden Scale for Predicting Pressure Sore Risk*[®]. Other tools may be used.
- Check C if the resident's risk for pressure ulcer development is based on clinical assessment. A clinical assessment could include a head-to-toe physical examination of the skin and observation or medical record review of pressure ulcer risk factors. Examples of risk factors include the following:
 - impaired/decreased mobility and decreased functional ability
 - co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus;
 - drugs, such as steroids, that may affect wound healing;
 - impaired diffuse or localized blood flow (e.g., generalized atherosclerosis or lower extremity arterial insufficiency);

DEFINITIONS

PRESSURE ULCER RISK FACTOR

Examples of risk factors include immobility and decreased functional ability; co-morbid conditions such as end-stage renal disease, thyroid disease, or diabetes; drugs such as steroids; impaired diffuse or localized blood flow; resident refusal of care and treatment; cognitive impairment; exposure of skin to urinary and fecal incontinence; under nutrition, malnutrition, and hydration deficits; and a healed ulcer.

PRESSURE ULCER RISK TOOLS

Screening tools that are designed to help identify residents who might develop a pressure ulcer. A common risk assessment tool is the Braden Scale for Predicting Pressure Sore Risk[®].

M0100: Determination of Pressure Ulcer Risk (cont.)

- resident refusal of some aspects of care and treatment;
 - cognitive impairment;
 - urinary and fecal incontinence;
 - under nutrition, malnutrition, and hydration deficits; and
 - healed pressure ulcers, especially Stage 3 or 4 which are more likely to have recurrent breakdown.
- Check Z if none of the above apply.

M0150: Risk of Pressure Ulcers

M0150. Risk of Pressure Ulcers	
Enter Code	Is this resident at risk of developing pressure ulcers?
<input type="checkbox"/>	0. No
	1. Yes

Item Rationale

Health-related Quality of Life

- It is important to recognize and evaluate each resident’s risk factors and to identify and evaluate all areas at risk of constant pressure.

Planning for Care

- The care process should include efforts to stabilize, reduce, or remove underlying risk factors; to monitor the impact of the interventions; and to modify the interventions as appropriate.

Steps for Assessment

1. Based on the item(s) reviewed for M0100, determine if the resident is at risk for developing a pressure ulcer.
2. If the medical record reveals that the resident currently has a Stage 1 or greater pressure ulcer, a scar over a bony prominence, or a non-removable dressing or device, the resident is at risk for worsening or new pressure ulcers.
3. Review formal risk assessment tools to determine the resident’s “risk score.”
4. Review the components of the clinical assessment conducted for evidence of pressure ulcer risk.

Coding Instructions

- Code 0, no: if the resident is not at risk for developing pressure ulcers based on a review of information gathered for M0100.
- Code 1, yes: if the resident is at risk for developing pressure ulcers based on a review of information gathered for M0100.

M0210: Unhealed Pressure Ulcer(s)

M0210. Unhealed Pressure Ulcer(s)	
Enter Code <input type="checkbox"/>	<p>Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?</p> <p>0. No → Skip to M0900, Healed Pressure Ulcers</p> <p>1. Yes → Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage</p>

Item Rationale

Health-related Quality of Life

- Pressure ulcers and other wounds or lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- The pressure ulcer definitions used in the RAI Manual have been adapted from those recommended by the National Pressure Ulcer Advisory Panel (NPUAP) 2007 Pressure Ulcer Stages.
- An existing pressure ulcer identifies residents at risk for further complications or skin injury. Risk factors described in M0100 should be addressed.
- For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or sDTI that declares itself, should be coded in terms of what is assessed (seen or palpated, i.e. visible tissue, palpable bone) during the look-back period. Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. However, since CMS has adapted the NPUAP guidelines for MDS purposes, the definitions do not perfectly correlate with each stage as described by NPUAP. Therefore, you cannot use the NPUAP definitions to code the MDS. You must code the MDS according to the instructions in this manual.
- Pressure ulcer staging is an assessment system that provides a description and classification based on anatomic depth of soft tissue damage. This tissue damage can be visible or palpable in the ulcer bed. Pressure ulcer staging also informs expectations for healing times.

DEFINITIONS

PRESSURE ULCER
A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.

Steps for Assessment

1. Review the medical record, including skin care flow sheets or other skin tracking forms.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Examine the resident and determine whether any skin ulcers are present.
 - Key areas for pressure ulcer development include the sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony deformities, skin under braces, and skin subjected to excess pressure, shear or friction, are also at risk for pressure ulcers.
 - Without a full body skin assessment, a pressure ulcer can be missed.
 - Examine the resident in a well-lit room. Adequate lighting is important for detecting skin changes. For any pressure ulcers identified, measure and record the deepest anatomical stage.
4. Identify any known or likely unstageable pressure ulcers.

M0210: Unhealed Pressure Ulcer(s) (cont.)

Coding Instructions

Code based on the presence of any pressure ulcer (regardless of stage) in the past 7 days.

- Code 0, no: if the resident did not have a pressure ulcer in the 7-day look-back period. Then skip Items M0300–M0800.
- Code 1, yes: if the resident had any pressure ulcer (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300).

Coding Tips

- If an ulcer arises from a combination of factors which are primarily caused by pressure, then the ulcer should be included in this section as a pressure ulcer.
- Oral Mucosal ulcers caused by pressure should not be coded in Section M. These ulcers are captured in item **L0200C, Abnormal mouth tissue**. Mucosal ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made.
- If a pressure ulcer is surgically closed with a flap or graft, it should be coded as a surgical wound and not as a pressure ulcer. If the flap or graft fails, continue to code it as a surgical wound until healed.
- Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether the diabetic has an ulcer that is caused by pressure or other factors.
- If a resident with DM has a heel ulcer from pressure and the ulcer is present in the 7-day look-back period, **code 1** and proceed to code items M0300–M0900 as appropriate for the pressure ulcer.
- If a resident with DM has an ulcer on the plantar (bottom) surface of the foot closer to the metatarsal and the ulcer is present in the 7-day look-back period, **code 0** and proceed to M1040 to code the ulcer as a diabetic foot ulcer.
- Scabs and eschar are different both physically and chemically. Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound. A scab is made up of dried blood cells and serum, sits on the top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc.). A scab is evidence of wound healing. A pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2, and therefore, staging should not change. Eschar characteristics and the level of damage it causes to tissues is what makes it easy to distinguish from a scab. It is extremely important to have staff who are trained in wound assessment and who are able to distinguish scabs from eschar.
- If a resident had a pressure ulcer on the last assessment and it is now healed, complete **Healed Pressure Ulcers** item (M0900).
- If a pressure ulcer healed during the look-back period, and was not present on prior assessment, **code 0**.

M0300: Current Number of Unhealed Pressure Ulcers at Each Stage

Steps for completing M0300A–G

Step 1: Determine Deepest Anatomical Stage

For each pressure ulcer, determine the deepest anatomical stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement.

1. Observe and palpate the base of any identified pressure ulcers present to determine the anatomic depth of soft tissue damage involved.
2. Ulcer staging should be based on the ulcer's deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer's tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable (see Step 2 below). Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage. Nursing homes that carefully document and track pressure ulcers will be able to more accurately code this item.

Step 2: Identify Unstageable Pressure Ulcers

1. Visualization of the wound bed is necessary for accurate staging.
2. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed, should be classified as unstageable, as illustrated at <http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpg>
3. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer, and do not code this as unstageable.
4. A pressure ulcer with intact skin that is a suspected deep tissue injury (sDTI) should not be coded as a Stage 1 pressure ulcer. It should be coded as unstageable, as illustrated at <http://www.npuap.org/images/NPUAP-SuspectDTI.jpg>
5. Known pressure ulcers covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable.

M0300: Current Number of Unhealed Pressure Ulcers at Each Stage (cont.)

Step 3: Determine “Present on Admission”

*For each pressure ulcer, determine if the pressure ulcer was present at the time of admission/entry or reentry and **not** acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement.*

DEFINITIONS

ON ADMISSION

As close to the actual time of admission as possible.

1. Review the medical record for the history of the ulcer.
2. Review for location and stage at the time of admission/entry or reentry. If the pressure ulcer was present on admission/entry or reentry and subsequently increased in numerical stage during the resident’s stay, the pressure ulcer is coded at that higher stage, and that higher stage **should not be considered as “present on admission.”**
3. If the pressure ulcer was unstageable on admission/entry or reentry, but becomes numerically stageable later, it should be considered as “present on admission” at the stage at which it first becomes numerically stageable. If it subsequently increases in numerical stage, that higher stage **should not be considered “present on admission.”**
4. If a resident who has a pressure ulcer is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer **should not be coded as “present on admission”** because it was present at the facility prior to the hospitalization.
5. If a current pressure ulcer increases in numerical stage during a hospitalization, it is coded at the higher stage upon reentry and **should be coded as “present on admission.”**

M0300A: Number of Stage 1 Pressure Ulcers

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage	
Enter Number <input type="text"/>	A. Number of Stage 1 pressure ulcers Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

Item Rationale

Health-related Quality of Care

- Stage 1 pressure ulcers may deteriorate to more severe pressure ulcers without adequate intervention; as such, they are an important risk factor for further tissue damage.

Planning for Care

- Development of a Stage 1 pressure ulcer should be one of multiple factors that initiate pressure ulcer prevention interventions.

M0300A: Number of Stage 1 Pressure Ulcers (cont.)

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc).
2. For the purposes of coding, determine that the lesion being assessed is **primarily** related to pressure and that other conditions have been ruled out. If pressure is **not** the **primary** cause, do **not** code here.
3. Reliance on only one descriptor is inadequate to determine the staging of the pressure ulcer between Stage 1 and suspected deep tissue ulcers. The descriptors are similar for these two types of ulcers (e.g., temperature (warmth or coolness); tissue consistency (firm or boggy)).
4. Check any reddened areas for ability to blanch by firmly pressing a finger into the reddened tissues and then removing it. In non-blanchable reddened areas, there is no loss of skin color or pressure-induced pallor at the compressed site.
5. Search for other areas of skin that differ from surrounding tissue that may be painful, firm, soft, warmer, or cooler compared to adjacent tissue. Stage 1 may be difficult to detect in individuals with dark skin tones. Visible blanching may not be readily apparent in darker skin tones. Look for temperature or color changes.

DEFINITIONS

STAGE 1 PRESSURE ULCER

An observable, pressure-related alteration of intact skin, whose indicators as compared to an adjacent or opposite area on the body may include changes in one or more of the following parameters: skin temperature (warmth or coolness); tissue consistency (firm or boggy); sensation (pain, itching); and/or a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

NON-BLANCHABLE

Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device.

Coding Instructions for M0300A

- Enter the number of Stage 1 pressure ulcers that are currently present.
- Enter 0 if no Stage 1 pressure ulcers are present.

Coding Tips

- If a resident had a pressure ulcer on the last assessment and it is now healed, complete **Healed Pressure Ulcers** item (M0900).
- If a pressure ulcer healed during the look-back period, and was not present on prior assessment, **code 0**.

M0300B: Stage 2 Pressure Ulcers

Enter Number <input type="text"/> Enter Number <input type="text"/>	<p>B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister</p> <p>1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3</p> <p>2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p> <p>3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown:</p> <table style="width: 100%; text-align: center;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-size: 10px;">-</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-size: 10px;">-</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2">Month</td> <td></td> <td colspan="2">Day</td> <td></td> <td colspan="3">Year</td> </tr> </table>			-			-				Month			Day			Year		
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Item Rationale

Health-related Quality of Life

- Stage 2 pressure ulcers may worsen without proper interventions.
- These residents are at risk for further complications or skin injury.

Planning for Care

- **Most Stage 2** pressure ulcers should heal in a reasonable time frame (e.g., 60 days).
- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the patient's overall clinical condition should be reassessed.
- Stage 2 pressure ulcers are often related to friction and/or shearing force, and the care plan should incorporate efforts to limit these forces on the skin and tissues.
- Stage 2 pressure ulcers may be more likely to heal with treatment than higher stage pressure ulcers.
- The care plan should include individualized interventions and evidence that the interventions have been monitored and modified as appropriate.

DEFINITIONS

STAGE 2 PRESSURE ULCER

Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, **without slough**.

May also present as an intact or open/ruptured blister.

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc).
2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is **not** the primary cause, do **not** code here.

M0300B: Stage 2 Pressure Ulcers (cont.)

3. **Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage, (e.g., color change, tenderness, bogginess or firmness, warmth or coolness) these characteristics suggest a suspected deep tissue injury (sDTI) rather than a Stage 2 Pressure Ulcer.**
4. Stage 2 pressure ulcers will **generally** lack the surrounding characteristics found with a deep tissue injury.
5. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry (see instructions on page M-6).
6. Identify the oldest Stage 2 pressure ulcer and the date it was first noted at that stage.

Coding Instructions for M0300B

- Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 2.
- Enter 0 if no Stage 2 pressure ulcers are present and skip to **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300C).
- Enter the number of Stage 2 pressure ulcers that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 2 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 2 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).
- Enter 0 if no Stage 2 pressure ulcers were first noted at the time of admission/entry or reentry.
- Enter the date of the oldest Stage 2 pressure ulcer. The facility should make every effort to determine the actual date that the Stage 2 pressure ulcer was first identified whether or not it was acquired in the facility. If the facility is unable to determine the actual date that the Stage 2 pressure ulcer was first identified (i.e., the date is unknown), enter a dash in every block. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0." For example, January 2, 2012, should be entered as 01-02-2012.

Coding Tips

- A Stage 2 pressure ulcer presents as a shiny or dry shallow ulcer without slough or bruising.
- If the oldest Stage 2 pressure ulcer was present on admission/entry or reentry and the date it was first noted is unknown, enter a dash in every block.
- Do **not** code skin tears, tape burns, moisture associated skin damage, or excoriation here.
- When a pressure ulcer presents as an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury **is** determined, do **not** code as a Stage 2.

M0300C: Stage 3 Pressure Ulcers

Enter Number <input type="text"/> Enter Number <input type="text"/>	<p>C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling</p> <p>1. Number of Stage 3 pressure ulcers - If 0 → Skip to M0300D, Stage 4</p> <p>2. Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p>
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Item Rationale

Health-related Quality of Life

- Pressure ulcers affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, and care that may be more time or staff intensive.
- An existing pressure ulcer may put residents at risk for further complications or skin injury.
- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the resident's overall clinical condition should be reassessed.

DEFINITIONS

STAGE 3 PRESSURE ULCER
 Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling.

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc).
2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is **not** the primary cause, do **not** code here.
3. Identify all Stage 3 pressure ulcers currently present.
4. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry.

Coding Instructions for M0300C

- Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 3.
- Enter 0 if no Stage 3 pressure ulcers are present and skip to **Current Number of Unhealed Pressures Ulcers at Each Stage** item (M0300D).
- Enter the number of Stage 3 pressure ulcers that were first noted at Stage 3 at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 3 pressure ulcers that were acquired during the

M0300C: Stage 3 Pressure Ulcers (cont.)

hospitalization (i.e., the Stage 3 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).

- Enter 0 if no Stage 3 pressure ulcers were first noted at the time of admission/entry or reentry.

Coding Tips

- The depth of a Stage 3 pressure ulcer varies by anatomical location. Stage 3 pressure ulcers can be shallow, particularly on areas that do not have subcutaneous tissue, such as the bridge of the nose, ear, occiput, and malleolus.
- In contrast, areas of significant adiposity can develop extremely deep Stage 3 pressure ulcers. Therefore, observation and assessment of skin folds should be part of overall skin assessment.
- Bone/tendon/muscle is not visible or directly palpable in a Stage 3 pressure ulcer.

Examples

1. A pressure ulcer described as a Stage 2 was noted and documented in the resident's medical record on admission. On a later assessment, the wound is noted to be a full thickness ulcer without exposed bone, tendon, or muscle, thus it is now a Stage 3 pressure ulcer.

Coding: The current Stage 3 pressure ulcer would be coded at M0300C1 as Code 1, and at M0300C2 as 0, not present on admission/entry or reentry.

Rationale: The designation of "present on admission" requires that the pressure ulcer be at the same location and not have increased in numerical stage. This pressure ulcer worsened after admission.

2. A resident develops a Stage 2 pressure ulcer while at the nursing facility. The resident is hospitalized due to pneumonia for 8 days and returns with a Stage 3 pressure ulcer in the same location.

Coding: The pressure ulcer would be coded at M0300C1 as Code 1, and at M0300C2 as 1, present on admission/entry or reentry.

Rationale: Even though the resident had a pressure ulcer in the same anatomical location prior to transfer, because the pressure ulcer increased in numerical stage to Stage 3 during hospitalization, it should be coded as a Stage 3, present on admission/entry or reentry.

M0300C: Stage 3 Pressure Ulcers (cont.)

3. On admission, the resident has three small Stage 2 pressure ulcers on her coccyx. Two weeks later, the coccyx is assessed. Two of the Stage 2 pressure ulcers have merged and the third has increased in numerical stage to a Stage 3 pressure ulcer.

Coding: The two merged pressure ulcers would be coded at M0300B1 as 1, and at M0300B2 as 1, present on admission/entry or reentry. The Stage 3 pressure ulcer would be coded at M0300C1 as 1, and at M0300C2 as 0, not present on admission/entry or reentry.

Rationale: Two of the pressure ulcers on the coccyx have merged, but have remained at the same stage as they were at the time of admission; the one that increased in numerical stage to a Stage 3 cannot be coded in M0300C2 as present on admission/entry or reentry since the Stage 3 ulcer was not present on admission/entry or reentry.

4. A resident developed two Stage 2 pressure ulcers during her stay; one on the coccyx and the other on the left lateral malleolus. At some point she is hospitalized and returns with two pressure ulcers. One is the previous Stage 2 on the coccyx, which has not changed; the other is a new Stage 3 on the left trochanter. The Stage 2 previously on the left lateral malleolus has healed.

Coding: The Stage 2 pressure ulcer would be coded at M0300B1 as 1, and at M0300B2 as 0, not present on admission; the Stage 3 would be coded at M0300C1 as 1, and at M0300C2 as 1, present on admission/entry or reentry.

Rationale: The Stage 2 pressure ulcer on the coccyx was present prior to hospitalization; the Stage 3 pressure ulcer developed during hospitalization and is coded in M0300C2 as present on admission/entry or reentry. The Stage 2 pressure ulcer on the left lateral malleolus has healed and is therefore no longer coded here but in Item M0900, Healed Pressure Ulcers.

DEFINITIONS

STAGE 4 PRESSURE ULCER

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

M0300D: Stage 4 Pressure Ulcers

Enter Number <input type="text"/> Enter Number <input type="text"/>	<p>D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling</p> <p>1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable: Non-removable dressing</p> <p>2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p>
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Item Rationale

Health-related Quality of Life

- Pressure ulcers affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

M0300D: Stage 4 Pressure Ulcers (cont.)

Planning for Care

- Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, more frequent dressing changes, and treatment that is more time-consuming than with routine preventive care.
- An existing pressure ulcer may put residents at risk for further complications or skin injury.
- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the resident's overall clinical condition should be reassessed.

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).
2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is **not** the primary cause, do **not** code here.
3. Identify all Stage 4 pressure ulcers currently present.
4. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry.

Coding Instructions for M0300D

- Enter the number of pressure ulcers that are currently present and whose deepest anatomical stage is Stage 4.
- Enter 0 if no Stage 4 pressure ulcers are present and skip to **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300E).
- Enter the number of Stage 4 pressure ulcers that were first noted at Stage 4 at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, enter the number of Stage 4 pressure ulcers that were acquired during the hospitalization (i.e., the Stage 4 pressure ulcer was not acquired in the nursing facility prior to admission to the hospital).
- Enter 0 if no Stage 4 pressure ulcers were first noted at the time of admission/entry or reentry.

DEFINITIONS

TUNNELING

A passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound.

UNDERMINING

The destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface.

M0300D: Stage 4 Pressure Ulcers (cont.)

Coding Tips

- The depth of a Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and these ulcers can be shallow.
- Stage 4 pressure ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon, or joint capsule) making osteomyelitis possible.
- Exposed bone/tendon/muscle is visible or directly palpable.
- Cartilage serves the same anatomical function as bone. Therefore, pressure ulcers that have exposed cartilage should be classified as a Stage 4.

M0300E: Unstageable Pressure Ulcers Related to Non-removable Dressing/Device

Enter Number <input type="text"/> Enter Number <input type="text"/>	<p>E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device</p> <p>1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar</p> <p>2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p>
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Item Rationale

Health-related Quality of Life

- Although the wound bed cannot be visualized, and hence the pressure ulcer cannot be staged, the pressure ulcer may affect quality of life for residents because it may limit activity and may be painful.

Planning for Care

- Although the pressure ulcer itself cannot be observed, the surrounding area is monitored for signs of redness, swelling, increased drainage, or tenderness to touch, and the resident is monitored for adequate pain control.

DEFINITIONS

NON-REMOVABLE DRESSING/ DEVICE
 Includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast.

Steps for Assessment

1. Review the medical record for documentation of a pressure ulcer covered by a non-removable dressing.
2. Determine the number of pressure ulcers unstageable related to a non-removable dressing/device. Examples of non-removable dressings/devices include a dressing that is not to be removed per physician's order, an orthopedic device, or a cast.
3. Identify the number of these pressure ulcers that were present on admission/entry or reentry (see page M-6 for assessment process).

M0300E: Unstageable Pressure Ulcers Related to Non-removable Dressing/Device (cont.)

Coding Instructions for M0300E

- Enter the number of pressure ulcers that are unstageable related to non-removable dressing/device.
- Enter 0 if no unstageable pressure ulcers related to non-removable dressing/device are present and skip to **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300F).
- Enter the number of unstageable pressure ulcers related to a non-removable dressing/device that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, that were acquired during the hospitalization (i.e., the unstageable pressure ulcer related to a non-removable dressing/device was not acquired in the nursing facility prior to admission to the hospital).
- Enter 0 if no unstageable pressure ulcers related to non-removable dressing/device were first noted at the time of admission/entry or reentry.

M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar

Enter Number <input type="text"/> Enter Number <input type="text"/>	<p>F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar</p> <p>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 → Skip to M0300G, Unstageable: Deep tissue</p> <p>2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p>
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Item Rationale

Health-related Quality of Life

- Although the wound bed cannot be visualized, and hence the pressure ulcer cannot be staged, the pressure ulcer may affect quality of life for residents because it may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

Planning for Care

- Visualization of the wound bed is necessary for accurate staging.
- The presence of pressure ulcers and other skin changes should be accounted for in the interdisciplinary care plan.

DEFINITIONS

SLOUGH TISSUE

Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

ESCHAR TISSUE

Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.

M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar (cont.)

- Pressure ulcers that present as unstageable require care planning that includes, in the absence of ischemia, debridement of necrotic and dead tissue and restaging once this tissue is removed.

Steps for Assessment

1. Determine the number of pressure ulcers that are unstageable due to slough and/or eschar.
2. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry (see page M-6 for assessment process).

Coding Instructions for M0300F

- Enter the number of pressure ulcers that are unstageable related to slough and/or eschar.
- Enter 0 if no unstageable pressure ulcers related to slough and/or eschar are present and skip to **Current Number of Unhealed Pressure Ulcers at Each Stage** item (M0300G).
- Enter the number of unstageable pressure ulcers related to slough and/or eschar that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay that were acquired during the hospitalization (i.e., the unstageable pressure ulcer related to slough and/or eschar was not acquired in the nursing facility prior to admission to the hospital).
- Enter 0 if no unstageable pressure ulcers related to slough and/or eschar were first noted at the time of admission/entry or reentry.

Coding Tips

- Pressure ulcers that are covered with slough and/or eschar should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the anatomic depth of soft tissue damage involved, can the stage of the wound be determined.
- Stable eschar (i.e., dry, adherent, intact without erythema or fluctuance) on the heels serves as “the body’s natural (biological) cover” and should only be removed after careful clinical consideration, including ruling out ischemia, and consultation with the resident’s physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws.
- Once the pressure ulcer is debrided of slough and/or eschar such that the anatomic depth of soft tissue damage involved can be determined, then code the ulcer for the reclassified stage. The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue in order for reclassification of stage to occur.

DEFINITIONS

FLUCTUANCE

Used to describe the texture of wound tissue indicative of underlying unexposed fluid.

M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar (cont.)

Examples

1. A resident is admitted with a sacral pressure ulcer that is 100% covered with black eschar.

Coding: The pressure ulcer would be coded at M0300F1 as 1, and at M0300F2 as 1, present on admission/entry or reentry.

Rationale: The pressure ulcer depth is not observable because the pressure ulcer is covered with eschar. This pressure ulcer is unstageable and was present on admission.

2. A pressure ulcer on the sacrum was present on admission and was 100% covered with black eschar. On the admission assessment, it was coded as unstageable and present on admission. The pressure ulcer is later debrided using conservative methods and after 4 weeks the ulcer has 50% to 75% eschar present. The assessor can now see that the damage extends down to the bone.

Coding: The ulcer is reclassified as a Stage 4 pressure ulcer. On the subsequent MDS, it is coded at M0300D1 as 1, and at M0300D2 as 1, present on admission/entry or reentry.

Rationale: After debridement, the pressure ulcer is no longer unstageable because bone is visible in the wound bed. Therefore, this ulcer can be classified as a Stage 4 pressure ulcer and should be coded at M0300D. If this pressure ulcer has the largest surface area of all Stage 3 or 4 pressure ulcers for this resident, the pressure ulcer's dimensions would also be entered at M0610, Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough or Eschar.

3. Miss J. was admitted with one small Stage 2 pressure ulcer. Despite treatment, it is not improving. In fact, it now appears deeper than originally observed, and the wound bed is covered with slough.

Coding: Code at M0300F1 as 1, and at M0300F2 as 0, not present on admission/entry or reentry.

Rationale: The pressure ulcer depth is not observable because it is covered with slough. This pressure ulcer is unstageable and is not coded in M0300F2 as present on admission/entry or reentry because it can no longer be coded as a Stage 2.

M0300G: Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury

Enter Number <input style="width: 30px; height: 20px;" type="text"/> Enter Number <input style="width: 30px; height: 20px;" type="text"/>	<p>G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution</p> <ol style="list-style-type: none"> 1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar 2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
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M0300G: Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury (cont.)

Item Rationale

Health-related Quality of Life

- Deep tissue injury may precede the development of a Stage 3 or 4 pressure ulcer even with optimal treatment.
- Quality health care begins with prevention and risk assessment, and care planning begins with prevention. Appropriate care planning is essential in optimizing a resident's ability to avoid, as well as recover from, pressure (as well as all) wounds. Deep tissue injuries may sometimes indicate severe damage. Identification and management of suspected deep tissue injury (sDTI) is imperative.

Planning for Care

- Suspected deep tissue injury requires vigilant monitoring because of the potential for rapid deterioration. Such monitoring should be reflected in the care plan.

DEFINITIONS

SUSPECTED DEEP TISSUE INJURY
Purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Steps for Assessment

1. Perform head-to-toe assessment. Conduct a full body skin assessment focusing on bony prominences and pressure-bearing areas (sacrum, buttocks, heels, ankles, etc.).
2. For the purposes of coding, determine that the lesion being assessed is primarily a result of pressure and that other conditions have been ruled out. If pressure is **not** the primary cause, do **not** code here.
3. Examine the area adjacent to, or surrounding, an intact blister for evidence of tissue damage. If the tissue adjacent to, or surrounding, the blister **does not show** signs of tissue damage (e.g., color change, tenderness, bogginess or firmness, warmth or coolness), do **not** code as a suspected deep tissue injury.
4. In dark-skinned individuals, the area of injury is probably not purple/maroon, but rather darker than the surrounding tissue.
5. Determine the number of pressure ulcers that are unstageable related to suspected deep tissue injury.
6. Identify the number of **these** pressure ulcers that were present on admission/entry or reentry (see page M-6 for instructions).
7. Clearly document assessment findings in the resident's medical record, and track and document appropriate wound care planning and management.

M0300G: Unstageable Pressure Ulcers Related to Suspected Deep Tissue Injury (cont.)

Coding Instructions for M0300G

- Enter the number of unstageable pressure ulcers related to suspected deep tissue injury. Based on skin tone, the injured tissue area may present as a darker tone than the surrounding intact skin. These areas of discoloration are potentially areas of suspected deep tissue injury.
- Enter 0 if no unstageable pressure ulcers related to suspected deep tissue injury are present and skip to **Dimensions of Unhealed Stage 3 or Stage 4 Pressure Ulcers or Eschar** item (M0610).
- Enter the number of unstageable pressure ulcers related to suspected deep tissue injury that were first noted at the time of admission/entry AND—for residents who are reentering the facility after a hospital stay, that were acquired during the hospitalization (i.e., the unstageable pressure ulcer related to suspected deep tissue injury was not acquired in the nursing facility prior to admission to the hospital).
- Enter 0 if no unstageable pressure ulcers related to suspected deep tissue injury were first noted at the time of admission/entry or reentry.

Coding Tips

- Once suspected deep tissue injury has opened to an ulcer, reclassify the ulcer into the appropriate stage. Then code the ulcer for the reclassified stage.
- Deep tissue injury may be difficult to detect in individuals with dark skin tones.
- Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.
- When a lesion due to pressure presents with an intact blister AND the surrounding or adjacent soft tissue does NOT have the characteristics of deep tissue injury, do **not** code here.

M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough and/or Eschar

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar	
Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0	
If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:	
<input type="text"/> <input type="text"/> . <input type="text"/> cm	A. Pressure ulcer length: Longest length from head to toe
<input type="text"/> <input type="text"/> . <input type="text"/> cm	B. Pressure ulcer width: Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
<input type="text"/> <input type="text"/> . <input type="text"/> cm	C. Pressure ulcer depth: Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough and/or Eschar (cont.)

Item Rationale

Health-related Quality of Life

- Pressure ulcer dimensions are an important characteristic used to assess and monitor healing.

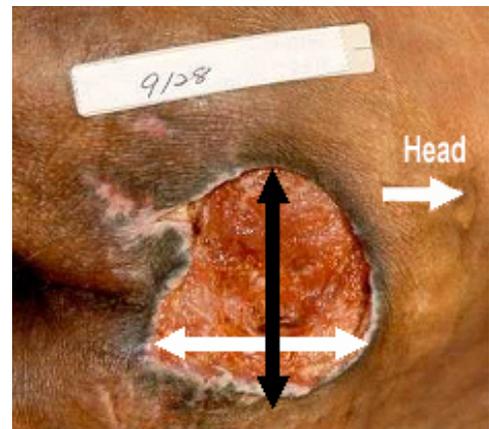
Planning for Care

- Evaluating the dimensions of the pressure ulcer is one aspect of the process of monitoring response to treatment.
- Pressure ulcer measurement findings are used to plan interventions that will best prepare the wound bed for healing.

Steps for Assessment

*If the resident has **one or more** unhealed Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough and/or eschar, **identify the pressure ulcer with the largest surface area** (length × width) and record in centimeters. **Complete only if a pressure ulcer is coded in M0300C1, M0300D1, or M0300F1.** The Figure (right) illustrates the measurement process.*

1. Measurement is based on observation of the Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar **after** the dressing and any exudate are removed.
2. Use a disposable measuring device or a cotton-tipped applicator.
3. Determine longest length (white arrow line) head to toe and greatest width (black arrow line) of each Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar.
4. Measure the longest length of the pressure ulcer. If using a cotton-tipped applicator, mark on the applicator the distance between healthy skin tissue at each margin and lay the applicator next to a centimeter ruler to determine length.
5. Using a similar approach, measure the longest width (perpendicular to the length forming a “+,” side to side).
6. Measure every Stage 3, Stage 4, and unstageable pressure ulcer due to slough and/or eschar that is present. **The clinician must be aware of all pressure ulcers present in order to determine which pressure ulcer is the largest.** Use a skin tracking sheet or other worksheet to record the dimensions for each pressure ulcer. Select the largest one by comparing the surface areas (length x width) of each.



M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough and/or Eschar (cont.)

7. Considering **only** the largest Stage 3 or 4 pressure ulcer due to slough or eschar, determine the deepest area and record the depth in centimeters. To measure wound depth, moisten a sterile, cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water. Place the applicator tip in the deepest aspect of the ulcer and measure the distance to the skin level. If the depth is uneven, measure several areas and document the depth of the ulcer that is the deepest. If depth cannot be assessed due to slough and/or eschar, enter dashes in M0610C.
8. If two pressure ulcers occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate pressure ulcers. Stage and measure each pressure ulcer separately.

Coding Instructions for M0610 Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Due to Slough and/or Eschar

- Enter the current longest length of the largest Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar in centimeters to one decimal point (e.g., 2.3 cm).
- Enter the widest width in centimeters of the largest Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar. Record the width in centimeters to one decimal point.
- Enter the depth measured in centimeters of the largest Stage 3 or 4. Record the depth in centimeters to one decimal point. Note that depth cannot be assessed if wound bed is unstageable due to being covered with slough and/or eschar. If a pressure ulcer covered with slough and/or eschar is the largest unhealed pressure ulcer identified for measurement, enter dashes in item M0610C.

Coding Tips

- Place the resident in the most appropriate position which will allow for accurate wound measurement.
- Select a uniform, consistent method for measuring wound length, width, and depth to facilitate meaningful comparisons of wound measurements across time.
- Assessment of the pressure ulcer for tunneling and undermining is an important part of the complete pressure ulcer assessment. Measurement of tunneling and undermining is not recorded on the MDS but should be assessed, monitored, and treated as part of the comprehensive care plan.

M0700: Most Severe Tissue Type for Any Pressure Ulcer

M0700. Most Severe Tissue Type for Any Pressure Ulcer	
Enter Code <input type="checkbox"/>	Select the best description of the most severe type of tissue present in any pressure ulcer bed 1. Epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin 2. Granulation tissue - pink or red tissue with shiny, moist, granular appearance 3. Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous 4. Necrotic tissue (Eschar) - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin 9. None of the Above

Item Rationale

Health-related Quality of Life

- The presence of a pressure ulcer may affect quality of life for residents because it may limit activity, may be painful, and may require time-consuming treatments and dressing changes.
- Identify tissue type.

Planning for Care

- Tissue characteristics of pressure ulcers should be considered when determining treatment options and choices.
- Changes in tissue characteristics over time are indicative of wound healing or degeneration.

Steps for Assessment

1. Examine the wound bed or base of each pressure ulcer. Adequate lighting is important to detect skin changes.
2. Determine the type(s) of tissue in the wound bed (e.g., epithelial, granulation, slough, eschar).

Coding Instructions for M0700

- Code 1, Epithelial tissue: if the wound is superficial and is re-epithelializing.
- Code 2, Granulation tissue: if the wound is clean (e.g., free of slough and eschar tissue) and contains granulation tissue.
- Code 3, Slough: if there is any amount of slough tissue present and eschar tissue is absent.
- Code 4, Necrotic tissue (eschar): if there is any eschar tissue present.
- Code 9, None of the above: if none of the above apply.

DEFINITIONS

EPITHELIAL TISSUE
 New skin that is light pink and shiny (even in person's with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound.

GRANULATION TISSUE
 Red tissue with "cobblestone" or bumpy appearance, bleeds easily when injured.

SLOUGH TISSUE
 Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

NECROTIC TISSUE (ESCHAR)
 Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound.

M0700: Most Severe Tissue Type for Any Pressure Ulcer (cont.)

Coding Tips and Special Populations

- Stage 2 pressure ulcers by definition have partial-thickness loss of the dermis. Granulation tissue, slough or eschar are not present in Stage 2 pressure ulcers. Therefore, Stage 2 pressure ulcers should **not** be coded as having granulation, slough, or eschar tissue and should be **coded as 1** for this item.
- Code for the most severe type of tissue present in the pressure ulcer wound bed.
- If the wound bed is covered with a mix of different types of tissue, code for the most severe type. For example, if a mixture of necrotic tissue (eschar and slough) is present, code for eschar.
- Code this item with **Code 9, None of the above**, in the following situations:
 - Stage 1 pressure ulcer
 - Stage 2 pressure ulcer with intact blister
 - Unstageable pressure ulcer related to non-removable dressing/device
 - Unstageable pressure ulcer related to suspected deep tissue injury

Code 9 is being used in these instances because the wound bed cannot be visualized and therefore cannot be assessed.

Examples

1. A resident has a Stage 2 pressure ulcer on the right ischial tuberosity that is healing and a Stage 3 pressure ulcer on the sacrum that is also healing with red granulation tissue that has filled 75% of the ulcer and epithelial tissue that has resurfaced 25% of the ulcer.

Coding: Code M0700 as 2, Granulation tissue.

Rationale: Coding for M0700 is based on the sacral ulcer, because it is the pressure ulcer with the most severe tissue type. Code 2, (Granulation tissue), is selected because this is the most severe tissue present in the wound.
2. A resident has a Stage 2 pressure ulcer on the right heel and no other pressure ulcers.

Coding: Code M0700 as 1, Epithelial tissue.

Rationale: Coding for M0700 is Code 1, (Epithelial tissue) because epithelial tissue is consistent with identification of this pressure ulcer as a Stage 2 pressure ulcer.
3. A resident has a pressure ulcer on the left trochanter that has 25% black eschar tissue present, 75% granulation tissue present, and some epithelialization at the edges of the wound.

Coding: Code M0700 as 4, Necrotic tissue (eschar).

Rationale: Coding is for the most severe tissue type present, which is not always the majority of type of tissue. Therefore, Coding for M0700 is Code 4, [Necrotic tissue (eschar)].

M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry	
Complete only if A0310E = 0	
Indicate the number of current pressure ulcers that were not present or were at a lesser stage on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.	
Enter Number <input type="checkbox"/>	A. Stage 2
Enter Number <input type="checkbox"/>	B. Stage 3
Enter Number <input type="checkbox"/>	C. Stage 4

Item Rationale

Health-related Quality of Life

- This item documents whether skin status, overall, has worsened since the last assessment. To track increasing skin damage, this item documents the number of new pressure ulcers and whether any pressure ulcers have “worsened” or increased in numerical stage since the last assessment. Such tracking of pressure ulcers is consistent with good clinical care.

Planning for Care

- The interdisciplinary care plan should be reevaluated to ensure that appropriate preventative measures and pressure ulcer management principles are being adhered to when new pressure ulcers develop or when pressure ulcers worsen.

Steps for Assessment

Look-back period for this item is back to the ARD of the prior assessment. If there was no prior assessment (i.e., if this is the first OBRA or scheduled PPS assessment), do not complete this item. Skip to M1030, Number of Venous and Arterial Ulcers.

1. Review the history of each current pressure ulcer. Specifically, compare the current stage to past stages to determine whether any pressure ulcer on the current assessment is new or at an increased numerical stage when compared to the last MDS assessment. This allows a more accurate assessment than simply comparing total counts on the current and prior MDS assessment.

DEFINITIONS

PRESSURE ULCER “WORSENING”

Pressure ulcer “worsening” is defined as a pressure ulcer that has progressed to a deeper level of tissue damage and is therefore staged at a higher number using a numerical scale of 1-4 (using the staging assessment system classifications assigned to each stage; starting at stage 1, and increasing in severity to stage 4) on an assessment as compared to the previous assessment. For the purposes of identifying the absence of a pressure ulcer, zero pressure ulcers is used when there is no skin breakdown or evidence of damage.

M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry (cont.)

2. For each current stage, count the number of current pressure ulcers that are new or have increased in numerical stage since the last MDS assessment was completed.

Coding Instructions for M0800

- Enter the number of pressure ulcers that were not present OR were at a lesser numerical stage on prior assessment.
- Code 0: if no pressure ulcers have increased in numerical stage OR there are no new pressure ulcers.

Coding Tips

- Coding this item will be easier for nursing homes that document and follow pressure ulcer status on a routine basis.
- If a numerically staged pressure ulcer increases in numerical staging it is considered worsened.
- Coding worsening of unstageable pressure ulcers:
 - If a pressure ulcer was unstageable on admission/entry or reentry, do not consider it to be worsened on the first assessment that it is able to be numerically staged. However, if the pressure ulcer subsequently increases in numerical stage after that assessment, it should be considered worsened.
 - If a pressure ulcer was numerically staged and becomes unstageable due to slough or eschar, do not consider this pressure ulcer as worsened. The only way to determine if this pressure ulcer has worsened is to remove enough slough or eschar so that the wound bed becomes visible. Once enough of the wound bed can be visualized and/or palpated such that the tissues can be identified and the wound restaged, the determination of worsening can be made.
 - If a pressure ulcer was numerically staged and becomes unstageable, and is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the pressure ulcer's current numerical stage has increased, consider this pressure ulcer as worsened.
 - If two pressure ulcers merge, do not code as worsened. Although two merged pressure ulcers might increase the overall surface area of the ulcer, there would need to be an increase in numerical stage in order for it to be considered as worsened.
 - If a pressure ulcer is acquired during a hospital admission, its stage should be coded on admission and is considered as present on admission/entry or reentry. It is **not** included or coded in this item.

M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry (cont.)

- If a pressure ulcer increases in numerical stage during a hospital admission, its stage should be coded on admission and is considered as present on admission/entry or reentry. It is **not** included or coded in this item. While not included in this item, it is important to recognize clinically on reentry that the resident's overall skin status deteriorated while in the hospital. In either case, if the pressure ulcer deteriorates further and increases in numerical stage on a subsequent MDS assessment, it would be considered as worsened and would be coded in this item.

Examples

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

Coding: Code M0800A as 0, M0800B as 1, and M0800C as 0.

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

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

Coding: Code M0800A as 0, M0800B as 0, and M0800C as 0.

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

3. A resident has previous medical record and MDS documentation of a Stage 2 pressure ulcer on the sacrum and a Stage 3 pressure ulcer on the right heel. Current skin care flow sheets indicate a Stage 3 pressure ulcer on the sacrum, a Stage 4 pressure ulcer on the right heel, as well as a new Stage 2 pressure ulcer on the left trochanter.

Coding: Code M0800A as 1, M0800B as 1, and M0800C as 1.

Rationale: M0800A would be coded 1 because the new Stage 2 pressure ulcer on the left trochanter was not present on the prior assessment. M0800B would be coded 1 and M0800C would be coded 1 for the increased numerical staging of both the sacrum and right heel pressure ulcers.

M0800: Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or scheduled PPS) or Last Admission/Entry or Reentry (cont.)

- A resident develops a Stage 3 pressure ulcer while at the nursing home. The wound bed is subsequently covered with slough and is coded on the next assessment as unstageable due to slough. After debridement, the wound bed is clean and the pressure ulcer is reassessed and determined to still be a Stage 3 pressure ulcer.

Coding: Code M0800A as 0, M0800B as 0, and M0800C as 0.

Rationale: M0800B would be coded 0 because the numerical stage of the pressure ulcer is the same numerical stage as it was prior to the period it became unstageable.

M0900: Healed Pressure Ulcers

M0900. Healed Pressure Ulcers Complete only if A0310E = 0	
Enter Code <input type="checkbox"/>	A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)? 0. No → Skip to M1030, Number of Venous and Arterial Ulcers 1. Yes → Continue to M0900B, Stage 2 Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA or scheduled PPS) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA or scheduled PPS), enter 0.
Enter Number <input type="checkbox"/>	B. Stage 2
Enter Number <input type="checkbox"/>	C. Stage 3
Enter Number <input type="checkbox"/>	D. Stage 4

Item Rationale

Health-related Quality of Life

- Pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development before they re-epithelialize. Stage 3 and 4 pressure ulcers fill with granulation tissue. This replacement tissue is never as strong as the tissue that was lost and hence is more prone to future breakdown.

DEFINITIONS

HEALED PRESSURE ULCER
 Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, *even if* the area continues to have some surface discoloration.

M0900: Healed Pressure Ulcers (cont.)

Planning for Care

- Pressure ulcers that heal require continued prevention interventions as the site is always at risk for future damage.
- **Most Stage 2** pressure ulcers should heal within a reasonable timeframe (e.g., 60 days). Full thickness Stage 3 and 4 pressure ulcers may require longer healing times.
- Clinical standards do not support reverse staging or backstaging as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Previous standards using reverse or backstaging would have permitted identification of this pressure ulcer as a Stage 3, then a Stage 2, and so on, when it reached a depth consistent with these stages. Clinical standards now would require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed. Nursing homes can document the healing of pressure ulcers using descriptive characteristics of the wound (i.e. depth, width, presence or absence of granulation tissue, etc.) or by using a validated pressure ulcer healing tool. Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage – in this example, a healed Stage 4 pressure ulcer. For care planning purposes, this healed Stage 4 pressure ulcer would remain at increased risk for future breakdown or injury and would require continued monitoring and preventative care.

Steps for Assessment

*Complete on all residents, including those without a current pressure ulcer. Look-back period for this item is the ARD of the prior assessment. **If no prior assessment (i.e., if this is the first OBRA or scheduled PPS assessment), do not complete this item. Skip to M1030.***

1. Review medical records to identify whether any pressure ulcers that were noted on the prior MDS assessment have healed by the ARD (A2300) of the current assessment.
2. Identify the deepest anatomical stage (see definition on page M-5) of each healed pressure ulcer.
3. Count the number of healed pressure ulcers for each stage.

M0900: Healed Pressure Ulcers (cont.)

Coding Instructions for M0900A

Complete on all residents (even if M0210 = 0)

- Enter 0: if there were no pressure ulcers on the prior assessment and skip to **Number of Venous and Arterial Ulcers** item (M1030).
- Enter 1: if there were pressure ulcers noted on the prior assessment.

Coding Instructions for M0900B, C, and D

- Enter the number of pressure ulcers that have healed since the last assessment for each Stage, 2 through 4.
- Enter 0: if there were no pressure ulcers at the given stage or no pressure ulcers that have healed.

Coding Tips

- Coding this item will be easier for nursing homes that systematically document and follow pressure ulcer status.
- If the prior assessment documents that a pressure ulcer healed between MDS assessments, but another pressure ulcer occurred at the same anatomical location, do **not** consider this pressure ulcer as healed. The re-opened pressure ulcer should be staged at its highest numerical stage until fully healed.

M1030: Number of Venous and Arterial Ulcers

M1030. Number of Venous and Arterial Ulcers	
Enter Number <input type="text"/>	Enter the total number of venous and arterial ulcers present

Item Rationale

Health-related Quality of Life

- Skin wounds and lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.

