

SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

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

O0110: Special Treatments, Procedures, and Programs

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

O0110. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed

a. On Admission	b. While a Resident	c. At Discharge
Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B	Performed while a resident of this facility and within the last 14 days	Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C
Check all that apply		
a. On Admission	b. While a Resident	c. At Discharge
Cancer Treatments		
A1. Chemotherapy	☐	☐
A2. IV	☐	☐
A3. Oral	☐	☐
A10. Other	☐	☐
B1. Radiation	☐	☐
Respiratory Treatments		
C1. Oxygen therapy	☐	☐
C2. Continuous	☐	☐
C3. Intermittent	☐	☐
C4. High-concentration	☐	☐
D1. Suctioning	☐	☐
D2. Scheduled	☐	☐
D3. As needed	☐	☐
E1. Tracheostomy care	☐	☐
F1. Invasive Mechanical Ventilator (ventilator or respirator)	☐	☐
G1. Non-invasive Mechanical Ventilator	☐	☐
G2. BiPAP	☐	☐
G3. CPAP	☐	☐

O0110: Special Treatments, Procedures, and Programs (cont.)

Other			
H1. IV Medications	☐	☐	☐
H2. Vasoactive medications	☐		☐
H3. Antibiotics	☐		☐
H4. Anticoagulant	☐		☐
H10. Other	☐		☐
I1. Transfusions	☐	☐	☐
J1. Dialysis	☐	☐	☐
J2. Hemodialysis	☐		☐
J3. Peritoneal dialysis	☐		☐
K1. Hospice care		☐	
M1. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)		☐	
O1. IV Access	☐	☐	☐
O2. Peripheral	☐		☐
O3. Midline	☐		☐
O4. Central (e.g., PICC, tunneled, port)	☐		☐
None of the Above			
Z1. None of the above	☐	☐	☐

Item Rationale

Health-related Quality of Life

- The treatments, procedures, and programs listed in Item O0110, Special Treatments, Procedures, and Programs, can have a profound effect on an individual's health status, self-image, dignity, and quality of life.

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.

O0110: Special Treatments, Procedures, and Programs (cont.)

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 assessment period defined for each column.

Coding Instructions for Column a. On Admission

Check all treatments, procedures, and programs received by, performed on, or participated in by the resident on days 1–3 of the SNF PPS Stay starting with A2400B. If no treatments, procedures, or programs were received or performed in the 3-day assessment period, **check Z, None of the above.**

Coding Instructions for Column b. While a Resident

Check all treatments, procedures, and programs that the resident received or performed **after** admission/entry or reentry to the facility and within the last 14 days. If no treatments, procedures or programs were received by, performed on, or participated in by the resident within the last 14 days or since admission/entry or reentry, **check Z, None of the above.**

Coding Instructions for Column c. At Discharge

Check all treatments, procedures, and programs received by, performed on, or participated in by the resident in the last 3 days of the SNF PPS Stay ending with A2400C. If no treatments, procedures or programs were received by, performed on, or participated in by the resident in the 3-day assessment period, **check Z, None of the above.**

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.
- **O0110A1, Chemotherapy**

Code any type of chemotherapy agent administered as an antineoplastic given by any route in this item. Each medication should be evaluated to determine its reason for use before coding it here. Medications coded here are those actually used for cancer treatment. For example, megestrol acetate is classified 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. Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer should **not** be coded in this item, as they are not considered chemotherapy for the purpose of coding the MDS. IVs, IV medication, and blood transfusions administered during chemotherapy are **not** recorded under items K0520A (Parenteral/IV), O0110H (IV Medications), or O0110I (Transfusions).

00110: Special Treatments, Procedures, and Programs (cont.)

Example: Resident J was diagnosed with estrogen receptor–positive breast cancer and was treated with chemotherapy and radiation. After their cancer treatment, Resident J was prescribed tamoxifen (a selective estrogen receptor modulator) to decrease the risk of recurrence and/or decrease the growth rate of cancer cells. Since the hormonal agent is being administered to decrease the risk of cancer recurrence, it cannot be coded as chemotherapy.

- **00110A2, IV**

Check if chemotherapy was administered intravenously.

- **00110A3, Oral**

Check if chemotherapy was administered orally (e.g., pills, capsules, or liquids the patient swallows). This sub-element also applies if the chemotherapy is administered through a feeding tube/PEG (i.e., enterally).

- **00110A10, Other**

Check if chemotherapy was given in a way other than intravenously or orally (e.g., intramuscular, intraventricular/intrathecal, intraperitoneal, or topical routes).

- **00110B1, Radiation**

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

- **00110C1, 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 their own oxygen mask, cannula.

- **00110C2, Continuous**

Check if oxygen therapy was continuously delivered for 14 hours or greater per day.

- **00110C3, Intermittent**

Check if oxygen therapy was intermittent (i.e., not delivered continuously for at least 14 hours per day).

- **00110C4, High-concentration**

Check if oxygen therapy was provided via a high-concentration delivery system. A high-concentration oxygen delivery system is one that delivers oxygen at a concentration that exceeds a fraction of inspired oxygen FiO_2 of 40% (i.e., exceeding that of simple low-flow nasal cannula at a flow rate of 4 liters per minute).

A high-concentration delivery system can include either high- or low-flow systems (e.g., simple face masks, partial and nonrebreather masks, face tents, venturi masks, aerosol masks, and high-flow cannula or masks).

O0110: Special Treatments, Procedures, and Programs (cont.)

These devices may also include invasive mechanical ventilators, non-invasive mechanical ventilators, or trach masks, if the delivered FiO₂ of these systems exceeds 40%.

Oxygen-conserving nasal cannula systems with reservoirs (e.g., mustache, pendant) should be included only if they are used to deliver an FiO₂ of greater than 40%.

- **O0110D1, 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 their own tracheal and/or nasopharyngeal suctioning.

- **O0110D2, Scheduled**

Check if suctioning was scheduled. Scheduled suctioning is performed when the resident is assessed as clinically benefiting from regular interventions, such as every hour or once per shift. Scheduled suctioning applies to medical orders for performing suctioning at specific intervals and/or implementation of facility-based clinical standards, protocols, and guidelines.