M1030: Number of Venous and Arterial Ulcers (cont.)

Planning for Care

- The presence of venous and arterial ulcers should be accounted for in the interdisciplinary care plan.
- This information identifies residents at risk for further complications or skin injury.

Steps for Assessment

1. Review the medical record, including skin care flow sheet or other skin tracking form.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Examine the resident and determine whether any venous or arterial ulcers are present.
 - Key areas for venous ulcer development include the area proximal to the lateral and medial malleolus (e.g., above the inner and outer ankle area).
 - Key areas for arterial ulcer development include the distal part of the foot, dorsum or tops of the foot, or tips and tops of the toes.
 - Venous ulcers may or may not be painful and are typically shallow with irregular wound edges, a red granular (e.g., bumpy) wound bed, minimal to moderate amounts of yellow fibrinous material, and moderate to large amounts of exudate. The surrounding tissues may be erythematous or reddened, or appear brown-tinged due to hemosiderin staining. Leg edema may also be present.
 - Arterial ulcers are often painful and have a pale pink wound bed, necrotic tissue, minimal exudate, and minimal bleeding.

Coding Instructions

Check all that apply in the last 7 days.

*Pressure ulcers coded in M0210 through M0900 should **not** be coded here.*

- Enter the number of venous and arterial ulcers present.
- Enter 0: if there were no venous or arterial ulcers present.

DEFINITIONS

VENOUS ULCERS

Ulcers caused by peripheral venous disease, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg.

ARTERIAL ULCERS

Ulcers caused by peripheral arterial disease, which commonly occur on the tips and tops of the toes, tops of the foot, or distal to the medial malleolus.

DEFINITIONS

HEMOSIDERIN

An intracellular storage form of iron; the granules consist of an ill-defined complex of ferric hydroxides, polysaccharides, and proteins having an iron content of approximately 33% by weight. It appears as a dark yellow-brown pigment.

M1030: Number of Venous and Arterial Ulcers (cont.)

Coding Tips

Arterial Ulcers

- Trophic skin changes (e.g., dry skin, loss of hair growth, muscle atrophy, brittle nails) may also be present. The wound may start with some kind of minor trauma, such as hitting the leg on a wheelchair. The wound does not typically occur over a bony prominence, however, can occur on the tops of the toes. Pressure forces play virtually no role in the development of the ulcer, however, for some residents, pressure may play a part. Ischemia is the major etiology of these ulcers. Lower extremity and foot pulses may be diminished or absent.

Venous Ulcers

- The wound may start with some kind of minor trauma, such as hitting the leg on a wheelchair. The wound does not typically occur over a bony prominence, and pressure forces play virtually **no** role in the development of the ulcer.

Example

1. A resident has three toes on her right foot that have black tips. She does not have diabetes, but has been diagnosed with peripheral vascular disease.

Coding: Code M1030 as 3.

Rationale: Ischemic changes point to the ulcer being vascular.

M1040: Other Ulcers, Wounds and Skin Problems

M1040. Other Ulcers, Wounds and Skin Problems	
↓ Check all that apply	
Foot Problems	
<input type="checkbox"/>	A. Infection of the foot (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	B. Diabetic foot ulcer(s)
<input type="checkbox"/>	C. Other open lesion(s) on the foot
Other Problems	
<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
<input type="checkbox"/>	E. Surgical wound(s)
<input type="checkbox"/>	F. Burn(s) (second or third degree)
<input type="checkbox"/>	G. Skin tear(s)
<input type="checkbox"/>	H. Moisture Associated Skin Damage (MASD) (i.e. incontinence (IAD), perspiration, drainage)
None of the Above	
<input type="checkbox"/>	Z. None of the above were present

M1040: Other Ulcers, Wounds and Skin Problems (cont.)

Item Rationale

Health-related Quality of Life

- Skin wounds and lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes.
- Many of these ulcers, wounds and skin problems can worsen or increase risk for local and systemic infections.

Planning for Care

- This list represents only a subset of skin conditions or changes that nursing homes will assess and evaluate in residents.
- The presence of wounds and skin changes should be accounted for in the interdisciplinary care plan.
- This information identifies residents at risk for further complications or skin injury.

Steps for Assessment

1. Review the medical record, including skin care flow sheets or other skin tracking forms.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Examine the resident and determine whether any ulcers, wounds, or skin problems are present.
 - Key areas for diabetic foot ulcers include the plantar (bottom) surface of the foot, especially the metatarsal heads (the ball of the foot).

Coding Instructions

*Check all that apply in the last 7 days. If there is no evidence of such problems in the last 7 days, check none of the above. Pressure ulcers coded in M0200 through M0900 should **not** be coded here.*

- M1040A, Infection of the foot (e.g., cellulitis, purulent drainage)
- M1040B, Diabetic foot ulcer(s)
- M1040C, Other open lesion(s) on the foot (e.g., cuts, fissures)

DEFINITIONS

DIABETIC FOOT ULCERS

Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful.

SURGICAL WOUNDS

Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites.

OPEN LESION OTHER THAN ULCERS, RASHES, CUTS

Most typically skin ulcers that develop as a result of diseases and conditions such as syphilis and cancer.

BURNS (SECOND OR THIRD DEGREE)

Skin and tissue injury caused by heat or chemicals and may be in any stage of healing.

M1040: Other Ulcers, Wounds and Skin Problems (cont.)

- M1040D, Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
- M1040E, Surgical wound(s)
- M1040F, Burn(s)(second or third degree)
- M1040G, Skin tear(s)
- M1040H, Moisture Associated Skin Damage (MASD) (i.e., incontinence (IAD), perspiration, drainage)
- M1040Z, None of the above were present

Coding Tips

M1040B Diabetic Foot Ulcers

- Diabetic neuropathy affects the lower extremities of individuals with diabetes. Individuals with diabetic neuropathy can have decreased awareness of pain in their feet. This means they are at high risk for foot injury, such as burns from hot water or heating pads, cuts or scrapes from stepping on foreign objects, and blisters from inappropriate or tight-fitting shoes. Because of decreased circulation and sensation, the resident may not be aware of the wound.
- Neuropathy can also cause changes in the structure of the bones and tissue in the foot. This means the individual with diabetes experiences pressure on the foot in areas not meant to bear pressure. Neuropathy can also cause changes in normal sweating, which means the individual with diabetes can have dry, cracked skin on his other foot.
- Do **not** include pressure ulcers that occur on residents with diabetes mellitus here. For example, an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer.

M1040D Open Lesion Other than Ulcers, Rashes, Cuts

- Do **not** code rashes, skin tears, cuts/lacerations here. Although not recorded on the MDS assessment, these skin conditions should be considered in the plan of care.

M1040E Surgical Wounds

- This category does not include healed surgical sites and healed stomas or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.
- Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing. A pressure ulcer that has been surgically debrided should continue to be coded as a pressure ulcer.

M1040: Other Ulcers, Wounds and Skin Problems (cont.)

- Code pressure ulcers that require surgical intervention for closure with graft and/or flap procedures in this item (e.g., excision of pressure ulcer with myocutaneous flap). Once a pressure ulcer is excised and a graft and/or flap is applied, it is no longer considered a pressure ulcer, but a surgical wound

M1040F Burns (Second or Third Degree)

- Do **not** include first degree burns (changes in skin color only).

M1040G Skin Tear(s)

- Skin tears are a result of shearing, friction or trauma to the skin that causes a separation of the skin layers. They can be partial or full thickness. Code all skin tears in this item, even if already coded in Item J1900B.

M1040H Moisture Associated Skin Damage (MASD)

- Moisture associated skin damage (MASD) is a result of skin damage caused by moisture rather than pressure. It is caused by sustained exposure to moisture which can be caused, for example, by incontinence, wound exudate and perspiration. It is characterized by inflammation of the skin, and occurs with or without skin erosion and/or infection. MASD is also referred to as incontinence-associated dermatitis and can cause other conditions such as intertriginous dermatitis, periwound moisture-associated dermatitis, and peristomal moisture-associated dermatitis. Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown.

Examples

1. A resident with diabetes mellitus presents with an ulcer on the heel that is due to pressure.
Coding: This ulcer is not checked at M1040B. **This ulcer should be coded where appropriate under the Pressure Ulcers items (M0210-M0900).**
Rationale: Persons with diabetes can still develop pressure ulcers.
2. A resident is readmitted from the hospital after myocutaneous flap surgery to excise and close his sacral pressure ulcer.
Coding: Check M1040E, Surgical Wound.
Rationale: A surgical flap procedure was used to close the resident's pressure ulcer. The pressure ulcer is now considered a surgical wound.
3. Mrs. J. was reaching over to get a magazine off of her bedside table and sustained a skin tear on her wrist from the edge of the table when she pulled the magazine back towards her.
Coding: Check M1040G, Skin Tear(s).
Rationale: The resident sustained a skin tear while reaching for a magazine.

M1040: Other Ulcers, Wounds and Skin Problems (cont.)

4. Mr. S. who is incontinent, is noted to have a large, red and excoriated area on his buttocks and interior thighs with serous exudate which is starting to cause skin glistening.

Coding: Check M1040H, Moisture Associated Skin Damage (MASD).

Rationale: Mr. S. skin assessment reveals characteristics of incontinence-associated dermatitis.

5. Mrs. F. complained of discomfort of her right great toe and when her stocking and shoe was removed, it was noted that her toe was red, inflamed and had pus draining from the edge of her nail bed. The podiatrist determined that Mrs. F. has an infected ingrown toenail.

Coding: Check M1040A, Infection of the foot.

Rationale: Mrs. F. has an infected right great toe due to an ingrown toenail.

6. Mr. G. has bullous pemphigoid and requires the application of sterile dressings to the open and weeping blistered areas.

Coding: Check M1040D, Open lesion other than ulcers, rashes, cuts.

Rationale: Mr. G. has open bullous pemphigoid blisters.

7. Mrs. A. was just admitted to the nursing home from the hospital burn unit after sustaining second and third degree burns in a house fire. She is here for continued treatment of her burns and for rehabilitative therapy.

Coding: Check M1040F, Burns (second or third degree).

Rationale: Mrs. A. has second and third degree burns, therefore, burns (second or third degree) should be checked.

M1200: Skin and Ulcer Treatments

M1200. Skin and Ulcer Treatments	
↓ Check all that apply	
<input type="checkbox"/>	A. Pressure reducing device for chair
<input type="checkbox"/>	B. Pressure reducing device for bed
<input type="checkbox"/>	C. Turning/repositioning program
<input type="checkbox"/>	D. Nutrition or hydration intervention to manage skin problems
<input type="checkbox"/>	E. Pressure ulcer care
<input type="checkbox"/>	F. Surgical wound care
<input type="checkbox"/>	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
<input type="checkbox"/>	H. Applications of ointments/medications other than to feet
<input type="checkbox"/>	I. Application of dressings to feet (with or without topical medications)
<input type="checkbox"/>	Z. None of the above were provided

M1200: Skin and Ulcer Treatments (cont.)

Item Rationale

Health-related Quality of Life

- Appropriate prevention and treatment of skin changes and ulcers reduce complications and promote healing.

Planning for Care

- These general skin treatments include basic pressure ulcer prevention and skin health interventions that are a part of providing quality care and consistent with good clinical practice for those with skin health problems.
- These general treatments should guide more individualized and specific interventions in the care plan.
- If skin changes are not improving or are worsening, this information may be helpful in determining more appropriate care.

DEFINITIONS

PRESSURE REDUCING DEVICE(S)

Equipment that aims to relieve pressure away from areas of high risk. May include foam, air, water gel, or other cushioning placed on a chair, wheelchair, or bed. Include pressure relieving, pressure reducing, and pressure redistributing devices. Devices are available for use with beds and seating.

Steps for Assessment

1. Review the medical record, including treatment records and health care provider orders for documented skin treatments during the past 7 days. Some skin treatments may be part of routine standard care for residents, so check the nursing facility's policies and procedures and indicate here if administered during the look-back period.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Some skin treatments can be determined by observation. For example, observation of the resident's wheelchair and bed will reveal if the resident is using pressure-reducing devices for the bed or wheelchair.

Coding Instructions

Check all that apply in the last 7 days. Check Z, None of the above were provided, if none applied in the past 7 days.

- M1200A, Pressure reducing device for chair
- M1200B, Pressure reducing device for bed
- M1200C, Turning/repositioning program
- M1200D, Nutrition or hydration intervention to manage skin problems
- M1200E, Pressure ulcer care
- M1200F, Surgical wound care

M1200: Skin and Ulcer Treatments (cont.)

- M1200G, Application of non-surgical dressings (with or without topical medications) other than to feet. Non-surgical dressings do not include Band-Aids.
- M1200H, Application of ointments/medications other than to feet
- M1200I, Application of dressings to feet (with or without topical medications)
- M1200Z, None of the above were provided

Coding Tips

M1200A/M1200B Pressure Reducing Devices

- Pressure reducing devices redistribute pressure so that there is some relief on or near the area of the ulcer. The appropriate reducing (redistribution) device should be selected based on the individualized needs of the resident.
- Do **not** include egg crate cushions of any type in this category.
- Do **not** include doughnut or ring devices in chairs.

M1200C Turning/Repositioning Program

- The turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours).
- Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.

M1200D Nutrition or Hydration Intervention to Manage Skin Problems

- The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. The interdisciplinary team should review the resident's diet and determine if the resident is taking in sufficient amounts of nutrients and fluids or are already taking supplements that are fortified with the US Recommended Daily Intake (US RDI) of nutrients.

DEFINITIONS

TURNING/ REPOSITIONING PROGRAM

Includes a consistent program for changing the resident's position and realigning the body. "Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs.

NUTRITION OR HYDRATION INTERVENTION TO MANAGE SKIN PROBLEMS

Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions, e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplementation to prevent skin breakdown, high-protein supplementation for wound healing.

M1200: Skin and Ulcer Treatments (cont.)

- Additional supplementation above the US RDI has not been proven to provide any further benefits for management of skin problems including pressure ulcers. Vitamin and mineral supplementation should only be employed as an intervention for managing skin problems, including pressure ulcers, when nutritional deficiencies are confirmed or suspected through a thorough nutritional assessment (AMDA PU Guideline, page 6). If it is determined that nutritional supplementation, i.e. adding additional protein, calories, or nutrients is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and “tailor nutritional supplementation to the individual’s intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed,” (AMDA PU Therapy Companion, page 4).
- It is important to remember that additional supplementation is not automatically required for pressure ulcer management. Any interventions should be specifically tailored to the resident’s needs, condition, and prognosis (AMDA PU Therapy Companion, page 11).

M1200E Pressure Ulcer Care

- Pressure ulcer care includes **any** intervention for treating pressure ulcers coded in **Current Number of Unhealed Pressure Ulcers at Each Stage (M0300A-G)**. Examples may include the use of topical dressings, enzymatic, mechanical or surgical debridement, wound irrigations, negative pressure wound therapy (NPWT), and/or hydrotherapy.

M1200F Surgical Wound Care

- Does not include post-operative care following eye or oral surgery.
- Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing, and thus, any wound care associated with pressure ulcer debridement would be coded in **M1200E, Pressure Ulcer Care**. The only time a surgical wound would be created is if the pressure ulcer itself was excised and a flap and/or graft used to close the pressure ulcer.
- Surgical wound care may include any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application.
- Surgical wound care for pressure ulcers that require surgical intervention for closure (e.g., excision of pressure ulcer with flap and/or graft coverage) can be coded in this item, as once a pressure ulcer is excised and flap and/or graft applied, it is no longer considered a pressure ulcer, but a surgical wound.

M1200: Skin and Ulcer Treatments (cont.)

M1200G Application of Non-surgical Dressings (with or without Topical Medications) Other than to Feet

- Do **not** code application of non-surgical dressings for pressure ulcer(s) other than to feet in this item; use **M1200E, Pressure Ulcer Care**.
- Dressings do not have to be applied daily in order to be coded on the MDS assessment. If any dressing meeting the MDS definitions was applied even once during the 7-day look-back period, the assessor should check that MDS item.
- This category may include but is not limited to: dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages, etc. Non-surgical dressings do not include adhesive bandages (e.g., BAND-AID® bandages).

M1200H Application of Ointments/Medications Other than to Feet

- Do **not** code application of ointments/medications (e.g., chemical or enzymatic debridement) for pressure ulcers here; use **M1200E, Pressure Ulcer Care**.
- This category may include ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents).
- Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions.
- This category does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain, testosterone cream).

M1200I Application of Dressings to the Feet (with or without Topical Medications)

- Includes interventions to treat any foot wound or ulcer **other than a pressure ulcer**.
- Do **not** code application of dressings to pressure ulcers on the foot, use **M1200E, Pressure Ulcer Care**.
- Do not code application of dressings to the ankle. The ankle is not considered part of the foot.

Examples

1. A resident is admitted with a Stage 3 pressure ulcer on the sacrum. Care during the last 7 days has included one debridement by the wound care consultant, application of daily dressings with enzymatic ointment for continued debridement, nutritional supplementation, and use of a pressure reducing (redistribution) pad on the wheelchair. The medical record documents delivery of care and notes that the resident is on a 2-hour turning/repositioning

M1200: Skin and Ulcer Treatments (cont.)

program that is organized, planned, documented, monitored and evaluated based on an individualized assessment of her needs. The physician documents that after reviewing the resident's nutritional intake, healing progress of the resident's pressure ulcer, dietician's nutritional assessment and laboratory results, that the resident has protein-calorie undernutrition. In order to support proper wound healing, the physician orders an oral supplement that provides all recommended daily allowances for protein, calories, nutrients and micronutrients. All mattresses in the nursing home are pressure reducing (redistribution) mattresses.

Coding: Check items M1200A, M1200B, M1200C, M1200D, and M1200E.

Rationale: Interventions include pressure reducing (redistribution) pad in the wheelchair (M1200A) and pressure reducing (redistribution) mattress on the bed (M1200B), turning and repositioning program (M1200C), nutritional supplementation (M1200D), enzymatic debridement and application of dressings (M1200E).

2. A resident has a venous ulcer on the right leg. During the past 7 days the resident has had a three layer compression bandaging system applied once (orders are to reapply the compression bandages every 5 days). The resident also has a pressure redistributing mattress and pad for the wheelchair.

Coding: Check items M1200A, M1200B, and M1200G.

Rationale: Treatments include pressure reducing (redistribution) mattress (M1200B) and pad (M1200A) in the wheelchair and application of the compression bandaging system (M1200G).

3. Mrs. S. has a diagnosis of right-sided hemiplegia from a previous stroke. As part of her assessment, it was noted that while in bed Mrs. S. is able to tolerate pressure on each side for approximately 3 hours before showing signs of the effects of pressure on her skin. Staff assist her to turn every 3 hours while in bed. When she is in her wheelchair, it is difficult for her to offload the pressure to her buttocks. Her assessment indicates that her skin cannot tolerate pressure for more than 1 hour without showing signs of the effect of the pressure when she is sitting, and therefore, Mrs. S. is assisted hourly by staff to stand for at least 1 full minute to relieve pressure. Staff document all of these interventions in the medical record and note the resident's response to the interventions.

Coding: Check M1200C.

Rationale: Treatments meet the criteria for a turning/repositioning program (i.e., it is organized, planned, documented, monitored, and evaluated), that is based on an assessment of the resident's unique needs.

M1200: Skin and Ulcer Treatments (cont.)

- Mr. J. has a diagnosis of Advanced Alzheimer's and is totally dependent on staff for all of his care. His care plan states that he is to be turned and repositioned, per facility policy, every 2 hours.

Coding: Do **not** check item M1200C.

Rationale: Treatments provided do not meet the criteria for a turning/repositioning program. There is no notation in the medical record about an assessed need for turning/repositioning, nor is there a specific approach or plan related to positioning and realigning of the body. There is no reassessment of the resident's response to turning and repositioning. There are not any skin or ulcer treatments being provided.

Scenarios for Pressure Ulcer Coding

Examples M0300, M0610, M0700 and M0800

- Mr. S was admitted to the nursing home on January 22, 2011 with a Stage 2 pressure ulcer. The pressure ulcer history was not available due to resident being admitted to the hospital from home prior to coming to the nursing home. On Mr. S' quarterly assessment, it was noted that the Stage 2 pressure ulcer had neither worsened nor improved. On the second quarterly assessment the Stage 2 pressure ulcer was noted to have worsened to a Stage 3. The current dimensions of the Stage 3 pressure ulcer are L 3.0cm, W 2.4cm, and D 0.2cm with 100% granulation tissue noted in the wound bed.

Admission Assessment:

Coding:

- M0300A (Number of Stage 1 pressure ulcers), Code 0.
- M0300B1 (Number of Stage 2 pressure ulcers), Code 1.
- M0300B2 (Number of these Stage 2 pressure ulcers present on admission/entry or reentry), Code 1.
- M0300B3 (Date of the oldest Stage 2 pressure ulcer), code with dashes.

Rationale: The resident had one Stage 2 pressure ulcer on admission and the date of the oldest pressure ulcer was unknown.

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage	
Enter Number <input type="text" value="0"/>	<p>A. Number of Stage 1 pressure ulcers Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues</p>
Enter Number <input type="text" value="1"/>	<p>B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister</p> <p>1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3</p>
Enter Number <input type="text" value="1"/>	<p>2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p> <p>3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown:</p> <p><input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/></p> <p style="text-align: center;">Month Day Year</p>

Scenarios for Pressure Ulcer Coding (cont.)

Quarterly Assessment #1:

Coding:

- M0300A (Number of Stage 1 pressure ulcers), Code 0.
- M0300B1 (Number of Stage 2 pressure ulcers), Code 1.
- M0300B2 (Number of these Stage 2 pressure ulcers present upon admission/entry or reentry), Code 1.
- M0300B3 (Date of the oldest Stage 2 pressure ulcer), code with dashes.

Rationale: On the quarterly assessment the Stage 2 pressure ulcer is still present and date was unknown. Therefore, M0300B3 is still coded with dashes.

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage	
Enter Number <input type="text" value="0"/>	<p>A. Number of Stage 1 pressure ulcers Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues</p>
Enter Number <input type="text" value="1"/>	<p>B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister</p> <p>1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3</p>
Enter Number <input type="text" value="1"/>	<p>2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p> <p>3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown:</p> <p><input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/></p> <p style="text-align: center;">Month Day Year</p>

Quarterly Assessment #2:

Coding:

- M0300A (Number of Stage 1 pressure ulcers), Code 0.
- M0300B1 (Number of Stage 2 pressure ulcers), Code 0 and skip to M0300C, Stage 3 pressure ulcers.
- M0300C1 (Number of Stage 3 pressure ulcers). Code 1.
- M0300C2 (Number of these Stage 3 pressure ulcers that were present upon admission//entry or reentry). Code 0.
- M0300D1, M0300E1, M0300F1, and M0300G1 Code 0's and proceed to code M0610 (Dimensions of unhealed Stage 3 or 4 pressure ulcers or unstageable pressure ulcer related to slough or eschar) with the dimensions of the Stage 3 ulcer.
- M0610A (Pressure ulcer length), Code 03.0, M0610B (Pressure ulcer width), Code 02.4, M0610C (Pressure ulcer depth) Code 00.2.
- M0700 (Most severe tissue type for any pressure ulcer), Code 2, Granulation tissue.
- M0800 (Worsening in pressure ulcer status since prior assessment – (OBRA or scheduled PPS or Last Admission/Entry or Reentry) – M0800A (Stage 2) Code 0, M0800B (Stage 3) Code 1, M0800C (Stage 4) Code 0.

Scenarios for Pressure Ulcer Coding (cont.)

Rationale:

- M0300B1 is coded 0 due to the fact that the resident now has a Stage 3 pressure ulcer and no longer has a Stage 2 pressure ulcer. Therefore, you are required to skip to M0300C (Stage 3 pressure ulcer).
- M0300C1 is coded as 1 due to the fact the resident has one Stage 3 pressure ulcer.
- M0300C2 is coded as 0 due to the fact that the Stage 3 pressure ulcer was not present on admission, but worsened from a Stage 2 to a Stage 3 in the facility.
- M0300D1, M0300E1, M0300F1, and M0300G1 are coded as zeros (due to the fact the resident does not have any Stage 4 or unstageable ulcers). Proceed to code M0610 with the dimensions of the Stage 3 ulcer.
- M0610A is coded, 03.0 for length, M0610B is coded 02.4 for width, and M0610C is coded 00.2 for depth. Since this resident only had one Stage 3 pressure ulcer at the time of second quarterly assessment, these are the dimensions that would be coded here as the largest ulcer.
- M0700 is coded as 2 (Granulation tissue) because this is the most severe type of tissue present.
- M0800A is coded as 0, M0800B is coded as 1, and M0800C is coded as 0 because the Stage 2 pressure ulcer that was present on admission has now worsened to a Stage 3 pressure ulcer since the last assessment.

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage	
Enter Number <input type="text" value="0"/>	<p>A. Number of Stage 1 pressure ulcers Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues</p>
Enter Number <input type="text" value="0"/>	<p>B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister</p> <p>1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3</p> <p>2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p> <p>3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown: <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year</p>
Enter Number <input type="text" value="1"/>	<p>C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling</p> <p>1. Number of Stage 3 pressure ulcers - If 0 → Skip to M0300D, Stage 4</p> <p>2. Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p>
Enter Number <input type="text" value="0"/>	<p>D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling</p> <p>1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable: Non-removable dressing</p> <p>2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p>
Enter Number <input type="text"/>	
M0300 continued on next page	

Scenarios for Pressure Ulcer Coding (cont.)

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage - Continued	
Enter Number <input type="text" value="0"/>	E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device 1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar
Enter Number <input type="text"/>	2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
Enter Number <input type="text" value="0"/>	F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar 1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 → Skip to M0300G, Unstageable: Deep tissue
Enter Number <input type="text"/>	2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
Enter Number <input type="text" value="0"/>	G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution 1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar
Enter Number <input type="text"/>	2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0 If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:	
<input type="text" value="0"/> <input type="text" value="3"/> . <input type="text" value="0"/> cm	A. Pressure ulcer length: Longest length from head to toe
<input type="text" value="0"/> <input type="text" value="2"/> . <input type="text" value="4"/> cm	B. Pressure ulcer width: Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length
<input type="text" value="0"/> <input type="text" value="0"/> . <input type="text" value="2"/> cm	C. Pressure ulcer depth: Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)
M0700. Most Severe Tissue Type for Any Pressure Ulcer	
Enter Code <input type="text" value="2"/>	Select the best description of the most severe type of tissue present in any pressure ulcer bed 1. Epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin 2. Granulation tissue - pink or red tissue with shiny, moist, granular appearance 3. Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous 4. Necrotic tissue (Eschar) - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin 9. None of the Above
M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry Complete only if A0310E = 0 Indicate the number of current pressure ulcers that were not present or were at a lesser stage on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.	
Enter Number <input type="text" value="0"/>	A. Stage 2
Enter Number <input type="text" value="1"/>	B. Stage 3
Enter Number <input type="text" value="0"/>	C. Stage 4

Scenarios for Pressure Ulcer Coding (cont.)

Example M0100-M1200

1. Mrs. P is admitted to the nursing home on 10/23/2010 for a Medicare stay. In completing the PPS 5-day assessment, it was noted that the resident had a head-to-toe skin assessment and her skin was intact, but upon assessment using the Braden scale, was found to be at risk for skin break down. On the 14-day PPS (ARD of 11/5/2010), the resident was noted to have a Stage 2 pressure ulcer that was identified on her coccyx on 11/1/2010. This Stage 2 pressure ulcer was noted to have pink tissue with some epithelialization present in the wound bed. Dimensions of the ulcer were length 01.1 cm, width 00.5 cm, and no measurable depth. Mrs. P does not have any arterial or venous ulcers, wounds, or skin problems. She is receiving ulcer care with application of a dressing applied to the coccygeal ulcer. Mrs. P. also has pressure redistribution devices on both her bed and chair, and has been placed on a 1½ hour turning and repositioning schedule per tissue tolerance. On 11/13/2010 the resident was discharged return anticipated and reentered the facility on 11/15/2010. Upon reentry the 5-day PPS ARD was set at 11/19/2010. In reviewing the record for this 5-day PPS assessment, it was noted that the resident had the same Stage 2 pressure ulcer on her coccyx, however, the measurements were now length 01.2 cm, width 00.6 cm, and still no measurable depth. It was also noted upon reentry that the resident had a suspected deep tissue injury of the right heel that was measured at length 01.9cm, width 02.5cm, and no visible depth.

5-Day PPS #1:

Coding:

- M0100B (Formal assessment instrument), Check box.
- M0100C (Clinical assessment), Check box.
- M0150 (Risk of Pressure Ulcers), Code 1.
- M0210 (One or more unhealed pressure ulcer(s) at Stage 1 or higher), Code 0 and skip to M0900 (Healed pressure ulcers).
- M0900 (Healed pressure ulcers). Skip to M1030 since this item is only completed if A0310E=0. The 5-Day PPS Assessment is the first assessment since the most recent admission/entry or reentry, therefore, A0310E=1.
- M1030 (Number of Venous and Arterial ulcers), Code 0.
- M1040 (Other ulcers, wounds and skin problems), Check Z (None of the above).
- M1200 (Skin and Ulcer Treatments), Check Z (None of the above were provided).

Rationale: The resident had a formal assessment using the Braden scale and also had a head-to-toe skin assessment completed. Pressure ulcer risk was identified via formal assessment. Upon assessment the resident's skin was noted to be intact, therefore, M0210 was coded 0, M0900 was skipped because the 5-Day PPS is the first assessment. M1030 was coded 0 due to the resident not having any of these conditions. M1040Z was checked since none of these problems were noted. M1200Z was checked because none of these treatments were provided.

Scenarios for Pressure Ulcer Coding (cont.)

M1030. Number of Venous and Arterial Ulcers	
Enter Number <input type="text" value="0"/>	Enter the total number of venous and arterial ulcers present
M1040. Other Ulcers, Wounds and Skin Problems	
↓ Check all that apply	
Foot Problems	
<input type="checkbox"/>	A. Infection of the foot (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	B. Diabetic foot ulcer(s)
<input type="checkbox"/>	C. Other open lesion(s) on the foot
Other Problems	
<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
<input type="checkbox"/>	E. Surgical wound(s)
<input type="checkbox"/>	F. Burn(s) (second or third degree)
<input type="checkbox"/>	G. Skin tear(s)
<input type="checkbox"/>	H. Moisture Associated Skin Damage (MASD) (i.e. incontinence (IAD), perspiration, drainage)
None of the Above	
<input checked="" type="checkbox"/>	Z. None of the above were present
M1200. Skin and Ulcer Treatments	
↓ Check all that apply	
<input type="checkbox"/>	A. Pressure reducing device for chair
<input type="checkbox"/>	B. Pressure reducing device for bed
<input type="checkbox"/>	C. Turning/repositioning program
<input type="checkbox"/>	D. Nutrition or hydration intervention to manage skin problems
<input type="checkbox"/>	E. Pressure ulcer care
<input type="checkbox"/>	F. Surgical wound care
<input type="checkbox"/>	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
<input type="checkbox"/>	H. Applications of ointments/medications other than to feet
<input type="checkbox"/>	I. Application of dressings to feet (with or without topical medications)
<input checked="" type="checkbox"/>	Z. None of the above were provided

Scenarios for Pressure Ulcer Coding (cont.)

14-Day PPS:

Coding:

- M0100A (Resident has a Stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device), Check box.
- M0100B (Formal assessment instrument), Check box.
- M0100C (Clinical assessment), Check box.
- M0150 (Risk of Pressure Ulcers), Code 1.
- M0210 (One or more unhealed pressure ulcer(s) at Stage 1 or higher), Code 1.
- M0300A (Number of Stage 1 pressure ulcers), Code 0.
- M0300B1 (Number of Stage 2 pressure ulcers), Code 1.
- M0300B2 (Number of these Stage 2 pressure ulcers present on admission/entry or reentry), Code 0.
- M0300B3 (Date of the oldest Stage 2 pressure ulcer), Enter 11-01-2010.
- M0300C1 (Number of Stage 3 pressure ulcers), Code 0 and skip to M0300D (Stage 4).
- M0300D1 (Number of Stage 4 pressure ulcers), Code 0 and skip to M0300E (Unstageable: Non-removable dressing).
- M0300E1 (Unstageable: Non-removable dressing), Code 0 and skip to M0300F (Unstageable: Slough and/or eschar).
- M0300F1 (Unstageable: Slough and/or eschar), Code 0 and skip to M0300G (Unstageable: Deep tissue).
- M0300G1 (Unstageable: Deep tissue), Code 0 and skip to M0610 (Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar).
- M0610 (Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar), is **not** completed, as the resident has a Stage 2 pressure ulcer.
- M0700 (Most severe tissue type for any pressure ulcer), Code 1 (Epithelial tissue).
- M0800 (Worsening in pressure ulcer status since prior assessment (OBRA or scheduled PPS or Last Admission/Entry or Reentry)), M0800A, Code 1; M0800B, Code 0; M0800C, Code 0. This item is completed because the 14-Day PPS is **not** the first assessment since the most recent admission/entry or reentry. Therefore, A0310E=0. M0800A is coded 1 because the resident has a new Stage 2 pressure ulcer that was not present on the prior assessment.
- M0900A (Healed pressure ulcers), Code 0. This is completed because the 14-Day PPS is **not** the first assessment since the most recent admission/entry or reentry. Therefore A0310E=0. Since there were no pressure ulcers noted on the 5-Day PPS assessment, this is coded 0, and skip to M1030.
- M1030 (Number of Venous and Arterial ulcers), Code 0.
- M1040 (Other ulcers, wounds and skin problems), Check Z (None of the above).

Scenarios for Pressure Ulcer Coding (cont.)

- M1200A (Pressure reducing device for chair), M1200B (Pressure reducing device for bed), M1200C (Turning/repositioning program), and M1200E (Pressure ulcer care) are all checked.

Rationale: The resident had a formal assessment using the Braden scale and also had a head-to-toe skin assessment completed. Pressure ulcer risk was identified via formal assessment. On the 5-Day PPS assessment the resident's skin was noted to be intact, however, on the 14-Day PPS assessment, it was noted that the resident had a new Stage 2 pressure ulcer. Since the resident has had both a 5-day and 14-Day PPS completed, the 14-Day PPS would be coded 0 at A0310E. This is because the 14-Day PPS is **not** the first assessment since the most recent admission/entry or reentry. Since A0310E=0, items M0800 (Worsening in pressure ulcer status) and M0900 (Healed pressure ulcers) would be completed. Since the resident did not have a pressure ulcer on the 5-Day PPS and did have one on the 14-Day PPS, the new Stage 2 pressure ulcer is documented under M0800 (Worsening in pressure ulcer status). M0900 (Healed pressure ulcers) is coded as 0 because there were no pressure ulcers noted on the prior assessment (5-Day PPS). There were no other skin problems noted. However the resident, since she is at an even higher risk of breakdown since the development of a new ulcer, has preventative measures put in place with pressure redistribution devices for her chair and bed. She was also placed on a turning and repositioning program based on tissue tolerance. Therefore M1200A, M1200B, and M1200C were all checked. She also now requires ulcer care and application of a dressing to the coccygeal ulcer, so M1200E is also checked. M1200G (Application of nonsurgical dressings – with or without topical medications) would **not** be coded here because **any** intervention for treating pressure ulcers is coded in M1200E (Pressure ulcer care).

Scenarios for Pressure Ulcer Coding (cont.)

M0100. Determination of Pressure Ulcer Risk	
↓ Check all that apply	
<input checked="" type="checkbox"/>	A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device
<input checked="" type="checkbox"/>	B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)
<input checked="" type="checkbox"/>	C. Clinical assessment
<input type="checkbox"/>	Z. None of the above
M0150. Risk of Pressure Ulcers	
Enter Code <input type="text" value="1"/>	Is this resident at risk of developing pressure ulcers? 0. No 1. Yes
M0210. Unhealed Pressure Ulcer(s)	
Enter Code <input type="text" value="1"/>	Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher? 0. No → Skip to M0900, Healed Pressure Ulcers 1. Yes → Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage
M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage	
Enter Number <input type="text" value="0"/>	A. Number of Stage 1 pressure ulcers Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues
Enter Number <input type="text" value="1"/>	B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister
Enter Number <input type="text" value="0"/>	
	<p>1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3</p> <p>2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p> <p>3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown: <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year</p>
Enter Number <input type="text" value="0"/>	C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling
Enter Number <input type="text"/>	<p>1. Number of Stage 3 pressure ulcers - If 0 → Skip to M0300D, Stage 4</p> <p>2. Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p>
Enter Number <input type="text" value="0"/>	
Enter Number <input type="text"/>	D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling
Enter Number <input type="text" value="0"/>	<p>1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable: Non-removable dressing</p> <p>2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p>
Enter Number <input type="text"/>	
M0300 continued on next page	

Scenarios for Pressure Ulcer Coding (cont.)

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage - Continued	
Enter Number <input type="text" value="0"/> Enter Number <input type="text"/>	<p>E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device</p> <p>1. Number of unstageable pressure ulcers due to non-removable dressing/device - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar</p> <p>2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p>
Enter Number <input type="text" value="0"/> Enter Number <input type="text"/>	<p>F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar</p> <p>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 → Skip to M0300G, Unstageable: Deep tissue</p> <p>2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p>
Enter Number <input type="text" value="0"/> Enter Number <input type="text"/>	<p>G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution</p> <p>1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar</p> <p>2. Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry</p>

M0700. Most Severe Tissue Type for Any Pressure Ulcer	
Enter Code <input type="text" value="1"/>	<p>Select the best description of the most severe type of tissue present in any pressure ulcer bed</p> <ol style="list-style-type: none"> 1. Epithelial tissue - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin 2. Granulation tissue - pink or red tissue with shiny, moist, granular appearance 3. Slough - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous 4. Necrotic tissue (Eschar) - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin 9. None of the Above
M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA or Scheduled PPS) or Last Admission/Entry or Reentry	
<p>Complete only if A0310E = 0</p> <p>Indicate the number of current pressure ulcers that were not present or were at a lesser stage on prior assessment (OBRA or scheduled PPS) or last entry. If no current pressure ulcer at a given stage, enter 0.</p>	
Enter Number <input type="text" value="1"/>	A. Stage 2
Enter Number <input type="text" value="0"/>	B. Stage 3
Enter Number <input type="text" value="0"/>	C. Stage 4

Scenarios for Pressure Ulcer Coding (cont.)

M0900. Healed Pressure Ulcers	
Complete only if A0310E = 0	
Enter Code <input type="text" value="0"/>	A. Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)? 0. No → Skip to M1030, Number of Venous and Arterial Ulcers 1. Yes → Continue to M0900B, Stage 2
Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA or scheduled PPS) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA or scheduled PPS), enter 0.	
Enter Number <input type="text"/>	B. Stage 2
Enter Number <input type="text"/>	C. Stage 3
Enter Number <input type="text"/>	D. Stage 4
M1030. Number of Venous and Arterial Ulcers	
Enter Number <input type="text" value="0"/>	Enter the total number of venous and arterial ulcers present
M1040. Other Ulcers, Wounds and Skin Problems	
↓ Check all that apply	
Foot Problems	
<input type="checkbox"/>	A. Infection of the foot (e.g., cellulitis, purulent drainage)
<input type="checkbox"/>	B. Diabetic foot ulcer(s)
<input type="checkbox"/>	C. Other open lesion(s) on the foot
Other Problems	
<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
<input type="checkbox"/>	E. Surgical wound(s)
<input type="checkbox"/>	F. Burn(s) (second or third degree)
<input type="checkbox"/>	G. Skin tear(s)
<input type="checkbox"/>	H. Moisture Associated Skin Damage (MASD) (i.e. incontinence (IAD), perspiration, drainage)
None of the Above	
<input checked="" type="checkbox"/>	Z. None of the above were present
M1200. Skin and Ulcer Treatments	
↓ Check all that apply	
<input checked="" type="checkbox"/>	A. Pressure reducing device for chair
<input checked="" type="checkbox"/>	B. Pressure reducing device for bed
<input checked="" type="checkbox"/>	C. Turning/repositioning program
<input type="checkbox"/>	D. Nutrition or hydration intervention to manage skin problems
<input checked="" type="checkbox"/>	E. Pressure ulcer care
<input type="checkbox"/>	F. Surgical wound care
<input type="checkbox"/>	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
<input type="checkbox"/>	H. Applications of ointments/medications other than to feet
<input type="checkbox"/>	I. Application of dressings to feet (with or without topical medications)
<input type="checkbox"/>	Z. None of the above were provided

N0410: Medications Received (cont.)

- Residents who are on antidepressants should be closely monitored for worsening of depression and/or suicidal ideation/behavior, especially during initiation or change of dosage in therapy. Stopping antidepressants abruptly puts one at higher risk of suicidal ideation and behavior.
- Anticoagulants must be monitored with dosage frequency determined by clinical circumstances, duration of use, and stability of monitoring results (e.g., Prothrombin Time [PT]/International Normalization Ratio [INR]).
 - Multiple medication interactions exist with use of anticoagulants (information on common medication-medication interactions can be found in the **State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities** [the **State Operations Manual** can be found at <http://www.cms.gov/Manuals/IOM/list.asp>]), which may
 - o significantly increase PT/INR results to levels associated with life-threatening bleeding, or
 - o decrease PT/INR results to ineffective levels, or increase or decrease the serum concentration of the interacting medication.
- Herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration (FDA). These products are not regulated by the FDA (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted as medications (e.g. chamomile, valerian root). Keep in mind that, for clinical purposes, it is important to document a resident's intake of such herbal and alternative medicine products elsewhere in the medical record and to monitor their potential effects as they can interact with medications the resident is currently taking. For more information consult the FDA website <http://www.fda.gov/food/dietarysupplements/consumerinformation/ucm110567.htm>.

Example

1. The Medication Administration Record for Mrs. P. reflects the following:
 - Risperidone 0.5 mg PO BID PRN: Received once a day on Monday, Wednesday, and Thursday.
 - Lorazepam 1 mg PO QAM: Received every day.
 - Temazepam 15 mg PO QHS PRN: Received at bedtime on Tuesday and Wednesday only.

Coding: Medications in N0410, would be checked as follows: A. Antipsychotic, risperidone is an antipsychotic medication, B. Antianxiety, lorazepam is an antianxiety medication, and D. Hypnotic, temazepam is a hypnotic medication.

Please note: if a resident is receiving medications in all three categories simultaneously there must be a clear clinical indication for the use of these medications. Administration of these types of medications, particularly in this combination, could be interpreted as chemically restraining the resident. Adequate documentation is essential in justifying their use.

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

Planning for Care

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

Steps for Assessment

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

Coding Instructions for Column 1

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

Coding Instructions for Column 2

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

Coding Tips

- Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.
- **O0100A, Chemotherapy**

Code any type of chemotherapy agent administered as an antineoplastic given by any route in this item. Each drug should be evaluated to determine its reason for use before coding it here. The drugs coded here are those actually used for cancer treatment. For example, megestrol acetate is classified in the **Physician's Desk Reference (PDR)** as an antineoplastic drug. One of its side effects is appetite stimulation and weight gain. If megestrol acetate is being given only for appetite stimulation, do **not** code it as chemotherapy in this item, as the resident is not receiving the medication for chemotherapy purposes in this situation. IV's, IV medication, and blood transfusions administered during chemotherapy are **not** recorded under items K0510A (Parenteral/IV), O0100H (IV Medications), or O01001 (Transfusions).

- **O0100B, Radiation**

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

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

- **O0100C, Oxygen therapy**

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

- **O0100D, Suctioning**

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

- **O0100E, Tracheostomy care**

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

- **O0100F, Ventilator or respirator**

Code any type of electrically or pneumatically powered closed-system mechanical ventilator support devices that ensure adequate ventilation in the resident who is, or who may become, unable to support his or her own respiration in this item. A resident who is being weaned off of a respirator or ventilator in the last 14 days should also be coded here. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.

- **O0100G, BiPAP/CPAP**

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

- **O0100H, IV medications**

Code any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Do **not** code flushes to keep an IV access port patent, or IV fluids without medication here. Epidural, intrathecal, and baclofen pumps may be coded here, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Subcutaneous pumps are **not** coded in this item. Do **not** include IV medications of any kind that were administered during dialysis or chemotherapy. Dextrose 50% and/or Lactated Ringers given IV are not considered medications, and should not be coded here. To determine what products are considered medications or for more information consult the FDA website:

- The Orange Book, <http://www.fda.gov/cder/ob/default.htm>
- The National Drug Code Directory, <http://www.fda.gov/cder/ndc/database/Default.htm>

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

- **O0100I, Transfusions**

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

- **O0100J, Dialysis**

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

- **O0100K, Hospice care**

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

- **O0100L, Respite care**

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

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

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

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

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

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

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

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

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

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

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

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

- **O0100Z, None of the above**

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

O0250: Influenza Vaccine

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

O0250: Influenza Vaccine (cont.)

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

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

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

O0250: Influenza Vaccine (cont.)

Coding Instructions for O0250B, Date Vaccine Received

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

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

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

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

Coding Tips and Special Populations

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

O0250: Influenza Vaccine (cont.)

Examples

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

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

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

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

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

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

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

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

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

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

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

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

O0300: Pneumococcal Vaccine

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

O0300: Pneumococcal Vaccine (cont.)

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

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

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

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

O0300: Pneumococcal Vaccine (cont.)

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

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

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

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

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

Coding Tips

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

Examples

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

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

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

O0300: Pneumococcal Vaccine (cont.)

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

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

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

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

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

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

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

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

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

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

O0400: Therapies (cont.)

Steps for Assessment

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

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

- **Individual minutes**—Enter the total number of minutes of therapy that were provided on an individual basis in the last 7 days. **Enter 0** if none were provided. Individual services are provided by one therapist or assistant to one resident at a time.
- **Concurrent minutes**—Enter the total number of minutes of therapy that were provided on a concurrent basis in the last 7 days. **Enter 0** if none were provided. Concurrent therapy is defined as the treatment of 2 residents at the same time, when the residents are not performing the same or similar activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant for Medicare Part A. When a Part A resident receives therapy that meets this definition, it is defined as concurrent therapy for the Part A resident regardless of the payer source for the second resident. For Part B, residents may not be treated concurrently: a therapist may treat one resident at a time, and the minutes during the day when the resident is treated individually are added, even if the therapist provides that treatment intermittently (first to one resident and then to another). For all other payers, follow Medicare Part A instructions.
- **Group minutes**—Enter the total number of minutes of therapy that were provided in a group in the last 7 days. **Enter 0** if none were provided. Group therapy is defined for Part A as the treatment of 4 residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals. For Medicare Part B, treatment of two patients (or more), regardless of payer source, at the same time is documented as group treatment. For all other payers, follow Medicare Part A instructions.
- **Days**—Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as skilled treatment for 15 minutes or more during the day. Use total minutes of therapy provided (individual plus concurrent plus group), without any adjustment, to determine if the day is counted. For example, if the resident received 20 minutes of concurrent therapy, the day requirement is considered met. **Enter 0** if therapy was provided but for less than 15 minutes every day for the last 7 days. If the total number of minutes (individual plus concurrent plus group) during the last 7 days is 0, skip this item and leave blank.
- **Therapy Start Date**—Record the date the most recent therapy regimen (since the most recent entry/reentry) started. This is the date the initial therapy evaluation is conducted regardless if treatment was rendered or not or the date of resumption (O0450B) on the resident's EOT OMRA, in cases where the resident discontinued and then resumed therapy.

O0400: Therapies (cont.)

Dates of Therapy

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

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

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

Coding values for his MDS are:

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

NOTE: When an EOT-R is completed, the Therapy Start Date (O0400A5, O0400B5, and O0400C5) on the next assessment is the same as the Resumption of Therapy Date (O0450B) on the EOT-R. If therapy is ongoing, the Therapy End Date (O0400A6, O0400B6, and O0400C6) would be filled out with dashes.

General Coding Example:

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

O0400: Therapies (cont.)

Coding:

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

Rationale:

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

O0400. Therapies																																																		
<p>Enter Number of Minutes</p> <table border="1" style="width: 100px; text-align: center;"> <tr><td> </td><td>1</td><td>9</td><td>0</td></tr> </table> <p>Enter Number of Minutes</p> <table border="1" style="width: 100px; text-align: center;"> <tr><td> </td><td> </td><td>7</td><td>0</td></tr> </table> <p>Enter Number of Minutes</p> <table border="1" style="width: 100px; text-align: center;"> <tr><td> </td><td> </td><td>7</td><td>5</td></tr> </table> <p>Enter Number of Days</p> <table border="1" style="width: 50px; text-align: center;"> <tr><td>5</td></tr> </table>		1	9	0			7	0			7	5	5	<p>A. Speech-Language Pathology and Audiology Services</p> <ol style="list-style-type: none"> Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400A5, Therapy start date</p> <ol style="list-style-type: none"> Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started <table style="width: 100%; text-align: center;"> <tr> <td style="border: 1px solid black; padding: 2px;">1</td> <td style="border: 1px solid black; padding: 2px;">0</td> <td style="border: 1px solid black; padding: 2px;">-</td> <td style="border: 1px solid black; padding: 2px;">0</td> <td style="border: 1px solid black; padding: 2px;">6</td> <td style="border: 1px solid black; padding: 2px;">-</td> <td style="border: 1px solid black; padding: 2px;">2</td> <td style="border: 1px solid black; padding: 2px;">0</td> <td style="border: 1px solid black; padding: 2px;">1</td> <td style="border: 1px solid black; padding: 2px;">1</td> </tr> <tr> <td>Month</td> <td>Day</td> <td></td> <td>Year</td> <td></td> <td></td> <td>Year</td> <td></td> <td></td> <td></td> </tr> </table> <ol style="list-style-type: none"> Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing <table style="width: 100%; text-align: center;"> <tr> <td style="border: 1px solid black; padding: 2px;">-</td> </tr> <tr> <td>Month</td> <td>Day</td> <td></td> <td>Year</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>	1	0	-	0	6	-	2	0	1	1	Month	Day		Year			Year				-	-	-	-	-	-	-	-	Month	Day		Year				
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O0400 continued on next page

O0400: Therapies (cont.)

O0400. Therapies - Continued	
<p>Enter Number of Minutes <input type="text" value="2"/> <input type="text" value="8"/> <input type="text" value="7"/></p> <p>Enter Number of Minutes <input type="text" value="1"/> <input type="text" value="0"/> <input type="text" value="0"/></p> <p>Enter Number of Minutes <input type="text" value=""/> <input type="text" value=""/> <input type="text" value="0"/></p> <p>Enter Number of Days <input type="text" value="5"/></p>	<p>C. Physical Therapy</p> <p>1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days</p> <p>2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days</p> <p>3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days</p> <p>If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date</p> <p>4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</p> <p>5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started <input type="text" value="1"/> <input type="text" value="0"/> - <input type="text" value="0"/> <input type="text" value="7"/> - <input type="text" value="2"/> <input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="1"/> Month Day Year</p> <p>6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> - <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/> <input type="text" value="-"/> Month Day Year</p>
<p>Enter Number of Minutes <input type="text" value=""/> <input type="text" value="5"/> <input type="text" value="0"/></p> <p>Enter Number of Days <input type="text" value="0"/></p>	<p>D. Respiratory Therapy</p> <p>1. Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0400E, Psychological Therapy</p> <p>2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</p>
<p>Enter Number of Minutes <input type="text" value=""/> <input type="text" value=""/> <input type="text" value="0"/></p> <p>Enter Number of Days <input type="text" value=""/></p>	<p>E. Psychological Therapy (by any licensed mental health professional)</p> <p>1. Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0400F, Recreational Therapy</p> <p>2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</p>
<p>Enter Number of Minutes <input type="text" value=""/> <input type="text" value="9"/> <input type="text" value="0"/></p> <p>Enter Number of Days <input type="text" value="3"/></p>	<p>F. Recreational Therapy (includes recreational and music therapy)</p> <p>1. Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days If zero, → skip to O0450, Resumption of Therapy</p> <p>2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days</p>

O0450: Resumption of Therapy

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

Item Rationale

In cases where therapy resumes after the EOT OMRA is performed and the resumption of therapy date is no more than 5 consecutive calendar days after the last day of therapy provided,

O0450: Resumption of Therapy (cont.)

and the therapy services have resumed at the same RUG-IV classification level that had been in effect prior to the EOT OMRA, an End of Therapy OMRA with Resumption (EOT-R) may be completed. The EOT-R reduces the number of assessments that need to be completed and reduces the number of interview items residents must answer.

Coding Instructions:

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

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

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

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

O0500: Restorative Nursing Programs

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

O0500: Restorative Nursing Programs (cont.)

- Measureable objective and interventions must be documented in the care plan and in the medical record. If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this reassessment should be documented in the resident's medical record.
- Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record. When not contraindicated by state practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established.
- Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity.
- A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a restorative nursing program. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents. Restorative nursing does not require a physician's order. Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In these situations, the services may not be coded as therapy in item O0400, Therapies, because the specific interventions are considered restorative nursing services. The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.
- This category does not include groups with more than four residents per supervising helper or caregiver.

Coding Instructions

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

O0500: Restorative Nursing Programs (cont.)

Technique

Activities provided by restorative nursing staff.

- O0500A, Range of Motion (Passive)
Code provision of passive movements in order to maintain flexibility and useful motion in the joints of the body. These exercises must be individualized to the resident's needs, planned, monitored, evaluated and documented in the resident's medical record.
- O0500B, Range of Motion (Active)
Code exercises performed by the resident, with cueing, supervision, or physical assist by staff that are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record. Include active ROM and active-assisted ROM.
- O0500C, Splint or Brace Assistance
Code provision of (1) verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint; or (2) a scheduled program of applying and removing a splint or brace. These sessions are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

Training and Skill Practice

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

- O0500D, Bed Mobility
Code activities provided to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side and positioning himself or herself in bed. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.
- O0500E, Transfer
Code activities provided to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.
- O0500F, Walking
Code activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

O0500: Restorative Nursing Programs (cont.)

- O0500G, Dressing and/or Grooming
Code activities provided to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.
- O0500H, Eating and/or Swallowing
Code activities provided to improve or maintain the resident's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.
- O0500I, Amputation/ Prosthesis Care
Code activities provided to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket). Dentures are not considered to be prostheses for coding this item. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.
- O0500J, Communication
Code activities provided to improve or maintain the resident's self-performance in functional communication skills or assisting the resident in using residual communication skills and adaptive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

Coding Tips and Special Populations

- For range of motion (passive): the caregiver moves the body part around a fixed point or joint through the resident's available range of motion. The resident provides no assistance.
- For range of motion (active): any participation by the resident in the ROM activity should be coded here.
- For both active and passive range of motion: movement by a resident that is incidental to dressing, bathing, etc., does not count as part of a formal restorative nursing program. For inclusion in this section, active or passive range of motion must be a component of an individualized program that is planned, monitored, evaluated, and documented in the resident's medical record. Range of motion should be delivered by staff who are trained in the procedures.
- For splint or brace assistance: assess the resident's skin and circulation under the device, and reposition the limb in correct alignment.
- The use of continuous passive motion (CPM) devices in a restorative nursing program is coded when the following criteria are met: (1) ordered by a physician, (2) nursing staff

O0500: Restorative Nursing Programs (cont.)

have been trained in technique (e.g., properly aligning resident's limb in device, adjusting available range of motion), and (3) monitoring of the device. Nursing staff should document the application of the device and the effects on the resident. Do not include the time the resident is receiving treatment in the device. Include only the actual time staff were engaged in applying and monitoring the device.

- Remember that persons with dementia learn skills best through repetition that occurs multiple times per day.
- Grooming programs, including programs to help residents learn to apply make-up, may be considered restorative nursing programs when conducted by a member of the activity staff. These grooming programs would need to be individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

Examples

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

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

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

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

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

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

O0500: Restorative Nursing Programs (cont.)

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

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

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

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

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

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

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

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

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

O0500: Restorative Nursing Programs (cont.)

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

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

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

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

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

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

O0600: Physician Examinations

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

O0600: Physician Examinations (cont.)

Steps for Assessment

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

Coding Instructions

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

Coding Tips and Special Populations

- Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law.
- Examination (partial or full) can occur in the facility or in the physician's office. Included in this item are telehealth visits as long as the requirements are met for physician/practitioner type as defined above and whether it qualifies as a telehealth billable visit. For eligibility requirements and additional information about Medicare telehealth services refer to:
 - Chapter 15 of the *Medicare Benefit Policy Manual* (Pub. 100-2) and Chapter 12 of the *Medicare Claims Processing Manual* (Pub. 100-4) may be accessed at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>.
- Do not include physician examinations that occurred prior to admission or readmission to the facility (e.g., during the resident's acute care stay).
- Do not include physician examinations that occurred during an emergency room visit or hospital observation stay.
- If a resident is evaluated by a physician off-site (e.g., while undergoing dialysis or radiation therapy), it can be coded as a physician examination as long as documentation of the physician's evaluation is included in the medical record. The physician's evaluation can include partial or complete examination of the resident, monitoring the resident for response to the treatment, or adjusting the treatment as a result of the examination.
- The licensed psychological therapy by a Psychologist (PhD) should be recorded in O0400E, **Psychological Therapy**.
- Does not include visits made by Medicine Men.

O0700: Physician Orders

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

Coding Instructions

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

Coding Tips and Special Populations

- Includes orders written by medical doctors, doctors of osteopathy, podiatrists, dentists, and physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law.
- Includes written, telephone, fax, or consultation orders for new or altered treatment. Does **not** include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. Orders written on the day of admission as a result for an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.
- The prohibition against counting standard admission or readmission orders applies regardless of whether or not the orders are given at one time or are received at different times on the date of admission or readmission.
- Do not count orders prior to the date of admission or re-entry.
- A sliding scale dosage schedule that is written to cover different dosages depending on lab values, does **not** count as an order change simply because a different dose is administered based on the sliding scale guidelines.

O0700: Physician Orders (cont.)

- When a PRN (as needed) order was already on file, the potential need for the service had already been identified. Notification of the physician that the PRN order was activated does **not** constitute a new or changed order and may **not** be counted when coding this item.
- A Medicare Certification/Recertification is a renewal of an existing order and should **not** be included when coding this item.
- If a resident has multiple physicians (e.g., surgeon, cardiologist, internal medicine), and they all visit and write orders on the same day, the MDS must be coded as 1 day during which a physician visited, and 1 day in which orders were changed.
- Orders requesting a consultation by another physician may be counted. However, the order must be reasonable (e.g., for a new or altered treatment).
- An order written on the last day of the MDS observation period for a consultation planned 3-6 months in the future should be carefully reviewed.
- Orders written to increase the resident's RUG classification and facility payment are **not** acceptable.
- Orders for transfer of care to another physician may **not** be counted.
- Do **not** count orders written by a pharmacist.

SECTION P: RESTRAINTS

Intent: The intent of this section is to record the frequency over the 7-day look-back period that the resident was restrained by any of the listed devices at any time during the day or night. Assessors will evaluate whether or not a device meets the definition of a physical restraint and code only the devices that meet the definition in the appropriate categories of Item P0100.

CMS is committed to reducing unnecessary physical restraints in nursing homes and ensuring that residents are free of physical restraints unless deemed necessary and appropriate as permitted by regulation. Proper interpretation of the physical restraint definition is necessary to understand if nursing homes are accurately assessing manual methods or physical or mechanical devices, materials or equipment as physical restraints and meeting the federal requirement for restraint use (see Centers for Medicare & Medicaid Services. [2007, June 22]. Memorandum to State Survey Agency Directors from CMS Director, Survey and Certification Group: Clarification of Terms Used in the Definition of Physical Restraints as Applied to the Requirements for Long Term Care Facilities. Retrieved December 18, 2012, from <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter07-22.pdf>).

Are Restraints Prohibited by CMS?

Federal regulations and CMS guidelines do not prohibit use of physical restraints in nursing homes, except when they are imposed for discipline or convenience and are not required to treat the resident's medical symptoms. The regulation specifically states, "The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms" (42 CFR 483.13(a)). Research and standards of practice show that physical restraints have many negative side effects and risks that far outweigh any benefit from their use.

Prior to using any physical restraint, the nursing home must assess the resident to properly identify the resident's needs and the medical symptom(s) that the restraint is being employed to address. If a physical restraint is needed to treat the resident's medical symptom, the nursing home is responsible for assessing the appropriateness of that restraint. When the decision is made to use a physical restraint, CMS encourages, to the extent possible, gradual restraint reduction because there are many negative outcomes associated with restraint use.

While a restraint-free environment is not a federal requirement, the use of physical restraints should be the exception, not the rule.

DEFINITIONS

PHYSICAL RESTRAINTS

Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body (State Operations Manual, Appendix PP).

P0100: Physical Restraints

P0100. Physical Restraints	
Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body	
Coding: 0. Not used 1. Used less than daily 2. Used daily	↓ Enter Codes in Boxes
	Used in Bed
	<input type="checkbox"/> A. Bed rail
	<input type="checkbox"/> B. Trunk restraint
	<input type="checkbox"/> C. Limb restraint
	<input type="checkbox"/> D. Other
	Used in Chair or Out of Bed
	<input type="checkbox"/> E. Trunk restraint
	<input type="checkbox"/> F. Limb restraint
	<input type="checkbox"/> G. Chair prevents rising
<input type="checkbox"/> H. Other	

Item Rationale

Health-related Quality of Life

- Although the requirements describe the narrow instances when physical restraints may be used, growing evidence supports that physical restraints have a limited role in medical care. Physical restraints limit mobility and increase the risk for a number of adverse outcomes, such as functional decline, agitation, diminished sense of dignity, depression, and pressure ulcers.
- Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used on this population be carefully considered and monitored. In many cases, the risk of using the physical restraint may be greater than the risk of it not being used.
- The risk of restraint-related injury and death is significant when physical restraints are used.

Planning for Care

- When the use of physical restraints is considered, thorough assessment of problems to be addressed by restraint use is necessary to determine reversible causes and contributing factors and to identify alternative methods of treating non-reversible issues.
- When the interdisciplinary team determines that the use of physical restraints is the appropriate course of action, and there is a signed physician order that gives the medical symptom supporting the use of the restraint, the least restrictive manual method or physical or mechanical device, material or equipment that will meet the resident's needs must be selected.
- Care planning must focus on preventing the adverse effects of physical restraint use.

P0100: Physical Restraints (cont.)

Steps for Assessment

1. Review the resident's medical record (e.g., physician orders, nurses' notes, nursing assistant documentation) to determine if physical restraints were used during the 7-day look-back period.
2. Consult the nursing staff to determine the resident's cognitive and physical status/limitations.
3. Considering the physical restraint definition as well as the clarifications listed below, observe the resident to determine the effect the restraint has on the resident's normal function. Do not focus on the type, intent, or reason behind its use.
4. Evaluate whether the resident can easily and voluntarily remove any manual method or physical or mechanical device, material, or equipment attached or adjacent to his or her body. If the resident cannot easily and voluntarily do this, continue with the assessment to determine whether or not the manual method or physical or mechanical device, material or equipment restrict freedom of movement or restrict the resident's access to his or her own body.
5. Any manual method or physical or mechanical device, material or equipment should be classified as a restraint only when it meets the criteria of the physical restraint definition. This can only be determined on a case-by-case basis by individually assessing each and every manual method or physical or mechanical device, material or equipment (whether or not it is listed specifically on the MDS) attached or adjacent to the resident's body, and the effect it has on the resident.
6. Determine if the manual method or physical or mechanical device, material, or equipment meets the definition of a physical restraint as clarified below. Remember, the decision about coding any manual method or physical or mechanical device, material, equipment as a restraint depends on the effect it has on the resident.
7. Any manual method or physical or mechanical device, material, or equipment that meets the definition of a physical restraint must have:
 - physician documentation of a medical symptom that supports the use of the restraint,
 - a physician's order for the type of restraint and parameters of use, and
 - a care plan and a process in place for systematic and gradual restraint reduction (and/or elimination, if possible), as appropriate.

Clarifications

- **“Remove easily”** means that the manual method or physical or mechanical device, material, or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff (e.g., side rails are put down or not climbed over, buckles are intentionally unbuckled, ties or knots are intentionally untied), considering the resident's physical condition and ability to accomplish his or her objective (e.g., transfer to a chair, get to the bathroom in time).
- **“Freedom of movement”** means any change in place or position for the body or any part of the body that the person is physically able to control or access.

P0100: Physical Restraints (cont.)

- **“Medical symptoms/diagnoses”** are defined as an indication or characteristic of a physical or psychological condition. Objective findings derived from clinical evaluation of the resident’s subjective symptoms and medical diagnoses should be considered when determining the presence of medical symptom(s) that might support restraint use. **The resident’s subjective symptoms may not be used as the sole basis for using a restraint. In addition, the resident’s medical symptoms/diagnoses should not be viewed in isolation; rather, the medical symptoms identified should become the context in which to determine the most appropriate method of treatment related to the resident’s condition, circumstances, and environment, and not a way to justify restraint use.**
- The identification of medical symptoms should assist the nursing home in determining if the specific medical symptom can be improved or addressed by using other, less restrictive interventions. The nursing home should perform all due diligence and document this process to ensure that they have exhausted alternative treatments and less restrictive measures before a physical restraint is employed to treat the medical symptom, protect the resident’s safety, help the resident attain or maintain his or her highest level of physical or psychological well-being and support the resident’s goals, wishes, independence, and self-direction.
- **Physical restraints as an intervention do not treat the underlying causes of medical symptoms. Therefore, as with other interventions, physical restraints should not be used without also seeking to identify and address the physical or psychological condition causing the medical symptom.**
- Physical restraints may be used, if warranted, as a temporary symptomatic intervention while the actual cause of the medical symptom is being evaluated and managed. Additionally, physical restraints may be used as a symptomatic intervention when they are immediately necessary to prevent a resident from injuring himself/herself or others and/or to prevent the resident from interfering with life-sustaining treatment when no other less restrictive or less risky interventions exist.
- Therefore, a clear link must exist between physical restraint use and how it benefits the resident by addressing the specific medical symptom. If it is determined, after thorough evaluation and attempts at using alternative treatments and less restrictive methods, that a physical restraint must still be employed, the medical symptoms that support the use of the restraint must be documented in the resident’s medical record, ongoing assessments, and care plans. There also must be a physician’s order reflecting the use of the physical restraint and the specific medical symptom being treated by its use. The physician’s order alone is not sufficient to employ the use of a physical restraint. CMS will hold the nursing home ultimately accountable for the appropriateness of that determination.

P0100: Physical Restraints (cont.)

Coding Instructions

Identify all physical restraints that were used at any time (day or night) during the 7-day look-back period.

After determining whether or not an item listed in (P0100) is a physical restraint and was used during the 7-day look-back period, code the frequency of use:

- Code 0, not used: if the item was not used during the 7-day look-back **or** it was used but did not meet the definition.
- Code 1, used less than daily: if the item met the definition and was used less than daily.
- Code 2, used daily: if the item met the definition and was used on a daily basis during the look-back period.

Coding Tips and Special Populations

- Any manual method or physical or mechanical device, material or equipment, that does not fit into the listed categories but that meets the definition of a physical restraint, and has not been excluded from this section, should be coded in items P0100D or P0100H, Other. These devices, although not coded on the MDS, must be assessed, care-planned, monitored, and evaluated.
- In classifying any manual method or physical or mechanical device, material or equipment as a physical restraint, the assessor must consider the effect it has on the resident, not the purpose or intent of its use. It is possible that a manual method or physical or mechanical device, material or equipment may improve a resident's mobility but also have the effect of physically restraining him or her.
- Exclude from this section items that are typically used in the provision of medical care, such as catheters, drainage tubes, casts, traction, leg, arm, neck, or back braces, abdominal binders, and bandages that are serving in their usual capacity to meet medical need(s).
- **Bed rails** include any combination of partial or full rails (e.g., one-side half-rail, one-side full rail, two-sided half-rails or quarter-rails, rails along the side of the bed that block three-quarters to the whole length of the mattress from top to bottom, etc.). Include in this category enclosed bed systems.
 - *Bed rails used as positioning devices.* If the use of bed rails (quarter-, half- or three-quarter, one or both, etc.) meet the definition of a physical restraint even though they may improve the resident's mobility in bed, the nursing home must code their use as a restraint at P0100A.
 - *Bed rails used with residents who are immobile.* If the resident is immobile and cannot voluntarily get out of bed because of a physical limitation or because proper assistive devices were not present, the bed rails do not meet the definition of a physical restraint.

For residents who have no voluntary movement, the staff need to determine if there is an appropriate use of bed rails. Bed rails may create a visual barrier and deter

P0100: Physical Restraints (cont.)

physical contact from others. Some residents have no ability to carry out voluntary movements, yet they exhibit involuntary movements. Involuntary movements, resident weight, and gravity's effects may lead to the resident's body shifting toward the edge of the bed. When bed rails are used in these cases, the resident could be at risk for entrapment. For this type of resident, clinical evaluation of alternatives (e.g., a concave mattress to keep the resident from going over the edge of the bed), coupled with frequent monitoring of the resident's position, should be considered. While the bed rails may not constitute a physical restraint, they may affect the resident's quality of life and create an accident hazard.

- **Trunk restraints** include any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the resident cannot easily remove such as, but not limited to, vest or waist restraints or belts used in a wheelchair that either restricts freedom of movement or access to his or her body
- **Limb restraints** include any manual method or physical or mechanical device, material or equipment that the resident cannot easily remove, that restricts movement of any part of an upper extremity (i.e., hand, arm, wrist) or lower extremity (i.e., foot, leg) that either restricts freedom of movement or access to his or her own body. Hand mitts/mittens are included in this category.
- **Trunk or limb restraints**, if used in both bed and chair, should be marked in both sections.
- **Chairs that prevent rising** include any type of chair with a locked lap board, that places the resident in a recumbent position that restricts rising, chairs that are soft and low to the floor, chairs that have a cushion placed in the seat that prohibit the resident from rising, geriatric chairs, and enclosed-frame wheeled walkers.
 - For residents who have the ability to transfer from other chairs, but cannot transfer from a geriatric chair, the geriatric chair would be considered a restraint to that individual, and should be coded as P0100G–Chair Prevents Rising.
 - For residents who have no ability to transfer independently, the geriatric chair does not meet the definition of a restraint, and should not be coded at P0100G–Chair Prevents Rising.
 - Geriatric chairs used for residents who are immobile. For residents who have no voluntary or involuntary movement, the geriatric chair does not meet the definition of a restraint.
 - Enclosed-frame wheeled walkers, with or without a posterior seat, and other devices like it should not automatically be classified as a physical restraint. These types of walkers are only classified as a physical restraint if the resident cannot exit the walker via opening a gate, bar, strap, latch, removing a tray, etc. When deemed a physical restraint, these walkers should be coded at P0100G–Chair Prevents Rising.
- **Restraints used in emergency situations.** If the resident needs emergency care, physical restraints may be used for brief periods to permit medical treatment to proceed, unless the

P0100: Physical Restraints (cont.)

resident or legal representative has previously made a valid refusal of the treatment in question. The resident's right to participate in care planning and the right to refuse treatment are addressed at 42 CFR §§483.10(b)(4) and 483.20(k)(2)(ii) respectively. The use of physical restraints in this instance should be limited to preventing the resident from interfering with life-sustaining procedures only and not for routine care.

- A resident who is injuring himself/herself or is threatening physical harm to others may be physically restrained in an emergency to safeguard the resident and others. A resident whose unanticipated violent or aggressive behavior places him/her or others in imminent danger does not have the right to refuse the use of physical restraints, as long as those restraints are used as a last resort to protect the safety of the resident or others and use is limited to the immediate episode.

Additional Information

- **Restraint reduction/elimination.** It is further expected, for residents whose care plan indicates the need for physical restraints, that the nursing home engages in a systematic and gradual process towards reducing (or eliminating, if possible) the restraints (e.g., gradually increasing the time for ambulation and strengthening activities). This systematic process also applies to recently-admitted residents for whom physical restraints were used in the previous setting.
- **Restraints as a fall prevention approach.** Although physical restraints have been traditionally used as a fall prevention approach, they have major drawbacks and can contribute to serious injuries. Falls do not constitute self-injurious behavior nor a medical symptom supporting the use of physical restraints. There is no evidence that the use of physical restraints, including but not limited to side rails, will prevent, reduce, or eliminate falls. In fact, in some instances, reducing the use of physical restraints may actually **decrease** the risk of falling. Additionally, falls that occur while a person is physically restrained often result in more severe injuries.
- **Request for restraints.** While a resident, family member, legal representative, or surrogate may request use of a physical restraint, the nursing home is responsible for evaluating the appropriateness of that request, just as they would for any medical treatment. As with other medical treatments, such as the use of prescription drugs, a resident, family member, legal representative, or surrogate has the right to refuse treatment, but not to demand its use when it is not deemed medically necessary.

According to 42 CFR 483.13(a), "The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms." CMS expects that no resident will be physically restrained for discipline or convenience. Prior to employing any physical restraint, the nursing home must perform a prescribed resident assessment to properly identify the resident's needs and the medical symptom the physical restraint is being employed to address. The guidelines in the State Operations Manual (SOM) state, "...the legal surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms. That is, the facility may not use restraints in violation of regulation

P0100: Physical Restraints (cont.)

solely based on a resident, legal surrogate or representative's request or approval." The SOM goes on to state, "While Federal regulations affirm the resident's right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate or representative to demand that the facility use specific medical interventions or treatment that the facility deems inappropriate. Statutory requirements hold the facility ultimately accountable for the resident's care and safety, including clinical decisions."

Q0100: Participation in Assessment (cont.)

- During the care planning meetings, he or she should be made comfortable and verbal communication should be directly with him or her.
- Residents should be asked about inviting family members, significant others, and/or guardian/legally authorized representatives to participate, and if they desire that they be involved in the assessment process.
- If the individual resident is unable to understand the process, his or her family member, significant other, and/or guardian/legally authorized representative, who represents the individual, should be invited to attend the assessment process whenever possible.
- When the resident is unable to participate in the assessment process, a family member or significant other, and/or guardian or legally authorized representatives can provide information about the resident's needs, goals, and priorities.

DEFINITIONS

FAMILY OR SIGNIFICANT OTHER

A spousal, kinship (e.g., sibling, child, parent, nephew), or in-law relationship; a partner, housemate, primary community caregiver or close friend. Significant other does not, however, include staff at the nursing home.

GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE

A person who is authorized, under applicable law, to make decisions for the resident, including giving and withholding consent for medical treatment.

Steps for Assessment

1. Review the medical record for documentation that the resident, family member and/or significant other, and guardian or legally authorized representative participated in the assessment process.
2. Ask the resident, the family member or significant other (when applicable), and the guardian or legally authorized representative (when applicable) if he or she actively participated in the assessment process.
3. Ask staff members who completed the assessment whether or not the resident, family or significant other, or guardian or legally authorized representative participated in the assessment process.

Coding Instructions for Q0100A, Resident Participated in Assessment

Record the participation of the resident in the assessment process.

- Code 0, No: if the resident did not actively participate in the assessment process.
- Code 1, Yes: if the resident actively and meaningfully participated in the assessment process.

Coding Instructions for Q0100B, Family or Significant Other Participated in Assessment

Record the participation of the family or significant other in the assessment process.

- Code 0, No: if the family or significant other did not participate in the assessment process.

Q0100: Participation in Assessment (cont.)

- Code 1, Yes: if the family or significant other(s) did participate in the assessment process.
- Code 9, No family or significant other available: None of the above—resident has no family or significant other.

Coding Instructions for Q0100C, Guardian or Legally Authorized Representative Participated in Assessment

Record the participation of the guardian or legally authorized representative in the assessment process.

- Code 0, No: if guardian or legally authorized representative did not participate in the assessment process.
- Code 1, Yes: if guardian or legally authorized representative did participate in the assessment process.
- Code 9, No guardian or legally authorized representative available: None of the above -- resident has no guardian or legally authorized representative.

Coding Tips

- While family, significant others, or, if necessary, the guardian or legally authorized representative can be involved, the response selected must reflect the resident's perspective if he or she is able to express it.
- Significant other does not include nursing home staff.
- No family or significant other available means the individual resident has no family or significant other, not that they were not consulted.

Q0300: Resident's Overall Expectation



Complete only when A0310E=1. (First assessment on admission/entry or reentry).

Q0300. Resident's Overall Expectation	
Complete only if A0310E = 1	
Enter Code <input type="checkbox"/>	A. Select one for resident's overall goal established during assessment process 1. Expects to be discharged to the community 2. Expects to remain in this facility 3. Expects to be discharged to another facility/institution 9. Unknown or uncertain
Enter Code <input type="checkbox"/>	B. Indicate information source for Q0300A 1. Resident 2. If not resident, then family or significant other 3. If not resident, family, or significant other, then guardian or legally authorized representative 9. Unknown or uncertain

Q0300: Resident's Overall Expectation (cont.)

6. Encourage the involvement of family or significant others in the discussion, if the resident consents. While family, significant others, or the guardian or legally authorized representative can be involved if the resident is uncertain about his or her goals, the response selected must reflect the resident's perspective if he or she is able to express it.
7. In some guardianship situations, the decision-making authority regarding the individual's care is vested in the guardian. But this should not create a presumption that the individual resident is not able to comprehend and communicate their wishes.

Coding Instructions for Q0300A, Resident's Overall Goals Established during Assessment Process

Record the resident's expectations as expressed by him or her. It is important to document his or her expectations.

- Code 1, Expects to be discharged to the community: if the resident indicates an expectation to return home, to assisted living, or to another community setting.
- Code 2, Expects to remain in this facility: if the resident indicates that he or she expects to remain in the nursing home.
- Code 3, Expects to be discharged to another facility/institution: if the resident expects to be discharged to another nursing home, rehabilitation facility, or another institution.
- Code 9, Unknown or uncertain: if the resident is uncertain or if the resident is not able to participate in the discussion or indicate a goal, and family, significant other, or guardian or legally authorized representative do not exist or are not available to participate in the discussion.

Coding Tips

- This item is individualized and resident-driven rather than what the nursing home staff judge to be in the best interest of the resident. This item focuses on exploring the resident's expectations; not whether or not the staff considers them to be realistic.
- Q0300A, Code 1 "Expects to be discharged to the community" may include newly admitted Medicare SNF residents with a facility arranged discharge plan or non-Medicare and Medicaid residents with adequate supports already in place that would not require referral to a local contact agency (LCA). It may also include residents who ask to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community (Q0500B, Code 1).
- Avoid trying to guess what the resident might identify as a goal or to judge the resident's goal. Do not infer a response based on a specific advance directive, e.g., "do not resuscitate" (DNR).
- The resident should be provided options, as well as, access to information that allows him or her to make the decision and to be supported in directing his or her care planning.

Q0300: Resident's Overall Expectation (cont.)

- If the resident is unable to communicate his or her preference either verbally or nonverbally, or has been legally determined incompetent, the information can be obtained from the family or significant other, as designated by the individual. Families, significant others or legal guardians should be consulted as part of the assessment.

Coding Instructions for Q0300B, Indicate Information Source for Q0300A

- Code 1, Resident: if the resident is the source for completing this item.
- Code 2, If not resident, then family or significant other: if the resident is unable to respond and a family member or significant other is the source for completing this item.
- Code 3, If not resident, family or significant other, then guardian or legally authorized representative: if the guardian or legally authorized representative is the source for completing this item because the resident is unable to respond and a family member or significant other is not available to respond.
- Code 9, Unknown or uncertain (none of the above): if the resident cannot respond and the family or significant other, or guardian or legally authorized representative does not exist or cannot be contacted or is unable to respond (Q0300A= 9).

Examples

1. Mrs. F. is a 55-year-old married woman who had a cerebrovascular accident (CVA, also known as stroke) 2 weeks ago. She was admitted to the nursing home 1 week ago for rehabilitation, specifically for transfer, gait training, and wheelchair mobility training. Mrs. F. is extremely motivated to return home. Her husband is supportive and has been busy adapting their home to promote her independence. Her goal is to return home once she has completed rehabilitation.

Coding: Q0300A would be coded 1, Expects to be discharged to the community.

Q0300B would be coded 1, Resident.

Rationale: Mrs. F. has clear expectations and a goal to return home.

2. Mr. W. is a 73-year-old man who has severe heart failure and renal dysfunction. He also has a new diagnosis of metastatic colorectal cancer and was readmitted to the nursing home after a prolonged hospitalization for lower gastrointestinal (GI) bleeding. He relies on nursing staff for all activities of daily living (ADLs). He indicates that he is "strongly optimistic" about his future and only wants to think "positive thoughts" about what is going to happen and needs to believe that he will return home.

Coding: Q0300A would be coded 1, Expects to be discharged to the community.

Q0300B would be coded 1, Resident.

Q0300: Resident's Overall Expectation (cont.)

Rationale: Mr. W has a clear goal to return home. Even if the staff believe this is unlikely based on available social supports and past nursing home residence, this item should be coded based on the resident's expressed goals.

3. Ms. T. is a 93-year-old woman with chronic renal failure, oxygen dependent chronic obstructive pulmonary disease (COPD), severe osteoporosis, and moderate dementia. When queried about her care preferences, she is unable to voice consistent preferences for her own care, simply stating that "It's such a nice day. Now let's talk about it more." When her daughter is asked about goals for her mother's care, she states that "We know her time is coming. The most important thing now is for her to be comfortable. Because of monetary constraints, the level of care that she needs, and other work and family responsibilities we cannot adequately meet her needs at home. Other than treating simple things, what we really want most is for her to live out whatever time she has in comfort and for us to spend as much time as we can with her." The assessor confirms that the daughter wants care oriented toward making her mother comfortable in her final days and that the family does not have the capacity to provide all the care the resident needs.

Coding: Q0300A would be coded 2, Expects to remain in this facility.
Q0300B would be coded 2, Family or significant other.

Rationale: Ms. T is not able to respond, but her daughter has clear expectations that her mother will remain in the nursing home where she will be made comfortable for her remaining days.

4. Mrs. G., an 84-year-old female with severe dementia, is admitted by her daughter for a 7-day period. Her daughter stated that she "just needs to have a break." Her mother has been wandering at times and has little interactive capacity. The daughter is planning to take her mother back home at the end of the week.

Coding: Q0300A would be coded 1, Expects to be discharged to the community.
Q0300B would be coded 2, Family or significant other.

Rationale: Mrs. G. is not able to respond but her daughter has clear expectations that her mother will return home at the end of the 7-day respite visit.

5. Mrs. C. is a 72-year-old woman who had been living alone and was admitted to the nursing home for rehabilitation after a severe fall. Upon admission, she was diagnosed with moderate dementia and was unable to voice consistent preferences for her own care. She has no living relatives and no significant other who is willing to participate in her care decisions. The court appointed a legal guardian to oversee her care. Community-based services, including assisted living and other residential care situations, were discussed with the guardian. The guardian decided that it is in Mrs. C.'s best interest that she be discharged to a nursing home that has a specialized dementia care unit once rehabilitation was complete.

Coding: Q0300A would be coded 3, Expects to be discharged to another facility/institution.
Q0300B would be coded 3, Guardian or legally authorized representative.

Q0300: Resident's Overall Expectation (cont.)

Rationale: Mrs. C. is not able to respond and has no family or significant other available to participate in her care decisions. A court-appointed legal guardian determined that it is in Mrs. C.'s best interest to be discharged to a nursing home that could provide dementia care once rehabilitation was complete.

6. Ms. K. is a 40-year-old with cerebral palsy and a learning disability. She lived in a group home 5 years ago, but after a hospitalization for pneumonia she was admitted to the nursing home for respiratory therapy. Although her group home bed is no longer available, she is now medically stable and there is no medical reason why she could not transition back to the community. Ms. K. states she wants to return to the group home. Her legal guardian agrees that she should return to the community to a small group home.

Coding: Q0300A would be coded 1, Expects to be discharged to the community (small group homes are considered to be community setting).

Q0300B would be coded 1, Resident

Rationale: Ms. K. understands and is able to respond and says she would like to go back to the group home. Her expression of choice should be recorded. When the legal guardian, with legal decision-making authority under state law, was told that Ms. K. is medically stable and would like to go back to the community, she confirmed that it is in Ms. K.'s best interest to be transferred to a group home. This information should also be recorded in the individual's clinical record. (If Ms. K had not been able to communicate her choice and the guardian made the decision, Q0300B would have been coded 3.)

Q0400: Discharge Plan

Q0400. Discharge Plan	
Enter Code	A. Is active discharge planning already occurring for the resident to return to the community?
<input type="checkbox"/>	0. No
	1. Yes → Skip to Q0600, Referral

Item Rationale

Health-related Quality of Life

- Returning home or to a non-institutional setting can be very important to a resident's health and quality of life.
- For residents who have been in the facility for a long time, it is important to discuss with them their interest in talking with local contact agency (LCA) experts about returning to the community. There are improved community resources and supports that may benefit these residents and allow them to return to a community setting.
- Being discharged from the nursing home without adequate discharge planning occurring (planning and implementation of a plan before discharge) could result in the resident's decline and increase the chances for rehospitalization and aftercare, so a thorough examination of the options with the resident and local community experts is imperative.

Q0400: Discharge Plan (cont.)

Coding Instructions for Q0400A, Is Active Discharge planning already occurring for the Resident to Return to the Community?

- Code 0, No: if there is not active discharge planning already occurring for the resident to return to the community.
- Code 1, Yes: if there is active discharge planning already occurring for the resident to return to the community; skip to **Referral** item (Q0600).

Q0490: Resident's Preference to Avoid Being Asked Question Q0500B

For Quarterly, Correction to Quarterly, and Not-OBRA Assessments. (A0310A=02, 06, 99)

Q0490. Resident's Preference to Avoid Being Asked Question Q0500B	
Complete only if A0310A = 02, 06, or 99	
Enter Code <input type="checkbox"/>	Does the resident's clinical record document a request that this question be asked only on comprehensive assessments? 0. No 1. Yes → Skip to Q0600, Referral 8. Information not available

Item Rationale

This item directs a check of the resident's clinical record to determine if the resident and/or family, etc. have indicated on a previous OBRA comprehensive assessment (A0310A = 01, 03, 04 or 05) that they do not want to be asked question Q0500B until their next comprehensive assessment. Some residents and their families do not want to be asked about their preference for returning to the community and would rather not be asked about it. Item Q0550 allows them to opt-out of being asked question Q0500B on quarterly (non-comprehensive) assessments. If there is a notation in the clinical record that the resident does not want to be asked again, and this is a quarterly assessment, then skip to item Q0600, **Referral**.

Note: Let the resident know that they can change their mind at any time and should be referred to the LCA if they voice their request, regardless of schedule of MDS assessment(s).

If this is a comprehensive assessment, do not skip to item Q0600, continue to item Q0500B.

Coding Instructions for Q0490, Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?

- Code 0, No: if there is no notation in the resident's clinical record that he or she does not want to be asked Question Q0500B again.

Q0490: Resident's Preference to Avoid Being Asked Question Q0500B (cont.)

- Code 1, Yes: if there is a notation in the resident's clinical record to not ask Question Q0500B again, except on comprehensive assessments.

Unless this is a comprehensive assessment (A0310A=01, 03, 04, 05), skip to item Q0600,

Referral. If this is a comprehensive assessment, proceed to the next item Q0500B.

- Code 8, Information not available: if there is no information available in the resident's clinical record or prior MDS 3.0 assessment.

Coding Tips

- Carefully review the resident's clinical record, including prior MDS 3.0 assessments, to determine if the resident or other respondent has previously responded No to item Q0550.

If this is a comprehensive assessment, proceed to item Q0500B, regardless of the previous responses to item Q0550A.

Examples

1. Ms. G is a 45-year old woman, 300 pounds, who is cognitively intact. She has CHF and shortness of breath requiring oxygen at all times. Ms. G also requires 2 person assistance with bathing and transfers to the commode. She was admitted to the nursing home 3 years ago after her daughter who was caring for her passed away. The nursing home social worker discussed options in which she could be cared for in the community but Ms. G refused to consider leaving the nursing home. During the review of her clinical record, the assessor found that on her last MDS assessment, Ms. G stated that she did not want to be asked again about returning to community living, that she has friends in the nursing facility and really likes the activities.

Coding: Q0490 would be coded 1, Yes, skip to Q0600; because this is a quarterly assessment.

If this is a comprehensive assessment, then proceed to the next item Q0500B.

Rationale: On her last MDS 3.0 assessment, Ms. G indicates her preference to not want to be asked again about returning to community living (No on Q0550A).

2. Mrs. R is an 82-year-old widowed woman with advanced Alzheimer's disease. She has resided at the nursing home for 4½ years and her family requests that she not be interviewed because she becomes agitated and upset and cannot be cared for by family members or in the community. The resident is not able to be interviewed.

Coding: Q0490 would be coded 1, Yes, skip to Q0600;

Unless this is a comprehensive assessment, then proceed to the next item Q0500B.

Rationale: Mrs. R is not able to be interviewed. Her family requests that she opt out of the return to the community question because she becomes agitated.

Q0500: Return to Community (cont.)

- Code 0, No: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does not want to talk to someone about the possibility of returning to the community.
- Code 1, Yes: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does want to talk to someone about the possibility of returning to the community.
- Code 9, Unknown or uncertain: if the resident cannot understand or respond and the family or significant other is not available to respond on the resident's behalf and a guardian or legally authorized representative is not available or has not been appointed by the court.

Coding Tips

- A “yes” response to item Q0500B will trigger follow-up care planning and contact with the designated local contact agency about the resident's request within approximately 10 business days of a yes response being given. This code is intended to initiate contact with the local agency for follow-up as the resident desires.
- Follow-up is expected in a “reasonable” amount of time and 10 business days is a recommendation and not a requirement. The level and type of response needed by an individual is determined on a resident-by-resident basis. Some States may determine that the LCAs can make an initial telephone contact to identify the resident's needs and/or set up the face-to-face visit/appointment. However, it is expected that most residents will have a face to face visit. In some States, an initial meeting is set up with the resident, facility staff, and LCA together to talk with the resident about their needs and community care options.
- Some residents will have a very clear expectation and some may change their expectations over time. Residents may also be unsure or unaware of the opportunities available to them for community living with services and supports. Talking with the resident regarding discharge goals and plans before referral to the LCA is a critical step. It is important to clarify the resident's discharge needs and expectations, determine what the SNF/NF usually provides and can arrange, and obtain information about transition barriers or challenges based on family, financial, guardian, cognition, assuring health and safety, and/or intensive 24- hour care issues, etc.
- The SNF/NF should not assume that the resident cannot transition out of the SNF/NF due to their level of care needs. The SNF/NF can talk with the LCA to see what is available that does not require family support.
- Current return to community questions may upset residents who cannot understand what the question means and result in them being agitated or saddened by being asked the question. If the level of cognitive impairment is such that the resident does not understand Q0500, a family member, significant other guardian and/or legally appointed decision-maker for that individual could be asked the question.

Q0500: Return to Community (cont.)

Examples

1. Mr. B. is an 82-year-old male with COPD. He was referred to the nursing home by his physician for end-of-life palliative care. He responded, "I'm afraid I can't" to item Q0500B. The assessor should ask follow-up questions to understand why Mr. B. is afraid and explain that obtaining more information may help overcome some of his fears. He should also be informed that someone from a local agency is available to provide him with more information about receiving services and supports in the community. At the close of this discussion, Mr. B. says that he would like more information on community supports.

Coding: Q0500B would be coded 1, Yes.

Rationale: Coding Q0500B as yes should trigger a visit by the nursing home social worker (or facility social worker) to assess fears and concerns, with any additional follow-up care planning that is needed and to initiate contact with the designated local agency within approximately 10 business days.

2. Ms. C. is a 45-year-old woman with cerebral palsy and a learning disability who has been living in the Hope Nursing Home for the past 20 years. She once lived in a group home but became ill and required hospitalization for pneumonia. After recovering in the hospital, Ms. C. was sent to the nursing home because she now required regular chest physical therapy and was told that she could no longer live in her previous group home because her needs were more intensive. No one had asked her about returning to the community until now. When administered the MDS assessment, she responded yes to item Q0500B.

Coding: Q0500B would be coded 1, Yes.