- **O0110D3, As needed**

Check if suctioning was performed on an as-needed basis, as opposed to at regular scheduled intervals, such as when secretions become so prominent that gurgling or choking is noted or a sudden desaturation occurs from a mucus plug.

- **O0110E1, Tracheostomy care**

Code cleansing of the tracheostomy and/or cannula in this item. This item may be coded if the resident performs their own tracheostomy care. This item includes laryngectomy tube care.

- **O0110F1, Invasive Mechanical Ventilator (ventilator or respirator)**

Code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become (such as during weaning attempts) **unable to support their own respiration** in this item. During invasive mechanical ventilation the resident's breathing is controlled by the ventilator. Residents receiving closed-system ventilation include those residents receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) or tracheostomy. A resident who has been weaned off of a respirator or ventilator in the last 14 days or is currently being weaned off a respirator or ventilator, 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.

Example: Resident J is connected to a ventilator via tracheostomy (invasive mechanical ventilation) 24 hours a day while a resident, because of an irreversible neurological injury and inability to breathe on their own. O0110F1b should be checked, as Resident J is using an invasive mechanical ventilator because they are unable to initiate spontaneous breathing on their own and the ventilator is controlling their breathing.

00110: Special Treatments, Procedures, and Programs (cont.)

- **00110G1, Non-invasive Mechanical Ventilator**

Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to **support their own spontaneous respiration** by providing enough pressure when the individual inhales to keep their 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 their own BiPAP/CPAP mask/device.

- **00110G2, BiPAP**

Check if the non-invasive mechanical ventilator support was BiPAP.

- **00110G3, CPAP**

Check if the non-invasive mechanical ventilator support was CPAP.

- **00110H1, 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. Lactated Ringers given IV is not considered a medication and should not be coded here. Resources and tools providing information on medications are available in Section N of this manual (see the end of item N0415 following the Example).

- **00110H2, Vasoactive medications**

Check when at least one of the IV medications was an IV vasoactive medication.

- **00110H3, Antibiotics**

Check when at least one of the IV medications was an IV antibiotic.

- **00110H4, Anticoagulation**

Check when at least one of the IV medications was an IV anticoagulant. Do not include subcutaneous administration of anticoagulant medications.

- **00110H10, Other**

Check when at least one of the IV medications was not an IV vasoactive medication, IV antibiotic, or IV anticoagulant. Examples include IV analgesics (e.g., morphine) and IV diuretics (e.g., furosemide).

O0110: Special Treatments, Procedures, and Programs (cont.)

- **O0110I1, Transfusions**

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

- **O0110J1, Dialysis**

Code peritoneal or renal dialysis which occurs at the nursing home or at another facility, record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are **not** to be coded under items K0520A (Parenteral/IV), O0110H (IV medications), or O0110I (transfusions). This item may be coded if the resident performs their own dialysis.

- **O0110J2, Hemodialysis**

Check when the dialysis was hemodialysis. In hemodialysis the patient's blood is circulated directly through a dialysis machine that uses special filters to remove waste products and excess fluid from the blood.

- **O0110J3, Peritoneal dialysis**

Check when the dialysis was peritoneal dialysis. In peritoneal dialysis, dialysate is infused into the peritoneal cavity and the peritoneum (the membrane that surrounds many of the internal organs of the abdominal cavity) serves as a filter to remove the waste products and excess fluid from the blood.

- **O0110K1, 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.

O0110: Special Treatments, Procedures, and Programs (cont.)

- **O0110M1, Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)**

Code only when the resident requires transmission-based precautions and single room isolation (alone in a separate room) because of *an* active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with *a* highly transmissible or epidemiologically significant pathogen. 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 *an* active infection with *a* highly transmissible or epidemiologically significant pathogen.
2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.
4. The resident must remain in their 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 <https://www.cdc.gov/infection-control/hcp/isolation-precautions/>
- SHEA/APIC Guideline: Infection Prevention and Control in the Long Term Care Facility https://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 O0110M for single room isolation since it is still being maintained while the resident is in the facility.

O0110: Special Treatments, Procedures, and Programs (cont.)

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, Section 2.6, 03. Significant Change in Status Assessment (SCSA) (A0310A = 04). 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.

- **O0110O1, IV Access**

Code IV access, which refers to a catheter inserted into a vein for a variety of clinical reasons, including long-term medication administration, large volumes of blood or fluid, frequent access for blood samples, intravenous fluid administration, total parenteral nutrition (TPN), or, in some instances, the measurement of central venous pressure. An arteriovenous (AV) fistula does not meet the definition of IV Access for O0110O1.

- **O0110O2, Peripheral**

Check when IV access was peripheral access (catheter is placed in a peripheral vein) and remains peripheral.

- **O0110O3, Midline**

Check when IV access was midline access. Midline catheters are inserted into the antecubital (or other upper arm) vein and do not reach all the way to a central vein such as the superior vena cava.

- **O0110O4, Central (e.g., PICC, tunneled, port)**

Check when IV access was centrally located (e.g., PICC, tunneled, port).

- **O0110Z1, None of the above**

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

O0110: Special Treatments, Procedures, and Programs (cont.)

Examples

1. Resident R, who was admitted five days ago, has advanced prostate cancer and is receiving radiation and docetaxel (IV) via a port in their right upper chest to treat their prostate cancer. They were admitted to the SNF following an inpatient stay for an acute pulmonary embolism.

Coding: Check boxes O0110A1a (Chemotherapy, On Admission), O0110A1b (Chemotherapy, While a Resident), and O0110A2a (IV, On Admission); O0110B1a (Radiation, On Admission) and O0110B1b (Radiation, While a Resident); and O0110O1a (IV Access, On Admission), O0110O1b (IV Access, While a Resident), and O0110O4a (Central, On Admission).

Rationale: The resident received intravenous therapy via a port (i.e., a central line in their right upper chest) and radiation during their first three days of their SNF PPS stay and while a resident.