Rationale: Ms. C.'s discussions with staff in the nursing home should result in a visit by the nursing home social worker or discharge planner. Her response should be noted in her care plan, and care planning should be initiated to assess her preferences and needs for possible transition to the community. Nursing home staff should contact the designated local contact agency within approximately 10 business days for them to initiate discussions with Ms. C. about returning to community living.

3. Mr. D. is a 65-year-old man with a severe heart condition and interstitial pulmonary fibrosis. At the last quarterly assessment, Mr. D. had been asked about returning to the community and his response was no. He also responds no to item Q0500B. The assessor should ask why he responded no. Depending on the response, follow-up questions could include, "Is it that you think you cannot get the care you need in the community? Do you have a home to return to? Do you have any family or friends to assist you in any way?" Mr. D. responds no to the follow-up questions and does not want to offer any more information or talk about it.

Coding: Q0500B would be coded 0, No.

Rationale: During this assessment, he was asked about returning to the community and he responded no.

Q0550: Resident's Preference to Avoid Being Asked Question Q0500B again

Q0550. Resident's Preference to Avoid Being Asked Question Q0500B Again	
Enter Code <input type="checkbox"/>	<p>A. Does the resident (or family or significant other or guardian, if resident is unable to respond) want to be asked about returning to the community on all assessments? (Rather than only on comprehensive assessments.)</p> <p>0. No - then document in resident's clinical record and ask again only on the next comprehensive assessment</p> <p>1. Yes</p> <p>8. Information not available</p>
Enter Code <input type="checkbox"/>	<p>B. Indicate information source for Q0550A</p> <p>1. Resident</p> <p>2. If not resident, then family or significant other</p> <p>3. If not resident, family or significant other, then guardian or legally authorized representative</p> <p>8. No information source available</p>

Item Rationale

Some individuals, such as those with cognitive impairments, mental illness, or end-stage life conditions, may be upset by asking them if they want to return to the community. CMS pilot tested Q0500 language and determined that respondents would be less likely to be upset by being asked if they want to talk to someone about returning to the community if they were given the opportunity to opt-out of being asked the question every quarter. The intent of the item is to achieve a better balance between giving residents a voice and a choice about the services they receive, while being sensitive to those individuals who may be unable to voice their preferences or be upset by being asked question Q0500B in the assessment process.

Coding Instructions for Q0550A, Does the resident, (or family or significant other or guardian, if resident is unable to respond) want to be asked about returning to the community on all assessments (rather than being asked yearly only on comprehensive assessments)?

- Code 0, No: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does not want to be asked again on quarterly assessments about returning to the community. Then document in resident's clinical record and ask question Q0500B again only on the next comprehensive assessment.
- Code 1, Yes: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does want to be asked the return to community question Q0500B on all assessments.
- Code 9, Information not available: if the resident cannot respond and the family or significant other is not available to respond on the resident's behalf and a guardian or legally authorized representative is not available or has not been appointed by the court.

Q0550: Resident's Preference to Avoid Being Asked Question Q0500B again (cont.)

Coding Instructions for Q0550B, Indicate information source for Q0550A

- Code 1, Resident: if resident responded to Q0550A.
- Code 2, If not resident, then family or significant other.
- Code 3, If not resident, family or significant other, then guardian or legally authorized representative.
- Code 8, No information source available: if the resident cannot respond and the family or significant other is not available to respond on the resident's behalf and a guardian or legally authorized representative is not available or has not been appointed by the court.

Example

1. Ms. W is an 81 year old woman who was admitted after a fall that broke her hip, wrist and collar bone. Her recovery is slow and her family visits regularly. Her apartment is awaiting her and she hopes within the next 4-6 months to be discharged home. She and her family requests that discharge planning occur when she can transfer and provide more self-care.

Coding: Q0550A would be coded 1, Yes.

Q0550B would be coded 1, Resident.

Rationale: Ms. W. needs longer term restorative nursing care to recover from her falls before she can return home. She has some elderly family members who will provide caregiver support. She will likely need community supports and the social worker will consult with LCA staff to consider community services and supports in advance of her discharge.

Q0600: Referral

Q0600. Referral	
Enter Code <input type="checkbox"/>	<p>Has a referral been made to the Local Contact Agency? (Document reasons in resident's clinical record)</p> <p>0. No - referral not needed</p> <p>1. No - referral is or may be needed (For more information see Appendix C, Care Area Assessment Resources #20)</p> <p>2. Yes - referral made</p>

Item Rationale

Health-related Quality of Life

- Returning home or to a non-institutional setting can be very important to the resident's health and quality of life.

Q0600: Referral (cont.)

Planning for Care

- Some nursing home residents may be able to return to the community if they are provided appropriate assistance and referral to appropriate community resources to facilitate care in a non-institutional setting.

Steps for Assessment: Interview Instructions

- If Item Q0400A is coded 1, yes, then complete this item.
- If Item Q0490B is coded 1, yes, then complete this item.
- If Item Q0500B is coded 1, yes, then complete this item.

Coding Instructions

- Code 0, No - referral not needed; determination has been made by the resident (or family or significant other, or guardian or legally authorized representative) and the care planning team that the designated local contact agency does not need to be contacted. If the resident's discharge planning has been completely developed by the nursing home staff, and there are no additional needs that the SNF/NF cannot arrange for, then there is no need for a LCA referral. Or, if resident or family, etc. responded no to Q0500B.
- Code 1, No - referral is or may be needed; determination has been made by the resident (or family or significant other, or guardian or legally authorized representative) that the designated local contact agency needs to be contacted but the referral has not been initiated at this time. If the resident has asked to talk to someone about available community services and supports and a referral is not made at this time, care planning and progress notes should indicate the status of discharge planning and why a referral was not initiated.
- Code 2, Yes - referral made; if referral was made to the local contact agency. For example, the resident responded yes to Q0500B. The facility care planning team was notified and initiated contact with the local contact agency.

DEFINITIONS

DESIGNATED LOCAL CONTACT AGENCY

Each state has community contact agencies that can provide individuals with information about community living options and available supports and services.

These local contact agencies may be a single entry point agency, an Aging and Disability Resource Center (ADRC), an Area Agency on Aging (AAA), a Center for Independent Living (CIL), or other state designated entities.

Section Q Point of Contact list for Local Contact Agencies:

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

Q0600: Referral (cont.)

Examples

1. Mr. S. is a 48-year-old man who suffered a stroke, resulting in paralysis below the waist. He is responsible for his 8-year old son, who now stays with his grandmother. At the last quarterly assessment, Mr. S. had been asked about returning to the community and his response was “Yes” to item Q0500B and he reports no contact from the LCA. Mr. S. is more hopeful he can return home as he becomes stronger in rehabilitation. He wants a location to be able to remain active in his son’s school and use accessible public transportation when he finds employment. He is worried whether he can afford or find accessible housing with wheelchair accessible sinks, cabinets, countertops and appliances.

Coding: Q0500B would be coded 1, Yes

Q0600 would be coded 2, Yes.

Rationale: The social worker or discharge planner would make a referral to the designated local contact agency for their area and Q0600 would be coded as 2, yes.

2. Ms. V. is an 82-year-old female with right sided paralysis, mild dementia, diabetes and was admitted by the family because of safety concerns because of falls and difficulties cooking and proper nutrition. She said yes to Q0500B. She needs to continue her rehabilitation therapy and regain her strength and ability to transfer. The social worker plans to talk to the resident and her family to determine whether a referral to the LCA is needed for Ms. V.

Coding: Q0600 would be coded 1, No.

Rationale: Ms. V indicated that she wanted to have an opportunity to talk to someone about return to community. The nursing home staff will focus on her therapies and talk to her and her family to obtain more information for discharge planning. Q0600 would be coded as no- “referral is or may be needed.” The Care Area Assessment #20 is triggered and it will be used to guide the follow-up process. Because a referral was not made at this time, care planning and progress notes should indicate the status of discharge planning and why a referral was not initiated to the designated local contact agency.

V0100: Items From the Most Recent Prior OBRA or PPS Assessment (cont.)

Coding Instructions for V0100B, Prior Assessment PPS Reason for Assessment (A0310B Value from Prior Assessment)

- Record in V0100B the value for A0310B (PPS Assessment) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see “Item Rationale”, above, for details). One of the available values (01 through 07 or 99) must be selected.

Note: The values for V0100A and V0100B cannot both be 99, indicating that the prior assessment is neither an OBRA nor a PPS assessment. If the value of V0100A is 99 (None of the above), then the value for V0100B must be 01 through 07, indicating a PPS assessment. If the value of V0100B is 99 (None of the above), then the value for V0100A must be 01 through 06, indicating an OBRA assessment.

Coding Instructions for V0100C, Prior Assessment Reference Date (A2300 Value from Prior Assessment)

- Record in V0100C the value of A2300 (Assessment Reference Date) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see “Item Rationale”, above, for details).

Coding Instructions for V0100D, Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 Value from Prior Assessment)

- Record in V0100D, the value for C0500 Mental Status (BIMS) Summary Score from the most recent prior OBRA or scheduled PPS assessment, if one is available (see “Item Rationale”, above, for details). This item will be compared with the corresponding item on the current assessment to evaluate resident improvement or decline in the Delirium care area.

Coding Instructions for V0100E, Prior Assessment Resident Mood Interview (PHQ-9[®]) Total Severity Score (D0300 Value from Prior Assessment)

- Record in V0100E the value of D0300 (Resident Mood Interview [PHQ-9[®]] Total Severity Score) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see “Item Rationale,” above, for details). This item will be compared with the corresponding item on the current assessment to evaluate resident decline in the Mood State care area.

Coding Instructions for V0100F, Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV[®]) Total Severity Score (D0600 Value from Prior Assessment)

- Record in V0100F the value for item D0600 (Staff Assessment of Resident Mood [PHQ-9-OV[®]] Total Severity Score) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see “Item Rationale”, above, for details). This item will be compared with the corresponding item on the current assessment to evaluate resident decline in the Mood State care area.

V0200: CAAs and Care Planning (cont.)

Item Rationale

- Items V0200A 01 through 20 document which triggered care areas require further assessment, decision as to whether or not a triggered care area is addressed in the resident care plan, and the location and date of CAA documentation. The CAA Summary documents the interdisciplinary team's and the resident, resident's family or representative's final decision(s) on which triggered care areas will be addressed in the care plan.

Coding Instructions for V0200A, CAAs

- Facility staff are to use the RAI triggering mechanism to determine which care areas require review and additional assessment. The triggered care areas are checked in Column A "Care Area Triggered" in the CAAs section. For each triggered care area, use the CAA process and current standard of practice, evidence-based or expert-endorsed clinical guidelines and resources to conduct further assessment of the care area. Document relevant assessment information regarding the resident's status. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation.
- For each triggered care area, Column B "Care Planning Decision" is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. The "Care Planning Decision" column must be completed within 7 days of completing the RAI, as indicated by the date in V0200C2, which is the date that the care planning decision(s) were completed and that the resident's care plan was completed. For each triggered care area, indicate the date and location of the CAA documentation in the "Location and Date of CAA Documentation" column. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation.

Coding Instructions for V0200B, Signature of RN Coordinator for CAA Process and Date Signed

V0200B1, Signature

- Signature of the RN coordinating the CAA process.

V0200B2, Date

- Date that the RN coordinating the CAA process certifies that the CAAs have been completed. The CAA review must be completed no later than the 14th day of admission (admission date + 13 calendar days) for an Admission assessment and within 14 days of the Assessment Reference Date (A2300) for an Annual assessment, Significant Change in Status Assessment, or a Significant Correction to Prior Comprehensive Assessment. This date is considered the date of completion for the RAI.

X0200: Name of Resident (cont.)

Coding Instructions for X0200C, Last Name

- Enter the last name of the resident exactly as submitted for item A0500C “Legal Name of Resident— Last Name” on the prior erroneous record to be modified/inactivated. Start entry with the leftmost box. The last name in X0200C cannot be blank.
- Note that the last name in X0200C does not have to match the current value of A0500C on a modification request. The entries may be different if the modification is correcting the last name.

X0300: Gender

X0300. Gender on existing record to be modified/inactivated	
Enter Code <input type="checkbox"/>	1. Male 2. Female

Coding Instructions for X0300, Gender

- Enter the gender code 1 “Male,” 2 “Female,” or – (dash value indicating unable to determine) exactly as submitted for item A0800 “Gender” on the prior erroneous record to be modified/inactivated.
- Although a dash (indicating unable to determine) is no longer an acceptable value in A0800, a dash must be used in X0300 on a modification or inactivation request to locate a record if a dash was previously entered in A0800 on the original record.
- Note that the gender in X0300 does not have to match the current value of A0800 on a modification request. The entries may be different if the modification is correcting the gender.

X0400: Birth Date

X0400. Birth Date on existing record to be modified/inactivated									
<input type="text"/>		-	<input type="text"/>		-	<input type="text"/>			
Month			Day			Year			

Coding Instructions for X0400, Birth Date

- Fill in the boxes with the birth date exactly as submitted for item A0900 “Birth Date” on the prior erroneous record to be modified/inactivated. If the month or day contains only a single digit, fill in the first box with a 0 For example, January 2, 1918, should be entered as:

0	1	0	2	1	9	1	8
---	---	---	---	---	---	---	---

If the birth date in MDS item A0900 on the prior record was a partial date, with day of the month unknown and the day of the month boxes were left blank, then the day of the month boxes must be blank in X0400. If the birth date in MDS item A0900 on the prior record was a partial date with both month and day of the month unknown and the month and day of the month boxes were left blank, then the month and day of the month boxes must be blank in X0400.

- Note that the birth date in X0400 does not have to match the current value of A0900 on a modification request. The entries may be different if the modification is correcting the birth date.

Z0400: Signatures of Persons Completing the Assessment or Entry/Death Reporting

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting			
<p>I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.</p>			
Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Item Rationale

- To obtain the signature of all persons who completed any part of the MDS. Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. Each person completing a section or portion of a section of the MDS is required to sign the Attestation Statement.
- The importance of accurately completing and submitting the MDS cannot be over-emphasized. The MDS is the basis for:
 - the development of an individualized care plan;
 - the Medicare Prospective Payment System
 - Medicaid reimbursement programs
 - quality monitoring activities, such as the quality indicator/quality measure reports
 - the data-driven survey and certification process
 - the quality measures used for public reporting
 - research and policy development.

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

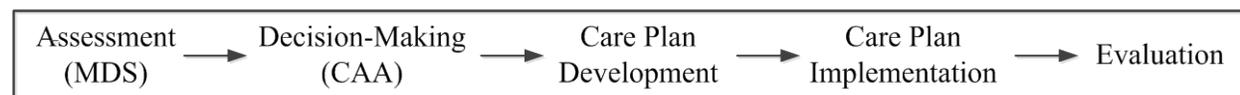
4.1 Background and Rationale

The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) mandated that nursing facilities provide necessary care and services to help each resident attain or maintain the highest practicable well-being. Facilities must ensure that residents improve when possible and do not deteriorate unless the resident's clinical condition demonstrates that the decline was unavoidable.

Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs, in relation to a number of specified areas (e.g., customary routine, vision, and continence). The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive plan of care.

This chapter provides information about the Care Area Assessments (CAAs), Care Area Triggers (CATs), and the process for care plan development for nursing home residents.

4.2 Overview of the Resident Assessment Instrument (RAI) and Care Area Assessments (CAAs)



As discussed in Chapter 1, the updated Resident Assessment Instrument (RAI) consists of three basic components: 1) the Minimum Data Set (MDS) Version 3.0, 2) the Care Area Assessment (CAA) process, and 3) the RAI Utilization Guidelines. The RAI-related processes help staff identify key information about residents as a basis for identifying resident-specific issues and objectives. In accordance with 42 CFR 483.20(k) the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and any services that would otherwise be required but are not provided due to the resident's exercise of rights including the right to refuse treatment.

The MDS is a starting point. The Minimum Data Set (MDS) is a standardized instrument used to assess nursing home residents. It is a collection of basic physical (e.g., medical conditions, mood, and vision), functional (e.g., activities of daily living, behavior), and psychosocial (e.g., preferences, goals, and interests) information about residents. For example, assessing a resident's orientation and recall helps staff complete portions of the MDS that relate to cognition (Section C), and weighing a resident and identifying his or her food intake helps staff complete portions

of the MDS related to nutritional status (Section K). When it is completed, the MDS provides a foundation for a more thorough assessment and the development of an individualized care plan. The MDS 3.0 manual explains in detail how to complete the MDS.

The information in the MDS constitutes the core of the required State-specified Resident Assessment Instrument (RAI). Based on assessing the resident, the MDS identifies actual or potential areas of concern. The remainder of the RAI process supports the efforts of nursing home staff, health professionals, and practitioners to further assess these triggered areas of concern in order to identify, to the extent possible, whether the findings represent a problem or risk requiring further intervention, as well as the causes and risk factors related to the triggered care area under assessment. These conclusions then provide the basis for developing an individualized care plan for each resident.

The CAA process framework. The CAA process provides a framework for guiding the review of triggered areas, and clarification of a resident's functional status and related causes of impairments. It also provides a basis for additional assessment of potential issues, including related risk factors. The assessment of the causes and contributing factors gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care.

When implemented properly, the CAA process should help staff:

- Consider each resident as a whole, with unique characteristics and strengths that affect his or her capacity to function;
- Identify areas of concern that may warrant interventions;
- Develop, to the extent possible, interventions to help improve, stabilize, or prevent decline in physical, functional, and psychosocial well-being, in the context of the resident's condition, choices, and preferences for interventions; and
- Address the need and desire for other important considerations, such as advanced care planning and palliative care; e.g., symptom relief and pain management.

4.3 What Are the Care Area Assessments (CAAs)?

The completed MDS must be analyzed and combined with other relevant information to develop an individualized care plan. To help nursing facilities apply assessment data collected on the MDS, Care Area Assessments (CAAs) are triggered responses to items coded on the MDS specific to a resident's possible problems, needs or strengths. Specific "CAT logic" for each care area is identified under section 4.10 (The Twenty Care Areas). The CAAs reflect conditions, symptoms, and other areas of concern that are common in nursing home residents and are commonly identified or suggested by MDS findings. Interpreting and addressing the care areas identified by the CATs is the basis of the Care Area Assessment process, and can help provide additional information for the development of an individualized care plan.

Additional evaluation is then required to identify whether the resident has delirium, dementia, or both; how current symptoms and patterns compare to their usual or previous baseline, whether potentially reversible causes are present, what else might be needed to identify underlying causes (including medical diagnoses and history), and what symptomatic and cause-specific interventions are appropriate for the resident. If the Nutritional Status (#12) CAA also triggered, due to weight loss and the resident being found to have delirium, then it is possible that both findings could have a common cause (e.g., an infection or medication side effects), that delirium resulted in impaired nutritional status, or that impaired nutritional status led to delirium, or still other possibilities. Thus, identifying the sequence of events is essential to understanding causes and choosing appropriate interventions.

The RAI is not intended to provide diagnostic advice, nor is it intended to specify which triggered areas may be related to one another or and how those problems relate to underlying causes. It is up to the IDT, including the resident's physician, to determine these connections and underlying causes as they assess the triggered care areas and any other areas pertinent to the individual resident.

Not all triggers identify deficits or problems. Some triggers indicate areas of resident strengths, and can suggest possible approaches to improve a resident's functioning or minimize decline. For example, MDS item responses indicate the "resident believes he or she is capable of increased independence in at least some ADLs" (Item G0900A) may focus the assessment and care plan on functional areas most important to the resident or on the area with the greatest potential for improvement.

In addition to identifying causes and risk factors that contribute to the resident's care area issues or conditions, the CAA process may help the IDT:

- Identify and address associated causes and effects;
- Determine whether and how multiple triggered conditions are related;
- Identify a need to obtain additional medical, functional, psychosocial, financial, or other information about a resident's condition that may be obtained from sources such as the resident, the resident's family or other responsible party, the attending physician, direct care staff, rehabilitative staff, or that requires laboratory and diagnostic tests;
- Identify whether and how a triggered condition actually affects the resident's function and quality of life, or whether the resident is at particular risk of developing the conditions;
- Review the resident's situation with a health care practitioner (e.g., attending physician, medical director, or nurse practitioner), to try to identify links among causes and between causes and consequences, and to identify pertinent tests, consultations, and interventions;
- Determine whether a resident could potentially benefit from rehabilitative interventions;
- Begin to develop an individualized care plan with measurable objectives and timetables to meet a resident's medical, functional, mental and psychosocial needs as identified through the comprehensive assessment.

4.5 Other Considerations Regarding Use of the CAAs

Assigning responsibility for completing the MDS and CAAs. Per the OBRA statute, the resident's assessment must be conducted or coordinated by a registered nurse (RN) with the appropriate participation of health professionals. It is common practice for facilities to assign specific MDS items or portion(s) of items (and subsequently CAAs associated with those items) to those of various disciplines (e.g., the dietitian completes the Nutritional Status and Feeding Tube CAAs, if triggered). The proper assessment and management of CAAs that are triggered for a given resident may involve aspects of diagnosis and treatment selection that exceed the scope of training or practice of any one discipline involved in the care (for example, identifying specific medical conditions or medication side effects that cause anorexia leading to a resident's weight loss). It is the facility's responsibility to obtain the input that is needed for clinical decision making (e.g., identifying causes and selecting interventions) that is consistent with relevant clinical standards of practice. For example, a physician may need to get a more detailed history or perform a physical examination in order to establish or confirm a diagnosis and/or related complications.

Identifying policies and practices related to the assessment and care planning processes.

Under the OBRA regulations, 42 CFR 483.75(i) identifies the medical director as being responsible for overseeing the "implementation of resident care policies" in each facility, "and the coordination of medical care in the facility." Therefore, it is recommended that the facility's IDT members collaborate with the medical director to identify current evidence-based or expert-endorsed resources and standards of practice that they will use for the expanded assessments and analyses that may be needed to adequately address triggered areas. The facility should be able to provide surveyors the resources that they have used upon request as part of the survey review process.¹

CAA documentation. CAA documentation helps to explain the basis for the care plan by showing how the IDT determined that the underlying causes, contributing factors, and risk factors were related to the care area condition for a specific resident; for example, the documentation should indicate the basis for these decisions, why the finding(s) require(s) an intervention, and the rationale(s) for selecting specific interventions. Based on the review of the comprehensive assessment, the IDT and the resident and/or the resident's representative determine the areas that require care plan intervention(s) and develop, revise, or continue the individualized care plan.

- Relevant documentation for each triggered CAA describes: causes and contributing factors;
- The nature of the issue or condition (may include presence or lack of objective data and subjective complaints). In other words, what exactly is the issue/problem for this resident and why is it a problem;
- Complications affecting or caused by the care area for this resident;
- Risk factors related to the presence of the condition that affects the staff's decision to proceed to care planning;

¹ In Appendix C, CMS has provided CAA resources that facilities may choose to use but that are neither mandatory nor endorsed by the government. Please note that Appendix C does not provide an all-inclusive list.

- Factors that must be considered in developing individualized care plan interventions, including the decision to care plan or not to care plan various findings for the individual resident;
- The need for additional evaluation by the attending physician and other health professionals, as appropriate;
- The resource(s), or assessment tool(s) used for decision-making, and conclusions that arose from performing the CAA;
- Completion of Section V (CAA Summary; see Chapter 3 for coding instructions) of the MDS.

Written documentation of the CAA findings and decision making process may appear anywhere in a resident's record; for example, in discipline-specific flow sheets, progress notes, the care plan summary notes, a CAA summary narrative, etc. Nursing homes should use a format that provides the information as outlined in this manual and the State Operations Manual (SOM). If it is not clear that a facility's documentation provides this information, surveyors may ask facility staff to provide such evidence.

Use the "Location and Date of CAA Documentation" column on the CAA Summary (Section V of the MDS 3.0) to note where the CAA information and decision making documentation can be found in the resident's record. Also indicate in the column "Care Planning Decision" whether the triggered care area is addressed in the care plan.

4.6 When Is the RAI Not Enough?

Federal requirements support a nursing home's ongoing responsibility to assess residents. The Quality of Care regulation requires that "each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care" (42 CFR 483.25 [F 309]).

Services provided or arranged by the nursing home must also meet professional standards of quality. Per 42 CFR 483.75(b), the facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. Furthermore, surveyor guidance within OBRA (e.g., F314 42 CFR 483.25(c) Pressure Sores and F329 42 CFR 483.25(l) Unnecessary Medications) identifies additional elements of assessment and care related to specific issues and/or conditions that are consistent with professional standards.

Therefore, facilities are responsible for assessing and addressing all care issues that are relevant to individual residents, regardless of whether or not they are covered by the RAI (42 CFR 483.20(b)), including monitoring each resident's condition and responding with appropriate interventions.

Limitations of the RAI-related instruments. The RAI provides tools related to assessment including substantial detail for completing the MDS, how CATs are triggered, and a framework for the CAA process. However, the process of completing the MDS and related portions of the

Table 2. Clinical Problem Solving and Decision Making Process Steps and Objectives

Process Step / Objectives *	Key Tasks **
<p>Recognition / Assessment</p> <p><i>Gather essential information about the individual</i></p>	<ul style="list-style-type: none"> – Identify and collect information that is needed to identify an individual’s conditions that enables proper definition of their conditions, strengths, needs, risks, problems, and prognosis – Obtain a personal and medical history – Perform a physical assessment
<p>Problem definition</p> <p><i>Define the individual's problems, risks, and issues</i></p>	<ul style="list-style-type: none"> – Identify any current consequences and complications of the individual's situation, underlying condition and illnesses, etc. – Clearly state the individual’s issues and physical, functional, and psychosocial strengths, problems, needs, deficits, and concerns – Define significant risk factors
<p>Diagnosis / Cause-and-effect analysis</p> <p><i>Identify physical, functional, and psychosocial causes of risks, problems, and other issues, and relate to one another and to their consequences</i></p>	<ul style="list-style-type: none"> – Identify causes of, and factors contributing to, the individual's current dysfunctions, disabilities, impairments, and risks – Identify pertinent evaluations and diagnostic tests – Identify how existing symptoms, signs, diagnoses, test results, dysfunctions, impairments, disabilities, and other findings relate to one another – Identify how addressing those causes is likely to affect consequences
<p>Identifying goals and objectives of care</p> <p><i>Clarify purpose of providing care and of specific interventions, and the criteria that will be used to determine whether the objectives are being met</i></p>	<ul style="list-style-type: none"> – Clarify prognosis – Define overall goals for the individual – Identify criteria for meeting goals
<p>Selecting interventions / planning care</p> <p><i>Identify and implement interventions and treatments to address the individual's physical, functional, and psychosocial needs, concerns, problems, and risks</i></p>	<ul style="list-style-type: none"> – Identify specific symptomatic and cause-specific interventions (physical, functional, and psychosocial) – Identify how current and proposed treatments and services are expected to address causes, consequences, and risk factors, and help attain overall goals for the individual – Define anticipated benefits and risks of various interventions – Clarify how specific treatments and services will be evaluated for their effectiveness and possible adverse consequences
<p>Monitoring of progress</p> <p><i>Review individual's progress towards goals and modify approaches as needed</i></p>	<ul style="list-style-type: none"> – Identify the individual’s response to interventions and treatments – Identify factors that are affecting progress towards achieving goals – Define or refine the prognosis – Define or refine when to stop or modify interventions – Review effectiveness and adverse consequences related to treatments – Adjust interventions as needed – Identify when care objectives have been achieved sufficiently to allow for discharge, transfer, or change in level of care

* Refers to key steps in the care delivery process, related to clinical problem solving and decision making

** Refers to key tasks at each step in the care delivery process

The care plan is driven not only by identified resident issues and/or conditions but also by a resident’s unique characteristics, strengths, and needs. A care plan that is based on a thorough

not need to be developed after each SCSA, SCPA, or Annual reassessment. Instead, the nursing home may revise an existing care plan using the results of the latest comprehensive assessment. Facilities should also evaluate the appropriateness of the care plan at all times including after Quarterly assessments, modifying as needed.

- 6) If the RAI (MDS and CAAs) is not completed until the last possible date (the end of calendar day 14 of the stay), many of the appropriate care area issues, risk factors, or conditions may have already been identified, causes may have been considered, and a preliminary care plan and related interventions may have been initiated. A complete care plan is required no later than 7 days after the RAI is completed.
- 7) Review of the CAAs after completing the MDS may raise questions about the need to modify or continue services. Conditions that originally triggered the CAA may no longer be present because they resolved, or consideration of alternative causes may be necessary because the initial approach to an issue, risk, or condition did not work or was not fully implemented.
- 8) On the Annual assessment, if a resident triggers the same CAA(s) that triggered on the last comprehensive assessment, the CAA should be reviewed again. Even if the CAA is triggered for the same reason (no difference in MDS responses), there may be a new or changed related event identified during CAA review that might call for a revision to the resident's plan of care. The IDT with the input of the resident, family or resident's representative determines when a problem or potential problem needs to be addressed in the care plan.
- 9) The RN Coordinator for the CAA process (V0200B1) does not need to be the same RN as the RN Assessment Coordinator who verifies completion of the MDS assessment (Z0500). The date entered in V0200B2 on the CAA Summary is the date on which the RN Coordinator for the CAA process verified completion of the CAAs, which includes assessment of each triggered care area and completion of the location and date of the CAA assessment documentation section. See Chapter 2 for detailed instructions on the RAI completion schedule.
- 10) The Signature of Person Completing Care Plan Decision (V0200C1) can be that of any person(s) who facilitates the care plan decision making. It is an interdisciplinary process. The date entered in V0200C2 is the day the RN certifies that the CAAs have been completed and the day V0200C1 is signed.

4.9 Using the Care Area Assessment (CAA) Resources

Based on the preceding discussions in this Chapter, the following summarizes the steps involved in the CAA process, for those facilities that choose to use the CAA resources in this manual.

Please note: Because MDS 3.0 trigger logic is complex, please refer to the CAT Logic tables within each CAA description (Section 4.10) for detailed information on triggers.

Step 1: Identification of Triggered CAAs. After completing the MDS, identify triggered care areas. Many facilities will use automated systems to trigger CAAs. The resulting set of triggered CAAs generated by the software program should be matched against the trigger definitions to make sure that triggered CAAs have been correctly identified. CMS has developed test files for

facility validation of a software program's triggering logic. Generally, software vendors use these test files to test their systems, but the nursing home is responsible for ensuring that the software is triggering correctly.

It is prudent to consider whether or not the software has triggered relevant CAAs for individual residents. For example, did the software miss some CAAs you thought should have been triggered? Do some of the CAAs seem to be missing and are there other CAAs triggered that you did not expect?

For nursing homes that do not use an automated system, the CAT logic will provide the information necessary to manually identify triggered CAAs. The CAT logic is found within the CAT logic tables of each care area's description in section 4.10. These tables provide the MDS items that trigger the 20 (twenty) care areas. Facilities are not required to use this information or to maintain it in the resident's clinical record. Rather, the information is a resource that may be used by the IDT members to determine which CAAs are triggered from a completed MDS.

To identify the triggered CAAs manually using the CAT logic tables in section 4.10:

1. Compare the completed MDS with the CAT logic tables to determine which CAAs have been triggered for review.
2. The CAT logic table will list the MDS item numbers and specific codes that will trigger the particular CAA. To identify a triggered CAA, match the resident's MDS item responses with the MDS item number(s) and code(s) for each care area as listed in the CAT logic tables within section 4.10. If a particular item response matches a code in the CAT logic table for a particular care area, read through the logic statement and qualifiers (i.e., 'IF', 'AND', and 'OR') for that particular care area to determine if that care area is triggered. This means that further assessment using the CAA process is required for that particular care area.
3. Note which CAAs are triggered by particular MDS items. If desired, circle or highlight the trigger indicator or the title of the column.
4. Continue through the CAT logic tables for each of the 20 (twenty) care areas matching recorded MDS item responses with trigger indicators until all triggered CAAs have been identified.
5. When the CAT logic review is completed, document on the CAA Summary which CAAs were triggered by checking the boxes in the column titled "Care Area Triggered."

Step 2: Analysis of Triggered CAAs. Review a triggered CAA by doing an in-depth, resident-specific assessment of the triggered condition in terms of the potential need for care plan interventions. While reviewing the CAA, consider what MDS items caused the CAA to be triggered. This is also an opportunity to consider any issues and/or conditions that may contribute to the triggered condition, but are not necessarily captured in MDS data. Review of CAAs helps staff to decide if care plan intervention is necessary, and what types of intervention may be appropriate.

Using the results of the assessment can help the interdisciplinary team (IDT) and the resident and/or resident's representative to identify areas of concern that:

- Warrant intervention;

- Affect the resident's capacity to help identify and implement interventions to improve, stabilize, or maintain current level of function to the extent possible, based upon the resident's condition and choices and preferences for interventions;
- Can help to minimize the onset or progression of impairments and disabilities; and
- Can help to address the need and desire for other specialized services (e.g. palliative care, including symptom relief and pain management).

Use the information gathered thus far to make a clear issue or problem statement. An issue or problem is different from a finding (e.g., a single piece of information from the MDS or a test result). The chief complaint (e.g., the resident has a headache, is vomiting, or is not participating in activities) is not the same thing as an issue or problem statement that clearly identifies the situation. Trying to care plan a chief complaint may lead to inappropriate, irrelevant, or problematic interventions.

Example:

Chief Complaint: New onset of falls

Problem Statement: Resident currently falling 2-3 times per week. Falls are preceded by lightheadedness. Most falls occurred after she stood up and started walking; a few falls occurred while attempting to stand up from a sitting or lying position.

It is clear that the problem statement reflects assessment findings from which the investigation may continue and relevant conclusions drawn.

While the CAAs can help the IDT identify conditions or findings that could potentially be a problem or risk for the resident, additional thought is needed to define these issues and determine whether and to what extent the care area issue and/or condition is a problem or issue needing an intervention (assessment, testing, treatment, etc.) or simply a minor or inconsequential finding that does not need additional care planning. For example, a resident may exhibit sadness without being depressed or may appear to be underweight despite having a stable nutritional status consistent with their past history. The IDT should identify and document the functional and behavioral implications of identified problematic issues/conditions, limitations, improvement possibilities, and so forth (e.g., how the condition is a problem for the resident; how the condition limits or impairs the resident's ability to complete activities of daily living; or how the condition affects the resident's well-being in some way).

Identify links among triggers and their causes. CMS does not require that each care area triggered be care planned separately. The IDT may find during their discussions that several problematic issues and/or conditions have a related cause, or they might identify that those issues and/or conditions stand alone and are unrelated. Goals and approaches for each problematic issue and/or condition may overlap, and consequently the IDT may decide to address the problematic issues and/or conditions collectively in the care plan.

For example, behavior, mood, cognition, communication, and psychosocial well-being typically have common risk factors and common or closely related causes of related impairments. Thus, the following CATs naturally coexist and could be combined, assessed through the CAA process, and care planned together as a starting point for any resident: Delirium (CAA #1), Cognitive

Loss/Dementia (CAA #2), Communication (CAA #4), Psychosocial Well-Being (CAA #7), Mood State (CAA #8) Behavioral Symptoms (CAA #9), and Psychotropic Drug Use (CAA #17).

Usually, illnesses and impairments happen in sequence (i.e., one thing leads to another, which leads to another, and so on). The symptom or trigger often represents only the most recent or most apparent finding in a series of complications or related impairments. Thus, a detailed history is often essential to identifying causes and selecting the most beneficial interventions, e.g., the sequence over time of how the resident developed incontinence, pain, or anorexia. While the MDS presents diverse information about residents, and the CAAs cover various implications and complications, neither one is designed to give a detailed or chronological medical, psychosocial, or personal history. For example, knowing that the Behavioral Symptoms CAA (#9) is triggered and that the resident also has a diagnosis of UTI is not enough information to know whether the diagnosis of UTI is old or new, whether there is any link between the behavioral issue and the UTI, and whether there are other conditions such as kidney stones or bladder obstruction that might be causing or predisposing the resident to a UTI.

It is the facility's responsibility to refer to sources as needed to help with clinical problem solving and decision making that is consistent with professional standards of practice. It is often necessary to involve the attending physician to identify specific underlying causes of problems, including multiple causes of a single problem or multiple problems or complications related to one or more underlying causes.

Steps 3 and 4: Decision Making and CAA Documentation. The care plan is driven not only by identified resident issues and/or conditions but also by a resident's unique characteristics, strengths, and needs. The resident, family, or resident's representative should be an integral part of the team care planning process. A care plan that is based on a thorough assessment, effective clinical decision making, and is compatible with professional standards of practice should support optimal approaches to addressing quality of care and quality of life needs of individual residents.

Key components of the care plan may include, but are not limited to the following:

- Specific interventions, including those that address common causes of multiple issues
- Additional follow-up and clarification
- Items needing additional assessment, testing, and review with the practitioner
- Items that may require additional monitoring but do not require other interventions

Staff who have participated in the assessment and who have provided pertinent information about the resident's status for triggered care areas should be a part of the IDT that develops the resident's care plan. In order to provide continuity of care for the resident and good communication with all persons involved in the resident's care, information from the assessment that led the team to their care planning decision should be clearly documented. **See Table 2. Clinical Problem Solving and Decision Making Process Steps and Objectives.**

Documentation related to CAAs should include the items previously discussed in Section 4.5.

4.10 The Twenty Care Areas

NOTE: Each of the following descriptions of the Twenty Care Areas includes a table listing the Care Area Trigger (CAT) logical specifications. For those MDS items that require a numerical response, the logical specifications will reference the numerical response that triggered the Care Area. For those MDS items that require a check mark response (e.g. H0100, J0800, K0510, etc.), the logical specifications will reference this response in numerical form when the check box response is one that triggers a Care Area. Therefore, in the tables below, when a check mark has been placed in a check box item on the MDS and triggers a Care Area, the logical specifications will reference a value of "1." Example: "H0100A=1" means that a check mark has been placed in the check box item H0100A. Similarly, the Care Area logical specifications will reference a value of "0" (zero) to indicate that a check box item is not checked. Example: "I4800=0" means that a check mark has not been placed in the check box item I4800.

1. Delirium

Delirium is acute brain failure caused by medical conditions, which presents with psychiatric symptoms, acute confusion, and fluctuations in levels of consciousness. It is a serious condition that can be caused by medical issues/conditions such as medication-related adverse consequences, infections, or dehydration. It can easily be mistaken for the onset or progression of dementia, particularly in individuals with more advanced pre-existing dementia.

Unlike dementia, delirium typically has a rapid onset (hours to days). Typical signs include fluctuating states of consciousness; disorientation; decreased environmental awareness and behavioral changes; difficulty paying attention; fluctuating behavior or cognitive function throughout the day; restlessness; sleepiness periodically during the day; rambling, nonsensical speech; and altered perceptions, such as misinterpretations (illusions), seeing or feeling things that are not there (hallucinations), or a fixed false belief (delusions).

Delirium CAT Logic Table

Triggering Conditions (any of the following):

1. Worsening mental status is indicated by the BIMS summary score having a non-missing value of 00 to 15 on both the current non-admission comprehensive assessment (A0310A = 03, 04 or 05) and the prior assessment, and the summary score on the current non-admission assessment being less than the prior assessment as indicated by:

(A0310A = 03, 04, OR 05) AND

((C0500 >= 0) AND (C0500 <= 15)) AND

((V0100D >= 0) AND (V0100D <= 15)) AND

(C0500 < V0100D)

2. Acute mental status change is indicated on the current comprehensive assessment as follows:

C1600 = 1

Delirium is never a part of normal aging, and it is associated with high mortality and morbidity unless it is recognized and treated appropriately. Staff who are closely involved with residents should report promptly any new onset or worsening of cognitive impairment and the other aforementioned symptoms in that resident.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered if the resident is exhibiting a worsening or an acute change in mental status.

The information gleaned from the assessment should be used to identify and address the underlying clinical issue(s) and/or condition(s), as well as to identify related underlying causes and contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying clinical issues/conditions identified through this assessment process (e.g., treating infections, addressing dehydration, identifying and treating hypo- or hyperthyroidism, relieving pain and depression, managing medications, and promoting adaptation and a comfortable environment for the resident to function. Other simple preventive measures that can be applied in all settings include addressing hearing and visual impairments to the extent possible (e.g., with the use of glasses and hearing aids) and minimizing the use of indwelling urinary catheters.

2. Cognitive Loss/Dementia

Cognitive prerequisites for an independent life include the ability to remember recent events and the ability to make safe daily decisions. Although the aging process may be associated with mild impairment, decline in cognition is often the result of other factors such as delirium, another mental health issue and/or condition, a stroke, and/or dementia. Dementia is not a specific condition but a syndrome that may be linked to several causes. According to the *Diagnostic and Statistical Manual, Fourth Edition, Text Revision* (DSM-IV-TR), the dementia syndrome is defined by the presence of three criteria: a short-term memory issue and/or condition and trouble with at least one cognitive function (e.g., abstract thought, judgment, orientation, language, behavior) and these troubles have an impact on the performance of activities of daily living. The cognitive loss/dementia CAA focuses on declining or worsening cognitive abilities that threaten personal independence and increase the risk for long-term nursing home placement or impair the potential for return to the community.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident has evidence of cognitive loss.

Cognitive Loss/Dementia CAT Logic Table

Triggering Conditions (any of the following):

1. BIMS summary score is less than 13 as indicated by:
C0500 >= 00 AND C0500 < 13
2. BIMS summary score has a missing value and there is a problem with short-term memory as indicated by:
**(C0500 = 99, -, OR ^) AND
(C0700 = 1)**
3. BIMS summary score has a missing value and there is a problem with long-term memory as indicated by:
**(C0500 = 99, -, OR ^) AND
(C0800 = 1)**
4. BIMS summary score has missing value of 99 or – and at least some difficulty making decisions regarding tasks of daily life as indicated by:
**(C0500 = 99, -, OR ^) AND
(C1000 >= 1 AND C1000 <= 3)**
5. BIMS, staff assessment or clinical record suggests presence of inattention, disorganized thinking, altered level of consciousness or psychomotor retardation as indicated by:
**(C1300A = 1 OR C1300A = 2) OR
(C1300B = 1 OR C1300B = 2) OR
(C1300C = 1 OR C1300C = 2) OR
(C1300D = 1 OR C1300D = 2)**
6. Presence of any behavioral symptom (verbal, physical or other) as indicated by:
**(E0200A >= 1 AND E0200A <= 3) OR
(E0200B >= 1 AND E0200B <= 3) OR
(E0200C >= 1 AND E0200C <= 3)**
7. Rejection of care occurred at least 1 day in the past 7 days as indicated by:
E0800 >= 1 AND E0800 <= 3
8. Wandering occurred at least 1 day in the past 7 days as indicated by:
E0900 >= 1 AND E0900 <= 3

The information gleaned from the assessment should be used to evaluate the situation, to identify and address (where possible) the underlying cause(s) of cognitive loss/dementia, as well as to identify any related possible contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. It is important to define the nature of the impairment, e.g., identify whether the cognitive issue and/or condition is new or a worsening or change in existing cognitive impairment—characteristics of potentially reversible delirium—or whether it indicates a long-term, largely irreversible cognitive loss. If the issue

and/or condition is apparently not related to reversible causes, assessment should focus on the details of the cognitive issue/condition (i.e., forgetfulness and/or impulsivity and/or behavior issues/conditions, etc.) and risk factors for the resident presented by the cognitive loss, to facilitate care planning specific to the resident's needs, issues and/or conditions, and strengths. The focus of the care plan should be to optimize remaining function by addressing underlying issues identified through this assessment process, such as relieving pain, optimizing medication use, ensuring optimal sensory input (e.g., with the use of glasses and hearing aids), and promoting as much social and functional independence as possible while maintaining health and safety.

3. Visual Function

The aging process leads to a decline in visual acuity, for example, a decreased ability to focus on close objects or to see small print, a reduced capacity to adjust to changes in light and dark and diminished ability to discriminate colors. The safety and quality consequences of vision loss are wide ranging and can seriously affect physical safety, self-image, and participation in social, personal, self-care, and rehabilitation activities.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident has a diagnosis of glaucoma, macular degeneration or cataracts or B1000 is coded 1-4.

Visual Function CAT Logic Table

Triggering Conditions (any of the following):

1. Cataracts, glaucoma, or macular degeneration on the current assessment as indicated by:

$$\mathbf{I6500 = 1}$$

2. Vision item has a value of 1 through 4 indicating vision problems on the current assessment as indicated by:

$$\mathbf{B1000 \geq 1 \text{ AND } B1000 \leq 4}$$

The information gleaned from the assessment should be used to identify and address the underlying cause(s) of the resident's declining visual acuity, identifying residents who have treatable conditions that place them at risk of permanent blindness (e.g., glaucoma, diabetes, retinal hemorrhage) and those who have impaired vision whose quality of life could be improved through use of appropriate visual appliances, as well as to determine any possibly related contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to prevent decline when possible and to enhance vision to the extent possible when reversal of visual impairment is not possible, as well as to address any underlying clinical issues and/or conditions identified through the CAA or subsequent assessment process. This might include treating infections and glaucoma or providing appropriate glasses or other visual appliances to improve visual acuity, quality of life, and safety.

4. Communication

Normal communication involves related activities, including expressive communication (making oneself understood to others, both verbally and via non-verbal exchange) and receptive communication (comprehending or understanding the verbal, written, or visual communication of others). Typical expressive issues and/or conditions include disruptions in language, speech, and voice production. Typical receptive communication issues and/or conditions include changes or difficulties in hearing, speech discrimination, vocabulary comprehension, and reading and interpreting facial expressions. While many conditions can affect how a person expresses and comprehends information, the communication CAA focuses on the interplay between the person's communication status and his or her cognitive skills for everyday decision making.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident's ability to hear, to express ideas and wants, or to understand verbal content may be impaired.

Communication CAT Logic Table

Triggering Conditions (any of the following):

1. Hearing item has a value of 1 through 3 indicating hearing problems on the current assessment as indicated by:

B0200 >= 1 AND B0200 <= 3

1. Impaired ability to make self understood through verbal and non-verbal expression of ideas/wants as indicated by:

B0700 >= 1 AND B0700 <= 3

2. Impaired ability to understand others through verbal content as indicated by:

B0800 >= 1 AND B0800 <= 3

The information gleaned from the assessment should be used to evaluate the characteristics of the problematic issue/condition and the underlying cause(s), the success of any attempted remedial actions, the person's ability to compensate with nonverbal strategies (e.g., the ability to visually follow non-verbal signs and signals), and the willingness and ability of caregivers to ensure effective communication. The assessment should also help to identify any related possible contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address any underlying issues/conditions and causes, as well as verbal and nonverbal strategies, in order to help the resident improve quality of life, health, and safety. In the presence of reduced language skills, both caregivers and the resident can strive to expand their nonverbal communication skills, for example, touch, facial expressions, eye contact, hand movements, tone of voice, and posture.

5. ADL Functional/Rehabilitation Potential

The ADL Functional/Rehabilitation CAA addresses the resident's self-sufficiency in performing basic activities of daily living, including dressing, personal hygiene, walking, transferring, toilet

use, bed mobility, and eating. Nursing home staff should identify and address, to the extent possible, any issues or conditions that may impair function or impede efforts to improve that function. The resident's potential for improved functioning should also be clarified before rehabilitation is attempted.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when a resident requires assistance to improve performance or to prevent avoidable functional decline.

The information gleaned from the assessment should be used to identify the resident's actual functional deficits and risk factors, as well as to identify any possible contributing and/or risk factors related to the functional issues/conditions. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause or causes, improving or maintaining function when possible, and preventing additional decline when improvement is not possible. An ongoing assessment is critical to identify and address risk factors that can lead to functional decline.

ADL Functional/Rehabilitation Potential CAT Logic Table

Triggering Conditions (any of the following):

1. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for bed mobility was needed as indicated by:

**(G0110A1 >= 1 AND G0110A1 <= 4) AND
((C1000 >= 0 AND C1000 <= 2) OR
(C0500 >= 5 AND C0500 <= 15))**

2. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for transfer between surfaces (excluding to/from bath/toilets) was needed as indicated by:

**(G0110B1 >= 1 AND G0110B1 <= 4) AND
((C1000 >= 0 AND C1000 <= 2) OR
(C0500 >= 5 AND C0500 <= 15))**

3. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for walking in his/her room was needed as indicated by:

**(G0110C1 >= 1 AND G0110C1 <= 4) AND
((C1000 >= 0 AND C1000 <= 2) OR
(C0500 >= 5 AND C0500 <= 15))**

4. Cognitive skills for daily decision making has a value of 0 through 2 or BIMS summary score is 5 or greater, while ADL assistance for walking in corridor was needed as indicated by:

-
8. Resident has one or more unhealed pressure ulcer(s) at Stage 2 or higher, or one or more likely pressure ulcers that are unstageable at this time as indicated by:

((M0300B1 > 0 AND M0300B1 <= 9) OR

(M0300C1 > 0 AND M0300C1 <= 9) OR

(M0300D1 > 0 AND M0300D1 <= 9) OR

(M0300E1 > 0 AND M0300E1 <= 9) OR

(M0300F1 > 0 AND M0300F1 <= 9) OR

(M0300G1 > 0 AND M0300G1 <= 9))

13. Feeding Tubes

This CAA focuses on the long-term (greater than 1 month) use of feeding tubes. It is important to balance the benefits and risks of feeding tubes in individual residents in deciding whether to make such an intervention a part of the plan of care. In some acute and longer term situations, feeding tubes may provide adequate nutrition that cannot be obtained by other means. In other circumstances, feeding tubes may not enhance survival or improve quality of life, e.g., in individuals with advanced dementia. Also, feeding tubes can be associated with diverse complications that may further impair quality of life or adversely impact survival. For example, tube feedings will not prevent aspiration of gastric contents or oral secretions and feeding tubes may irritate or perforate the stomach or intestines.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident has a need for a feeding tube for nutrition.

Feeding Tubes CAT Logic Table

Triggering Conditions (any of the following):

1. Feeding tube while NOT a resident or while a resident is used as nutritional approach as indicated by:

K0510B1 = 1 OR K0510B2 = 1

The information gleaned from the assessment should be used to identify and address the resident's status and underlying issues/conditions that necessitated the use of a feeding tube. In addition, the CAA information should be used to identify any related risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause(s), including any reversible issues and conditions that led to using a feeding tube.

Physical Restraints CAT Logic Table

Triggering Conditions (any of the following):

1. Bed rail restraint used in bed has value of 1 or 2 as indicated by:
P0100A = 1 OR P0100A = 2
2. Trunk restraint used in bed has value of 1 or 2 as indicated by:
P0100B = 1 OR P0100B = 2
3. Limb restraint used in bed has value of 1 or 2 as indicated by:
P0100C = 1 OR P0100C = 2
4. Other restraint used in bed has value of 1 or 2 as indicated by:
P0100D = 1 OR P0100D = 2
5. Trunk restraint used in chair or out of bed has value of 1 or 2 as indicated by:
P0100E = 1 OR P0100E = 2
6. Limb restraint used in chair or out of bed has value of 1 or 2 as indicated by:
P0100F = 1 OR P0100F = 2
7. Chair restraint that prevents rising used in chair or out of bed has value of 1 or 2 as indicated by:
P0100G = 1 OR P0100G = 2
8. Other restraint used in chair or out of bed has value of 1 or 2 as indicated by:
P0100H = 1 OR P0100H = 2

The information gleaned from the assessment should be used to identify the specific reasons for and the appropriateness of the use of the restraint and any adverse consequences caused by or risks related to restraint use.

The focus of an individualized care plan based directly on these conclusions should be to address the underlying physical or psychological condition(s) that led to restraint use. By addressing underlying conditions and causes, the facility may eliminate the medical symptom that led to using restraints. In addition, a review of underlying needs, risks, or issues/conditions may help to identify other potential kinds of treatments. The ultimate goal is to eliminate restraint use by employing alternatives. When elimination of restraints is not possible, assessment must result in using the least restrictive device possible.

19. Pain

Pain is “an unpleasant sensory and emotional experience associated with actual or potential tissue damage.” Pain can be affected by damage to various organ systems and tissues, for example, musculoskeletal (e.g., arthritis, fractures, injury from peripheral vascular disease, wounds), neurological (e.g., diabetic neuropathy, herpes zoster), and cancer. The presence of pain

CHAPTER 5: SUBMISSION AND CORRECTION OF THE MDS ASSESSMENTS

Nursing homes are required to submit Omnibus Budget Reconciliation Act required (OBRA) MDS records for all residents in Medicare- or Medicaid-certified beds regardless of the pay source. Skilled nursing facilities (SNFs) and hospitals with a swing bed agreement (swing beds) are required to transmit additional MDS assessments for all Medicare beneficiaries in a Part A stay reimbursable under the SNF Prospective Payment System (PPS).

5.1 Transmitting MDS Data

All Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Required MDS records are those assessments and tracking records that are mandated under OBRA and SNF PPS. Assessments that are completed for purposes other than OBRA and SNF PPS reasons are not to be submitted, e.g., private insurance, including but not limited to Medicare Advantage Plans. After completion of the required assessment and/or tracking records, each provider must create electronic transmission files that meet the requirements detailed in the current MDS 3.0 Data Submission Specifications available on the CMS MDS 3.0 web site at:

http://www.cms.gov/NursingHomeQualityInits/30_NHQIMDS30TechnicalInformation.asp

In addition, providers must be certain they are submitting MDS assessments under the appropriate authority. There must be a federal and/or state authority to submit MDS assessment data to the QIES ASAP system. The software used by providers should have a prompt for confirming the authority to submit each record.

The provider indicates the submission authority for a record in item A0410, Submission Requirement.

- Value = 1 Neither federal nor state required submission.
- Value = 2 State but not federal required submission (FOR NURSING HOMES ONLY).
- Value = 3 Federal required submission.

See Chapter 3 for details concerning the coding of item A0410, Submission Requirement. Note: CMS certified Swing Bed unit assessments are always Value 3, Federal required submission.

Providers must establish communication with the QIES ASAP system in order to submit a file. This is accomplished by using specialized communications software and hardware and the CMS wide area network. Details about these processes are available on the QIES Technical Support Office web site at: <https://www.qtso.com>.

Once communication is established with the QIES ASAP system, the provider can access the CMS MDS Welcome Page in the MDS system. This site allows providers to submit MDS assessment data and access various information sources such as Bulletins and Questions and Answers. The *Minimum Data Set (MDS) 3.0 Provider User's Guide* provides more detailed information about the MDS system. It is available on the QTSO MDS 3.0 web site at <https://www.qtso.com/mds30.html>.

When the transmission file is received by the QIES ASAP system, the system performs a series of validation edits to evaluate whether or not the data submitted meet the required standards. MDS records are edited to verify that clinical responses are within valid ranges and are consistent, dates are reasonable, and records are in the proper order with regard to records that were previously accepted by the QIES ASAP system for the same resident. The provider is notified of the results of this evaluation by error and warning messages on a Final Validation Report. All error and warning messages are detailed and explained in the *Minimum Data Set (MDS) 3.0 Provider User's Guide*.

5.2 Timeliness Criteria

In accordance with the requirements at 42 CFR §483.20(f)(1), (f)(2), and (f)(3), long-term care facilities participating in the Medicare and Medicaid programs must meet the following conditions:

- **Completion Timing:**
 - For all non-admission OBRA and PPS assessments, the MDS Completion Date (Z0500B) must be no later than 14 days after the Assessment Reference Date (ARD) (A2300).
 - For the Admission assessment, the MDS Completion Date (Z0500B) must be no later than 13 days after the Assessment Reference Date (ARD) (A2300).
 - For the Admission assessment, the Care Area Assessment (CAA) Completion Date (V0200B2) must be no more than 13 days after the Entry Date (A1600).
 - For the Annual assessment, the CAA Completion Date (V0200B2) must be no later than 14 days after the ARD (A2300).
 - For the other comprehensive MDS assessments, Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment, the CAA Completion Date (V0200B2) must be no later than 14 days from the ARD (A2300) and no later than 14 days from the determination date of the significant change in status or the significant error, respectively.
 - For Entry and Death in Facility tracking records, the MDS Completion Date (Z0500B) must be no later than 7 days from the Event Date (A1600 for an entry record; A2000 for a death-in-facility record).
- **State Requirements:** Many states have established additional MDS requirements for Medicaid payment and/or quality monitoring purposes. For information on state requirements, contact your State RAI Coordinator. (See Appendix B for a list of state RAI coordinators.)
- **Encoding Data:** Within 7 days after completing a resident's MDS assessment or tracking information, the provider should encode the MDS data (i.e., enter the information into the facility MDS software). The encoding requirements are as follows:

- For a comprehensive assessment (Admission, Annual, Significant Change in Status, and Significant Correction to Prior Comprehensive), encoding must occur within 7 days after the Care Plan Completion Date (V0200C2 + 7 days).
- For a Quarterly, Significant Correction to Prior Quarterly, Discharge, or PPS assessment, encoding must occur within 7 days after the MDS Completion Date (Z0500B + 7 days).
- For a tracking record, encoding should occur within 7 days of the Event Date (A1600 + 7 days for Entry records and A2000 + 7 days for Death in Facility records).
- **Submission Format:** For submission, the MDS data must be in record and file formats that conform to standard record layouts and data dictionaries, and pass standardized edits defined by CMS and the State. Each MDS record must be a separate file in a required XML format. The submission file is a compressed ZIP file that may contain multiple XML files. See the MDS 3.0 Data Submission Specifications on the CMS MDS 3.0 web site for details concerning file and record formats, XML structure, and ZIP files.
- **Transmitting Data:** Submission files are transmitted to the QIES ASAP system using the CMS wide area network. Providers must transmit all sections of the MDS 3.0 required for their State-specific instrument, including the Care Area Assessment Summary (Section V) and all tracking or correction information. Transmission requirements apply to all MDS 3.0 records used to meet both Federal and state requirements. Care plans are not required to be transmitted.
 - **Assessment Transmission:** Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days).
 - **Tracking Information Transmission:** For Entry and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date (A1600 + 14 days for Entry records and A2000 + 14 days for Death in Facility records).

Submission Time Frame for MDS Records

Type of Assessment/Tracking	Primary Reason (A0310A)	Secondary Reason (A0310B)	Entry/Discharge Reporting (A0310F)	Final Completion or Event Date	Submit By
Admission Assessment	01	All values	10, 11, 99	V0200C2	V0200C2 + 14
Annual Assessment	03	All values	10, 11, 99	V0200C2	V0200C2 + 14
Sign. Change in Status Assessment	04	All values	10, 11, 99	V0200C2	V0200C2 + 14
Sign. Correction to Prior Comprehensive Assessment.	05	All values	10, 11, 99	V0200C2	V0200C2 + 14
Quarterly Review Assessment.	02	All values	10, 11, 99	Z0500B	Z0500B +14
Sign. Correction Prior Quarterly Assessment.	06	All values	10, 11, 99	Z0500B	Z0500B + 14

(continued)

Submission Time Frame for MDS Records (continued)

Type of Assessment/Tracking	Primary Reason (A0310A)	Secondary Reason (A0310B)	Entry/Discharge Reporting (A0310F)	Final Completion or Event Date	Submit By
PPS Assessment	99	01 through 07	10, 11, 99	Z0500B	Z0500B + 14
Discharge Assessment	All values	All values	10 or 11	Z0500B	Z0500B + 14
Death in Facility Tracking	99	99	12	A2000	A2000 + 14
Entry Tracking	99	99	1	A1600	A1600 + 14
Correction Request (Modification or Inactivation)	N/A	N/A	N/A	X1100E	X1100E + 14

Table Legend:

Item	Description
V0200C2	Care Plan Completion Date: Date of the signature of the person completing the care planning decision on the Care Area Assessment (CAA) Summary sheet (Section V), indicating which Care Areas are addressed in the care plan. This is the date of care plan completion.
Z0500B	MDS Assessment Completion Date: Date of the RN assessment coordinator's signature, indicating that the MDS assessment is complete.
A2000	Date of discharge or death
A1600	Date of entry
X1100E	Date of the RN coordinator's signature on the Correction Request (Section X) certifying completion of the correction request information and the corrected assessment or tracking information.

- Assessment Schedule:** An OBRA assessment (comprehensive or quarterly) is due every quarter unless the resident is no longer in the facility. There should be no more than 92 days between OBRA assessments. An OBRA comprehensive assessment is due every year unless the resident is no longer in the facility. There should be no more than 366 days between comprehensive assessments. PPS assessments follow their own schedule. See Chapter 6 for details.

5.3 Validation Edits

The QIES ASAP system has validation edits designed to monitor the timeliness and accuracy of MDS record submissions. If transmitted MDS records do not meet the edit requirements, the system will provide error and warning messages on the provider's Final Validation Report.

Initial Submission Feedback. For each file submitted, the submitter will receive confirmation that the file was received for processing and editing by the MDS system. This confirmation information includes the file submission number as well as the date and time the file was received for processing.

Validation and Editing Process. Each time a user accesses the QIES ASAP system and transmits an MDS file, the QIES ASAP system performs three types of validation:

1. **Fatal File Errors.** If the file structure is unacceptable (e.g., it is not a ZIP file), the records in the ZIP file cannot be extracted, or the file cannot be read, then the file will be rejected. The Submitter Final Validation Report will list the Fatal File Errors. Files that are rejected must be corrected and resubmitted.
2. **Fatal Record Errors.** If the file structure is acceptable, then each MDS record in the file is validated individually for Fatal Record Errors. These errors include, but are not limited to:
 - Out of range responses (e.g., the valid codes for the item are 1, 2, 3, and 4 and the submitted value is a 6).
 - Inconsistent relationships between items. One example is a skip pattern violation. The resident is coded as comatose (B0100 = 1) but the Brief Interview for Mental Status is conducted (C0100 = 1). Another example is an inconsistent date pattern, such as the resident's Birth Date (Item A0900) is later than the Entry Date (Item A1600).

Fatal Record Errors result in rejection of individual records by the QIES ASAP system. The provider is informed of Fatal Record Errors on the Final Validation Report. Rejected records must be corrected and resubmitted.

3. **Non-Fatal Errors (Warnings).** The record is also validated for Non-Fatal Errors. Non-Fatal Errors include, but are not limited to, missing or questionable data of a non-critical nature or item consistency errors of a non-critical nature. Examples are timing errors. Timing errors for a Quarterly assessment include (a) the submission date is more than 14 days after the MDS assessment completion date (Z0500B) or (b) the assessment completion is more than 14 days after the ARD (A2300). Another example is a record sequencing error, where an Entry record (A0310F = 01) is submitted after a Quarterly assessment record (A0310A = 02) with no intervening discharge record (A0310F = 10, 11 or 12). Any Non-Fatal Errors are reported to the provider in the Final Validation Report as warnings. The provider must evaluate each warning to identify necessary corrective actions.

Storage to the QIES ASAP System. If there are any Fatal Record Errors, the record will be rejected and not stored in the QIES ASAP system. If there are no Fatal Record Errors, the record is loaded into the QIES ASAP system, even if the record has Non-Fatal Errors (Warnings).

Detailed information on the validation edits and the error and warning messages is available in the MDS 3.0 Data Submission Specifications on the CMS MDS 3.0 web site and in Section 5 of the *Minimum Data Set (MDS) 3.0 Provider User's Guide* on the QTSO MDS 3.0 web site.

5.4 Additional Medicare Submission Requirements that Impact Billing Under the SNF PPS

As stated in CFR §413.343(a) and (b), providers reimbursed under the SNF PPS “are required to submit the resident assessment data described at §483.20... in the manner necessary to administer the payment rate methodology described in §413.337.” This provision includes the

frequency, scope, and number of assessments required in accordance with the methodology described in CFR §413.337(c) related to the adjustment of the Federal rates for case mix. SNFs must submit assessments according to a standard schedule. This schedule must include performance of resident assessments in specified windows near the 5th, 14th, 30th, 60th, and 90th days of the Medicare Part A stay.

HIPPS Codes: Health Insurance Prospective Payment System (HIPPS) codes are billing codes used when submitting Medicare Part A SNF payment claims to the Part A/Part B Medicare Administrative Contractor (A/B MAC). The HIPPS code consists of five positions. The first three positions represent the Resource Utilization Group-IV (RUG-IV) case mix code for the SNF resident, and the last two positions are an Assessment Indicator (AI) code indicating which type of assessment was completed. Standard “grouper” logic and software for RUG-IV and the AI code are provided by CMS on the MDS 3.0 web site.

The standard grouper uses MDS 3.0 items to determine both the RUG-IV group and the AI code. It is anticipated that MDS 3.0 software used by the provider will incorporate the standard grouper to automatically calculate the RUG-IV group and AI code. Detailed logic for determining the RUG-IV group and AI code is provided in Chapter 6.

The HIPPS codes to be used for Medicare Part A SNF claims are included on the MDS. There are two different HIPPS codes.

1. The Medicare Part A HIPPS code (Item Z0100A) is most often used on the claim. The RUG version code in Item Z0100B documents which version of RUG-IV was used to determine the RUG-IV group in the Medicare Part A HIPPS code.
2. The Medicare non-therapy Part A HIPPS code (Item Z0150A) is used when the provider is required to bill the non-therapy HIPPS. An example when the non-therapy HIPPS is to be billed is when the resident has been receiving rehabilitation therapy (physical therapy, occupational therapy, and/or speech-language pathology services), all rehabilitation therapy ends, and the resident continues on Part A (see Chapter 6 for details, including other instances when this HIPPS code is used for billing purposes). The RUG version code in Item Z0150B documents which version of RUG-IV was used to determine the RUG-IV group in the Medicare non-therapy Part A HIPPS code.

There is also a Medicare Short Stay indicator (Item Z0100C) on the MDS. For a qualifying Medicare short stay, the RUG-IV grouper uses alternative rehabilitation classification logic when there has been insufficient time to establish a full rehabilitation regime. The standard grouper uses MDS 3.0 items to determine the Medicare short stay indicator. See Chapter 6 for details.

Both HIPPS codes (Z0100A and Z0150A), the RUG version codes (Z0100B and Z0150B), and the Medicare Short Stay indicator (Z0100C) must be submitted to the QIES ASAP system on all Medicare PPS assessment records (indicated by A0310B= 01, 02, 03, 04, 05, 06, or 07). All of these values are validated by the QIES ASAP system. The Final Validation Report will indicate if any of these items is in error and the correct value for an incorrect item. Note that an error in one of these items is usually a non-fatal warning and the record will still be accepted in the QIES ASAP system. A record will receive a fatal error (-3804) if the record is a Start of Therapy (SOT) Other Medicare-Required Assessment (OMRA) (A0310C = 1 or 3) and the QIES ASAP

system calculated value for the Medicare Part A HIPPS code (Z0100A) is not a group that begins with 'R', i.e., Rehabilitation Plus Extensive Services or Rehabilitation group.

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

5.5 MDS Correction Policy

Once completed, edited, and accepted into the QIES ASAP system, providers may not change a previously completed MDS assessment as the resident's status changes during the course of the resident's stay – the MDS must be accurate as of the ARD. Minor changes in the resident's status should be noted in the resident's record (e.g., in progress notes), in accordance with standards of clinical practice and documentation. Such monitoring and documentation is a part of the provider's responsibility to provide necessary care and services. A significant change in the resident's status warrants a new comprehensive assessment (see Chapter 2 for details).

It is important to remember that the electronic record submitted to and accepted into the QIES ASAP system is the legal assessment. Corrections made to the electronic record after QIES ASAP acceptance or to the paper copy maintained in the medical record are not recognized as proper corrections. It is the responsibility of the provider to ensure that any corrections made to a record are submitted to the QIES ASAP system in accordance with the MDS Correction Policy.

Several processes have been put into place to assure that the MDS data are accurate both at the provider and in the QIES ASAP system:

- If an error is discovered within 7 days of the completion of an MDS and before submission to the QIES ASAP system, the response may be corrected using standard editing procedures on the hard copy (cross out, enter correct response, initial and date) and/or correction of the MDS record in the facility's database. The resident's care plan should also be reviewed for any needed changes.
- Software used by the provider to encode the MDS must run all standard edits as defined in the data specifications released by CMS.
- Enhanced record rejection standards have been implemented in the QIES ASAP system.
- If an MDS record contains responses that are out of range, e.g., a 4 is entered when only 0-3 are allowable responses for an item, or item responses are inconsistent (e.g., a skip pattern is not observed), the record is rejected. Rejected records are not stored in the QIES ASAP database.
- If an error is discovered in a record that has been accepted by the QIES ASAP system, Modification or Inactivation procedures **must** be implemented by the provider to assure that the QIES ASAP system information is corrected.
- Clinical corrections must also be undertaken as necessary to assure that the resident is accurately assessed, the care plan is accurate, and the resident is receiving the necessary care. A Significant Change in Status Assessment (SCSA, Significant Correction to

Prior Quarterly (SCQA) or a Significant Correction to Prior Comprehensive (SCPA) may be needed as well as corrections to the information in the QIES ASAP system. An SCSA is required only if a change in the resident's clinical status occurred. An SCPA or SCQA is required when an uncorrected significant error is identified. See Chapter 2 for details.

The remaining sections of this chapter present the decision processes necessary to identify the proper correction steps. A flow chart is provided at the end of these sections that summarizes these decisions and correction steps.

5.6 Correcting Errors in MDS Records That Have Not Yet Been Accepted Into the QIES ASAP System

If an MDS assessment is found to have errors that incorrectly reflect the resident's status, then that assessment must be corrected. The correction process depends upon the type of error. MDS assessments that have not yet been accepted in the QIES ASAP system include 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. These records can generally be corrected and retransmitted without any special correction procedures, since they were never accepted by the QIES ASAP system. The paper copy should be corrected according to standard procedures detailed below.

Errors Identified During the Encoding Period

Facilities have up to 7 days to encode (enter into the software) and edit an MDS assessment after the MDS has been completed. Changes may be made to the electronic record for any item during the encoding and editing period, provided the response refers to the same observation period. To make revisions to the paper copy, enter the correct response, draw a line through the previous response without obliterating it, and initial and date the corrected entry. This procedure is similar to how an entry in the medical record is corrected.

When the data are encoded into the provider's MDS system from paper, the provider is responsible for verifying that all responses in the computer file match the responses on the paper form. Any discrepancies must be corrected in the computer file during the 7-day encoding period.

In addition, the provider is responsible for running encoded MDS assessment data against CMS and State-specific edits that software vendors are responsible for building into MDS Version 3.0 computer systems. For each MDS item, the response must be within the required range and also be consistent with other item responses. During this 7-day encoding period that follows the completion of the MDS assessment, a provider may correct item responses to meet required edits. Only MDS assessments that meet all of the required edits are considered complete. For corrected items, the provider must use the same observation period as was used for the original item completion (i.e., the same ARD (A2300) and look-back period). Both the electronic and paper copies of the MDS must be corrected.

Errors Identified After the Encoding Period

Errors identified after the encoding and editing period must be corrected within 14 days after identifying the errors. If the record in error is an Entry tracking record, Death in Facility tracking record, Discharge assessment, or PPS assessment record (i.e., MDS Item A0310A = 99), then the record should be corrected and submitted to the QIES ASAP system. The correction process may be more complex if the record in error is an OBRA comprehensive or quarterly assessment record (i.e., Item A0310A = 01 through 06).

Significant versus Minor Errors in a Nursing Home OBRA Comprehensive or Quarterly Assessment Record. OBRA comprehensive and Quarterly assessment errors are classified as significant or minor errors. Errors that inaccurately reflect the resident's clinical status and/or result in an inappropriate plan of care are considered **significant errors**. All other errors related to the coding of MDS items are considered **minor errors**.

If the only errors in the OBRA comprehensive or Quarterly assessment are minor errors, then the only requirement is for the record to be corrected and submitted to the QIES ASAP system.

The correction process is more complicated for nursing home OBRA comprehensive or Quarterly assessments with **any significant errors** identified after the end of the 7-day encoding and editing period but before the records have been accepted into the QIES ASAP system. First, the nursing home must correct the original OBRA comprehensive or Quarterly assessment to reflect the resident's actual status as of the ARD for that original assessment and submit the record. Second, to insure an up-to-date view of the resident's status and an appropriate care plan, the nursing home must perform an additional new assessment, either a Significant Change in Status Assessment or Significant Correction to Prior Assessment with a current observation period and ARD. If correction of the error on the MDS revealed that the resident's status met the criteria for a Significant Change in Status Assessment, then a Significant Change in Status assessment is required. If the criteria for a Significant Change in Status Assessment are not met, then a Significant Correction to Prior Assessment is required. See Chapter 2 for details.

In summary, the nursing home must take the following actions for an OBRA comprehensive or Quarterly assessment that has **not** been submitted to the QIES ASAP system when it contains significant errors:

- Correct the errors in the original OBRA comprehensive or quarterly assessment.
- Submit the corrected assessment.
- Perform a **new** assessment – a Significant Change in Status Assessment or a Significant Correction to Prior Assessment and update the care plan as necessary.

If the assessment was performed for Medicare purposes only (A0310A = 99 and A0310B = 01 through 07) or for a discharge (A0310A = 99 and A0310F = 10 or 11), no Significant Change in Status Assessment or Significant Correction to Prior Assessment is required. The provider would determine if the Medicare-required or Discharge assessment should be modified or inactivated. Care Area Assessments (Section V) and updated care planning are not required with Medicare-only and Discharge assessments.

5.7 Correcting Errors in MDS Records That Have Been Accepted Into the QIES ASAP System

Facilities should correct any errors necessary to insure that the information in the QIES ASAP system accurately reflects the resident's identification, location, overall clinical status, or payment status. A correction can be submitted for any accepted record, regardless of the age of the original record. A record may be corrected even if subsequent records have been accepted for the resident.

Errors identified in QIES ASAP system records must be corrected within 14 days after identifying the errors. Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, software product errors, item coding errors or other errors. The following two processes have been established to correct MDS records (assessments, Entry tracking records or Death in Facility tracking records) that have been accepted into the QIES ASAP system:

- Modification
- Inactivation

A Modification request moves the inaccurate record into history in the QIES ASAP system and replaces it with the corrected record as the active record. An Inactivation request also moves the inaccurate record into history in the QIES ASAP system, but does not replace it with a new record. Both the Modification and Inactivation processes require the MDS Correction Request items to be completed in Section X of the MDS 3.0.

The MDS Correction Request items in Section X contain the minimum amount of information necessary to enable location of the erroneous MDS record previously submitted and accepted into the QIES ASAP system. Section X items are defined in the MDS 3.0 Data Submission Specifications posted on the CMS MDS 3.0 web site.

When a facility maintains the MDS electronically without the use of electronic signatures, a hard copy of the Correction Request items in Section X must be kept with the corrected paper copy of the MDS record in the clinical file to track the changes made with the modification. In addition, the facility would keep a hard copy of the Correction Request items (Section X) with an inactivated record. For details on electronic records, see Chapter 2, Section 2.4.

Modification Requests

A Modification Request should be used when an MDS record (assessment, Entry tracking record or Death in Facility tracking record) is in the QIES ASAP system, but the information in the record contains clinical or demographic errors.

The Modification Request is used to modify most MDS items, including:

- Target Date
 - Entry Date (Item A1600) on an Entry tracking record (Item A0310F = 1)
 - Discharge Date (Item A2000) on a Discharge/Death in Facility record (Item A0310F = 10, 11, 12),

- Assessment Reference Date (Item A2300) on an OBRA or PPS assessment.*
- Type of Assessment (Item A0310)**
- Clinical Items (Items B0100-V0200C)

*Note: The ARD (Item A2300) can be changed when the ARD on the assessment represents a data entry/typographical error. However, the ARD cannot be altered if it results in a change in the look back period and alters the actual assessment timeframe. Consider the following examples:

- When entering the assessment into the facility's software, the ARD, intended to be 02/12/2013, was inadvertently entered as 02/02/2013. The interdisciplinary team (IDT) completed the assessment based on the ARD of 2/12/2013 (that is, the seven day look back was 2/06/2012 through 2/12/2013. This would be an acceptable use of the modification process to modify the ARD (A2300) to reflect 02/12/2013.
- An assessment was completed by the team and entered into the software based on the ARD of 1/10/2013 (and seven day look back of 1/04/2013 through 1/10/2013). Three weeks later, the IDT determines that the date used represents a date that is not compliant with the PPS schedule and proposes changing the ARD to 1/07/2013. This would alter the look back period and result in a new assessment (rather than correcting a typographical error); this would not be an acceptable modification and shall not occur.

**Note: The Type of Assessment items (Item A0310) can only be modified when the Item Set Code (ISC) of that assessment does not change. In other words, if the Item Subset (full list can be found in Chapter 2, Section 2.5) would change, the modification cannot be done. Consider the following examples:

- A stand-alone Discharge assessment (ISC = ND) was completed and accepted into the ASAP system. The provider later (that is, after the day of discharge) determined that the assessment should have been a 30-day PPS assessment combined with a Discharge assessment (ISC = NP). This modification would not be allowed as the ISC for the Discharge assessment combined with the 30-day PPS is different than the stand-alone Discharge ISC. This is an example of a missing 30-day assessment.
- An Admission assessment (ISC = NC) was completed and accepted into the ASAP system. The provider intended to code the assessment as an Admission and a 5-day PPS assessment (ISC = NC). The modification process could be used in this case as the ISC would not change.

There are a few items for which the modification process shall not be used. These items require the following correction measures if an error is identified:

- An Inactivation of the existing record followed by submission of a new corrected record is required to correct an error of the Type of Provider (Item A0200)
- An MDS 3.0 Manual Assessment Correction/Deletion Request is required to correct:
 - Submission Requirement (Item A0410),
 - State-assigned facility submission ID (FAC_ID),
 - Production/test code (PRODN_TEST_CD).

See Section 5.8 for details on the MDS 3.0 Manual Assessment Correction/Deletion Request.

When an error is discovered (except for those items listed in the preceding paragraph and instances listed in Section 5.8) in an MDS 3.0 Entry tracking record, Death in Facility tracking record, Discharge assessment, or PPS assessment that is not an OBRA assessment (where Item A0310A = 99), the provider must take the following actions to correct the record:

1. Create a corrected record with all items included, not just the items in error.
2. Complete the required Correction Request Section X items and include with the corrected record. Item A0050 should have a value of 2, indicating a modification request.
3. Submit this modification request record.

If errors are discovered in a nursing home OBRA comprehensive or Quarterly assessment (Item A0310A = 01 through 06) in the QIES ASAP system, then the nursing home must determine if there are any significant errors. If the *only errors are minor errors*, the nursing home must take the following actions to correct the OBRA assessment:

1. Create a corrected record with all items included, not just the items in error.
2. Complete the required Correction Request Section X items and include with the corrected record. Item A0050 should have a value of 2, indicating a modification request.
3. Submit this modification request record.

When any *significant error* is discovered in an OBRA comprehensive or Quarterly assessment in the QIES ASAP system, the nursing home must take the following actions to correct the OBRA assessment:

1. Create a corrected record with all items included, not just the items in error.
2. Complete the required Correction Request Section X items and include with the corrected record. Item A0050 should have a value of 2, indicating a modification request.
3. Submit this modification request record.
4. Perform a *new* Significant Correction to Prior Assessment or Significant Change in Status Assessment and update the care plan as necessary.

A Significant Change in Status Assessment would be required only if correction of the MDS item(s) revealed that the resident met the criteria for a Significant Change in Status Assessment.

If criteria for Significant Change in Status Assessment were not met, then a Significant Correction to Prior Assessment is required.

When errors in an OBRA comprehensive or Quarterly assessment in the QIES ASAP system have been corrected in a more current OBRA comprehensive or Quarterly assessment (Item A0310A = 01 through 06), the nursing home is not required to perform a new additional assessment (Significant Change in Status or Significant Correction to Prior assessment). In this situation, the nursing home has already updated the resident's status and care plan. However, the nursing home must use the Modification process to assure that the erroneous assessment residing in the QIES ASAP system is corrected.

Inactivation Requests

An Inactivation should be used when a record has been accepted into the QIES ASAP system but the corresponding event did not occur. For example, a Discharge assessment was submitted for a resident but there was no actual discharge. An Inactivation (Item A0050 = 3) **must** be completed when any of the following items are inaccurate:

- Type of Provider (Item A0200)
- Type of Assessment (A0310) **when the Item Subset would change had the MDS been modified**
- Entry Date (Item A1600) on an Entry tracking record (Item A0310F = 1) **when the look-back period and/or clinical assessment would change had the MDS been modified**
- Discharge Date (Item A2000) on a Discharge/Death in Facility record (Item A0310F = 10, 11, 12) **when the look-back period and/or clinical assessment would change had the MDS been modified**
- Assessment Reference Date (Item A2300) on an OBRA or PPS assessment **when the look-back period and/or clinical assessment would change had the MDS been modified**

When inactivating a record, the provider is required to submit an electronic Inactivation Request record. This record is an MDS record but only the Section X items and Item A0050 are completed. This is sufficient information to locate the record in the QIES ASAP system, inactivate the record and document the reason for inactivation.

For instances when the provider determines that the Type of Provider is incorrect, the provider must inactivate the record in the QIES ASAP system, then complete and submit a new MDS 3.0 record with the correct Type of Provider, ensuring that the clinical information is accurate.

Inactivations should be rare and are appropriate only under the narrow set of circumstances that indicate a record is invalid.

In such instances a new ARD date must be established based on MDS requirements, which is the date the error is determined or later, but not earlier. The new MDS 3.0 record being submitted to replace the inactivated record must include new signatures and dates for all items based on the look-back period established by the new ARD and according to established MDS assessment completion requirements.

5.8 Special Manual Record Correction Request

A few types of errors in a record in the QIES ASAP system cannot be corrected with an automated Modification or Inactivation request. These errors are:

1. The record is a test record inadvertently submitted as production.

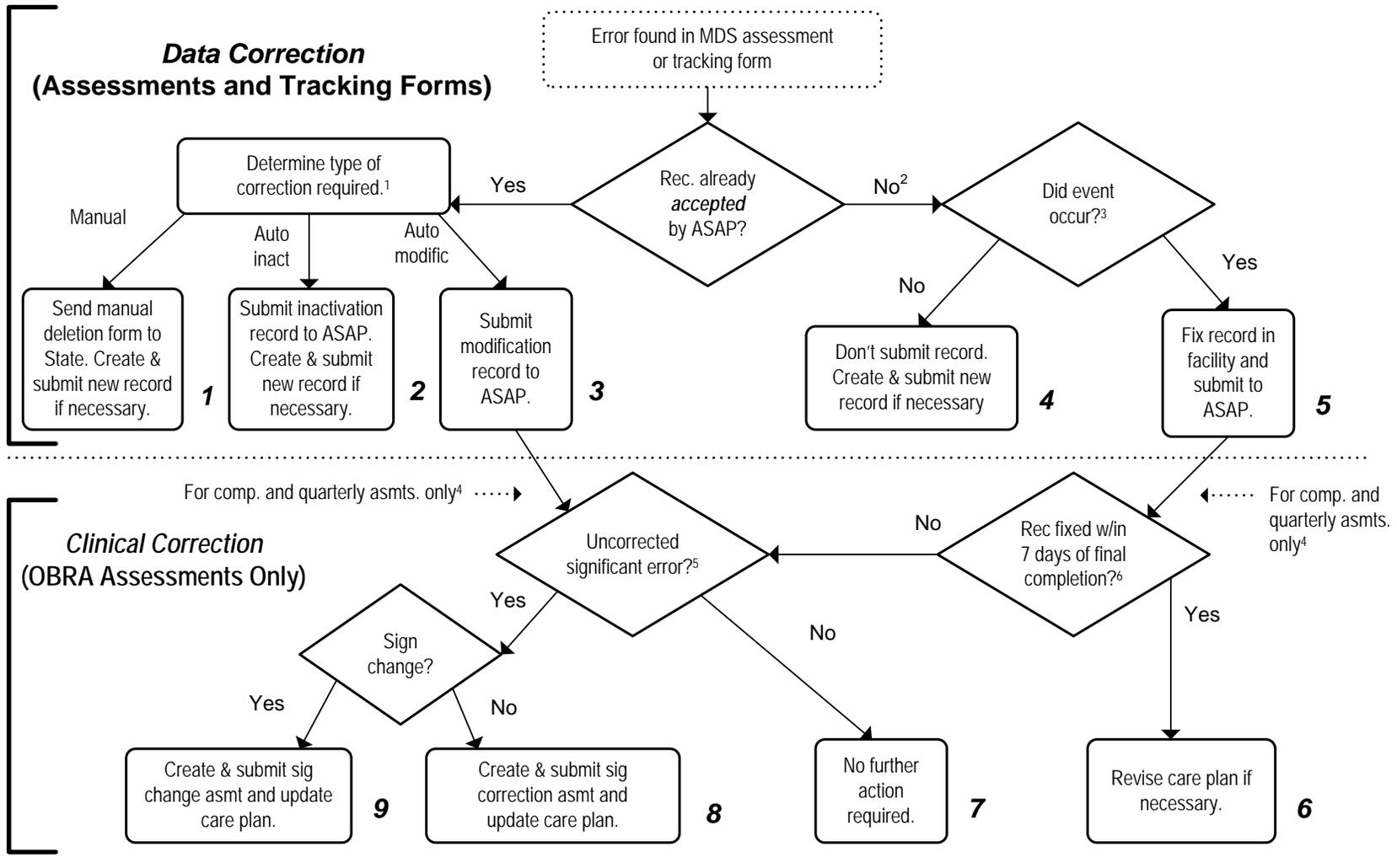
2. The record has the wrong submission requirement in Item A0410.
3. The record has the wrong facility ID in the control Item FAC_ID.

In all of these cases, the facility must contact the State Agency to have the problems fixed. The State Agency will send the facility the MDS 3.0 Manual Assessment Correction/Deletion Request form. The facility is responsible for completing the form. The facility **must** submit the completed form to the State Agency via certified mail through the United States Postal Service (USPS). The State Agency **must** approve the provider's request and submit a signed form to the QIES Help Desk via certified mail through the USPS.

When a test record is in the QIES ASAP system, the problem must be manually evaluated in the QIES ASAP system and the QIES ASAP system appropriately corrected. A normal Inactivation request will not totally fix the problem, since it will leave the test record in a history file and may also leave information about a fictitious resident. Manual correction is necessary to completely remove the test record and associated information.

A QIES ASAP system record with an incorrect submission requirement in Item A0410 is a very serious problem. Submission of MDS assessment records to the QIES ASAP system constitutes a release of private information and must conform to privacy laws. Item A0410 is intended to allow appropriate privacy safeguards, controlling who can access the record and whether the record can even be accepted into the QIES ASAP system. A normal Modification or Inactivation request cannot be used to correct the A0410 value, since a copy of the record in error will remain in the QIES ASAP system history file with the wrong access control. Consider a record in the QIES ASAP system with an A0410 value of 3 (federal submission requirement) but there was actually no state or federal requirement for the record (A0410 should have been 1). The record should not be in the QIES ASAP system at all and manual correction is necessary to completely remove the record from the QIES ASAP system. Consider a record with an A0410 value of 3 (federal submission requirement) but the record is only required by the state (A0410 should have been 2). In this case there is both federal and state access to the record, but access should be limited to the state. Manual correction is necessary to correct A0410 and reset access control, without leaving a copy of the record with the wrong access in the QIES ASAP system history file.

If a QIES ASAP system record has the wrong main facility ID (control item FAC_ID), then the record must be removed without leaving any trace in the QIES ASAP system. The record also should be resubmitted with the correct FAC_ID value when indicated.



¹Manual deletion request is required if test record submitted as production record, if record contains incorrect FAC_ID, or if record was submitted with an incorrect submission requirement value (A0410), for example send in as federally required (A0410 = 3) but should have been state required (A0410 = 2). Otherwise, automated inactivation or modification required: (a) if event did not occur (see note #3 below), submit automated inactivation, (b) if event occurred, submit automated modification.

²Record has not been data entered, has not been submitted, or has been submitted and rejected by ASAP.

³The event occurred if the record reflects an actual entry or discharge or if an assessment was actually performed for the resident. If a record was created in error (e.g., a discharge was created for a resident who was not actually discharged), then the event did not occur.

⁴OBRA comprehensive assessments with A0310 A=01,03,04,05 and quarterly assessments with A0310B=02,06.

⁵The assessment contains a significant error which has not been corrected by a subsequent assessment.

⁶Final completion date is item V0200C2 for a comprehensive and Z0500B for all other assessments.

Track Changes
from Title Page V1.09
to Title Page V1.10

Chapter	Section	Page	Change
Title Page	-	-	October, 2012 May 2013

**Track Changes
from Table of Contents V1.09
to Table of Contents V1.10**

Chapter	Section	Page	Change
1	-	i	Chapter 1: Resident Assessment Instrument (RAI) (V1.0910)
2	-	i	Chapter 2: Assessments for the Resident Assessment Instrument (RAI) (V1.0910)
3	-	i	Chapter 3: Overview to the Item-by-Item Guide to the MDS 3.0 Section A Identification Information (V1.0910)..... A-1 Section B Hearing, Speech, and Vision (V1.0510) B-1 Section C Cognitive Patterns (V1.0810) C-1 Section D Mood (V1.0510)..... D-1 Section E Behavior (V1.0810)..... E-1 Section F Preferences for Customary Routine and Activities (V1.05).....F-1 Section G Functional Status (V1.0810)..... G-1 Section H Bladder and Bowel (V1.0410)..... H-1 Section I Active Diagnoses (V1.0910)..... I-1 Section J Health Conditions (V1.08) J-1 Section K Swallowing/Nutritional Status (V1.0910) K-1 Section L Oral/Dental Status (V1.0410) L-1 Section M Skin Conditions (V1.0910)..... M-1 Section N Medications (V1.09)..... N-1 Section O Special Treatments, Procedures, and Programs (V1.0910) O-1 Section P Restraints (V1.0410)..... P-1 Section Q Participation in Assessment and Goal Setting (V1.0810)..... Q-1 Section S (Reserved)..... S-1 Section V Care Area Assessment (CAA) Summary (V1.0810)..... V-1 Section X Correction Request (V1.0910)..... X-1 Section Z Assessment Administration (V1.0810) Z-1
4	-	ii	Chapter 4: Care Area Assessment (CAA) Process and Care Planning (V1.0910)
4	-	ii	Chapter 5: Submission and Correction of the MDS Assessments (V1.0910) 5.8 Special Manual Record Correction Request 5-4213

**Track Changes
from Chapter 1 V1.09
to Chapter 1 V1.10**

Chapter	Section	Page	Change			
1	-	1-1	<ul style="list-style-type: none"> Linda Drummond, MSNM Jennifer Pettis, RN, BS, WCC 			
1	-	1-3	<ul style="list-style-type: none"> Jemima Drake, RN Shelly Ray, RN 			
1	1.2	1-6	<p>— Care Area Assessment is the further investigation of triggered areas, to determine if the care area triggers require interventions and care planning. The CAA resources are provided as a courtesy to facilities in Appendix C. These resources include a compilation of checklists and Web links that may be helpful in performing the assessment of a triggered care area. The use of these resources are not mandatory and represent neither an all-inclusive list nor government endorsement.</p>			
1	1.3	1-7	<ul style="list-style-type: none"> Medicaid Payment Systems. The MDS contains items... 			
1	1.3	1-7	<ul style="list-style-type: none"> Consumer Access to Nursing Home Information. Consumers are also able to access information about every Medicare- and/or Medicaid-certified nursing home in the country. The Nursing Home Compare tool (http://www.medicare.gov/NHCompare) provides public access to nursing home characteristics, staffing and quality of care measures for certified nursing homes. 			
1	1.3	1-8	<p>Given the requirements of participation of appropriate health professionals and direct care staff, completion of the RAI is best accomplished by an interdisciplinary team (IDT) that includes nursing home staff with varied clinical backgrounds, including nursing staff and the resident’s physician. Such a team brings their combined experience and knowledge to the table in providing an understanding of the strengths, needs and preferences of a resident to ensure the best possible quality of care and quality of life. It is important to note that even nursing homes that have been granted a RN waiver under 42 CFR 483.30 (c) or (d) must provide an RN to conduct or coordinate the assessment and sign off the assessment as complete.</p>			
1	1.7	1-14	<table border="0"> <tr> <td style="text-align: center; vertical-align: middle;">A</td> <td style="vertical-align: middle;">Identification Information</td> <td style="vertical-align: middle;">Obtain key information to uniquely identify each resident, nursing home, type of record, and reasons for assessment.</td> </tr> </table>	A	Identification Information	Obtain key information to uniquely identify each resident, nursing home, type of record, and reasons for assessment.
A	Identification Information	Obtain key information to uniquely identify each resident, nursing home, type of record, and reasons for assessment.				
1	1.7	1-14	<table border="0"> <tr> <td style="text-align: center; vertical-align: middle;">X</td> <td style="vertical-align: middle;">Correction Request</td> <td style="vertical-align: middle;">Indicate whether an MDS record is a new record to be added to the QIES ASAP system or a Request to modify or inactivate a record already present in the QIES ASAP database.</td> </tr> </table>	X	Correction Request	Indicate whether an MDS record is a new record to be added to the QIES ASAP system or a Request to modify or inactivate a record already present in the QIES ASAP database.
X	Correction Request	Indicate whether an MDS record is a new record to be added to the QIES ASAP system or a Request to modify or inactivate a record already present in the QIES ASAP database.				
1	1.8	1-15	<p>Contractual Agreements</p> <p>Providers, who are part of a multi-facility corporation, may release</p>			

**Track Changes
from Chapter 1 V1.09
to Chapter 1 V1.10**

Chapter	Section	Page	Change
			data to their corporate office or parent company but not to other providers within their multi-facility corporation one-organization . The parent company is required to “act” in the same manner as the facility and is permitted to use data only to the extent the facility is permitted to do so (as described in the 42 CFR at 483.10(e)(3)).
1	1.8	1-16	PAGE LENGTH CHANGE.
1	1.8	1-17	Legal Notice Regarding MDS 3.0 - Copyright 2011 United States of America and InterRAI. This work may be freely used and distributed solely within the United States. Portions of the MDS 3.0 are under separate copyright protections; Pfizer Inc. holds the copyright for the PHQ-9 and the Annals of Internal Medicine holds the copyright for the CAM. Both Pfizer Inc. and the Annals of Internal Medicine have granted permission to freely use these instruments in association with the MDS 3.0.