2. Resident M was admitted to the SNF for rehabilitation following cardiac surgery three weeks ago. They have sleep apnea and require a CPAP device nightly. While in the SNF, the staff set up the humidifier element of the CPAP, and Resident M put on the CPAP mask prior to falling asleep each night through their discharge to home.

Coding: Check boxes O0110G1b (Non-invasive Mechanical Ventilator, While a Resident), O0110G1c (Non-invasive Mechanical Ventilator, At Discharge), and O0110G3c (CPAP, At Discharge).

Rationale: Resident M can breathe on their own but requires CPAP while sleeping to manage their sleep apnea. CPAP was used while a resident, including during the three-day discharge assessment period.

3. Resident D was admitted 10 days ago to the SNF for rehabilitation following spinal surgery. They have sleep apnea and require a CPAP device while sleeping. The staff set up the water receptacle and humidifier element of the machine. Each night since admission, Resident D puts on the CPAP mask and starts the machine prior to falling asleep.

Coding: Check O0110G1a (Non-invasive Mechanical Ventilator, On Admission), O0110G1b (Non-invasive Mechanical Ventilator, While a Resident) and O0110G3a (CPAP, On Admission).

Rationale: Resident D can breathe on their own but requires CPAP while sleeping to manage their sleep apnea. CPAP was used while a resident, including during the three-day admission assessment period.

O0250: Influenza Vaccine

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

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.
- A vaccine, like any other medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small.
- Serious problems from inactivated influenza vaccine are very rare. The viruses in inactivated influenza vaccine have been killed, so individuals cannot get influenza from the vaccine.
 - **Mild problems:** soreness, redness or swelling where the shot was given; hoarseness; sore, red or itchy eyes; cough; fever; aches; headache; itching; and/or fatigue. If these problems occur, they usually begin soon after the shot and last 1–2 days.

O0250: Influenza Vaccine (cont.)

— Severe problems:

- Life-threatening allergic reactions from vaccines are very rare. If they do occur, it is usually within a few minutes to a few hours after the shot.
- In 1976, a type of inactivated influenza (swine flu) vaccine was associated with Guillain-Barré Syndrome (GBS). Since then, influenza vaccines have not been clearly linked to GBS. However, if there is a risk of GBS from current influenza vaccines, it would be no more than 1 or 2 cases per million people vaccinated. This is much lower than the risk of severe influenza, which can be prevented by vaccination.
- People who are moderately or severely ill should usually wait until they recover before getting the influenza vaccine. People with mild illness can usually get the vaccine.
- Influenza vaccine may be given at the same time as other vaccines, including pneumococcal vaccine.
- The safety of vaccines is always being monitored. For more information, visit: Vaccine Safety Monitoring and Vaccine Safety Activities of the CDC:
<https://www.cdc.gov/vaccine-safety-systems/>.

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 vaccination season. If vaccination status is unknown, proceed to the next step.
2. Ask the resident if they received an influenza vaccine outside of the facility for this year's influenza vaccination 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 influenza vaccination status is still unknown, proceed to the next step.
4. If influenza vaccination status cannot be determined, administer the influenza 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 vaccination season?

- **Code 0, No:** if the resident **did NOT receive the influenza vaccine in this facility** during this year's influenza vaccination 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 influenza vaccine received** (O0250B).

O0250: Influenza Vaccine (cont.)

Coding Instructions for O0250B, Date influenza vaccine received

- Enter the date that the influenza vaccine was 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 17, 2014 should be entered as 01-17-2014.
 - If the day only contains a single digit, then fill the first box of the day with the “0.” For example, October 6, 2013 should be entered as 10-06-2013. A full 8-character date is required.
 - A full 8-character date is required. If the date is unknown or the information is not available, only 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 vaccination season (i.e., O0250A = 0), code the reason from the following list:

- **Code 1, Resident not in this facility during this year's influenza vaccination season:** resident was not in this facility during this year's influenza vaccination 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 vaccination season.
- **Code 3, Not eligible - medical contraindication:** if influenza vaccine not received due to medical contraindications. Influenza vaccine is contraindicated for a resident with severe reaction (e.g., respiratory distress) to a previous dose of influenza vaccine or to a vaccine component. Precautions for influenza vaccine include moderate to severe acute illness with or without fever (influenza vaccine can be administered after the acute illness) and history of Guillain-Barré Syndrome within six weeks after previous influenza vaccination.
- **Code 4, Offered and declined:** resident or responsible party/legal guardian has been informed of the risks and benefits of receiving the influenza vaccine and chooses not to accept vaccination.
- **Code 5, Not offered:** resident or responsible party/legal guardian not offered the influenza vaccine.
- **Code 6, Inability to obtain influenza vaccine due to a declared shortage:** vaccine is unavailable at this facility due to a declared influenza vaccine shortage.
- **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.

O0250: Influenza Vaccine (cont.)

Coding Tips and Special Populations

- 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.
- Influenza can occur at any time, but most influenza occurs from October through May. However, residents should be immunized as soon as the vaccine becomes available. More information about when facilities must offer residents the influenza vaccine is available in 42 CFR 483.80(d), Influenza and pneumococcal immunizations, which can be found in Appendix PP of the State Operations Manual: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf#page=708.
- Information about the 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: <https://www.cdc.gov/flu/about/season.html>, <https://www.cdc.gov/fluview/surveillance/usmap.html>.
- Facilities can also contact their local health department website for local influenza surveillance information.
- The annual supply of inactivated influenza vaccine and the timing of its distribution cannot be guaranteed in any year. Therefore, in the event that a declared influenza vaccine shortage occurs in your geographical area, residents should still be vaccinated once the facility receives the influenza vaccine.
- A “high dose” inactivated influenza vaccine is available for people 65 years of age and older. Consult with the resident’s primary care physician (or nurse practitioner) to determine if this high dose is appropriate for the resident.

Examples

1. Resident J received the influenza vaccine in the facility during this year’s influenza vaccination season, on January 7, 2014.

Coding: O0250A would be **coded 1, Yes**; O0250B would be **coded 01-07-2014**, and O0250C would be skipped.

Rationale: Resident J received the vaccine in the facility on January 7, 2014, during this year’s influenza vaccination season.

2. Resident R did not receive the influenza vaccine in the facility during this year’s influenza vaccination season due to their 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, Resident R did not receive the vaccine.

O0250: Influenza Vaccine (cont.)

3. Resident T received the influenza vaccine at their doctor's office during this year's influenza vaccination season. Their doctor provided documentation of receipt of the vaccine to the facility to place in Resident T's medical record. They also provided documentation that Resident T was explained the benefits and risks of the influenza vaccine prior to administration.

Coding: O0250A would be **coded 0, No**; and O0250C would be **coded 2, Received outside of this facility**.

Rationale: Resident T received the influenza vaccine at their doctor's office during this year's influenza vaccination season.

4. Resident K wanted to receive the influenza vaccine if it arrived prior to their scheduled discharge on October 5th. Resident K was discharged prior to the facility receiving their annual shipment of influenza vaccine, and therefore, Resident K did not receive the influenza vaccine in the facility.

Resident K was encouraged to receive the influenza vaccine at their 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: Resident 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 their discharge. None of the codes in **O0250C, Influenza vaccine not received, state reason**, are applicable.

O0300: Pneumococcal Vaccine

O0300. Pneumococcal Vaccine	
Enter Code ☐	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 O0350, Resident's COVID-19 vaccination is up to date
Enter Code ☐	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

- Pneumococcus is one of the leading causes of community-acquired infections in the United States, with the highest disease burden among the elderly.
- Adults 65 years of age and older and those with chronic medical conditions are at increased risk for invasive pneumococcal disease and have higher case-fatality rates.

O0300: Pneumococcal Vaccine (cont.)

- Pneumococcal vaccines can help reduce the risk of invasive pneumococcal disease and pneumonia.

Planning for Care

- Early detection of outbreaks is essential to control outbreaks of pneumococcal disease in long-term care facilities.
- Individuals living in nursing homes and other long-term care facilities with an identified increased risk of invasive pneumococcal disease or its complications should receive pneumococcal vaccination.
- Conditions that increase the risk of invasive pneumococcal disease include decreased immune function; damaged or no spleen; sickle cell and other hemoglobinopathies; cerebrospinal fluid (CSF) leak; cochlear implants; and chronic diseases of the heart, lungs, liver, and kidneys, including dialysis, diabetes, alcoholism, and smoking. CDC guidance about risk conditions can be found at <https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/risk-indications.html>.

Steps for Assessment

1. Review the resident's medical record to determine whether any pneumococcal vaccines have been received. If vaccination status is unknown, proceed to the next step.
2. Ask the resident if they received any pneumococcal vaccines outside of the facility. If vaccination status is still unknown, proceed to the next step.
3. If the resident is unable to answer, 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 pneumococcal vaccination status cannot be determined, administer the recommended vaccine(s) to the resident, according to the standards of clinical practice.
 - If the resident has had a severe allergic reaction to a pneumococcal vaccine or its components, the vaccine should not be administered.
 - If the resident has a moderate to severe acute illness, the vaccine should be administered after the illness.
 - If the resident has a minor illness (e.g., a cold) check with the resident's physician before administering the vaccine.

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 **O0350**, **Resident's COVID-19 vaccination is up to date**.

O0300: Pneumococcal Vaccine (cont.)

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

- Specific guidance about pneumococcal vaccine recommendations and timing for adults can be found at <https://www.cdc.gov/pneumococcal/downloads/vaccine-timing-adults-jobaid.pdf>.
- “Up to date” in item O0300A means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations.

For up-to-date information on timing and intervals between vaccines, please refer to ACIP vaccine recommendations available at

— <https://www.cdc.gov/vaccines/hcp/imz-schedules/>

— <https://www.cdc.gov/acip-recs/hcp/vaccine-specific/>

— <https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/>

- If a resident has received one or more pneumococcal vaccinations and is indicated to get an additional pneumococcal vaccination but is not yet eligible for the next vaccination because the recommended time interval between vaccines has not lapsed, O0300A is coded 1, yes, indicating the resident’s pneumococcal vaccination is up to date.

Examples

1. Resident L, who is 72 years old, received the PCV13 pneumococcal vaccine at their physician’s office last year. They had previously been vaccinated with PPSV23 at age 66.

Coding: O0300A would be **coded 1, Yes**; skip to **O0350, Resident’s COVID-19 vaccination is up to date**.

Rationale: Resident L, who is over 65 years old, has received the recommended PCV13 and PPSV23 vaccines. Because it is not at least 5 years after the last pneumococcal vaccine, PCV20 or PCV21 are not considered by the physician at this time.

O0300: Pneumococcal Vaccine (cont.)

2. Resident B, who is 95 years old, has never received a pneumococcal vaccine. Their physician has an order stating that they are NOT to be immunized.

Coding: O0300A would be **coded 0, No**; and O0300B would be **coded 1, Not eligible**.

Rationale: Resident B has never received the pneumococcal vaccine; therefore, their vaccine is not up to date. Their physician has written an order for them not to receive a pneumococcal vaccine, thus they are not eligible for the vaccine.

3. Resident A, who has congestive heart failure, received PPSV23 vaccine at age 62 when they were hospitalized for a broken hip. They are now 78 years old and were admitted to the nursing home one week ago for rehabilitation. They were offered and given PCV20 on admission.

Coding: O0300A would be **coded 1, Yes**; skip to **O0350, Resident's COVID-19 vaccination is up to date**.

Rationale: Resident A received PPSV23 before age 65 years because they have a chronic heart disease. Because it was at least one year since Resident A received the PPSV23, the facility offered and administered PCV20.

4. Resident T, who has a long history of smoking cigarettes, received the PPSV23 pneumococcal vaccine at age 62 when they were living in a congregate care community. They are now 64 years old and are being admitted to the nursing home for chemotherapy and respite care. They have not been offered any additional pneumococcal vaccines.

Coding: O0300A would be **coded 0, No**; and O0300B would be **coded 3, Not offered**.