**Track Changes
from Chapter 2 V1.09
to Chapter 2 V1.10**

Chapter	Section	Page	Change
2	2.2	2-1	While states must use all Federally-required MDS 3.0 items, they have some flexibility in adding optional Section S items. As such, each State must have CMS approval of the State's Comprehensive and Quarterly assessments.
2	2.3	2-3	— Given the nature of a short-term or respite resident, staff members may not have access to all information required to complete some MDS items prior to the resident's discharge. In that case, the "not assessed/no information" coding convention should be used ("-") (See eChapter 3 for more information).
2	2.3	2-3	<ul style="list-style-type: none"> • Swing bed facility residents: Swing beds of non-critical access hospitals that provide Part A skilled nursing facility-level services were phased into the SNF PPS on July 1, 2002 (referred to as swing beds in this manual). Swing bed providers must assess the clinical condition of beneficiaries by completing the MDS assessment for each Medicare resident receiving Part A SNF level of care in order to be reimbursed under the SNF PPS. In addition, effective October 1, 2010, CMS collects will begin to collect MDS data for quality monitoring purposes of swing bed facilities effective October 1, 2010. Therefore, swing bed providers must also complete the Entry record, Discharge assessments, and Death in Facility record. Requirements for the Medicare-required PPS assessments, Entry record, Discharge assessments and Death in Facility record outlined in this manual also apply to swing bed facilities, including but not limited to, completion date, encoding requirements, submission time frame, and RN signature. There is no longer a separate swing bed MDS assessment manual.
2	2.4	2-6	— In cases where the resident returns to the facility after a long break in care (i.e., 15 months or longer), staff may want to review the older record to and familiarize themselves with the resident history and care needs. However, the decision on retaining the prior stay record in the active clinical record is a matter of facility policy and is not a CMS requirement.
2	2.5	2-8	Assessment Reference Date (ARD) refers to the last day of the observation (or "look back") period that the assessment covers for the resident. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. The facility is required to set the ARD on the MDS Item Set or in the facility software within the appropriate required timeframe of the assessment type being completed. This concept of setting the ARD is used for all assessment types (OBRA and Medicare-required PPS) and varies by assessment type and facility determination.

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Chapter	Section	Page	Change
2	2.5	2-13	Reentry refers to the situation when a resident was previously in this nursing home and had an OBRA A admission assessment completed and was discharged return anticipated and returned within 30 days of discharge. Upon the resident’s return to the facility, the facility is required to complete an Entry tracking record. In determining if the resident returned to facility within 30 days, the day of discharge from the facility is not counted in the 30 days. For example, a resident who is discharged return anticipated on December 1 would need to return to the facility by December 31 to meet the “within 30 day” requirement.
2	2.5	2-14	Respite refers to short-term, temporary care provided to a resident to allow family members to take a break from the daily routine of care giving. The nursing home is required to complete an Entry tracking record and a Discharge assessment for all respite residents. If the respite stay is 14 days or longer, the facility must have completed an OBRA admission Admission .
2	2.6	2-17	<ul style="list-style-type: none"> • If a resident goes to the hospital prior to completion of the OBRA A admission assessment, when the resident returns, the nursing home must consider the resident as a new admission. The nursing home may not complete a Significant Change in Status Assessment until after an OBRA Admission assessment has been completed. • If a resident had an OBRA A admission assessment completed and then goes to the hospital (discharge return anticipated and returns within 30 days) and returns during an assessment period and most of the assessment was completed prior to the hospitalization, then the nursing home may wish to continue with the original assessment, provided the resident does not meet the criteria for a SCSA. In this case, the ARD remains the same and the assessment must be completed by the completion dates required of the assessment type based on the timeframe in which the assessment was started. Otherwise, the assessment should be reinitiated with a new ARD and completed within 14 days after re-entry from the hospital. The portion of the resident’s assessment that was previously completed should be stored on the resident’s record with a notation that the assessment was reinitiated because the resident was hospitalized.
2	2.6	2-24	<ul style="list-style-type: none"> • Well-established, predictable cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions (e.g., depressive symptoms in a resident previously diagnosed with bipolar disease would not precipitate a Significant Change Assessment).

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Chapter	Section	Page	Change
2	2.7	2-38	The RAI process, which includes the Federally-mandated MDS, is the basis for an accurate assessment of nursing home residents. The MDS information and the CAA process provide the foundation upon which the care plan is formulated. There are 20 problem-oriented CAAs, each of which includes MDS-based “trigger” conditions that signal the need for additional assessment and review of the triggered care area. Detailed information regarding each care area and the CAA process, including definitions and triggers, appear in Chapter 4 of this manual. Chapter 4 also contains detailed information on care planning development utilizing the RAI and CAA process.
2	2.8	2-39	Assessment Window Each of the Medicare-required scheduled assessments has defined days within which the Assessment Reference Date (ARD) must be set. The facility is required to set the ARD on the MDS form itself or in the facility software within the appropriate timeframe of the assessment type being completed. For example, the ARD for the Medicare-required 5-day scheduled assessment must be set on days 1 through 58. Timeliness of the PPS assessment is defined by selecting an ARD within the prescribed ARD window. See Scheduled Medicare PPS Assessments chart below for the allowed ARDs for each of the Medicare-required assessments and other assessment information.
2	2.8	2-40	^Applicable Standard Medicare Payment Days may vary when assessment types are combined. For example, when a provider combines an unscheduled assessment, such as a Significant Change in Status Assessment (SCSA), with a scheduled assessment, such as a 30-day Medicare-required assessment, the new resource utilization group (RUG) would take effect on the ARD of the assessment. If the ARD of this assessment was day 28, the new RUG would take effect on day 28 of the stay. The exception would be if the ARD fell within the grace days. In that case, the new RUG would be effective on the first day of the regular payment period. For example, if the ARD of an unscheduled assessment combined with the 60-day assessment, was day 62, the new RUG would take effect on day 61
2	2.8	2-41	2. <i>Significant Correction to Prior Comprehensive Assessment:</i> Assessment: Complete because a significant error was made in the prior comprehensive assessment (see section 2.6).
2	2.9	2-45	<ul style="list-style-type: none"> If a resident goes from Medicare Advantage to Medicare Part A, the Medicare PPS schedule must start over with a 5 -day PPS assessment as the resident is now beginning a Medicare Part A stay.
2	2.9	2-47	— For example if the 5-day assessment is performed on performed on Day 8 and an SOT is performed in that window, the ARD for the SOT would be Day 8 as well.

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Chapter	Section	Page	Change
2	2.9	2-49	<ul style="list-style-type: none"> Mrs. A. who was in RVL did not receive therapy on Saturday and Sunday because the facility did not provide weekend services and she missed therapy on Monday because of a doctor's appointment, but resumed therapy Tuesday. The IDT determined that her RUG-IV therapy classification level did not change as she had not had any significant clinical changes during the lapsed therapy days. An EOT-R was completed and Mrs. A was placed into ES3 for the three days she did not receive therapy. On Tuesday, Mrs. A. was placed was placed back into RVL, which was the same therapy RUG group she was in prior to the discontinuation of therapy. A new therapy evaluation was not required.
2	2.9	2-49	<p>NOTE: When an EOT-R is completed, the Therapy start date (O0400A5, O0400B5, and O0400C5) on the next PPS assessment is the date of the Resumption of therapy on the EOT-R (O0450B). If therapy is ongoing, the Therapy end date (O0400A6, O0400B6, and O0400C6) would be filled out with dashes.</p> <p>NOTE: When an EOT-R is completed, the Therapy Start Date (O0400A5, O0400B5, and O0400C5) on the next PPS assessment is the same as the Therapy Start Date on the EOT-R. If therapy is ongoing, the Therapy End Date (O0400A6, O0400B6, and O0400C6) would be filled out with dashes.</p>
2	2.9	2-52	<ul style="list-style-type: none"> Is similar to the OBRA Significant Change in Status Assessment with the exceptions of the CAA process and the timing related to the OBRA A admission assessment. See Section 2.6 of this chapter.
2	2.11	2-57	<ul style="list-style-type: none"> When the OBRA and Medicare assessment time frames coincide, one assessment may be used to satisfy both requirements. PPS and OBRA assessments may be combined when the ARD windows overlap allowing for a common assessment reference date. When combining the OBRA and Medicare assessments, the most stringent requirements for ARD, item set, and CAA completion requirements must be met. For example, the skilled nursing facility staff must be very careful in selecting the ARD for an OBRA Admission assessment combined with a 14-day Medicare assessment. For the OBRA A admission standard, the ARD must be set between days 1 and 14 counting the date of admission as day 1. For Medicare, the ARD must be set for days 13 or 14, but the regulation allows grace days up to day 18. However, when combining a 14-day Medicare assessment with the Admission assessment, the use of grace days for the PPS assessment would result in a late OBRA Admission assessment. To assure

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Chapter	Section	Page	Change
			<p>the assessment meets both standards, an ARD of day 13 or 14 would have to be chosen in this situation. In addition, the completion standards must be met. While a PPS assessment can be completed within 14 days after the ARD when it is not combined with an OBRA assessment, the CAA completion date for the OBRA Admission assessment (Item V0200B2) must be day 14 or earlier. With the combined OBRA Admission/Medicare 14-day assessment, completion by day 14 would be required. Finally, when combining a Medicare assessment with an OBRA assessment, the SNF staff must ensure that all required items are completed. For example, when combining the Medicare-required 30-day assessment with a Significant Change in Status Assessment, the provider would need to complete a comprehensive item set, including CAAs.</p>
2	2.12	2-61	<ul style="list-style-type: none"> • ARD (Item A2300) must be set for the day of discharge (Item A2000) and the date of discharge must falls within the allowed window of the Medicare scheduled assessment as described earlier in Section 2.9.
2	2.12	2-62	<ul style="list-style-type: none"> • ARD (Item A2300) must be set for the day of discharge (Item A2000) and the date of discharge must fall within 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date). The ARD must be set by no more than two days after the date of discharge. (See Section 2.8 for further clarification.)
2	2.12	2-64	<ul style="list-style-type: none"> • ARD (Item A2300) must be set for the day of discharge (Item A2000) and the date of discharge must falls within 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest). The ARD must be set by no more than two days after the date of discharge. (See Section 2.8 for further clarification).
2	2.12	2-67	<ul style="list-style-type: none"> • ARD (Item A2300) must be set for the day of discharge (Item A2000) and the date of discharge must falls within 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) and 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6). The ARD must be set by no more than two days after the date of discharge. (See Section 2.8 for further clarification).
2	2.12	2-69	<ul style="list-style-type: none"> • ARD (Item A2300) must be set for the day of discharge (Item A2000) and be on the last day of a COT 7-day observation period. The ARD must be set by no more than two days after

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Chapter	Section	Page	Change												
			the date of discharge. (See Section 2.8 for further clarification.)												
2	2.13	2-74	<p><i>Missed PPS Assessment</i></p> <p>If the SNF fails to set the ARD of a scheduled PPS assessment prior to the end of the last day of the ARD window, including grace days, and the resident was already discharged from Medicare Part A when this error is discovered, the provider cannot complete an assessment for SNF PPS purposes and the days cannot be billed to Part A. An existing OBRA assessment (except a stand-alone discharge assessment) in the QIES ASAP system may be used to bill for some Part A days when specific circumstances are met. See Chapter 6, Section 6.8 for greater detail.</p>												
2	2.14	2-76	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Next Record</th> <th style="text-align: center;">Entry</th> <th style="text-align: center;">OBRA Admission</th> </tr> </thead> <tbody> <tr> <td>Entry</td> <td style="text-align: center;">no</td> <td style="text-align: center;">no</td> </tr> <tr> <td>OBRA Admission</td> <td></td> <td style="text-align: center;">no</td> </tr> <tr> <td>OBRA Annual</td> <td></td> <td style="text-align: center;">no</td> </tr> </tbody> </table> <p>OBRA Quarterly, sign. change, sign correction</p>	Next Record	Entry	OBRA Admission	Entry	no	no	OBRA Admission		no	OBRA Annual		no
Next Record	Entry	OBRA Admission													
Entry	no	no													
OBRA Admission		no													
OBRA Annual		no													
2	2.15	2-78	<p>Consider examples of the use of this table. If Items A0310A = 01, A0310B = 99, A0310C= 0 and Item A0310F = 99 (a standalone admission assessment), then these values are matched in row 21 and the item set is an OBRA comprehensive assessment (NC). The same row would be selected if Item A0310F is changed to 10 (admission assessment combined with a return not anticipated discharge assessment). The item set is again an OBRA comprehensive assessment (NC). If Items A0310A = 99, A0310B = 99, A0310C= 0 and Item A0310F = 12 (a death in facility tracking record), then these values are matched in the last row and the item set is a tracking record (NT). Finally, if Items A0310A = 99, A0310B = 99, A0310C= 0 and A0310F = 99, then no row matches these entries, and the record is invalid and would be rejected.</p>												

**Track Changes
from Chapter 3 Intro V1.05
to Chapter 3 Intro V1.10
May 2013**

Chapter	Section	Page	Change
3	Intro	3-2	<p>Added hyperlink function:</p> <ul style="list-style-type: none"> Check the MDS 3.0 Web site regularly for updates at: http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp <p>Field Code Changed:</p> <ul style="list-style-type: none"> If you <u>require</u> further assistance, submit your question to your State RAI Coordinator listed in Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts available on CMS' website: http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp
3	Intro	3-2	<ul style="list-style-type: none"> Become familiar with the item itself with its coding choices and responses, keeping in mind the clarifications, issues of note, and other pertinent information needed to understand how to code the item. Do the definitions and instructions differ from current practice at your facility? Become familiar with the item itself with its coding choices and responses, keeping in mind the clarifications, issues of note, and other pertinent information needed to understand how to code the item. Do the definitions and instructions differ from current practice at your facility?
3	Intro	3-3	<p>Field Code Changed:</p> <ul style="list-style-type: none"> It will take time to go through all this material. Do it slowly and carefully without rushing. Discuss any clarifications, questions or issues with your State RAI Coordinator (see Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts available on CMS' website: http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp)
3	3.3	3-3	<ul style="list-style-type: none"> With the exception of certain items (e.g., some items in Sections K and O), the look-back period generally <u>does not</u> include a hospital stay.
3	3.3	3-4	<ul style="list-style-type: none"> There are five five four date items (A2400C, M0300B3, O0400A6, O0400B6, and O0400C6) that use a dash-filled value to indicate that the event has not yet occurred. For example, if there is an ongoing Medicare stay, then the end date for that Medicare stay (A2400C) has not occurred, therefore, this item would be dash-filled.

**Track Changes
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to Chapter 3 Intro V1.10
May 2013**

Chapter	Section	Page	Change						
3	3.3	3-4	<ul style="list-style-type: none"> — The few items that do not allow dash values include identification items in Section A (e.g., reasons for assessment, resident name, assessment reference date) and ICD-9 diagnosis codes (Item I8000). — To determine whether a specific item allows a dash value or not, refer to the MDS 3.0 Data Submission Specifications at: http://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp#TopOfPage – The few items that do not allow dash values include identification items in Section A [e.g., Legal Name of Resident (Item A0500), Assessment Reference Date (Item A2300), Type of Assessment (Item A0310), and Gender (Item A0800)] and ICD-9 diagnosis codes (Item I8000). All items for which a dash is not an acceptable value can be found on the CMS MDS 3.0 Technical Information web page at the following link: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html 						
3	3.3	3-5	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center; vertical-align: top;">A</td> <td style="width: 25%; vertical-align: top;">Identification Information</td> <td style="vertical-align: top;">Obtain key information to uniquely identify each resident, nursing home, type of record, and reasons for assessment.</td> </tr> <tr> <td style="width: 5%; text-align: center; vertical-align: top;">X</td> <td style="width: 25%; vertical-align: top;">Correction Request</td> <td style="vertical-align: top;">Indicate whether an MDS record is a new record to be added to the QIES ASAP system or a rRRequest to modify or inactivate a record already present in the QIES ASAP database.</td> </tr> </table>	A	Identification Information	Obtain key information to uniquely identify each resident, nursing home, type of record , and reasons for assessment.	X	Correction Request	Indicate whether an MDS record is a new record to be added to the QIES ASAP system or a r R Request to modify or inactivate a record already present in the QIES ASAP database.
A	Identification Information	Obtain key information to uniquely identify each resident, nursing home, type of record , and reasons for assessment.							
X	Correction Request	Indicate whether an MDS record is a new record to be added to the QIES ASAP system or a r R Request to modify or inactivate a record already present in the QIES ASAP database.							

**Track Changes
from Chapter 3, Section A V1.09
to Chapter 3, Section A V1.10**

Chapter	Section	Page	Change
3	A0050	A-2	<p>Example: A MDS assessment for Joan L. Smith is submitted and accepted by the QIES ASAP system. A data entry error is then identified on the previously submitted and accepted record. The encoder mistakenly entered “John” instead of “Joan” when entering a prior assessment for Joan L. Smith. When the encoder “data entered” the prior assessment for Joan L. Smith, he typed “John” by mistake. To correct this data entry error, the facility will modify the erroneous record and complete the items in Section X including items under Identification of Record to be Modified/Inactivated. When completing X0200A, the Resident First Name, “John” will be entered in this item. This will permit the MDS system to locate the previously submitted assessment that is being corrected. If the correct name “Joan” were entered, the QIES ASAP system would not locate the prior assessment.</p>
3	A0310	A-5	<p>Coding Tips and Special Populations</p> <ul style="list-style-type: none"> • If a nursing home resident elects the hospice benefit, the nursing home is required to complete an MDS significant change in status assessment (SCSA). The nursing home is required to complete a SCSA when they come off the hospice benefit (revoke). See Chapter 2 for details on this requirement. • It is a CMS requirement to have a significant change in status assessment SCSA completed EVERY time the hospice benefit has been elected, even if a recent MDS was done and the only change is the election of the hospice benefit.
3	A0310	A-6	<p>Coding Instructions for A0310C, PPS Other Medicare Required Assessment—OMRA</p> <ul style="list-style-type: none"> • Code 1, Start of therapy assessment (OPTIONAL): with an assessment reference date (ARD) that is 5 to 7 days after the first day therapy services are provided (except when the assessment is used as a Sshort Sstay assessment, see Chapter 6). No need to combine with the 5-day assessment except for short stay. Only complete if therapy RUG (index maximized), otherwise the assessment will be rejected. • Code 3, both the Start and End of therapy assessment: with an ARD that is both 5 to 7 days after the first day therapy services were provided and that is 1 to 3 days after the last day therapy services were provided (except when the assessment is used as a Sshort Sstay assessment, see Chapter 6).

Track Changes
from Chapter 3, Section A V1.09
to Chapter 3, Section A V1.10

Chapter	Section	Page	Change
3	A0310	A-6	<p>Coding Instructions for A0310D, Is This a Swing Bed Clinical Change Assessment?</p> <ul style="list-style-type: none"> Code 0, no: if this assessment is not a swing Swing Bed Clinical Change assessment.
3	A0310	A-6	<p>Coding Tips and Special Populations</p> <ul style="list-style-type: none"> A0310E = 0 for any tracking record (E Entry or D Death in F Facility) because tracking records are not considered assessments.
3	A1500	A-17	<p>Steps for Assessment</p> <ul style="list-style-type: none"> Complete if A0310A = 01, 03, 04 or 05 (admission Admission assessment, A Annual assessment, S Significant Change in s Status a Assessment, S Significant e C Correction to p P Prior e C Comprehensive A A Assessment).
3	A1500	A-17	<p>Coding Instructions</p> <ul style="list-style-type: none"> Level II screening determined that the resident does not have a serious mental illness and/or intellectual/developmental developmental disability or related condition, or
3	A1550	A-19	<p>Steps for Assessment</p> <ol style="list-style-type: none"> If resident is 22 years of age or older on the assessment reference date, complete only if A0310A = 01 (A Admission assessment). If resident is 21 years of age or younger on the assessment reference date, complete if A0310A = 01, 03, 04, or 05 (admission Admission assessment, annual Annual assessment, S Significant Change in S Status A Assessment, S Significant C e Correction to P p Prior C e Comprehensive A A Assessment).
3	A1700	A-21	<ol style="list-style-type: none"> resident has been in this facility previously and was discharged prior to completion of the OBRA A Admission assessment; OR
3	A1700	A-21	<ol style="list-style-type: none"> admitted to this nursing home (i.e., OBRA A Admission assessment was completed), AND
3	A2200	A-25	<p>Item Rationale</p> <ol style="list-style-type: none"> To identify the ARD of a previous comprehensive or quarterly Quarterly assessment (A0310A = 05 or 06) in which a significant error is discovered. <p>Coding Instructions</p> <ul style="list-style-type: none"> Complete only if A0310A = 05 (Significant C e Correction to P p Prior e C Comprehensive a A Assessment) or A0310A = 06

**Track Changes
from Chapter 3, Section A V1.09
to Chapter 3, Section A V1.10**

Chapter	Section	Page	Change
			<p>(Significant eCorrection to Pprior Qquarterly aAssessment).</p> <ul style="list-style-type: none"> Enter the ARD of the prior comprehensive or Qquarterly assessment in which a significant error has been identified and a correction is required.
3	A2400	A-29	<p>Examples</p> <ol style="list-style-type: none"> Mrs. G. began receiving services under Medicare Part A on October 14, 2010. Due to her stable condition and ability to manage her medications and dressing changes, the facility determined that she no longer qualified for Part A SNF coverage and issued an Advanced Beneficiary Notice (ABN) and a Generic Notice with the last day of coverage as November 23, 2010. Mrs. G. was discharged from the facility on November 24, 2010. Code the following on her discharge Discharge assessment: Mr. R. began receiving services under Medicare Part A on October 15, 2010. He was discharged return anticipated on October 20, 2010, to the hospital. Code the following on his discharge Discharge assessment:

**Track Changes
from Chapter 3, Section B V1.05
to Chapter 3, Section B V1.10**

Chapter	Section	Page	Change
3	B0200	B-3	<p>Steps for Assessment</p> <p>1. Ensure that the resident is using his or her normal hearing appliance if they have one. Hearing devices may not be as conventional as a hearing aid. Some residents by choice may use hearing amplifiers or a microphone and headphones as an alternative to hearing aids. Ensure whatever the hearing appliance is used, it is operational.</p>
3	B0300	B-4	<p>Item Rationale</p> <p>Health-related Quality of Life</p> <ul style="list-style-type: none"> • Problems with hearing can contribute to social isolation and mood and behavior disorders. • Many residents without with impaired hearing could benefit from hearing aids or other hearing appliances could benefit from them. • Many persons residents residents who benefit from and who own hearing aids do not have the hearing aids with them hearing aids with them on arrival at the nursing home or have the hearing aid is not functional.

**Track Changes
from Chapter 3, Section C V1.08
to Chapter 3, Section C V1.10**

Chapter	Section	Page	Change
3	C0100	C-1	<ul style="list-style-type: none"> Code 0, no: if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status.
3	C0100	C-2	<p>Coding Tips</p> <ul style="list-style-type: none"> If the resident needs an interpreter, every effort should be made to have an interpreter present for the BIMS. If it is not possible for a needed interpreter to participate on the day of the interview, code C0100 = 0 to indicate interview not attempted and complete C0700-C1000, Staff Assessment of Mental Status, instead of C0200-C0500, Brief Interview for Mental Status. Includes residents who use American Sign Language (ASL).
3	C0200-C0500	C-3	<p>2. Interview any resident not screened out by Should Brief Interview for Mental Status Be Conducted? item (Item C0100).</p>

**Track Changes
from Chapter 3, Section D V1.05
to Chapter 3, Section D V1.10**

Chapter	Section	Page	Change
3	D0300	D-9	3. The maximum resident score is 27 (3 x 9).
3	D0300	D-9	20-27: severe depression
3	D0300	D-15	20-30: severe depression

**Track Changes
from Chapter 3, Section E V1.08
to Chapter 3, Section E V1.10**

Chapter	Section	Page	Change
3	E0500	E-9	2. During the last 7 days, a resident with vascular dementia and severe hypertension, hits staff during incontinent care making it very difficult to change her. Six out of the last seven days the resident refuses all her medication including her antihypertensive. The resident would closes her mouth and shaking her head and will not take it even if re-approached multiple times.
3	E0600	E-12	4. When eating in the dining room, a resident frequently grabs food off the plates of other residents. Although their other resident's food is replaced, and the behavior does not compromise their nutrition, other residents become anxious in anticipation of this recurring behavior.
3	E0600	E-13	Rationale: This behavior does not put other residents at risk for significant injury. However, t The behavior restricts full participation in the organized activity, and limits the enjoyment of other residents. It also causes fear, thereby disrupting the living environment.
3	E0600	E-16	3. A resident goes to bed at night without changing out of the clothes he wore during the day. When a nursing assistant offers to help him get undressed, he declines, stating that he prefers to sleep in his clothes tonight. The clothes are wet with urine. This has happened 2 of the past 5-7 days. The resident was previously fastidious, recently has expressed embarrassment at being incontinent, and has care goals that include maintaining personal hygiene and skin integrity.
3	E1100	E-22	1. On the prior assessment, the resident was reported to wander on 4 out of 5-7 days. Because of elopement, the behavior placed the resident at significant risk of getting to a dangerous place. On the current assessment, the resident was found to wander on 2 of the last 5-7 days. Because a door alarm system is now in use, the resident was not at risk for elopement and getting to a dangerous place. However, the resident is now wandering into the rooms of other residents, intruding on their privacy. This requires occasional redirection by staff.

Track Changes
from Chapter 3, Section G V1.08
to Chapter 3, Section G V1.10

Chapter	Section	Page	Change
3	G0110	G-3	<ul style="list-style-type: none"> To assist in coding ADL self-performance items, please use the algorithm on page G-6.
3	G0110	G-5	<ul style="list-style-type: none"> When there are three or more episodes of a combination of full staff performance, weight-bearing assistance, and/or non-weight-bearing assistance—code limited assistance (2).
3	G0110	G-6	Replaced algorithm image.
3	G0110	G-14	<p>3. Mr. H. enjoyed walking in the nursing home garden when weather permitted. Due to inclement weather during the assessment period, he required various levels of assistance on the days he walked through the garden. On two occasions, he required limited assistance for balance of one staff person and on another occasion he only required supervision. On one day he was able to walk through the garden completely by himself.</p>
3	G0110	G-15	<p>5. Mrs. U. is severely cognitively impaired. She is unable to feed herself. She relied on one staff member for all nourishment during the 7-day look-back period. During the 7-day look-back period, one staff member had to assist her with eating every meal.</p> <p>Rationale: Resident did not participate and required one staff person to feed her all of her meals during the 7-day look-back period.</p>
3	G0110	G-16	<p>3. Staff must assist Mr. P. to zip his pants, hand him a washcloth, and remind him to wash his hands after using the toilet daily. This occurred multiple times each day during the 7-day look-back period.</p>
3	G0110	G-17	<p>5. Miss W. is cognitively and physically impaired. During the 7-day look-back period, she was on strict bed rest. Staff were unable to physically transfer her to toilet during this time. Miss W. is incontinent of both bowel and bladder. One staff member was required to provide all the care for her elimination and personal hygiene needs several times each day.</p> <p>Rationale: Resident did not participate and required one staff person to provide total care for toileting and personal hygiene each time during the entire 7-day look-back period.</p>
3	G0120	G-18	<ul style="list-style-type: none"> Bathing is the only ADL activity for which the ADL Self-Performance codes in Item G0110, Column 1 (Self-Performance), do not apply. A unique set of self-performance codes is used in the bathing assessment given that bathing may not occur as frequently as the other ADL's ADLs in the 7-day look-back period.
3	G0300	G-28	<ul style="list-style-type: none"> Code 8, activity did not occur: <ul style="list-style-type: none"> If the resident did not transfer between bed and chair or

**Track Changes
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to Chapter 3, Section G V1.10**

Chapter	Section	Page	Change
			wheelchair during the 7-day look-back period.
3	G0300	G-28	Examples for G0300E, Surface-to-Surface Transfer (Transferring from Between Bed and Chair or Wheelchair)
3	G0300	G-28	Rationale: The resident was unsteady when transferring from bed to wheelchair and required staff assistance to make a steady transfer.

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from Chapter 3, Section H V1.08
to Chapter 3, Section H V1.10

Chapter	Section	Page	Change
3	H0100	H-2	— In men, eCondom catheters (males), and in females, external urinary pouches (females), are commonly often used intermittently or at night only. This use should be; these should be coded as external catheters.
3	H0100	H-2	<p>DEFINITIONS</p> <p>EXTERNAL CATHETER Device attached to the shaft of the penis like a condom for males or a receptacle pouch that fits around the labia majora majora for females and connected to a drainage bag.</p>
3	H0200	H-4	<i>The look-back period for this item is to since the most recent admission/entry or reentry admission or since urinary assessment, the most recent prior assessment, or to when incontinence was first noted within the facility.</i>
3	H0200	H-5	<ul style="list-style-type: none"> Code 1, yes: for residents who underwent a trial of an individualized, resident- centered toileting program at least once since admission/readmission, prior assessment prior assessment, or when urinary incontinence was first noted.
3	H0300	H-7	<p>DEFINITIONS</p> <p>URINARY INCONTINENCE The involuntary loss of urine.</p> <p>CONTINENCE Any void into a commode, urinal, or bedpan that occurs voluntarily, or voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting.</p>
3	H0600	H-12	— side effects of medications.

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from Chapter 3, Section I V1.09
to Chapter 3, Section I V1.10**

Chapter	Section	Page	Change
3	1	I-3	I: Active Diagnoses in the Last 7 Days (cont.)
3	1	I-4	I: Active Diagnoses in the Last 7 Days (cont.)
3	1	I-4	<ul style="list-style-type: none"> Computer specifications are written such that the ICD code should be automatically justified. The important element is to ensure that the ICD code's decimal point is in its own box and should be right justified (aligned with the right margin so that any unused boxes and on the left.)
3	1	I-9	<p>The CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC) has released infection prevention and control guidelines that contain recommendations that should be applied in all healthcare settings. At this site you will find information related to UTI's UTIs and many other issues related to infections in LTC.</p> <p>http://www.cdc.gov/ncidod/dhqp/gl_longterm_care.html</p>

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to Chapter 3, Section K V1.10**

Chapter	Section	Page	Change
3	K0300	K-4	<ul style="list-style-type: none"> • At a point closest to 1830-days preceding the current weight. • At a point closest to 3180-days preceding the current weight.
3	K0300	K-5	<p>For Subsequent Assessments</p> <ol style="list-style-type: none"> 1. From the medical record, compare the resident's weight in the 7-day look-back current observation period to his or her weight in the observation period 30 days ago. 3. From the medical record, compare the resident's weight in the 7-day look-back current observation period to his or her weight in the observation period 180 days ago.
3	K0310	K-8	<p>Steps for Assessment</p> <p><i>This item compares the resident's weight in the 7-day look-back current observation period with his or her weight at two snapshots in time:</i></p>
3	K0310	K-9	<p>For Subsequent Assessments</p> <ol style="list-style-type: none"> 1. From the medical record, compare the resident's weight in the 7-day look-back current observation period to his or her weight in the observation period 30 days ago. 3. From the medical record, compare the resident's weight in the 7-day look-back current observation period to his or her weight in the observation period 180 days ago.
3	K0700	K-15	<p><i>Code for the average number of cc's per day of fluid the resident received per day by via IV or tube feeding. Record what was actually received by the resident, not what was ordered.</i></p>
3	K0700	K-16	<p>Coding: K0500b K0700b would be coded 1, 500 cc/day or less.</p>

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from Chapter 3, Section L V1.04
to Chapter 3, Section L V1.10**

Chapter	Section	Page	Change
3	L0200	L-2	<p>Coding Instructions</p> <ul style="list-style-type: none"> • Check L0200-A L0200A, broken or loosely fitting full or partial denture: if the denture or partial is chipped, cracked, uncleanable, or loose. A denture is coded as loose if the resident complains that it is loose, the denture visibly moves when the resident opens his or her mouth, or the denture moves when the resident tries to talk. • Check L0200-B L0200B, no natural teeth or tooth fragment(s) (edentulous): if the resident is edentulous or lacks all natural teeth or parts of teeth. • Check L0200-C L0200C, abnormal mouth tissue (ulcers, masses, oral lesions): Sselect if any ulcer, mass, or oral lesion is noted on any oral surface. • Check L0200-D L0200D, obvious or likely cavity or broken natural teeth: if any cavity or broken tooth is seen. • Check L0200-E L0200E, inflamed or bleeding gums or loose natural teeth: if gums appear irritated, red, swollen, or bleeding. Teeth are coded as loose if they readily move when light pressure is applied with a fingertip. • Check L0200-F L0200F, mouth or facial pain or discomfort with chewing: if the resident reports any pain in the mouth or face, or discomfort with chewing. • Check L0200-G L0200G, unable to examine: if the resident's mouth cannot be examined. • Check L0200-Z L0200Z, none of the above: if none of conditions A through F is present.
3	L	L-3	<ul style="list-style-type: none"> • Mouth or facial pain coded for this item should also be coded in Section J, items J0100 through J0850, in any items in which the coding requirements of Section J are met.

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to Chapter 3, Section M V1.10**

Chapter	Section	Page	Change
3	M0210	M-2	<ul style="list-style-type: none"> • Check C if the resident’s risk for pressure ulcer development is based on clinical assessment. A clinical assessment could include a head-to-toe physical examination of the skin and observation or medical record review of pressure ulcer risk factors. Examples of risk factors include the following: <ul style="list-style-type: none"> • impaired/decreased mobility and decreased functional ability • co-morbid conditions, such as end-stage renal disease, thyroid disease, or diabetes mellitus; • drugs, such as steroids, that may affect wound healing; • impaired diffuse or localized blood flow (e.g., generalized atherosclerosis or lower extremity arterial insufficiency); — impaired/decreased mobility and decreased functional ability — co-morbid conditions, such as end stage renal disease, thyroid disease, or diabetes mellitus; — drugs, such as steroids, that may affect wound healing; — impaired diffuse or localized blood flow (e.g., generalized atherosclerosis or lower extremity arterial insufficiency);
3	M0210	M-3	<ul style="list-style-type: none"> • resident refusal of some aspects of care and treatment; • cognitive impairment; • urinary and fecal incontinence; • under nutrition, malnutrition, and hydration deficits; and • healed pressure ulcers, especially Stage 3 or 4 which are more likely to have recurrent breakdown. — resident refusal of some aspects of care and treatment; — cognitive impairment; — urinary and fecal incontinence; — under nutrition, malnutrition, and hydration deficits; and — healed pressure ulcers, especially Stage 3 or 4 which are more likely to have recurrent breakdown.
3	M0210	M-4	<ul style="list-style-type: none"> • For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or sDTI that declares itself, should be coded in terms of what is assessed (seen and or palpated, i.e. visible tissue, palpable bone) during the look-back period. Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. However, since CMS has adapted the NPUAP guidelines for MDS purposes, the definitions do not perfectly correlate with each stage as

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			<p>described by NPUAP. Therefore, you cannot use the NPUAP definitions to code the MDS. You must code the MDS according to the instructions in this manual.</p> <ul style="list-style-type: none"> Pressure ulcer staging is an assessment system that provides a description and classification based on of anatomic depth of soft tissue damage. This tissue damage can be visible or palpable in the ulcer bed. Pressure ulcer staging and also informs expectations for healing times
3	M0210	M-4	<p>3. Examine the resident and determine whether any skin ulcers are present.</p> <ul style="list-style-type: none"> Key areas for pressure ulcer development include the sacrum, coccyx, trochanters, ischial tuberosities, and heels. Other areas, such as bony deformities, skin under braces, and skin subjected to excess pressure, shear or friction, are also at risk for pressure ulcers.
3	M0210	M-5	<p>Coding Tips</p> <ul style="list-style-type: none"> If an ulcer arises from a combination of factors which are primarily caused by pressure, then the ulcer should be included in this section as a pressure ulcer. Each ulcer should be coded only once, either as a pressure ulcer or an ulcer due to another cause. Oral Mucosal ulcers caused by pressure should not be coded in Section M. These ulcers are captured in item L0200C, Abnormal mouth tissue. Mucosal ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made. If a pressure ulcer is surgically closed/repaired with a flap or graft, it should be coded as a surgical wound and not as a pressure ulcer. If the flap or graft fails, continue to code it as a surgical wound until healed.
3	M0210	M-5	<ul style="list-style-type: none"> If a resident had a pressure ulcer on the last assessment and it is now healed, complete Healed Pressure Ulcers item (M0900). If a pressure ulcer healed during the look-back period, and was not present on prior assessment, code 0.
3	M0300	M-6	<p>Step 1...</p> <ol style="list-style-type: none"> Observe and palpate the base of any identified pressure ulcers present to determine the anatomic depth of soft tissue damage layers involved. Ulcer staging should be based on the ulcer's deepest visible anatomical soft tissue damage that is visible or palpable level.

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			<p>If a pressure ulcer's tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable (see Step 2 below). Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a higher deeper numerical stage than what is observed now, it should continue to be classified at the higher deeper numerical stage. Nursing homes that carefully document and track pressure ulcers will be able to more accurately code this item.</p> <p>Step 2...</p> <ol style="list-style-type: none"> 1. Visualization of the wound bed is necessary for accurate staging. However, if the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured, do not code as unstageable. 2. Pressure ulcers that have neerotic or eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage layers involved with the pressure ulcer cannot be visualized or palpated in the wound bed, determined, should be classified as unstageable, as illustrated at http://www.npuap.org/images/NPUAP-Unstage2.jpghttp://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpg 3. If the wound bed is only partially covered by eschar or slough, and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer, and do not code this as unstageable. Pressure ulcers in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) are unstageable. 4. A pressure ulcer with intact skin that is a suspected deep tissue injury (sDTI) should not be coded as a Stage 1 pressure ulcer. It should be coded as unstageable, as illustrated at http://www.npuap.org/images/NPUAP-SuspectDTI.jpg
3	M0300	M-7	<p>Step 3...</p> <ol style="list-style-type: none"> 1. Review the medical record for the history of the ulcer. 2. Review for location and stage at the time of admission/entry or reentry. If the pressure ulcer was present on admission/entry or reentry and subsequently increased in numerical worsened to a higher stage during the resident's stay, the pressure ulcer is coded at that higher stage, and that higher stage should not be considered as "present on admission."