Rationale: Resident T is not up to date with their pneumococcal vaccination and has not been offered another vaccination to bring them up to date per current vaccination recommendations. Resident T received 1 dose of PPSV23 vaccine prior to 65 years of age because they are a smoker. Because Resident T is age 50 years or older and it is at least one year since they received the PPSV23 vaccine, they should receive one dose of PCV20 or PCV21 or one dose of PCV15. Their vaccines would then be complete.

O0350: Resident's COVID-19 vaccination is up to date

O0350. Resident's COVID-19 vaccination is up to date

Enter Code

☐

0. No, resident is not up to date
1. Yes, resident is up to date

Item Rationale

Health-related Quality of Life

- The intent of this item is to report if a person is up to date with their COVID-19 vaccine status.
- Age is the strongest risk factor for severe coronavirus disease 2019 (COVID-19) outcomes. In 2020, persons aged 65 years or older accounted for 81 percent of U.S. COVID-19–related deaths.
- Severe illness caused by COVID-19 means that the person with COVID-19 may require hospitalization, intensive care, or ventilator support for breathing, or may even die.

Planning for Care

- A strong infection prevention and control program is vital to protect both residents and healthcare personnel.
- Remaining up to date with all recommended COVID-19 vaccine doses is critical to protect both staff and residents from Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) infection.
- COVID-19 vaccines currently approved or authorized by the U.S. Food & Drug Administration are effective in reducing the risk of serious outcomes of COVID-19, including severe disease, hospitalization, and death.
- Efforts to increase the number of people in the United States who are up to date with their COVID-19 vaccines remain an important strategy for preventing illnesses, hospitalizations, and deaths from COVID-19.
- A vaccine, like any other medicine, could possibly cause serious problems, such as severe allergic reactions. Serious problems from the COVID-19 vaccine are very rare. More information about potential side effects of the COVID-19 vaccine, precautions, and contraindications can be found on the CDC webpage “Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States” at <https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#contraindications>.

O0350: Resident's COVID-19 vaccination is up to date (cont.)

Steps for Assessment

1. Vaccination status may be determined based on information from any available source.
 - Review the resident's medical record or documentation of COVID-19 vaccination and/or interview the resident, family or other caregivers or healthcare providers to determine whether the resident is up to date with their COVID-19 vaccine.
2. If the resident is **not up to date**, and the facility has the vaccine available, ask the resident if they would like to receive the COVID-19 vaccine.

Coding Instructions

- Code 0, No, resident is not up to date if the resident does not meet the CDC's definition of up to date.
 - This includes residents who have not received one or more recommended COVID-19 vaccine doses **for any reason** including medical, religious, or other qualified exemptions.
 - This includes residents for whom vaccination status cannot be determined.
- Code 1, Yes, resident is up to date if the resident meets the CDC's definition of up to date.
- A dash is a valid response, indicating the item was not assessed. CMS expects dash use to be a rare occurrence.

DEFINITION

UP TO DATE for COVID-19 Vaccine

For the definition of "up to date," providers should refer to the CDC webpage "Staying Up to Date with COVID-19 Vaccines" at <https://www.cdc.gov/covid/vaccines/stay-up-to-date.html>.

Coding Tip

- Current COVID-19 vaccine recommendations are available on the Centers for Disease Control and Prevention's (CDC's) webpage "Staying Up to Date with COVID-19 Vaccines" at <https://www.cdc.gov/covid/vaccines/stay-up-to-date.html>.

O0390: Therapy Services

O0390. Therapy Services	
Indicate therapies administered for at least 15 minutes a day on one or more days in the last 7 days	
↓	Check all that apply
☐	A. Speech-Language Pathology and Audiology Services
☐	B. Occupational Therapy
☐	C. Physical Therapy
☐	D. Respiratory Therapy
☐	E. Psychological Therapy
☐	Z. None of the above

Item Rationale

Health-related Quality of Life

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

Planning for Care

- Code only medically necessary therapies that occurred after admission/readmission to the nursing home that were (1) ordered by a physician (physician's assistant, nurse practitioner, and/or clinical nurse specialist) based on a qualified therapist's assessment (i.e., one who meets Medicare requirements or, in some instances, under such a person's direct supervision) and treatment plan, (2) documented in the resident's medical record, and (3) care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective. Therapy treatment may occur either inside or outside of the facility.
- **For definitions of the types of therapies listed in this section, please refer to the Glossary in Appendix A.**

Steps for Assessment

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

O0390: Therapy Services (cont.)

Coding Instructions

Check each therapy service that was administered for at least 15 minutes per day on one or more days in the last 7 days. Check none of the above if the resident did not receive therapy services for at least 15 minutes per day on one or more days in the last 7 days.

A day of therapy is defined as skilled treatment for 15 or more minutes during the day.

- **O0390A, Speech-Language Pathology and Audiology Services**
- **O0390B, Occupational Therapy**
- **O0390C, Physical Therapy**
- **O0390D, Respiratory Therapy**
- **O0390E, Psychological Therapy**
- **O0390Z, None of the above were provided**

Coding Tips and Special Populations

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

Minutes of Therapy

- Includes only therapies that were provided once the individual is actually living/being cared for at the long-term care facility. Do NOT include therapies that occurred while the person was an inpatient at a hospital or recuperative/rehabilitation center or other long-term care facility, or a recipient of home care or community-based services.
- If a resident returns from a hospital stay, an initial evaluation must be performed after entry/reentry to the facility, and only those therapies that occurred since admission/reentry to the facility and after the initial evaluation shall be counted, except in the case of an interrupted stay.
- O0390 therapy items do not require at least 15 minutes of a single mode of therapy to be checked on the MDS. Minutes from the same therapy discipline (e.g., physical therapy) but different therapy modes (e.g., individual and concurrent) may be combined to meet the “at least 15 minutes” of skilled therapy in a day requirement.
- The therapist’s time spent on documentation or on initial evaluation is not included.
- The therapist’s time spent on subsequent reevaluations, conducted as part of the treatment process, should be counted.
- Family education when the resident is present is counted and must be documented in the resident’s record.