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			<p>3. If the pressure ulcer was unstageable on admission/entry or reentry, but becomes numerically stageable later, it should be considered as “present on admission” at the stage at which it first becomes numerically stageable. If it subsequently worsens to a higher increases in numerical stage, that higher stage should not be considered “present on admission.”</p> <p>4. If a resident who has a pressure ulcer is hospitalized and returns with that pressure ulcer at the same numerical stage, the pressure ulcer should not be coded as “present on admission” because it was present at the facility prior to the hospitalization.</p> <p>5. If a current pressure ulcer increases in numerical worsens to a higher stage during a hospitalization, it is coded at the higher stage upon reentry and should be coded as “present on admission.”</p>
3	M0300	M-7	<div style="border: 1px solid black; padding: 5px;"> <p>DEFINITIONS</p> <p>ON ADMISSION On-admission is defined as: as As close to the actual time of admission as possible.</p> </div>
3	M0300	M-8	<p>Steps for Assessment</p> <p>2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is NOTnot the primary cause, do notNOT code here.</p> <p>5. Search for other areas of skin that differ from surrounding tissue that may be painful, firm, soft, warmer, or cooler compared to adjacent tissue. Stage 1 may be difficult to detect in individuals with dark skin tones. Visible blanching may not be readily apparent in darker skin tones. Look for temperature or color changes.</p>
3	M0300	M-9	<p>Planning for Care</p> <ul style="list-style-type: none"> If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the patient’s overall clinical condition should be reassessed.
3	M0300	M-9	<p>Steps for Assessment</p> <p>2. For the purposes of coding, determine that the lesion being</p>

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			assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is not not the primary cause, do not not code here.
3	M0300	M-10	3. <u>Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage, (e.g., color change, tenderness, bogginess or firmness, warmth or coolness) these characteristics suggest a suspected deep tissue injury (sDTI) rather than a Stage 2 Pressure Ulcer.</u>
3	M0300	M-10	Coding Instructions for M0300B <ul style="list-style-type: none"> Enter the date of the oldest Stage 2 pressure ulcer. The facility should make every effort to determine the actual date that the Stage 2 pressure ulcer was first identified whether or not it was acquired in the facility. If the facility is unable to determine the actual date that the Stage 2 pressure ulcer was first identified (i.e., the date is unknown), enter a dash in every block. Do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a “0.” For example, January 2, 2014², should be entered as 01-02-2014².
3	M0300	M-10	Coding Tips <ul style="list-style-type: none"> Do not NOT code skin tears, tape burns, perineal moisture associated skin damage dermatitis, maceration, or excoriation, or suspected deep tissue injury here. When a lesion that is related to pressure ulcer presents as with an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury is determined, do not NOT code as a Stage 2.
3	M0300	M-11	Steps for Assessment <ol style="list-style-type: none"> For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is NOT not the primary cause, do NOT not code here.
3	M0300	M-12	Examples <ol style="list-style-type: none"> A pressure ulcer described as a Stage 2 was noted and documented in the resident’s medical record on admission. On a later assessment, the wound is noted to be a full thickness

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			<p>ulcer without exposed bone, tendon, or muscle, thus it is now a Stage 3 pressure ulcer.</p> <p>Coding: The current Stage 3 pressure ulcer would be coded at M0300C1 as Code 1, and at M0300C2 as 0, not present on admission/entry or reentry.</p> <p>Rationale: The designation of “present on admission” requires that the pressure ulcer be at the same location and not have increased in numerical worsened to a deeper anatomical stage. This pressure ulcer worsened after admission.</p> <p>2. A resident develops a Stage 2 pressure ulcer while at the nursing facility. The resident is hospitalized due to pneumonia for 8 days and returns with a Stage 3 pressure ulcer in the same location.</p> <p>Coding: The pressure ulcer would be coded at M0300C1 as Code 1, and at M0300C2 as 1, present on admission/entry or reentry.</p> <p>Rationale: Even though the resident had a pressure ulcer in the same anatomical location prior to transfer, because the pressure ulcer increased in numerical stage it worsened to a Stage 3 during hospitalization, it should be coded as a Stage 3, present on admission/entry or reentry.</p>
3	M0300	M-13	<p>3. On admission, the resident has three small Stage 2 pressure ulcers on her coccyx. Two weeks later, the coccyx is assessed. Two of the Stage 2 pressure ulcers have merged and the third has increased in numerical stage worsened to a Stage 3 pressure ulcer.</p> <p>Coding: The two merged pressure ulcers would be coded at M0300B1 as 1, and at M0300B2 as 1, present on admission/entry or reentry. The Stage 3 pressure ulcer would be coded at M0300C1 as 1, and at M0300C2 as 0, not present on admission/entry or reentry.</p> <p>Rationale: Two of the pressure ulcers on the coccyx have merged, but have remained at the same stage as they were at the time of admission; the one that increased in numerical stage to a Stage 3 has increased in stage</p>

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			<p>since admission and hence cannot be coded in M0300C2 as present on admission/entry or reentry since the Stage 3 ulcer was not present on admission/entry or reentry.</p> <p>4. A resident developed two Stage 2 pressure ulcers during her stay; one on the coccyx and the other on the left lateral malleolus. At some point she is hospitalized and returns with two pressure ulcers. One is the previous Stage 2 on the coccyx, which has not changed; the other is a new Stage 3 on the left trochanter. The Stage 2 previously on the left lateral malleolus has healed.</p> <p>Coding: The Stage 2 pressure ulcer would be coded at M0300B1 as 1, and at M0300B2 as 0, not present on admission; the Stage 3 would be coded at M0300C1 as 1, and at M0300C2 as 1, present on admission/entry or reentry.</p> <p>Rationale: The Stage 2 pressure ulcer on the coccyx was present prior to hospitalization; the Stage 3 pressure ulcer developed during hospitalization and is coded in M0300C2 as present on admission/entry or reentry. The Stage 2 pressure ulcer on the left lateral malleolus has healed and is therefore no longer coded here but in Item M0900, Healed Pressure Ulcers.</p>
3	M0300	M-14	<p>Steps for Assessment</p> <p>2. For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is not NOT the primary cause, do not NOT code here.</p>
3	M0300	M-15	<p>Coding Tips</p> <ul style="list-style-type: none"> Cartilage serves the same anatomical function as bone. Therefore, pressure ulcers that have exposed cartilage should be classified as a Stage 4.
3	M0300	M-16	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	M0300	M-17	<ul style="list-style-type: none"> Pressure ulcers that present as unstageable require care planning that includes, in the absence of ischemia, debridement of necrotic and dead tissue and restaging once this necrotic tissue is removed.
3	M0300	M-17	<p>Steps for Assessment</p> <p>1. Determine the number of pressure ulcers that are unstageable</p>

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			<p>due to slough and/or eschar.</p> <p>Coding Tips</p> <ul style="list-style-type: none"> Pressure ulcers that are covered with slough and/or eschar should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. Only until enough slough and/or eschar is removed to expose the anatomic depth of the soft tissue damage layers involved, can the stage of the wound be determined. Once the pressure ulcer is debrided of slough and/or eschar such that the anatomic depth of soft tissue damage tissues involved can be determined, then code the ulcer for the reclassified stage. The pressure ulcer does not have to be completely debrided or free of all slough and/or eschar tissue in order for reclassification of stage to occur.
3	M0300	M-18	<p>Examples</p> <ol style="list-style-type: none"> A resident is admitted with a sacral pressure ulcer that is 100% covered with black eschar. Coding: The pressure ulcer would be coded at M0300F1 as 1, and at M0300F2 as 1, present on admission/entry or reentry. Rationale: The pressure ulcer depth is not observable because the pressure ulcer is covered with eschar. This pressure ulcer so it is unstageable, and it was present on admission. A pressure ulcer on the sacrum was present on admission, and was 100% covered with black eschar. On the admission assessment, it was coded as unstageable and present on admission. The pressure ulcer is later debrided using conservative methods and after 4 weeks the ulcer has 50% to 75% eschar present. The assessor can now see that the damage extends down to the bone. Coding: The ulcer is reclassified as a Stage 4 pressure ulcer. On the subsequent MDS, it is coded at M0300D1 as 1, and at M0300D2 as 1, present on admission/entry or reentry. Rationale: After debridement, the pressure ulcer is no longer unstageable because bone is visible in the wound bed. Therefore, this ulcer can be classified as it can be

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			<p>observed to be a Stage 4 pressure ulcer and should be coded at M0300D. If this pressure ulcer has the largest surface area of all Stage 3 or 4 pressure ulcers for this resident, the pressure ulcer's dimensions would also be entered at M0610, Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough or Eschar if this pressure ulcer has the largest surface area of all Stage 3 or 4 pressure ulcers for this resident.</p> <p>3. Miss J. was admitted with one small Stage 2 pressure ulcer. Despite treatment, it is not improving. In fact, it now appears deeper than originally observed, and the wound bed is covered with slough.</p> <p style="padding-left: 40px;">Coding: Code at M0300F1 as 1, and at M0300F2 as 0, not present on admission/entry or reentry.</p> <p style="padding-left: 40px;">Rationale: The pressure ulcer depth is not observable because the pressure ulcer it is coded as unstageable due to coverage of the wound bed by with slough. This pressure ulcer is unstageable, and is but not coded in M0300F2 as present on admission/entry or reentry because it can no longer be coded as a Stage 2.</p>
3	M0300	M-19	<p style="text-align: center;">Health-related Quality of Life</p> <ul style="list-style-type: none"> • Quality health care begins with prevention and risk assessment, and care planning begins with prevention. Appropriate care planning is essential in optimizing a resident's ability to avoid, as well as recover from, pressure (as well as all) wounds. Deep tissue injuries may sometimes indicate severe damage. Identification and management of S suspected D Deep Tissue I injury (sDTI) is imperative.
3	M0300	M-19	<p style="text-align: center;">Steps for Assessment</p> <p>2. For the purposes of coding, determine that the lesion being assessed is primarily a result of pressure and that other conditions have been ruled out. If pressure is not NOT the primary cause, do not NOT code here.</p> <p>3. Examine the area adjacent to, or surrounding, an intact blister for evidence of tissue damage. If the tissue adjacent to, or surrounding, the blister does not show signs of tissue damage (e.g., color change, tenderness, boggy or firmness, warmth or coolness), do not NOT code as a suspected D Deep Tissue</p>

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			<p>Injury.</p> <p>5. Determine the number of pressure ulcers that are unstageable related to suspected Ddeep Ttissue Iinjury.</p>
3	M0300	M-20	<p>Coding Instructions for M0300G</p> <ul style="list-style-type: none"> Enter the number of unstageable pressure ulcers related to suspected deep tissue injury. Based on skin tone, the injured tissue area may present as a darker tone than the surrounding intact skin. These areas of discoloration are potentially areas of suspected deep tissue injury. <p>Coding Tips</p> <ul style="list-style-type: none"> When a lesion due to pressure presents with an intact blister AND the surrounding or adjacent soft tissue does NOT have the characteristics of dDeep TTissue IInjury, do notNOT code here.
3	M0610	M-20	<p>M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough and/or Eschar</p>
3	M0610	M-21	<p>M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough and/or Eschar (cont.)</p>
3	M0610	M-21	<p>Steps for Assessment</p> <p><i>If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough and/or eschar, identify the pressure ulcer with the largest surface area (length × width) and record in centimeters. Complete only if a pressure ulcer is coded in M0300C1, M0300D1, or M0300F1. The Figure (right) illustrates the measurement process.</i></p> <ol style="list-style-type: none"> Measurement is based on observation of the Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar after the dressing and any exudate are removed. Determine longest length (white arrow line) head to toe and greatest width (black arrow line) of each Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar. Measure every Stage 3, Stage 4, and unstageable pressure ulcer due to slough and/or eschar that is present. The clinician must be aware of all pressure ulcers present in order to determine which pressure ulcer is the largest. Use a skin tracking sheet or other worksheet to record the dimensions for

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			each pressure ulcer. Select the largest one by comparing the surface areas (length x width) of each.
3	M0610	M-22	M0610: Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Pressure Ulcer Due to Slough and/or Eschar (cont.)
3	M0610	M-22	<p>7. Considering only the largest Stage 3 or 4 pressure ulcer due to slough or eschar, determine the deepest area and record the depth in centimeters. To measure wound depth, moisten a sterile, cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water. Place the applicator tip in the deepest aspect of the ulcer and measure the distance to the skin level. If the depth is uneven, measure several areas and document the depth of the ulcer that is the deepest. If depth cannot be assessed due to slough and/or eschar, enter dashes in M0610C.</p> <p>8. If two pressure ulcers occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate pressure ulcers. Classify the sStage and measure each pressure ulcer separately.</p>
3	M0610	M-22	<p>Coding Instructions for M0610 Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Due to Slough and/or Eschar</p> <ul style="list-style-type: none"> • Enter the current longest length of the largest Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar in centimeters to one decimal point (e.g., 2.3 cm). • Enter the widest width in centimeters of the largest Stage 3, Stage 4, or unstageable pressure ulcer due to slough and/or eschar. Record the width in centimeters to one decimal point. • Enter the depth measured in centimeters of the largest Stage 3 or 4. Record the depth in centimeters to one decimal point. Note that depth cannot be assessed if wound bed is unstageable due to being covered with slough and/or eschar. If a pressure ulcer covered with slough and/or eschar is the largest unhealed pressure ulcer identified for measurement, enter dashes in item M0610C.
3	M0700	M-23	<p>Coding Instructions for M0700</p> <ul style="list-style-type: none"> • Code 1, eEpithelial tissue: if the wound is superficial and is re-epithelializing.

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			<ul style="list-style-type: none"> • Code 2, gGranulation tissue: if the wound is clean (e.g., free of slough and escharneerotic tissue) and contains granulation tissue. • Code 3, sSlough: if there is any amount of slough tissue present and neeroticeschar tissue is absent. • Code 4, nNecrotic tissue (eschar): if there is any neerotic tissue (eschar) tissue present. • Code 9, None of the above: if none of the above apply.
3	M0700	M-24	<p>Coding Tips and Special Populations</p> <ul style="list-style-type: none"> • Stage 2 pressure ulcers should not be coded as having granulation, slough, or necrotic tissue as by definition Stage 2 pressure ulcers they by definition have partial-thickness do not have this extent loss of the dermis. of tissue damage Granulation tissue, slough or eschar are not present in Stage 2 pressure ulcers. Therefore, Stage 2 pressure ulcers should not be coded as having granulation, slough, or eschar tissue and All Stage 2 pressure ulcers should be coded as 1 for this item. • If the wound bed is covered with a mix of different types of tissue, code for the most severe type. For example, if a mixture of necrotic tissue (eschar) and slough) is present, code for neerotic tissue (eschar). • Code this item with Code 9, None of the above, in the following situations: <ul style="list-style-type: none"> • Stage 1 pressure ulcer • Stage 2 pressure ulcer with intact blister • Unstageable pressure ulcer related to non-removable dressing /device • Unstageable pressure ulcer related to suspected deep tissue injury <ul style="list-style-type: none"> — Stage 1 pressure ulcer — Stage 2 pressure ulcer with intact blister — Unstageable pressure ulcer related to non-removable dressing/device — Unstageable pressure ulcer related to suspected deep tissue injury
3	M0700	M-24	<p>Examples</p> <ol style="list-style-type: none"> 1. A resident has a Stage 2 pressure ulcer on the right ischial tuberosity that is healing and a Stage 3 pressure ulcer on the sacrum that is also healing with red granulation tissue that has

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			<p>filled 75% of the ulcer and epithelial tissue that has resurfaced 25% of the ulcer. Coding: Code M0700 as 2, gGranulation tissue. Rationale: Coding for M0700 is based on the sacral ulcer, because it is the pressure ulcer with the most severe tissue type. Code 2, (Granulation tissue), is selected because this is the most severe tissue present in the wound.</p> <p>2. A resident has a Stage 2 pressure ulcer on the right heel and no other pressure ulcers. Coding: Code M0700 as 1, eEpithelial tissue. Rationale: Coding for M0700 is Code 1, (Epithelial tissue) because epithelial tissue is consistent with identification of this pressure ulcer as a Stage 2 pressure ulcer.</p> <p>3. A resident has a pressure ulcer on the left trochanter that has 25% black eschar necrotic tissue present, 75% granulation tissue present, and some epithelialization at the edges of the wound. Coding: Code M0700 as 4, nNecrotic tissue (eschar). Rationale: Coding is for the most severe tissue type present, which is not always the majority of type of tissue. Therefore, Coding for M0700 is Code 4, [(Necrotic tissue (eschar))].</p>
3	M0800	M-25	<p>Health-related Quality of Life</p> <ul style="list-style-type: none"> This item documents whether skin status, overall, has worsened since the last assessment. To track increasing skin damage, this item documents the number of new pressure ulcers and whether any pressure ulcers have “worsened” or increased in numerical to a higher (deeper) stage since the last assessment. Such tracking of pressure ulcers is consistent with good clinical care. <p>Planning for Care</p> <ul style="list-style-type: none"> The interdisciplinary care plan should be reevaluated to ensure that appropriate preventative measures and pressure ulcer management principles are being adhered to when new pressure ulcers develop or when pressure ulcers worsen. Pressure ulcers that degenerate or worsen to a higher (deeper) stage require a reevaluation of the interdisciplinary care plan.

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3	M0800	M-25	<p>Steps for Assessment</p> <p>1. Review the history of each current pressure ulcer. Specifically, compare the current stage to past stages to determine whether any pressure ulcer on the current assessment is new or at an increased numerical higher (deeper) stage when compared to the last MDS assessment. This allows a more accurate assessment than simply comparing total counts on the current and prior MDS assessment.</p>
3	M0800	M-26	<p>2. For each current stage, count the number of current pressure ulcers that are new or have increased in numerical stage worsened since the last MDS assessment was completed.</p>
3	M0800	M-26	<p>Coding Tips</p> <ul style="list-style-type: none"> • Coding this item will be easier for nursing homes that document and follow pressure ulcer status on a routine basis. • If a numerically staged pressure ulcer increases in numerical staging it is considered worsened. • Coding worsening of unstageable pressure ulcers: <ul style="list-style-type: none"> — If an pressure ulcer was unstageable on admission/entry or reentry, do not consider it to be worsened on the first assessment that it is able to be numerically staged. However, if the pressure ulcer subsequently increases in numerical stage it worsens after that assessment, it should be considered worsened included. — If a pressure ulcer was numerically previously staged pressure ulcer and becomes unstageable due to slough or eschar, do not consider this pressure ulcer de as worsened. The only way to determine if this pressure ulcer has worsened is to remove enough slough or eschar so that the wound bed becomes visible. Once enough of the wound bed can be visualized and/or palpated such that the tissues can be identified and the wound restaged, the determination of worsening can be made. — If a pressure ulcer was previously numerically staged pressure ulcer and becomes unstageable, and then is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the pressure ulcer's current numerical stage has increased, consider this pressure ulcer as worsened, code it as such in this item.

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			<p>— If two pressure ulcers merge, do not code as worsened. Although two merged pressure ulcers might increase the overall surface area of the ulcer, there would need to be an increase in numerical stage in order for it to be considered as worsened.</p> <p>— If a pressure ulcer is acquired during a hospital admission, its stage should be coded on admission and is is considered coded as present on admission/entry or reentry. It and is not included or coded in a count of this item worsening pressure ulcers.</p>
3	M0800	M-27	<p>— If a pressure ulcer increases in numerical worsens to a more severe stage during a hospital admission, its stage should be coded on admission and is considered should also be coded as present on admission/entry or reentry. It is and not included or coded in counts of worsening pressure ulcers this item. While not included in counts of worsening pressure ulcers this item, it is important to recognize clinically on reentry that the resident's overall skin status deteriorated while in the hospital. In either case, if the pressure ulcer deteriorates further (worsens) to a higher (deeper) stage and increases in numerical stage on a subsequent MDS assessments, it would be considered as then be included in counts of worsening pressure ulcers worsened and would be coded in this item.</p> <p>Examples</p> <ol style="list-style-type: none"> 1. A resident has a pressure ulcer on the right ischial tuberosity that was Stage 2 on the previous MDS assessment and has now increased in numerical stage deteriorated (worsened) to a Stage 3 pressure ulcer. Coding: Code M0800A as 0, M0800B as 1, and M0800C as 0. Rationale: The pressure ulcer was at a lesser numerical stage on the prior assessment. 2. A resident is admitted with an unstageable pressure ulcer on the sacrum, which is debrided and reclassified as a Stage 4 pressure ulcer 3 weeks later. The initial MDS assessment listed the pressure ulcer as unstageable. Coding: Code M0800A as 0, M0800B as 0, and M0800C as 0. Rationale: The unstageable pressure ulcer was present

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			<p>on the initial MDS assessment. After debridement it numerically staged as was a Stage 4 pressure ulcer. This is the first numerical staging since debridement and therefore, should not be considered or coded as worsening on the MDS assessment.</p> <p>3. A resident has previous medical record and MDS documentation of a Stage 2 pressure ulcer on the sacrum and a Stage 3 pressure ulcer on the right heel. Current skin care flow sheets indicate a Stage 3 pressure ulcer on the sacrum, a Stage 4 pressure ulcer on the right heel, as well as nd a new Stage 2 pressure ulcer on the left trochanter.</p> <p style="padding-left: 40px;">Coding: Code M0800A as 1, M0800B as 1, and M0800C as 1.</p> <p style="padding-left: 40px;">Rationale: M0800A would be coded 1 because the new Stage 2 pressure ulcer on the left trochanter was not present on the prior assessment. M0800B would be coded 1 and M0800C would be coded 1 for the increased numerical staging worsening in pressure ulcer status (i.e. increased severity) of both the sacrum and right heel pressure ulcers.</p>
3	M0800	M-28	<p>4. A resident develops a Stage 3 pressure ulcer while at the nursing home. The wound bed is subsequently covered with slough and is coded on the next assessment as unstageable due to slough. After debridement, the wound bed is clean and the pressure ulcer is reassessed and determined to still be coded as a Stage 3 pressure ulcer.</p> <p style="padding-left: 40px;">Coding: Code M0800A as 0, M0800B as 0, and M0800C as 0.</p> <p style="padding-left: 40px;">Rationale: M0800B would be coded 0 because the numerical stage of the current Stage 3 pressure ulcer is the same numerical stage as it was prior to the period it became unstageable.</p>
3	M0900	M-28	<p>Health-related Quality of Life</p> <ul style="list-style-type: none"> Pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during the pressure ulcer development before they re-epithelialize. Stage 3 and 4 pressure ulcers fill with granulation tissue (primarily endothelial cells, fibroblasts, collagen and extracellular matrix). This r Replacement tissue is never as strong as the tissue that was lost and hence is more prone to future

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3	M0900	M-29	<p>breakdown.</p> <p>Planning for Care</p> <ul style="list-style-type: none"> • Pressure ulcers that heal require continued prevention interventions as the site is always at risk for future damage. • Most Stage 2 pressure ulcers should heal within a reasonable timeframe (e.g. 60 days). Full thickness Stage 3 and 4 pressure ulcers may require longer healing times. • Current Clinical standards do not support reverse staging or backstaging as a way to document healing as it does not accurately characterize what is physiologically occurring as the ulcer heals. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Previous standards using reverse or backstaging would have permitted identification of the is pressure ulcer as a Stage 3, then a Stage 2, and so on, 2 pressure ulcer when it reached a depth consistent with these stages Stage 2 pressure ulcers. Clinical current standards now would require that this is ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed. Nursing homes can document the healing of pressure ulcers using descriptive characteristics of the wound (i.e. depth, width, presence or absence of granulation tissue, etc.) or by using a validated pressure ulcer healing tool. Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage – in this example, a healed Stage 4 pressure ulcer. For care planning purposes, this a healed Stage 4 pressure ulcer would remain at increased risk for future breakdown or injury and would it require continued monitoring and preventative care. <p>Steps for Assessment</p> <p><i>Complete on all residents, including those without a current pressure ulcer. Look-back period for this item is the ARD of the prior assessment. If no prior assessment (i.e., if this is the first OBRA or scheduled PPS assessment), do not complete this item. Skip to M1030.</i></p> <ol style="list-style-type: none"> 1. Review medical records to identify whether any pressure ulcers that were noted on the prior MDS assessment have completely closed healed by the ARD (A2300) of the current assessment.

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			2. Identify the deepest anatomical stage (see definition on page M-5) of each resurfaced (or healed) pressure ulcer.
3	M0900	M-30	Complete on all residents (even if M0210 = 0) Complete on all residents (even if M0210 = 0)
3	M0900	M-30	Coding Instructions for M0900B, C, and D. <ul style="list-style-type: none"> Enter the number of pressure ulcers that have healed since the last assessment for each Stage, 2 through 4.
3	M0900	M-30	Coding Tips <ul style="list-style-type: none"> If the prior assessment documents that a pressure ulcer healed between MDS assessments, but another pressure ulcer occurred at the same anatomical location, do not consider this pressure ulcer as healed. The re-opened pressure ulcer should be staged at its highest numerical stage until fully healed.
3	M10300	M-31	Coding Instructions <i>Check all that apply in the last 7 days.</i> Pressure ulcers coded in M0210 through M0900 should not NOT be coded here.
3	M1030 & M1040	M-32	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	M1040	M-33	Coding Instructions <i>Check all that apply in the last 7 days. If there is no evidence of such problems in the last 7 days, check none of the above.</i> Pressure ulcers coded in M0200 through M0900 should not NOT be coded here. <ul style="list-style-type: none"> M1040A, i Infection of the foot (e.g., cellulitis, purulent drainage) M1040B, e Diabetic foot ulcer(s) M1040C, o Other open lesion(s) on the foot (e.g., cuts, fissures)
3	M10400	M-34	<ul style="list-style-type: none"> M1040D, o Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion) M1040E, s Surgical wound(s) M1040F, b Burn(s)(second or third degree) M1040G, s Skin tear(s)

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			<ul style="list-style-type: none"> • M1040H, Moisture Associated Skin Damage (MASD) (i.e., incontinence (IAD), perspiration, drainage) • M1040Z, None None of the above were present
3	M1040	M-34	<p>Coding Tips</p> <p>M1040B Diabetic Foot Ulcers</p> <ul style="list-style-type: none"> • Do NOT not include pressure ulcers that occur on residents with diabetes mellitus here. For example, an ulcer caused by pressure on the heel of a diabetic resident is a pressure ulcer and not a diabetic foot ulcer. <p>M1040D Open Lesion Other than Ulcers, Rashes, Cuts</p> <ul style="list-style-type: none"> • Do NOT not code rashes, skin tears, cuts/lacerations here. Although not recorded on the MDS assessment, these skin conditions should be considered in the plan of care. <p>M1040E Surgical Wounds</p> <ul style="list-style-type: none"> • Do not code pressure ulcers that have been surgically debrided as surgical wounds. They continue to be coded as pressure ulcers. Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing. A pressure ulcer that has been surgically debrided should continue to be coded as a pressure ulcer.
3	M1040	M-35	<p>M1040: Other Ulcers, Wounds and Skin Problems (cont.)</p> <ul style="list-style-type: none"> • This coding is appropriate for pressure ulcers that require are surgically intervention for repaired-closure with grafts and/or flap procedures in this item (e.g. excision of pressure ulcer with myocutaneous flap). Once a pressure ulcer is excised and a graft and/or flap is applied, it is no longer considered a pressure ulcer, but a surgical wound. <p>M1040F Burns (Second or Third Degree)</p> <ul style="list-style-type: none"> • Do NOT not include first degree burns (changes in skin

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			<p>color only).</p> <p>M1040H Moisture Associated Skin Damage (MASD)</p> <ul style="list-style-type: none"> Moisture associated skin damage (MASD) is a result of skin damage caused by moisture rather than pressure. It is caused by sustained exposure to moisture which can be caused, for example, by incontinence, wound exudate and perspiration. It is characterized by inflammation of the skin, and occurs with or without skin erosion and/or infection. MASD is also referred to as incontinence-associated dermatitis and can cause other conditions such as intertriginous dermatitis, periwound moisture-associated dermatitis, and peristomal moisture-associated dermatitis. Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown. <p>Examples</p> <ol style="list-style-type: none"> A resident with diabetes mellitus presents with an ulcer on the heel that is due to pressure. <p style="margin-left: 40px;">Coding: This ulcer is not checked at M1040B. This ulcer should be coded where appropriate under the Pressure Ulcers items (M0210-M0900).</p> <p style="margin-left: 40px;">Rationale: Persons with diabetes can still develop pressure ulcers.</p> A resident is readmitted from the hospital after myocutaneous flap surgery to repair excise and close his a sacral pressure ulcer. <p style="margin-left: 40px;">Coding: Check M1040E, (Surgical Wound(s)).</p> <p style="margin-left: 40px;">Rationale: A surgical flap procedure was used to repair close the resident's pressure ulcer. The pressure ulcer is now considered s changes the coding to a surgical wound.</p> Mrs. J. was reaching over to get a magazine off of her bedside table and sustained a skin tear on her wrist from the edge of the table when she pulled the magazine back towards her. <p style="margin-left: 40px;">Coding: Check M1040G, Skin Tear(s).</p> <p style="margin-left: 40px;">Rationale: The resident sustained a skin tear while</p>

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			reaching for a magazine.
3	M1040	M-36	<p>4. Mr. S. who is incontinent, is noted to have a large, red and excoriated area on his buttocks and interior thighs with serous exudate which is starting to cause skin glistening.</p> <p style="padding-left: 40px;">Coding: Check M1040H, Moisture Associated Skin Damage (MASD).</p> <p style="padding-left: 40px;">Rationale: Mr. S. skin assessment reveals characteristics of incontinence-associated dermatitis.</p> <p>5. Mrs. F. complained of discomfort of her right great toe and when her stocking and shoe was removed, it was noted that her toe was red, inflamed and had pus draining from the edge of her nail bed. The podiatrist determined that Mrs. F. has an infected ingrown toenail.</p> <p style="padding-left: 40px;">Coding: Check M1040A, Infection of the foot.</p> <p style="padding-left: 40px;">Rationale: Mrs. F. has an infected right great toe due to an ingrown toenail.</p> <p>6. Mr. G. has bullous pemphigoid and requires the application of sterile dressings to the open and weeping blistered areas.</p> <p style="padding-left: 40px;">Coding: Check M1040D, Open lesion other than ulcers, rashes, cuts.</p> <p style="padding-left: 40px;">Rationale: Mr. G. has open bullous pemphigoid blisters.</p> <p>7. Mrs. A. was just admitted to the nursing home from the hospital burn unit after sustaining second and third degree burns in a house fire. She is here for continued treatment of her burns and for rehabilitative therapy.</p> <p style="padding-left: 40px;">Coding: Check M1040F, Burns (second or third degree).</p> <p style="padding-left: 40px;">Rationale: Mrs. A. has second and third degree burns, therefore, burns (second or third degree) should be checked.</p>
3	M1200	M-37	<p>Coding Instructions</p> <ul style="list-style-type: none"> • M1200A, pPressure reducing device for chair • M1200B, pPressure reducing device for bed • M1200C, tTurning/repositioning program • M1200D, nNutrition or hydration intervention to manage

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			<p>skin problems</p> <ul style="list-style-type: none"> • M1200E, pPressure ulcer care • M1200F, sSurgical wound care
3	M1200	M-38	<ul style="list-style-type: none"> • M1200G, aApplication of non-surgical dressings (with or without topical medications) other than to feet. Non-surgical dressings do not include Band-Aids. • M1200H, aApplication of ointments/medications other than to feet • M1200I, aApplication of dressings to feet (with or without topical medications) • M1200Z, nNone of the above were provided <p>Coding Tips</p> <p>M1200A/M1200B Pressure Reducing Devices</p> <ul style="list-style-type: none"> • Pressure reducing devices redistribute pressure so that there is some relief on or near the area of the ulcer. The appropriate reducing (redistribution) device should be selected based on the individualized needs of the resident. • Do not include egg crate cushions of any type in this category. • Do not NOT include doughnut or ring devices in chairs.
3	M1200	M-39	<p>M1200E Pressure Ulcer Care</p> <ul style="list-style-type: none"> • Pressure ulcer care includes any intervention for treating pressure ulcers coded in Current Number of Unhealed Pressure Ulcers at Each Stage item (M0300A-G). Examples may include the use of topical dressings, enzymatic, mechanical or surgical debridement, wound irrigations, negative pressure wound therapy (NPWT), and/or hydrotherapy. <p>M1200F Surgical Wound Care</p> <ul style="list-style-type: none"> • Does not include post-operative care following eye or oral surgery. • Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing, and thus, any wound care associated with pressure ulcer debridement would be coded in

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			<p>M1200E, Pressure Ulcer Care. The only time a surgical wound would be created is if the pressure ulcer itself was excised and a flap and/or graft used to close the pressure ulcer. continues to be coded as a pressure ulcer.</p> <ul style="list-style-type: none"> • Surgical wound care may include any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application. • Surgical wound care for pressure ulcers that require surgical intervention for closure (e.g., excision of pressure ulcer with flap and/or graft coverage) can be coded in this item, as once a pressure ulcer is excised and flap and/or graft applied, it is no longer considered a pressure ulcer, but a surgical wound.
3	M1200	M-40	<p>M1200G Application of Non-surgical Dressings (with or without Topical Medications) Other than to Feet</p> <ul style="list-style-type: none"> • Do not NOT code application of non-surgical dressings for pressure ulcer(s) other than to feet in this item; use M1200E, Pressure Ulcer Care item (M1200E). • Dressings do not have to be applied daily in order to be coded on the MDS assessment. If any dressing meeting the MDS definitions was applied even once during the 7-day look-back period, the assessor should check that MDS item. • This category may include but is not limited to: dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages, etc. Non-surgical dressings do not include adhesive bandages (e.g., BAND-AID® bandages) ids. <p>M1200H Application of Ointments/Medications Other than to Feet</p> <ul style="list-style-type: none"> • Do not NOT code application of ointments/medications (e.g. chemical or enzymatic debridement) for pressure ulcers here; use M1200E, Pressure Ulcer Care, item (M1200E). • This category may include ointments or medications used

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			<p>to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents).</p> <ul style="list-style-type: none"> • Ointments/medications may include topical creams, powders, and liquid sealants used to treat or prevent skin conditions. • This category definition does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain, testosterone cream). <p>M1200I Application of Dressings to the Feet (with or without Topical Medications)</p> <ul style="list-style-type: none"> • Includes interventions to treat any foot wound or ulcer other than a pressure ulcer. • Do not NOT code application of dressings to pressure ulcers on the foot, use M1200E, Pressure Ulcer Care item (M1200E). • Do not code application of dressings to the ankle. The ankle is made up of two joints (ankle joint proper and subtalar joint) and is not considered part of the foot.
3	M1200	M-41	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	M1200	M-42	<p>4. Mr. J. has a diagnosis of Advanced Alzheimer’s and is totally dependent on staff for all of his care. His care plan states that he is to be turned and repositioned, per facility policy, every 2 hours.</p> <p style="text-align: center;">Coding: Do not not check item M1200C.</p>
3	M1200	M-42	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	M1200	M-43	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	M1200	M-44	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	M1200	M-45	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	M1200	M-46	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	M1200	M-47	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	M1200	M-48	<ul style="list-style-type: none"> • M0610 (Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar), is not NOT completed, as the resident has a Stage 2 pressure ulcer. • M0700 (Most severe tissue type for any pressure ulcer), Code 1 (Epithelial tissue). • M0800 (Worsening in pressure ulcer status since prior assessment (OBRA or scheduled PPS or Last Admission/Entry or Reentry)), M0800A, Code 1; M0800B, Code 0; M0800C, Code 0. This item is completed because

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			<p>the 14-Day PPS is not NOT the first assessment since the most recent admission/entry or reentry. Therefore, A0310E=0.</p> <p>M0800A is coded 1 because the resident has a new Stage 2 pressure ulcer that was not present on the prior assessment.</p> <ul style="list-style-type: none"> • M0900A (Healed pressure ulcers), Code 0. This is completed because the 14-Day PPS is not NOT the first assessment since the most recent admission/entry or reentry. Therefore A0310E=0. Since there were no pressure ulcers noted on the 5-Day PPS assessment, this is coded 0, and skip to M1030.
3	M1200	M-49	<p>Rationale: The resident had a formal assessment using the Braden scale and also had a head-to-toe skin assessment completed. Pressure ulcer risk was identified via formal assessment. On the 5-Day PPS assessment the resident's skin was noted to be intact, however, on the 14-Day PPS assessment, it was noted that the resident had a new Stage 2 pressure ulcer. Since the resident has had both a 5-day and 14-Day PPS completed, the 14-Day PPS would be coded 0 at A0310E. This is because the 14-Day PPS is not NOT the first assessment since the most recent admission/entry or reentry. Since A0310E=0, items M0800 (Worsening in pressure ulcer status) and M0900 (Healed pressure ulcers) would be completed. Since the resident did not have a pressure ulcer on the 5-Day PPS and did have one on the 14-Day PPS, the new Stage 2 pressure ulcer is documented under M0800 (Worsening in pressure ulcer status). M0900 (Healed pressure ulcers) is coded as 0 because there were no pressure ulcers noted on the prior assessment (5-Day PPS). There were no other skin problems noted. However the resident, since she is at an even higher risk of breakdown since the development of a new ulcer, has preventative measures put in place with pressure redistribution devices for her chair and bed. She was also placed on a turning and repositioning program based on tissue tolerance. Therefore M1200A, M1200B, and M1200C were all checked. She also now requires ulcer care and application of a dressing to the coccygeal ulcer, so M1200E is also checked. M1200G (Application of nonsurgical dressings – with or without topical medications) would not NOT be coded here because any intervention for treating pressure ulcers is coded in M1200E (Pressure ulcer care).</p>
3	M1200	M-50	PAGE LENGTH AND/OR PAGE NUMBER CHANGE

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3	M1200	M-51	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	M1200	M-52	PAGE LENGTH AND/OR PAGE NUMBER CHANGE

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3	N0410	N-8	<p>Example</p> <p>1. The Medication Administration Record for Mrs. P. reflects the following:</p> <ul style="list-style-type: none"> • Risperidone 0.5 mg PO BID PRN: Received once a day on Monday, Wednesday, and Thursday. • Lorazepam 1 mg PO QAM: Received every day. • Temazepam 15 mg PO QHS PRN: Received at bedtime on Tuesday and Wednesday only. <p>Coding: Medications in N0410, would be checked as follows: A. Antipsychotic, risperidone is an antipsychotic medication, B. Antianxiety, lorazepam is an antianxiety medication, and D. Hypnotic, temazepam is a hypnotic medication. Please note: if a resident is receiving medications in all three categories simultaneously there must be a clear clinical indication for the use of these medications. Administration of these types of medications, particularly in this combination, could be interpreted as chemically restraining the resident. Adequate documentation is essential in justifying their use.</p>

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3	O0100	O-2	<p>Coding Instructions for Column 1</p> <p>Check all treatments, procedures, and programs received or performed by the resident prior to admission/entry or reentry to the facility and within the 14-day look-back period. Leave Column 1 blank if the resident was admitted/entered or reentered the facility more than 14 days ago. If no items apply in the last 14 days, check Z, none of the above.</p> <p>Coding Instructions for Column 2</p> <p>Check all treatments, procedures, and programs received or performed by the resident after admission/entry or re-entry reentry to the facility and within the 14-day look-back period.</p> <p>Coding Tips</p> <ul style="list-style-type: none"> • O0100A, eChemotherapy • O0100B, rRadiation
3	O0100	O-3	<ul style="list-style-type: none"> • O0100C, eOxygen therapy • O0100D, sSuctioning • O0100E, tTracheostomy care • O0100F, vVentilator or respirator
3	O0100	O-4	<ul style="list-style-type: none"> • O0100I, tTransfusions • O0100J, eDialysis • O0100K, hHospice care • O0100L, rRespite care • O0100M, iIsolation for active infectious disease (does not include standard precautions)
3	O0100	O-5	<ul style="list-style-type: none"> • 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Isolation2007.pdf http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html • SHEA/APIC Guideline: Infection Prevention and Control in the Long Term Care Facility http://www.apic.org/Content/NavigationMenu/PracticeGuidance/APIC

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			<p>SHEA_Guideline.pdf http://www.apic.org/Resource_/TinyMceFileManager/Practice_Guidance/id_APIC-SHEA_GuidelineforICinLTCFs.pdf</p> <p>As the CDC guideline notes, there are psychosocial risks associated with such restriction, and it has been recommended that psychosocial needs be balanced with infection control needs in the long-term care facility setting.</p> <ul style="list-style-type: none"> • O0100Z, nNone of the above
3	O0100	O-6	<p>Planning for Care</p> <ul style="list-style-type: none"> • Determining the rate of vaccination and causes for non-vaccination assists nursing homes in reaching the Healthy People 2020 (www.healthypeople.gov http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=23) national goal of 90 percent immunization among nursing home residents. <p>Steps for Assessment</p> <ol style="list-style-type: none"> 1. Review the resident’s medical record to determine whether an influenza vaccine was received in the facility for this year’s influenza season. If vaccination status is unknown, proceed to the next step. 2. Ask the resident if he or she received an influenza vaccine outside of the facility for this year’s influenza season. If vaccination status is still unknown, proceed to the next step.
3	O0100	O-6	<p>Coding Instructions for O0250A, ...</p> <ul style="list-style-type: none"> • Code 0, no: if the resident did NOT receive the influenza vaccine in this facility during this year’s influenza season. Proceed to If influenza vaccine not received, state reason (O0250C). • Code 1, yes: if the resident did receive the influenza vaccine in this facility during this year’s influenza season. Continue to Date Vaccine Received (O0250B).
3	O0100	O-7	<p>Coding Instructions for O0250B, ...</p> <ul style="list-style-type: none"> • Enter date vaccine received. Do not leave any boxes blank. If the month contains only a single digit, fill in the first box of the month with a “0”. For example, January 7, 2010 should be entered as 01-07-2010. If the day only contains

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			<p>a single digit, then fill the first box of the day with the “0”. For example, May 6, 2009¹² should be entered as 05-06-2009¹². A full 8 character date is required. If the date is unknown or the information is not available, a single dash needs to be entered in the first box.</p> <p>Coding Instructions for O0250C, ...</p> <p><i>If the resident has not received the influenza vaccine for this year’s influenza season (i.e., O250A=0), code the reason from the following list:</i></p> <ul style="list-style-type: none"> • Code 1, Resident not in facility during this year’s influenza season: resident not in the facility during this year’s influenza season. • Code 2, Received outside of this facility: includes influenza vaccinations administered in any other setting (e.g., physician office, health fair, grocery store, hospital, fire station) during this year’s influenza season. • Code 3, Not eligible—medical contraindication: if influenza vaccination not received due to medical contraindications, including allergic reaction to eggs or other vaccine component(s), a physician order not to immunize, or an acute febrile illness is present. However, the resident should be vaccinated if contraindications end. • Code 4, Offered and declined: resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the influenza vaccine. • Code 5, Not offered: resident or responsible party/legal guardian not offered the influenza vaccine. • Code 6, Inability to obtain vaccine due to a declared shortage: influenza vaccine unavailable at the facility due to declared influenza vaccine shortage. However, the resident should be vaccinated once the facility receives the vaccine. The annual supply of inactivated influenza vaccine and the timing of its distribution cannot be guaranteed in any year. • Code 9, None of the above: if none of the listed reasons describe why the influenza vaccination was not administered. This code is also used if the answer is

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			unknown.
3	O0100	O-7	<p>Coding Tips and Special Populations</p> <ul style="list-style-type: none"> The influenza season varies annually. Information about current influenza season can be obtained by accessing the CDC Seasonal Influenza (Flu) website. This website provides information on influenza activity and has an interactive map that shows geographic spread of influenza: http://www.cdc.gov/flu/weekly/fluactivitysurv.htm, http://www.cdc.gov/flu/weekly/usmap.htm. Facilities can also contact their local health department website for their local influenza surveillance information. The influenza season ends when influenza is no longer active in your geographic area.
3	O0100	O-8	<p>Examples</p> <ol style="list-style-type: none"> Mrs. J. received the influenza vaccine in the facility during this year's influenza season, on January 7, 2010. Rationale: Mrs. J. received the vaccine in the facility on January 7, 2010, during this year's influenza season. Mr. R. did not receive the influenza vaccine in the facility during this year's influenza season due to his known allergy to egg protein.
3	O0100	O-8	<p>Rationale: Mr. K. was unable to receive the influenza vaccine in the facility due to the fact that the facility did not receive its shipment of influenza vaccine until after his discharge. None of the codes in O0250C, Influenza vaccine not received, state reason, are applicable.</p>
3	O0100	O-9	<p>Planning for Care</p> <ul style="list-style-type: none"> Determining the rate of pneumococcal vaccination and causes for non-vaccination assists nursing homes in reaching the Healthy People 2020 (www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=23) national goal of 90% immunization among nursing home residents.
3	O0100	O-10	<p>{Centers for Disease Control and Prevention. (2009, May). <i>The Pink Book: Chapters: Epidemiology and Prevention of Vaccine Preventable Diseases (11th ed.)</i>. Retrieved from http://www.cdc.gov/vaccines/pubs/pinkbook/pink-chapters.htmhttp://www.cdc.gov/vaccines/pubs/pinkbook/index.html#chapters}</p>

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3	O0100	O-12	<p>Coding Instructions O0300B, ...</p> <ul style="list-style-type: none"> Code 1, Not eligible: if the resident is not eligible due to medical contraindications, including a life-threatening allergic reaction to the pneumococcal vaccine or any vaccine component(s) or a physician order not to immunize. Code 2, Offered and declined: resident or responsible party/legal guardian has been informed of what is being offered and chooses not to accept the pneumococcal vaccine. Code 3, Not offered: resident or responsible party/legal guardian not offered the pneumococcal vaccine.
3	O0100	O-13	<p>2. Mrs. B, who is 95 years...</p> <p>Rationale: Mrs. B. has never received the pneumococcal vaccine, therefore, her vaccine is not up to date. Her physician has written an order for her not to receive a pneumococcal vaccine, thus she is not eligible for the vaccine.</p>
3	O0100	O-13	<p>4. Mr. T. received the...</p> <p>Rationale: Mr. T. received his first dose of pneumococcal vaccine prior to the age of 65 due to him residing in congregate care at the age of 62. Even though Mr. T. is now immune compromised immunocompromised, less than 5 years have lapsed since he originally received the vaccine. He would be considered up to date with his vaccination.</p>
3	O0100	O-16	<ul style="list-style-type: none"> Therapy Start Date—Record the date the most recent therapy regimen (since the most recent entry/reentry) started. This is the date the initial therapy evaluation is conducted regardless if treatment was rendered or not or the date of resumption (O0450B) on the resident’s EOT OMRA, in cases where the resident discontinued and then resumed therapy.
3	O0100	O-26	<p>A resident may have more than one regimen of therapy treatment during an episode of a stay. When this situation occurs the Therapy Start Date for the most recent episode of treatment for the particular therapy (SLP, PT, or OT) should be coded. When a resident’s episode of treatment for a given type of therapy extends beyond the ARD (i.e., therapy is ongoing), enter dashes in the appropriate Therapy End Date. When a resident’s Medicare Part A stay is eight days or less, Therapy is considered to be ongoing if:</p>
3	O0100	O-26	<p>NOTE: When an EOT-R is completed, the Therapy sStart eDate</p>

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			(O0400A5, O0400B5, and O0400C5) on the <u>next PPS</u> -assessment is the date of same as the Resumption of Resumption of Therapy Start Date (O0450B) on the EOT-R- (O0450B) . If therapy is ongoing, the Therapy e End d Date (O0400A6, O0400B6, and O0400C6) would be filled out with dashes.
3	O0100	O-29	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	O0100	O-31	NOTE: When an EOT-R is completed, the Therapy start date (O0400A5, O0400B5, and O0400C5) on the next PPS assessment is the date of the Resumption of therapy on the EOT R (O0450B). If therapy is ongoing, the Therapy end date (O0400A6, O0400B6, and O0400C6) would be filled out with dashes. NOTE: When an EOT-R is completed, the Therapy Start Date (O0400A5, O0400B5, and O0400C5) on the next PPS assessment is the same as the Therapy Start Date on the EOT-R. If therapy is ongoing, the Therapy End Date (O0400A6, O0400B6, and O0400C6) would be filled out with dashes.
3	O0100	O-31	Coding Instructions: When an EOT OMRA has been performed, determine whether therapy will resume. If it will, determine whether therapy will resume no more than five consecutive calendar days after the last day of therapy was provided AND whether the therapy services will resume at the same RUG-IV classification level for each discipline , if no, skip to O0500 , Restorative Nursing Programs. If Yes, code item O0450A as 1 . Determine when therapy will resume and code item O0450B with the date that therapy will resume. For example:
3	O0100	O-31	<ul style="list-style-type: none"> Mrs. A. who was in RVL did not receive therapy on Saturday and Sunday because the facility did not provide weekend services and she missed therapy on Monday because of a doctor's appointment. She resumed therapy on Tuesday, November 13, 2011. The IDT determined that her RUG-IV therapy classification level did not change as she had not had any significant clinical changes during the lapsed therapy days. When the EOT was filled out, item O0450 A was coded as 1 because therapy was resuming within 5 days from the last day of therapy and it was resuming at the same RUG-IV classification level. Item O0450B was coded as 11132011 because therapy resumed on November 13, 2011.
3	O0100	O-32	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	O0100	O-33	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	O0100	O-34	<ul style="list-style-type: none"> O0500B, Range of Motion (Active) Code exercises performed by the resident, with cueing, supervision, or physical assist by staff that are individualized to

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			the resident's needs, planned, monitored, evaluated , evaluated , and documented in the resident's medical record. Include active ROM and active-assisted ROM.
3	O0100	O-34	<ul style="list-style-type: none"> O0500C, Splint or Brace Assistance <p>Code provision of (1) verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint; or (2) a scheduled program of applying and removing a splint or brace. These sessions are individualized to the resident's needs, planned, monitored, evaluated, evaluated, and documented in the resident's medical record.</p>
3	O0100	O-35	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	O0100	O-36	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	O0100	O-37	<p>5. Mrs. J. had a CVA less than a year ago resulting in left-sided hemiplegia. Mrs. J. has a strong desire to participate in her own care. Although she cannot dress herself independently, she is capable of participating in this activity of daily living. Mrs. J.'s overall care plan goal is to maximize her independence in ADL's ADLs. A plan, documented on the care plan, has been developed to assist Mrs. J. in how to maintain the ability to put on and take off her blouse with no physical assistance from the staff. All of her blouses have been adapted for front closure with velcro. The nursing assistants have been instructed in how to verbally guide Mrs. J. as she puts on and takes off her blouse to enhance her efficiency and maintain her level of function. It takes approximately 20 minutes per day for Mrs. J. to complete this task (dressing and undressing).</p>
3	O0100	O-38	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	O0100	O-39	<p>Coding Tips and Special Populations</p> <ul style="list-style-type: none"> Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law. Examination (partial or full) can occur in the facility or in the physician's office. Included in this item are telehealth visits as long as the requirements are met for physician/practitioner type as defined above and whether it qualifies as a telehealth billable visit. For eligibility requirements and additional information about Medicare telehealth services refer to: <ul style="list-style-type: none"> — Chapter 15 of the <i>Medicare Benefit Policy Manual</i> (Pub. 100-2) and Chapter 12 of the <i>Medicare Claims</i>

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			<p style="text-align: center;"><i>Processing Manual</i> (Pub. 100-4) may be accessed at: http://www.cms.hhs.gov/Manuals/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html</p>
3	O0100	O-40	PAGE LENGTH AND/OR PAGE NUMBER CHANGE
3	O0100	O-41	<ul style="list-style-type: none"> • A monthly-Medicare Certification/Recertification is a renewal of an existing order and should not be included when coding this item.

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3	-	P-1	<p>CMS is committed to reducing unnecessary physical restraints in nursing homes and ensuring that residents are free of physical restraints unless deemed necessary and appropriate as permitted by regulation. Proper interpretation of the physical restraint definition is necessary to understand if nursing homes are accurately assessing manual methods or physical or mechanical devices, materials or equipment as physical restraints and meeting the federal requirement for restraint use (see Centers for Medicare & Medicaid Services. [2007, June 22]. Memorandum to State Survey Agency Directors from CMS Director, Survey and Certification Group: Clarification of Terms Used in the Definition of Physical Restraints as Applied to the Requirements for Long Term Care Facilities. Retrieved October 16, 2009 December 18, 2012, from http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter07-22.pdf).</p> <p>Are Restraints Prohibited by CMS?</p> <p>Federal regulations and CMS guidelines do not prohibit use of physical restraints in nursing homes, except when they are imposed for discipline or convenience and are not required to treat the resident’s medical symptoms. The regulation specifically states, “The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident’s medical symptoms” (42 CFR 483.13(a)). Research and standards of practice show that physical restraints have many negative side effects and risks that far outweigh any benefit from their use.</p> <p>Prior to using any physical restraint, the nursing home must assess the resident to properly identify the resident’s needs and the medical symptom(s) that the restraint is being employed to address. If a physical restraint is needed to treat the resident’s medical symptom, the nursing home is responsible for assessing the appropriateness of that restraint. When the decision is made to use a physical restraint, CMS encourages, to the extent possible, gradual restraint reduction because there are many negative outcomes associated with restraint use.</p> <p>While a restraint-free environment is not a federal requirement, the use of physical restraints should be the exception, not the rule.</p>
3	P0100	P-2	<p>Item Rationale</p> <p>Health-related Quality of Life</p> <ul style="list-style-type: none"> Although the requirements describe the narrow instances

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			<p>when physical restraints may be used, growing evidence supports that physical restraints have a limited role in medical care. Physical Restraints limit mobility and increase the risk for a number of adverse outcomes, such as functional decline, agitation, diminished sense of dignity, depression, and pressure ulcers.</p> <ul style="list-style-type: none"> Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used on this population be carefully considered and monitored. In many cases, the risk of using the device physical restraint may be greater than the risk of it not being used ing the device. The risk of restraint-related injury and death is significant when physical restraints are used. <p>Planning for Care</p> <ul style="list-style-type: none"> When the use of physical restraints is considered, thorough assessment of problems to be addressed by restraint use is necessary to determine reversible causes and contributing factors and to identify alternative methods of treating non-reversible issues. When the interdisciplinary team determines that the use of physical restraints is the appropriate course of action, and there is a signed physician order that gives the medical symptom supporting the use of the restraint, the least restrictive device manual method or physical or mechanical device, material or equipment that will meet the resident's needs must be selected. Care planning must focus on preventing the adverse effects of physical restraint use.
3	P0100	P-3	<p>Steps for Assessment</p> <ol style="list-style-type: none"> Considering the physical restraint definition as well as the clarifications listed below, observe the resident to determine the effect the restraint has on the resident's normal function. Do not focus on the type of device, intent, or reason behind its the use of the device. Evaluate whether the resident can easily and voluntarily remove the any manual method or physical or mechanical device, material, or equipment attached or adjacent to his or her body. If the resident cannot easily and voluntarily do this remove the restraint, continue with the assessment to determine whether or not the manual method or physical or

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			<p>mechanical device, material or equipment the device restricts freedom of movement or restrict the resident's access to his or her own body.</p> <p>5. Any manual method or physical or mechanical device, material or equipment should be classified as a restraint only when it meets the criteria of the physical restraint definition. This can only be determined on a case-by-case basis by individually assessing each and every manual method or physical or mechanical device, material or equipment (whether or not it is listed specifically on the MDS) attached or adjacent to the resident's body, and the its effect it has on the resident.</p> <p>6. Determine if the manual method or physical or mechanical device, material, or equipment meets the definition of a physical restraint as clarified below. Remember, the decision about coding any manual method or physical or mechanical device, material, equipment, or physical or manual method as a restraint depends on the effect it the device has on the resident.</p> <p>7. Any manual method or physical or mechanical device, material, or equipment that meets the definition of a physical restraint must have:</p> <p>Clarifications</p> <ul style="list-style-type: none"> • “Remove easily” means that the manual method, or physical or mechanical device, material, or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff (e.g., side rails are put down or not climbed over, buckles are intentionally unbuckled, ties or knots are intentionally untied), considering the resident's physical condition and ability to accomplish his or her objective (e.g., transfer to a chair, get to the bathroom in time).
3	P0100	P-4	<ul style="list-style-type: none"> • “Medical symptoms/diagnoses” are defined as an indication or characteristic of a physical or psychological condition. Objective findings derived from clinical evaluation of the resident's subjective symptoms and medical diagnoses and subjective symptoms should be considered when determining the presence of medical symptom(s) that might support restraint use. The resident's subjective symptoms may not be used as the sole basis for using a restraint. In addition, the resident's medical symptoms/diagnoses should not be viewed in isolation; rather, the medical symptoms identified should become the context in which to determine the most appropriate

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			<p>method of treatment related to the resident’s condition, circumstances, and environment, and not a way to justify restraint use.</p> <ul style="list-style-type: none"> • The identification of medical symptoms should assist the nursing home in determining if the specific medical symptom can be improved or addressed by using other, less restrictive interventions. The nursing home should perform all due diligence and document this process to ensure that they have exhausted alternative treatments and less restrictive measures before a physical restraint is employed to treat the medical symptom, protect the resident’s safety, help the resident attain or maintain his or her highest level of physical or psychological well-being and support the resident’s goals, wishes, independence, and self-direction. • Physical restraints as an intervention do not treat the underlying causes of medical symptoms. Therefore, as with other interventions, physical restraints should not be used without also seeking to identify and address the physical or psychological condition causing the medical symptom. • Physical rRestraints may be used, if warranted, as a temporary symptomatic intervention while the actual cause of the medical symptom is being evaluated and managed. Additionally, physical restraints may be used as a symptomatic intervention when they are immediately necessary to prevent a resident from injuring himself/herself or others and/or to prevent the resident from interfering with life-sustaining treatment when no other less restrictive or less risky interventions exist. • Therefore, a clear link must exist between thephysical restraint use and how it benefits the resident by addressing the specific medical symptom. If it is determined, after thorough evaluation and attempts at using alternative treatments and less restrictive methods, that a physical restraint must still be employed, the medical symptoms that support the use of the restraints must be documented in the resident’s medical record, ongoing assessments, and care plans. There also must be a physician’s order reflecting the use of the physical restraint and the specific medical symptom being treated by its use. The physician’s order alone is not sufficient to employ the use of a physical restraint. CMS will hold the nursing home ultimately

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			accountable for the appropriateness of that determination.
3	P0100	P-5	<p>Coding Instructions</p> <p><i>Identify all physical restraints that were used at anytime any time (day or night) during the 7-day look-back period.</i></p> <p>After determining whether or not an item a device listed in (P0100) is a physical restraint and was used during the 7-day look-back period, code the frequency of use:</p> <ul style="list-style-type: none"> • Code 0, not used: if the item device was not used during the 7-day look-back or it was used but did not meet the definition. • Code 1, used less than daily: if the item device met the definition and was used less than daily. • Code 2, used daily: if the item device met the definition and was used on a daily basis during the look-back period. <p>Coding Tips and Special Populations</p> <ul style="list-style-type: none"> • Any manual method or physical or mechanical device, material or equipment, that does not fit into the listed categories but that meets the definition of a physical restraint, and has not been excluded from this section, should be coded in items P0100D or P0100H, Other. These devices, although not coded on the MDS, must be assessed, care-planned, and-monitored, and evaluated. • In classifying any manual method or physical or mechanical device, material or equipment as a physical restraint, the assessor must consider the effect it the device has on the resident, not the purpose or intent of its use. It is possible that for a manual method or physical or mechanical device, material or equipment, may to improve at the resident's mobility but and also have the effect of physically restraining him or her. <ul style="list-style-type: none"> — Bed rails used as positioning devices Bed rails used as positioning devices. If the use of bed rails (quarter-, half- or three-quarter, one or both, etc.) meets the definition of a physical restraint even though they may improve the resident's mobility in bed, the nursing home must code their use as a restraint at P0100A. — Bed rails used with residents who are immobile Bed rails used with residents who are immobile. If the

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			<p>resident is immobile and cannot voluntarily get out of bed because of a physical limitation and not due to a restraining device or because proper assistive devices were not present, the bed rails do not do not meet the definition of a physical restraint.</p>
3	P0100	P-6	<p>For residents who have no voluntary movement, the staff need to determine if there is an appropriate use of bed rails. Bed rails may create a visual barrier and deter physical contact from others. Some residents have no ability to carry out voluntary movements, yet they exhibit involuntary movements. Involuntary movements, resident weight, and gravity's effects may lead to the resident's body shifting toward the edge of the bed. When bed rails are used in these cases, the resident could be at risk for entrapment. For this type of resident, clinical evaluation of alternatives (e.g., a concave mattress to keep the resident from going over the edge of the bed), coupled with frequent monitoring of the resident's position, should be considered. While the bed rails may not constitute a physical restraint, they may affect the resident's quality of life and create an accident hazard.</p> <ul style="list-style-type: none"> • Trunk restraints include any manual method or physical or mechanical device, material or equipment or material attached or adjacent to the resident's body that the resident cannot easily remove such as, but not limited to, vest or waist restraints or belts used in a wheelchair that either restricts freedom of movement or access to his or her body. • Limb restraints include any manual method or physical or mechanical device, or material or equipment or material that the resident cannot easily remove, that restricts movement of any part of an upper extremity (i.e., hand, arm, wrist) or lower extremity (i.e., foot, leg) that either restricts freedom of movement or access to his or her own body. Hand mitts/mittens are included in this category. Included in this category are mittens. • Chairs that prevent rising include any type of chair with a locked lap board, that places the resident in a recumbent position that restricts rising, or a chair that is soft and low to the floor, chairs that have a cushion placed in the seat that prohibit the resident from rising, geriatric chairs, and enclosed-frame wheeled walkers. Included here are chairs that have a cushion placed in the seat that prohibit

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			<p>the resident from rising.</p> <ul style="list-style-type: none"> — For residents who have the ability to transfer from other chairs, but cannot transfer from a geriatric chair, the geriatric chair would be considered a restraint would be considered a restraint to that individual, and should be coded as P0100G–Chair Prevents Rising. — For residents who have no ability to transfer independently, the geriatric chair does not does not meet the definition of a restraint, and should not be coded at P0100G–Chair Prevents Rising. — Geriatric chairs used for residents who are immobile. For residents who have no voluntary or involuntary movement, the geriatric chair does not does not meet the definition of a restraint. — Enclosed-frame wheeled walkers, with or without a posterior seat, and other devices like it should not automatically be classified as a physical restraint. These types of walkers are only classified as a physical restraint if the resident cannot exit the walker via opening a gate, bar, strap, latch, removing a tray, etc. When deemed a physical restraint, these walkers should be coded at P0100G–Chair Prevents Rising. <ul style="list-style-type: none"> • Restraints used in emergency situations. If the resident needs emergency care, physical restraints may be used for brief periods to permit medical treatment to proceed, unless the
3	P0100	P-7	<ul style="list-style-type: none"> — A resident who is injuring himself/herself or is threatening physical harm to others may be physically restrained in an emergency to safeguard the resident and others. A resident whose unanticipated violent or aggressive behavior places him/her or others in imminent danger does not have the right to refuse the use of physical restraints, as long as those restraints are used as a last resort to protect the safety of the resident or others and use is limited to the immediate episode. <p>Additional Information</p> <ul style="list-style-type: none"> • Restraint reduction/elimination. It is further expected, for residents whose care plan indicates the need for physical restraints, that the nursing home engages in a systematic and gradual process towards reducing (or eliminating, if possible) the restraints (e.g., gradually increasing the time for ambulation and strengthening

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			<p>activities). This systematic process also applies to recently-admitted residents for whom physical restraints were used in the previous setting.</p> <ul style="list-style-type: none"> • Restraints as a fall prevention approach. Although physical restraints have been traditionally used as a fall prevention approach, they have major drawbacks and can contribute to serious injuries. Falls do not constitute self-injurious behavior nor a medical symptom supporting the use of physical restraints. There is no evidence that the use of physical restraints, including but not limited to side rails, will prevent, reduce, or eliminate falls. In fact, in some instances, reducing the use of physical restraints may actually decrease the risk of falling. Additionally, falls that occur while a person is physically restrained often result in more severe injuries. • Request for restraints. While a resident, family member, legal representative, or surrogate may request use of a physical restraint, the nursing home is responsible for evaluating the appropriateness of that request, just as they would for any medical treatment. As with other medical treatments, such as the use of prescription drugs, a resident, family member, legal representative, or surrogate has the right to refuse treatment, but not to demand its use when it is not deemed medically necessary. <p>According to 42 CFR 483.13(a), “The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident’s medical symptoms.” CMS expects that no resident will be physically restrained for discipline or convenience. Prior to employing any physical restraint, the nursing home must perform a prescribed resident assessment to properly identify the resident’s needs and the medical symptom the physical restraint is being employed to address. The guidelines in the State Operations Manual (SOM) state, “...the legal surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident’s medical symptoms. That is, the facility may not use restraints in violation of regulation</p>

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3	Q0100	Q-2	<p>Coding Instructions for Q0100A, ...</p> <ul style="list-style-type: none"> Code 0, No: if the resident did not actively participate in the assessment process. Code 1, Yes: if the resident actively and meaningfully participated in the assessment process. <p>Coding Instructions for Q0100B, ...</p> <ul style="list-style-type: none"> Code 0, No: if the family or significant other did not participate in the assessment process.
3	Q0100	Q-3	<ul style="list-style-type: none"> Code 1, Yes: if the family or significant other(s) did participate in the assessment process. Code 9, No family or significant other available: None of the above—resident <u>has no</u> family or significant other.
3	Q0100	Q-3	<p>Coding Instructions for Q0100C, ...</p> <ul style="list-style-type: none"> Code 0, No: if guardian or legally authorized representative did not participate in the assessment process. Code 1, Yes: if guardian or legally authorized representative did participate in the assessment process. Code 9, No guardian or legally authorized representative available: None of the above -- resident <u>has no</u> guardian or legally authorized representative.
3	Q0100	Q-5	<p>Coding Instructions for Q0300A, ...</p> <p><i>Record the resident's expectations as expressed by herhim or himher. It is important to document his or hertheir expectations.</i></p> <ul style="list-style-type: none"> Code 1, Expects to be discharged to the community: if the resident indicates an expectation to return home, to assisted living, or to another community setting. Code 2, Expects to remain in this facility: if the resident indicates that he or she expects to remain in the nursing home. Code 3, Expects to be discharged to another facility/institution: if the resident expects to be discharged to another nursing home, rehabilitation facility, or another institution.

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			<ul style="list-style-type: none"> Code 9, UUnknown or uncertain: if the resident is uncertain or if the resident is not able to participate in the discussion or indicate a goal, and family, significant other, or guardian or legally authorized representative do not exist or are not available to participate in the discussion.
3	Q0100	Q-5	<p>Coding Tips</p> <ul style="list-style-type: none"> This item is individualized and resident-driven rather than what the nursing home staff judge to be in the best interest of the resident. This item focuses on exploring the resident’s expectations; not whether or not the staff considers them to be realistic or not. Q0300A, Code 1 “Expects to be discharged to the community” may include newly admitted Medicare SNF residents with a facility arranged discharge plan or non-Medicare and Medicaid residents with adequate supports already in place that would not require referral to a local contact agency (LCA). It may also include residents who ask to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community (Q0500B, Code 1).
3	Q0100	Q-6	<p>Coding Instructions for Q0300B, ...</p> <ul style="list-style-type: none"> Code 1, Resident: if the resident is the source for completing this item. Code 2, If not resident, then family or significant other: if the resident is unable to respond and a family member or significant other is the source for completing this item. Code 3, If not resident, family or significant other, then guardian or legally authorized representative: if the guardian or legally authorized representative is the source for completing this item because the resident is unable to respond and a family member or significant other is not available to respond. Code 9, UUnknown or uncertain (none of the above): if the resident cannot respond and the family or significant other, or guardian or legally authorized representative does not exist or cannot be contacted or is unable to respond (Q0300A= 9). <p>Examples</p>

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			<p>1. Mrs. F. is a ...</p> <p style="padding-left: 40px;">Coding: Q0300A would be coded 1, eExpects to be discharged to the community. Q0300B would be coded 1, rResident.</p> <p>2. Mr. W. is a ...</p> <p style="padding-left: 40px;">Coding: Q0300A would be coded 1, eExpects to be discharged to the community. Q0300B would be coded 1, rResident.</p>
3	Q0100	Q-7	<p>3. Ms. T. is a ...</p> <p style="padding-left: 40px;">Coding: Q0300A would be coded 2, eExpects to remain in this facility. Q0300B would be coded 2, fFamily or significant other.</p>
3	Q0100	Q-7	<p>4. Mrs. G., an 84-year-old female ...</p> <p style="padding-left: 40px;">Coding: Q0300A would be coded 1, eExpects to be discharged to the community. Q0300B would be coded 2, fFamily or significant other.</p> <p>5. Mrs. C. is a ...</p> <p style="padding-left: 40px;">Coding: Q0300A would be coded 3, eExpects to be discharged to another facility/institution. Q0300B would be coded 3, gGuardian or legally authorized representative.</p>
3	Q0100	Q-8	<p>6. Ms. K. is a ...</p> <p style="padding-left: 40px;">Coding: Q0300A would be coded 1, eExpects to be discharged to the community (small group homes are considered to be community setting).</p>
3	Q0100	Q-12	<p>Coding Instructions for Q0400A, ...</p> <ul style="list-style-type: none"> • Code 0, nNo: if there is not active discharge planning already occurring for the resident to return to the community. • Code 1, yYes: if there is active discharge planning already occurring for the resident to return to the

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			community; skip to Referral item (Q0600).
3	Q0100	Q-12	<p>Item Rationale</p> <p>This item directs a check of the resident’s clinical record to determine if the resident and/or family, etc. have indicated on a previous OBRA comprehensive assessment (A0310A = 01, 03, 04 or 05) that they do not want to be asked question Q0500B until their next annual comprehensive assessment. Some residents and their families do not want to be asked about their preference for returning to the community and would rather not be asked about it. Item Q0550 allows them to opt-out of being asked question Q0500B on quarterly (non-comprehensive) assessments. If there is a notation in the clinical record that the resident does not want to be asked again, and this is a quarterly assessment, then skip to item Q0600. Referral. Q0600, Referral.</p> <p>Coding Instructions for Q0490, ...</p> <p>Code 0, NO: if there is no notation in the resident’s clinical record that he or she does not want to be asked Question Q0500B again.</p>
3	Q0100	Q-13	<p>Q0490: Resident’s Preference to Avoid Being Asked Question Q0500B (cont.)</p> <ul style="list-style-type: none"> Code 1, yYes: if there is a notation in the resident’s clinical record to not ask Question Q0500B again, except on comprehensive assessments.
3	Q0100	Q-13	<p>2. Mrs. R is ...</p> <p>Unless this is a comprehensive assessment Unless this is a comprehensive assessment, then proceed to the next item Q0500B.</p>
3	Q0100	Q-16	<ul style="list-style-type: none"> Code 0, NO: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does not want to talk to someone about the possibility of returning to the community. Code 1, yYes: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does want to talk to someone about the possibility of returning to the community. Code 9, UUnknown or uncertain: if the resident cannot <u>understand or respond</u> and the family or significant other is not available to respond on the resident’s behalf and a guardian or legally authorized representative is not available or has not

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			been appointed by the court.
3	Q0100	Q-17	<p>Examples</p> <p>1. Mr. B. is ... Coding: Q0500B would be coded 1, yYes.</p> <p>2. Ms. C. is ... Coding: Q0500B would be coded 1, yYes.</p> <p>3. Mr. D. is ... Coding: Q0500B would be coded 0, nNo. Rationale: During this assessment, he was asked about returning to the community and he responded no.</p>
3	Q0100	Q-18	<p>Coding Instructions for Q0550A</p> <ul style="list-style-type: none"> Code 0, nNo: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does not want to be asked again on quarterly assessments about returning to the community. Then document in resident's clinical record and ask question Q0500B again only on the next comprehensive assessment. Code 1, yYes: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does want to be asked the return to community question Q0500B on all assessments. Code 9, iInformation not available: if the resident cannot respond and the family or significant other is not available to respond on the resident's behalf and a guardian or legally authorized representative is not available or has not been appointed by the court.
3	Q0100	Q-19	<p>Example</p> <p>1. Ms. W is ... Coding: Q0550A would be coded 1, Yes. Q0550B would be coded 1, Resident.</p>
3	Q0100	Q-20	<p>Coding Instructions</p> <ul style="list-style-type: none"> Code 0, nNo: Referral not needed; ... Code 1, nNo: Referral is or may be needed; ... Code 2, yYes: Referral made; ... <p>Local Contact Agency (LCA) Point of Contact List</p>

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			<p style="text-align: center;">See www.cms.gov/CommunityServices/downloads/State_by_State_POC_list.pdf for listings.</p> <p style="text-align: center;">Section Q Point of Contact list for Local Contact Agencies: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html</p>
3	Q0100	Q-20	<p style="text-align: center;">DEFINITIONS</p> <p>DESIGNATED LOCAL CONTACT AGENCY</p> <p>Each state has community contact agencies that can provide individuals with information about community living options and available supports and services.</p> <p>These local contact agencies may be a single entry point agency, an Aging and Disability Resource Center (ADRC), an Area Agency on Aging (AAA), a Center for Independent Living (CIL), or other state designated entities.</p>
3	Q0100	Q-22	<p>1. Mr. S. is ... Coding: Q0500B would be coded 1, YYes Q0600 would be coded 2, YYes.</p> <p>2. Ms. V. is ... Coding: Q0600 would be coded 1, NNo.</p>

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3	V0100	V-3	<p>Coding Instructions for V0100F, Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV[®]) Total Severity Score (D0600 Value from Prior Assessment)</p> <ul style="list-style-type: none"> Record in V0100F the value for item D0600 (Staff Assessment of Resident Mood Interview-[PHQ-9-OV[®]] Total Severity Score) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see “Item Rationale”, above, for details). This item will be compared with the corresponding item on the current assessment to evaluate resident decline in the Mood State care area.
3	V0200	V-5	<p>V0200B2, Date</p> <ul style="list-style-type: none"> Date that the RN coordinating the CAA process certifies that the CAAs have been completed. The CAA review must be completed no later than the 14th day of admission (admission date + 13 calendar days) for an Admission assessment and within 14 days of the Assessment Reference Date (A2300) for an Annual assessment, Significant Change in Status Assessment, or a Significant Correction to Prior Comprehensive aAssessment. This date is considered the date of completion for the RAI.

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3	X0300	X-3	<ul style="list-style-type: none">• Although a dash (indicating unable to determine) is no longer an acceptable value in A0800, a dash must be used in X0300 on a modification or inactivation request to locate a record if a dash was previously entered in A0800 on the original record.

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3	Z0400	Z-6	<ul style="list-style-type: none"><li data-bbox="597 285 1414 390">• The importance of accurately completing and submitting the MDS cannot be over- emphasized. The MDS is the basis forthe development of:<li data-bbox="597 415 1252 451">• the development of an individualized care plan;

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Chapter	Section	Page	Change
4	4.2	4-1	The MDS is a starting point The MDS is a starting point. The Minimum Data Set (MDS) is . . .
4	4.2	4-2	The CAA process framework The CAA process framework. The CAA process provides . . .
4	4.4	4-5	Not all triggers identify deficits or problems. Some triggers indicate areas of resident strengths, and can suggest possible approaches to improve a resident’s functioning or minimize decline. For example, MDS item responses indicate the “resident believes he or she is capable of increased independence in at least some ADLs” (item Item G0900A) may focus the assessment and care plan on functional areas most important to the resident or on the area with the greatest potential for improvement.
4	4.5	4-6	Assigning responsibility for completing the MDS and CAAs Assigning responsibility for completing the MDS and CAAs. Per the OBRA statute . . .
4	4.5	4-6	Identifying policies and practices related to the assessment and care planning processes Identifying policies and practices related to the assessment and care planning processes. Under the OBRA regulations . . .
4	4.5	4-6	CAA documentation CAA documentation CAA documentation . CAA documentation helps . . .
4	4.6	4-7	Limitations of the RAI-related instruments Limitations of the RAI-related instruments. The RAI provides . . .
4	4.7	4-9	Fixed table spacing.
4	4.9	4-12	Step 1: Identification of Triggered CAAs Step 1: Identification of Triggered CAAs. After completing the MDS . . .
4	4.9	4-13	Step 2: Analysis of Triggered CAAs Step 2: Analysis of Triggered CAAs. Review a triggered . . .
4	4.9	4-14	Chief Complaint: Chief Complaint: New onset of falls . . .
4	4.9	4-14	Problem Statement: Problem Statement: Resident currently falling 2-3 times per week. Falls are preceded by lightheadedness. Most falls occurred after she stood up and started walking; a few falls occurred while attempting to stand up from a sitting or lying position.
4	4.9	4-15	Steps 3 and 4: Decision Making and CAA Documentation Steps 3 and 4: Decision Making and CAA Documentation. The care plan is driven . . .
4	4.10	4-16	NOTE: Each of the following descriptions of the Twenty Care Areas includes a table listing the Care Area Trigger (CAT) logical specifications. For those MDS items that require a numerical response, the logical specifications will reference the numerical response that triggered the Care Area. For those

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			<p>MDS items that require a check mark response (e.g. H0100, J0800, K0510, etc.), the logical specifications will reference this response in numerical form when the check box response is one that triggers a Care Area. Therefore, in the tables below, when a check mark has been placed in a check box item on the MDS and triggers a Care Area, the logical specifications will reference a value of "1." Example: "H0100A=1" means that a check mark has been placed in the check box item H0100A. Similarly, the Care Area logical specifications will reference a value of "0" (zero) to indicate that a check box item is not-not checked. Example: "I4800=0" means that a check mark has not-not been placed in the check box item I4800.</p>
4	4.10	4-16	<p>((V0100D >= 0) AND(V0100D AND (V0100D <= 15)) AND</p>
4	4.10	4-17	<p>Cognitive prerequisites for an independent life include the ability to remember recent events and the ability to make safe daily decisions. Although the aging process may be associated with mild impairment, decline in cognition is often the result of other factors such as delirium, another mental health issue and/or condition, a stroke, and/or dementia. Dementia is not a specific condition but a syndrome that may be linked to several causes. According to the <i>Diagnostic and Statistical Manual, Fourth Edition, Text Revision</i> (DSM-IV-TR), the dementia syndrome is defined by the presence of three criteria: a short-term memory issue and/or condition and-and trouble with at least one cognitive function (e.g., abstract thought, judgment, orientation, language, behavior) and-and these troubles have an impact on the performance of activities of daily living. The cognitive loss/dementia CAA focuses on declining or worsening cognitive abilities that threaten personal independence and increase the risk for long-term nursing home placement or impair the potential for return to the community.</p>
4	4.10	4-18	<p>2. (C0500 = 99,-,99, -, OR ^)</p> <p>3. (C0500 = 99,-,99, -, OR ^)</p> <p>4. (C0500 = 99,-,99, -, OR ^) AND</p> <p>8. E0900 >= 1 AND E0900 <= 3</p> <p>9. E0900 >= 1 AND E0900 <= 3</p> <p>The information gleaned from the assessment should be used to</p>

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			<p>evaluate the situation, to identify and address (where possible) the underlying cause(s) of cognitive loss/dementia, as well as to identify any related possible contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. It is important to define the nature of the impairment; e.g., identify whether the cognitive issue and/or condition is new or a worsening or change in existing cognitive impairment—characteristics of potentially reversible delirium—or whether it indicates a long-term, largely irreversible cognitive loss. If the issue</p>
4	4.10	4-19	<p>The aging process leads to a decline in visual acuity. For acuity, for for example, a decreased ability to focus on close objects or to see small print, a reduced capacity to adjust to changes in light and dark and diminished ability to discriminate colors. The safety and quality consequences of vision loss are wide ranging and can seriously affect physical safety, self-image self-image, and participation in social, personal, self-care, and rehabilitation activities.</p>
4	4.10	4-20	<p>The information gleaned from the assessment should be used to evaluate the characteristics of the problematic issue/condition and the underlying cause(s), the success of any attempted remedial actions, the person's ability to compensate with nonverbal strategies (e.g., the ability to visually follow non-verbal signs and signals), and the willingness and ability of caregivers to ensure effective communication. The assessment should also help to identify any related possible contributing and/or risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address any underlying issues/conditions and causes, as well as verbal and nonverbal strategies, in order to help the resident improve quality of life, health, and safety. In the presence of reduced language skills, both caregivers and the resident can strive to expand their nonverbal communication skills. For skills, for example, touch, facial expressions, eye contact, hand movements, tone of voice, and posture.</p>
4	4.10	4-20 & 4-21	<p>The ADL Functional/Rehabilitation CAA addresses the resident's self-sufficiency self-sufficiency in performing basic activities of daily living, including dressing, personal hygiene, walking, transferring, t toilet using, changing position in bed bed bed mobility, and eating. Nursing home staff should identify and address, to the extent possible, any issues or conditions that may impair function or impede efforts to improve that function. The resident's potential for improved functioning should also be clarified before rehabilitation is attempted.</p>

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4	4.10	4-32	(M0300C1 > 0 AND M0300C1 <= 9) <= 9) OR
4	4.10	4-38	<p>The information gleaned from the assessment should be used to identify the specific reasons for, and for and the appropriateness of the use of, of the restraint and any adverse consequences caused by or risks related to restraint use.</p> <p>Pain is “an unpleasant sensory and emotional experience associated with actual or potential tissue damage.” Pain can be affected by damage to various organ systems and tissues. tissues, for example, musculoskeletal (e.g., arthritis, fractures, injury from peripheral vascular disease, wounds), neurological (e.g., diabetic neuropathy, herpes zoster), and cancer. The presence of pain</p>

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5	5.1	5-1	<p>All Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Required MDS records are those assessments and tracking records that are mandated under OBRA and SNF PPS. Assessments that are completed for purposes other than OBRA and SNF PPS reasons are not to be submitted, e.g., private insurance, including but not limited to Medicare Advantage plans. After completion of the required assessment and/or tracking records information, each provider must create electronic transmission files that meet the requirements detailed in the current MDS 3.0 Data Submission Specifications available on the CMS MDS 3.0 web site at:</p>
5	5.1	5-1	<p>The provider indicates the submission authority for a record in the MDS item A0410, Submission Requirement item (A0410):</p> <ul style="list-style-type: none"> • Value = 1 Neither federal nor state required submission. • Value = 2 State but not federal required submission (FOR NURSING HOMES ONLY). • (FOR NURSING HOMES ONLY) • Value = 3 Federal required submission. <p>See Chapter 3 for details concerning the coding of the item A0410, Submission Requirement item (A0410). Note: CMS-certified CMS certified Swing Bed units unit assessments are always Value 3, Federal required submission</p>
5	5.1	5-2	<p>Once communication is established with the QIES ASAP system, the provider can access the CMS MDS Welcome Page in the MDS system. This site allows providers to submit MDS assessment data and access various information sources such as Bulletins and Questions and Answers. The Minimum Data Set (MDS) 3.0 Provider User's Guide <i>Minimum Data Set (MDS) 3.0 Provider User's Guide</i> provides more detailed information about the MDS system. It is available on the QTSO MDS 3.0 web site at https://www.qtso.com/mds30.html.</p> <p>When the transmission file is received by the QIES ASAP system, the system performs a series of validation edits to evaluate whether or not the data submitted meet the required standards. MDS records are edited to verify that clinical responses are within valid ranges and are consistent, dates are reasonable, and records are in the proper order with regard to records that were previously accepted by the QIES ASAP</p>

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			<p>system for the same resident. The provider is notified of the results of this evaluation by error and warning messages on a Final Validation Report. All error and warning messages are detailed and explained in the Minimum Data Set (MDS) 3.0 Provider User's Guide <i>Minimum Data Set (MDS) 3.0 Provider User's Guide</i>.</p>
5	5.2	5-2	<ul style="list-style-type: none"> • Completion Timing: <ul style="list-style-type: none"> — For all non-comprehensive admission OBRA and PPS assessments, the MDS Completion Date (Z0500B) must be no later than 14 days from after the Assessment Reference Date (ARD) (A2300). — For the Admission assessment, the MDS Completion Date (Z0500B) must be no later than 13 days after the Assessment Reference Date (ARD) (A2300). — For the Admission assessment, the Care Area Assessment (CAA) Completion Date (V0200B2) must be no more than 143 days afterfrom the Entry Date (A1600). — For the Annual assessment, the CAA Completion Date (V0200B2) must be no later than 14 days from after the ARD (A2300). — For the other comprehensive MDS assessments, Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment, the CAA Completion Date (V0200B2) must be no later than 14 days from the ARD (A2300) and no later than 14 days from the determination date of the significant change in status or the signification significant correction error, respectively. — For Entry and Death in Facility tracking records, the MDS Completion Date (Z0500B) must be no later than must be completed within 7 days from of the Event Date (A1600 for an entry record; A2000 for a death-in-facility record). • State Requirements: Many states have established additional MDS requirements for Medicaid payment and/or quality monitoring purposes. For information on state requirements, contact your State RAI Coordinator. (See Appendix B for a list of state RAI coordinators.)
5	5.2	5-3	<ul style="list-style-type: none"> — For a comprehensive assessment (Admission, Annual, Significant Change in Status, and Significant Correction to Prior Comprehensive), encoding should must occur within

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			<p>7 days after the Care Plan Completion Date (V0200C2 + 7 days).</p> <p>— For a quarterly Quarterly, Significant Correction to Prior Quarterly, eDischarge, or PPS assessment, encoding should must occur within 7 days after the MDS Completion Date (Z0500B + 7 days).</p>
5	5.3	5-4	<p>The QIES ASAP system MDS system has validation edits designed to monitor the timeliness and accuracy of MDS record submissions. If transmitted MDS records do not meet the edit requirements, the system will provide error and warning messages on the provider's Final Validation Report.</p>
5	5.3	5-5	<p>Validation and Editing Process. Each time a user accesses the QIES ASAP MDS system and transmits an MDS file, the QIES ASAP MDS system performs three types of validation:</p> <p>Fatal Record Errors result in rejection of individual records by the QIES ASAP MDS system. The provider is informed of Fatal Record Errors on the Final Validation Report. Rejected records must be corrected and resubmitted.</p> <p>3. Non-Fatal Errors (Warnings). The record is also validated for Non-Fatal Errors. Non-Fatal Errors include, but are not limited to, missing or questionable data of a non-critical nature or item consistency errors of a non-critical nature. Examples are timing errors. Timing errors for a quarterly Quarterly assessment include (a) the submission date is more than 14 days after the MDS assessment completion date (Z0500B) or (b) the assessment completion is more than 14 days after the ARD (A2300). Another example is a record sequencing error, where an Entry record (A0310F = 01) is submitted after a Q quarterly assessment record (A0310A = 02) with no intervening discharge record (A0310F = 10, 11 or 12). Any Non-Fatal Errors are reported to the provider in the Final Validation Report as warnings. The provider must evaluate each warning to identify necessary corrective actions.</p> <p>Detailed information on the validation edits and the error and warning messages is available in the MDS 3.0 Data Submission Specifications on the CMS MDS 3.0 web site and in Chapter Section 5 of the <u>Minimum Data Set (MDS) 3.0 Provider User's Guide</u> Minimum Data Set (MDS) 3.0 Provider User's Guide on the QTSO MDS 3.0 web site.</p>

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5	5.4	5-6	<p>There is also a Medicare short Short-stay Stay indicator (Item Z0100C) on the MDS. For a qualifying Medicare short stay, the RUG-IV grouper uses alternative rehabilitation classification logic when there has been insufficient time to establish a full rehabilitation regime. The standard grouper uses MDS 3.0 items to determine the Medicare short stay indicator. See Chapter 6 for details.</p> <p>Both HIPPS codes (Z0100A and Z0150A), the RUG version codes (Z0100B and Z0150B), and the Medicare short Short-stay Stay indicator (Z0100C) must be submitted to the QIES ASAP system on all Medicare PPS assessment records (indicated by A0310B= 01, 02, 03, 04, 05, 06, or 07). All of these values are validated by the QIES ASAP system. The Final Validation Report will indicate if any of these items is in error and the correct value for an incorrect item. Note that an error in one of these items is usually a non-fatal warning and the record will still be accepted in the QIES ASAP system. A record will receive a fatal error (-3804) if the record is a Start of Therapy (SOT) Other Medicare-Required Assessment (OMRA) (A0310C = 1 or 3) and the QIES ASAP ...</p>
5	5.5	5-7	<ul style="list-style-type: none"> • If an error is discovered within 7 days of the completion of an MDS <u>and</u> before submission to the QIES ASAP system, the response may be corrected using standard editing procedures on the hard copy (cross out, enter correct response, initial and date) and <u>or</u> correction of the MDS record in the facility's database. The resident's care plan should also be reviewed for any needed changes.
5	5.5	5-7 & 5-8	<p>Clinical corrections must also be undertaken as necessary to assure that the resident is accurately assessed, the care plan is accurate, and the resident is receiving the necessary care. A Significant Change in Status Assessment (SCSA, Significant Correction to Prior Quarterly (SCQA) or a Significant Correction to Prior Assessment Comprehensive (SCPA) may be needed as well as corrections to the information in the QIES ASAP system. An SCSA is required only if a change in the resident's clinical status occurred. An SCPA or SCQA is required when an uncorrected significant error is identified. See Chapter 2 for details.</p>
5	5.6	5-8	<p>In addition, the provider is responsible for running encoded MDS assessment data against CMS and State-specific edits that software vendors are responsible for building into MDS Version 3.0 computer systems. For each MDS item, the response must be within the required range and also be consistent with other item responses. During this 7-day encoding period that follows</p>

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			<p>the completion of the MDS assessment, a provider may correct item responses to meet required edits. Only MDS assessments that meet all of the required edits are considered complete. For corrected items, the provider must use the same observation period as that was used for the original item completion {(i.e., the same ARD (A2300) and look-back period)}. Both the electronic and paper copies of the MDS must be corrected.</p>
5	5.6	5-9	<p>Significant versus Minor Errors in a Nursing Home OBRA Comprehensive or Quarterly Assessment Record. OBRA comprehensive and quarterly Quarterly assessment errors are classified as significant or minor errors. Errors that inaccurately reflect the resident’s clinical status and/or result in an inappropriate plan of care are considered significant errors. All other errors related to the coding of MDS items are considered minor errors.</p> <p>If the only errors in the OBRA comprehensive or quarterly Quarterly assessment are minor errors, then the only requirement is for the record to be corrected and submitted to the QIES ASAP system.</p> <p>The correction process is more complicated for nursing home OBRA comprehensive or quarterly Quarterly assessments with any significant errors identified after the end of the 7-day encoding and editing period but before the records have been accepted into the QIES ASAP system. First, the nursing home must correct the original OBRA comprehensive or quarterly Quarterly assessment to reflect the resident’s actual status as of the ARD for that original assessment and submit the record. Second, to insure an up-to-date view of the resident’s status and an appropriate care plan, the nursing home must perform an additional new assessment, either a Significant Change in Status Assessment or Significant Correction to Prior Assessment with a current observation period and ARD. If correction of the error on the MDS revealed that the resident’s status met the criteria for a Significant Change in Status Assessment, then a Significant Change in Status assessment is required. If the criteria for a Significant Change in Status Assessment are not met, then a Significant Correction to Prior Assessment is required. See Chapter 2 for details.</p> <p>In summary, the nursing home must take the following actions for an OBRA comprehensive or quarterly Quarterly assessment that has not been submitted to the QIES ASAP system when it contains</p>

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			significant errors:
5	5.7	5-10	The Modification Request is used to modify most MDS items. The exceptions are: including:
5	5.7	5-10 & 5-11	<ul style="list-style-type: none"> • Target Date <ul style="list-style-type: none"> — Entry Date (Item A1600) on an Entry tracking record (Item A0310F = 1) — Discharge Date (Item A2000) on a Discharge/Death in Facility record (Item A0310F = 10, 11, 12), — Assessment Reference Date (Item A2300) on an OBRA or PPS assessment.* • Type of Assessment (Item A0310)** • Clinical Items (Items B0100-V0200C) <p>*Note: The ARD (Item A2300) can be changed when the ARD on the assessment represents a data entry/typographical error. However, the ARD cannot be altered if it results in a change in the look back period and alters the actual assessment timeframe. Consider the following examples:</p> <ul style="list-style-type: none"> • When entering the assessment into the facility’s software, the ARD, intended to be 02/12/2013, was inadvertently entered as 02/02/2013. The interdisciplinary team (IDT) completed the assessment based on the ARD of 2/12/2013 (that is, the seven day look back was 2/06/2012 through 2/12/2013. This would be an acceptable use of the modification process to modify the ARD (A2300) to reflect 02/12/2013. • An assessment was completed by the team and entered into the software based on the ARD of 1/10/2013 (and seven day look back of 1/04/2013 through 1/10/2013). Three weeks later, the IDT determines that the date used represents a date that is not compliant with the PPS schedule and proposes changing the ARD to 1/07/2013. This would alter the look back period and result in a new assessment (rather than correcting a typographical error); this would not be an acceptable modification and shall not occur. <p>**Note: The Type of Assessment items (Item A0310) can only be modified when the Item Set Code (ISC) of that assessment does not change. In other words, if the Item Subset (full list can be found in Chapter 2, Section 2.5) would change, the modification</p>

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			<p>cannot be done. Consider the following examples:</p> <ul style="list-style-type: none"> • A stand-alone Discharge assessment (ISC = ND) was completed and accepted into the ASAP system. The provider later determined that the assessment should have been a 30-day PPS assessment combined with a Discharge assessment (ISC = NP). This modification would not be allowed as the ISC for the Discharge assessment combined with the 30-day PPS is different than the stand-alone Discharge ISC. This is an example of a missing 30-day assessment. • An Admission assessment (ISC = NC) was completed and accepted into the ASAP system. The provider intended to code the assessment as an Admission and a 5-day PPS assessment (ISC = NC). The modification process could be used in this case as the ISC would not change. <p>There are a few items for which the modification process shall not be used. These items require the following correction measures if an error is identified:</p> <ul style="list-style-type: none"> • An Inactivation of the existing record followed by submission of a new corrected record is required to correct an error of the Type of Provider (Item A0200)
5	5.7	5-11	<p>— Type of Provider (Item A0200), — Type of Assessment (A0310), — Entry Date (Item A1600) on an Entry tracking record (A0310F = 1), — Discharge Date (Item A2000) on a Discharge/Death in Facility record (A0310F = 10, 11, 12), — Assessment Reference Date (Item A2300) on an OBRA or PPS assessment.</p>
5	5.7	5-11	<ul style="list-style-type: none"> • A stand-alone Discharge assessment (ISC = ND) was completed and accepted into the ASAP system. The provider later (that is, after the day of discharge) determined that the assessment should have been a 30-day PPS assessment combined with a Discharge assessment (ISC = NP). This modification would not be allowed as the ISC for the Discharge assessment combined with the 30-day PPS is different than the stand-alone Discharge ISC. This is an example of a missing 30-day assessment.
5	5.7	5-12	<p>If errors are discovered in a nursing home OBRA comprehensive or quarterly Quarterly assessment (Item A0310A = 01 through 06) in the QIES ASAP system, then the</p>

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			<p>nursing home must determine if there are any significant errors. If the <i>only errors are minor errors</i>, the nursing home must take the following actions to correct the OBRA assessment:</p> <p>When any <i>significant error</i> is discovered in an OBRA comprehensive or quarterly Quarterly assessment in the QIES ASAP system, the nursing home must take the following actions to correct the OBRA assessment:</p>
5	5.7	5-12	<p>When errors in an OBRA comprehensive or Qquarterly assessment in the QIES ASAP system have been corrected in a more current OBRA comprehensive or Qquarterly assessment (Item A0310A = 01through 06), the nursing home is not required to perform a new additional assessment (Significant Change in Status or Significant Correction to Prior assessment). In this situation, the nursing home has already updated the resident's status and care plan. However, the nursing home must use the Modification process to assure that the erroneous assessment residing in the QIES ASAP system is corrected.</p>
5	5.7	5-13	<p>Inactivation Requests</p> <p>An Inactivation should be used when a record has been accepted into the QIES ASAP system but the corresponding event did not occur. For example, a Discharge assessment was submitted for a resident but there was no actual discharge. An Inactivation (Item A0050 = 3) must be completed when any of the following items are inaccurate: Type of Provider (Item A0200), Type of Assessment (A0310), Entry Date (Item A1600) on an Entry tracking record, Discharge Date (Item A2000) on a Discharge/Death in Facility record, or Assessment Reference Date (A2300) on an OBRA or PPS assessment.</p> <ul style="list-style-type: none"> • Type of Provider (Item A0200) • Type of Assessment (A0310) when the Item Subset would change had the MDS been modified • Entry Date (Item A1600) on an Entry tracking record (Item A0310F = 1) when the look-back period and/or clinical assessment would change had the MDS been modified • Discharge Date (Item A2000) on a Discharge/Death in Facility record (Item A0310F = 10, 11, 12) when the look-back period and/or clinical assessment would change had the MDS been modified • Assessment Reference Date (Item A2300) on an OBRA or PPS assessment when the look-back period and/or

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			<p><u>clinical assessment would change had the MDS been modified</u></p> <p>When inactivating a record, the provider is required to submit an electronic Inactivation Request record. This record is an MDS record but only the Section X items and Item A0050 are completed. This is sufficient information to locate the record in the QIES ASAP system, inactivate the record and document the reason for inactivation.</p> <p>For instances when the provider determines that an event date (ARD, entry date, and discharge date) or type of assessment item (A0310) the Type of Provider is incorrect, the provider must inactivate the record in the QIES ASAP system, then complete and submit a new MDS 3.0 record with the correct event date or type of assessment Type of Provider, ensuring that the clinical information is accurate.</p>
5	5.8	5-14	<p>2. The record has the wrong submission requirement in Item A0410.</p> <p>3. The record has the wrong facility ID in the control Item FAC_ID.</p>
5	5.8	5-14	A QIES ASAP system record with an incorrect submission requirement in Item A0410 is ...
5	5.8	5-15	PAGE NUMBER CHANGE