O0390: Therapy Services (cont.)

- Only skilled therapy time (i.e., requires the skills, knowledge, and judgment of a qualified therapist and all the requirements for skilled therapy are met) shall be recorded on the MDS. In some instances, the time during which a resident received a treatment modality includes partly skilled and partly unskilled time; only time that is skilled may be recorded on the MDS. Therapist time during a portion of a treatment that is non-skilled; during a non-therapeutic rest period; or during a treatment that does not meet the therapy mode definitions may not be included.
- The time required to adjust equipment or otherwise prepare the treatment area for skilled rehabilitation service is the set-up time and is to be included in the count of minutes of therapy delivered to the resident. Set up may be performed by the therapist, therapy assistant, or therapy aide.
- Respiratory therapy—only minutes that the respiratory therapist or respiratory nurse spends with the resident shall count towards the 15 minutes per day on one or more days when coding the MDS. This time includes resident evaluation/assessment, treatment administration and monitoring, and setup and removal of treatment equipment. Time that a resident self-administers *or receives* a nebulizer treatment *or maintenance level/prophylactic incentive spirometry* without *clinically indicated or medically necessary* supervision of the respiratory therapist or respiratory nurse is not included in the minutes recorded on the MDS. Do not include administration of metered-dose and/or dry powder inhalers in respiratory minutes.
- For Speech-Language Pathology Services (SLP), Physical Therapy (PT), Occupational Therapy (OT), include only skilled therapy services. Skilled therapy services **must** meet **all** of the following conditions (Refer to **Medicare Benefit Policy Manual**, Chapters 8 and 15, for detailed requirements and policies):
 - for Part A, services must be ordered by a physician. For Part B, the plan of care must be certified by a physician following the therapy evaluation;
 - the services must be directly and specifically related to an active written treatment plan that is approved by the physician after any needed consultation with the qualified therapist and is based on an initial evaluation performed by a qualified therapist prior to the start of therapy services in the facility;
 - the services must be of a level of complexity and sophistication, or the condition of the resident must be of a nature that requires the judgment, knowledge, and skills of a therapist;
 - the services must be provided with the expectation—based on the assessment of the resident's restoration potential made by the physician—that the condition of the patient will improve materially in a reasonable and generally predictable period of time; or, the services must be necessary for the establishment of a safe and effective maintenance program; or, the services must require the skills of a qualified therapist for the performance of a safe and effective maintenance program.

O0390: Therapy Services (cont.)

- the services must be considered under accepted standards of medical practice to be specific and effective treatment for the resident's condition; and,
- the services must be reasonable and necessary for the treatment of the resident's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable, and they must be furnished by qualified personnel.
- Include services provided by a qualified occupational/physical therapy assistant who is employed by (or under contract with) the long-term care facility only if they are under the direction of a qualified occupational/physical therapist. Medicare does not recognize speech-language pathology assistants; therefore, services provided by these individuals are not to be coded on the MDS.
- For purposes of the MDS, when the payer for therapy services is not Medicare Part B, follow the definitions and coding for Medicare Part A.
- **Do not round therapy minutes (e.g., reporting) to the nearest 5th minute when counting therapy minutes.** The conversion of units to minutes or minutes to units is not appropriate. Please note that therapy logs are not an MDS requirement but reflect a standard clinical practice expected of all therapy professionals. These therapy logs may be used to verify the provision of therapy services in accordance with the plan of care and to validate information reported on the MDS assessment.
- When therapy is provided, staff need to document the different modes of therapy and set up minutes that are being included on the MDS. It is important to keep records of time included for each.
- For purposes of the MDS, providers should record services for respiratory and psychological therapies (items O0390D and O0390E) when the following criteria are met:
 - the physician orders the therapy;
 - the physician's order includes a statement of frequency, duration, and scope of treatment;
 - the services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by qualified personnel (See Glossary in Appendix A for definitions of respiratory and psychological therapies);
 - the services are required and provided by qualified personnel (See Glossary in Appendix A for definitions of respiratory and psychological therapies); and
 - the services must be reasonable and necessary for treatment of the resident's condition.

O0390: Therapy Services (cont.)

Non-Skilled Services

- Services provided at the request of the resident or family that are not medically necessary (sometimes referred to as family-funded services) shall **not** be counted in items O0390, Therapy Services; *O0400, Therapies*; or O0425, Part A Therapies, even when performed by a therapist or an assistant.
- As noted above, therapy services can include the actual performance of a maintenance program in those instances where the skills of a qualified therapist are needed to accomplish this safely and effectively. However, when the performance of a maintenance program does not require the skills of a therapist because it could be accomplished safely and effectively by the patient or with the assistance of non-therapists (including unskilled caregivers), such services are not considered therapy services in this context. Sometimes a nursing home may nevertheless elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services even when the involvement of a qualified therapist is not medically necessary. In these situations, the services shall **not** be coded as therapy in items O0390, Therapy Services; *O0400, Therapies*; or O0425, Part A Therapies, since the specific interventions would be considered restorative nursing care when performed by nurses or aides. Services provided by therapists, licensed or not, that are not specifically listed in this manual or on the MDS item set shall **not** be coded as therapy in items O0390, Therapy Services; *O0400, Therapies*; or O0425, Part A Therapies. These services should be documented in the resident's medical record.
- In situations where the ongoing performance of a safe and effective maintenance program does not require any skilled services, once the qualified therapist has designed the maintenance program and discharged the resident from a rehabilitation (i.e., skilled) therapy program, the services performed by the therapist and the assistant are **not** to be reported in O0390, Therapy Services, or O0425, Part A Therapies. The services may be reported on the MDS assessment in item O0500, Restorative Nursing Care, provided the requirements for restorative nursing program are met.
- Services provided by therapy aides are **not** skilled services (see therapy aide section below).
- When a resident refuses to participate in therapy, it is important for care planning purposes to identify why the resident is refusing therapy. However, the time spent investigating the refusal or trying to persuade the resident to participate in treatment is not a skilled service and shall not be included in the therapy minutes.

O0390: Therapy Services (cont.)

Co-treatment

For Part A:

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

For Part B:

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

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

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

O0390: Therapy Services (cont.)

Therapy Aides and Students

Therapy Aides

Therapy Aides cannot provide skilled services. Only the time a therapy aide spends on set-up preceding skilled therapy may be coded on the MDS (e.g., set up the treatment area for wound therapy) and should be coded under the appropriate mode for the skilled therapy (individual, concurrent, or group) in O0390, Therapy Services, and/or O0425, Part A Therapies. The therapy aide must be under direct supervision of the therapist or assistant (i.e., the therapist/assistant must be in the facility and immediately available).

Therapy Students

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

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

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

O0390: Therapy Services (cont.)

Modes of Therapy

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

Individual Therapy

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

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

Example:

- A speech therapy graduate student treats Resident A for 30 minutes. Resident A's therapy is covered under the Medicare Part A benefit. The supervising speech-language pathologist is not treating any patients at this time but is not in the room with the student or Resident A. Resident A's therapy may be checked in O0390A, Speech-Language Pathology and Audiology Services, and coded as 30 minutes of individual therapy in O0425A1, Individual minutes, on the MDS.

O0390: Therapy Services (cont.)

Concurrent Therapy

Medicare Part A

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

When a therapy student is involved with the treatment, and one of the following occurs, the minutes may be checked in O0390 and coded as concurrent therapy in O0425, Part A Therapies:

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

Medicare Part B

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

Examples:

- A physical therapist provides therapies that are not the same or similar to Resident Q and Resident R at the same time for 30 minutes. Resident Q's stay is covered under the Medicare SNF PPS Part A benefit. Resident R is paying privately for therapy. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - Resident Q received at least 15 minutes of therapy (O0390) and concurrent therapy for 30 minutes (O0425).
 - Resident R received at least 15 minutes of therapy (O0390) and concurrent therapy for 30 minutes (O0425).

O0390: Therapy Services (cont.)

- A physical therapist provides therapies that are not the same or similar to Resident S and Resident T at the same time for 30 minutes. Resident S's stay is covered under the Medicare SNF PPS Part A benefit. Resident T's therapy is covered under Medicare Part B. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - Resident S received at least 15 minutes of therapy (O0390) and concurrent therapy for 30 minutes (O0425).
 - Resident T received at least 15 minutes of therapy (O0390) and group therapy (Medicare Part B definition) for 30 minutes (O0425). (Please refer to the **Medicare Benefit Policy Manual**, Chapter 15, and the **Medicare Claims Processing Manual**, Chapter 5, for coverage and billing requirements under the Medicare Part B benefit.)
- An Occupational Therapist provides therapy to Resident K for 60 minutes. An occupational therapy graduate student, who is supervised by the occupational therapist, is treating Resident R at the same time for the same 60 minutes, but Resident K and Resident R are not doing the same or similar activities. Both Resident K's and Resident R's stays are covered under the Medicare Part A benefit. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - Resident K received at least 15 minutes of therapy (O0390) and concurrent therapy for 60 minutes (O0425).
 - Resident R received at least 15 minutes of therapy (O0390) and concurrent therapy for 60 minutes (O0425).

Group Therapy

Medicare Part A

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

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

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

O0390: Therapy Services (cont.)

Medicare Part B

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

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

- The therapy student is providing group treatment, and the supervising therapist/assistant is not engaged in any other activity or treatment; or
- The supervising therapist/assistant is providing group treatment, and the therapy student is not providing treatment to any resident.

Examples:

- A Physical Therapist provides similar therapies to Resident W, Resident X, Resident Y, and Resident Z at the same time, for 30 minutes. Resident W's and Resident X's stays are covered under the Medicare SNF PPS Part A benefit. Resident Y's therapy is covered under Medicare Part B, and Resident Z has private insurance paying for therapy. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - Resident W received at least 15 minutes of therapy (O0390) and group therapy for 30 minutes (O0425).
 - Resident X received at least 15 minutes of therapy (O0390) and group therapy for 30 minutes (O0425).
 - Resident Y received at least 15 minutes of therapy (O0390) and group therapy for 30 minutes (O0425). (Please refer to the **Medicare Benefit Policy Manual**, Chapter 15, and the **Medicare Claims Processing Manual**, Chapter 5, for coverage and billing requirements under the Medicare Part B benefit.)
 - Resident Z received at least 15 minutes of therapy (O0390) and group therapy for 30 minutes (O0425).
- Resident V, whose stay is covered by SNF PPS Part A benefit, begins therapy in an individual session. After 13 minutes the therapist begins working with Resident S, whose therapy is covered by Medicare Part B, while Resident V continues with their skilled intervention and is in the line of sight of the treating therapist. The therapist provides treatment during the same time period to Resident V and Resident S who are not performing the same or similar activities for 24 minutes, at which time Resident V's therapy session ends. The therapist continues to treat Resident S individually for 10 minutes. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - Resident V received at least 15 minutes of therapy (O0390) and individual therapy for 13 minutes and concurrent therapy for 24 minutes (O0425).

O0390: Therapy Services (cont.)

- Resident S received at least 15 minutes of therapy (O0390) and group therapy (Medicare Part B definition) for 24 minutes (O0425) and individual therapy for 10 minutes (O0425). (Please refer to the **Medicare Benefit Policy Manual**, Chapter 15, and the **Medicare Claims Processing Manual**, Chapter 5, for coverage and billing requirements under the Medicare Part B benefit.)
- Resident A and Resident B, whose stays are covered by Medicare Part A, begin working with a physical therapist on two different therapy interventions. After 30 minutes, Resident A and Resident B are joined by Resident T and Resident E, whose stays are also covered by Medicare Part A, and the therapist begins working with all of them on the same therapy goals as part of a group session. After 15 minutes in this group session, Resident A becomes ill and is forced to leave the group, while the therapist continues working with the remaining group members for an additional 15 minutes. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
 - Resident A received at least 15 minutes of therapy (O0390) and concurrent therapy for 30 minutes (O0425) and group therapy for 15 minutes (O0425).
 - Resident B received at least 15 minutes of therapy (O0390) and concurrent therapy for 30 minutes (O0425) and group therapy for 30 minutes (O0425).
 - Resident T received at least 15 minutes of therapy (O0390) and group therapy for 30 minutes (O0425).
 - Resident E received at least 15 minutes of therapy (O0390) and group therapy for 30 minutes (O0425).

Therapy Modalities

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

O0390: Therapy Services (cont.)

Examples

1. Resident Z's assessment has an ARD of 09/05/24. Review of the records show Resident Z received occupational therapy on 08/30/24 for 25 minutes, 09/01/24 for 15 minutes, and 09/03/24 for 30 minutes.

Coding: O0390B would be **checked**.

Rationale: Resident Z received at least 15 minutes of occupational therapy on at least one day during the observation period.

2. On day two of the observation period, Resident T received 10 minutes of physical therapy in the morning and 10 minutes of physical therapy in the afternoon. Resident T did not receive physical therapy on any other days during the observation period.

Coding: O0390C would be **checked**.

Rationale: Resident T received at least 15 minutes of physical therapy on one day during the observation period.

3. During the observation period, Resident S received 10 minutes of *skilled* respiratory therapy on day one, 7 minutes of *skilled* respiratory therapy on day four and 13 minutes of *skilled* respiratory therapy on day five of the observation period.

Coding: O0390D would **not be checked**.

Rationale: Resident S did not receive at least 15 minutes of *skilled* respiratory therapy on a single day during the observation period.

4. *During the observation period, Resident P, who has stable COPD and no symptoms of respiratory distress, had an order for daily incentive spirometry to prevent respiratory decline. Nursing staff assisted Resident P to use the incentive spirometer and documented that Resident P completed the incentive spirometry for 15 minutes on each day of the observation period.*

Coding: O0390D would **not be checked**.

Rationale: *While nursing staff assisted the resident with their routine incentive spirometry use, given the resident's stable condition and absence of respiratory distress, the maintenance level/prophylactic treatment did not require the skills, knowledge, and judgment of a respiratory therapist or respiratory nurse and therefore did not meet the criteria for skilled respiratory therapy.*

5. Resident H did not receive any skilled therapy services during the observation period.

Coding: O0390Z would be **checked**.

Rationale: In order to check a therapy service in O0390, the resident must receive at least 15 minutes in a day of skilled therapy services during the observation period.

O0400: Therapies

O0400. Therapies

Complete only if O0390D is checked

D. Respiratory Therapy

Enter Number of Days

2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

Steps for Assessment

1. *Complete only if O0390D, Respiratory Therapy, is checked.*
2. Review the resident's medical record and consult with each of the qualified care providers to collect the information required for this item.
3. *Apply the therapy coding guidance from O0390, Therapy Services, for coding O0400D, Respiratory Therapy.*

Coding Instructions

- **Days**—Enter the number of days *skilled respiratory* 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.

Example

1. Following a stroke *and aspiration pneumonia*, Resident F was admitted to the skilled nursing facility on 10/06/26 under *Medicare* Part A skilled nursing facility coverage. *They* were referred to respiratory therapy. *During the 7-day look-back period, the resident received skilled respiratory therapy services Sunday–Wednesday for 10 minutes each day and Thursday–Saturday for 15 minutes each day.*

Coding: O0400D2 would be **coded 3**.

Rationale: *The resident only received skilled respiratory therapy services for 15 minutes on 3 days.* Therefore, O0400D equals **3 days**.

O0425: Part A Therapies

O0425. Part A Therapies

Complete only if A0310H = 1

A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes 	1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually since the start date of the resident's most recent Medicare Part A stay (A2400B)
Enter Number of Minutes 	2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident since the start date of the resident's most recent Medicare Part A stay (A2400B)
Enter Number of Minutes 	3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents since the start date of the resident's most recent Medicare Part A stay (A2400B)
If the sum of individual, concurrent, and group minutes is zero, → skip to O0425B, Occupational Therapy	
Enter Number of Minutes 	4. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions since the start date of the resident's most recent Medicare Part A stay (A2400B)
Enter Number of Days 	5. Days - record the number of days this therapy was administered for at least 15 minutes a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

B. Occupational Therapy

Enter Number of Minutes 	1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually since the start date of the resident's most recent Medicare Part A stay (A2400B)
Enter Number of Minutes 	2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident since the start date of the resident's most recent Medicare Part A stay (A2400B)
Enter Number of Minutes 	3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents since the start date of the resident's most recent Medicare Part A stay (A2400B)
If the sum of individual, concurrent, and group minutes is zero, → skip to O0425C, Physical Therapy	
Enter Number of Minutes 	4. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions since the start date of the resident's most recent Medicare Part A stay (A2400B)
Enter Number of Days 	5. Days - record the number of days this therapy was administered for at least 15 minutes a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

C. Physical Therapy

Enter Number of Minutes 	1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually since the start date of the resident's most recent Medicare Part A stay (A2400B)
Enter Number of Minutes 	2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident since the start date of the resident's most recent Medicare Part A stay (A2400B)
Enter Number of Minutes 	3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents since the start date of the resident's most recent Medicare Part A stay (A2400B)
If the sum of individual, concurrent, and group minutes is zero, → skip to O0430, Distinct Calendar Days of Part A Therapy	
Enter Number of Minutes 	4. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions since the start date of the resident's most recent Medicare Part A stay (A2400B)
Enter Number of Days 	5. Days - record the number of days this therapy was administered for at least 15 minutes a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

O0425: Part A Therapies (cont.)

Item Rationale

Health-related Quality of Life

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

Planning for Care

- Except in the case of an interrupted stay, code only medically necessary therapies that occurred after admission/readmission to the nursing home that were (1) ordered by a physician (physician's assistant, nurse practitioner, and/or clinical nurse specialist as allowable under state licensure laws) based on a qualified therapist's assessment (i.e., one who meets Medicare requirements or, in some instances, under such a person's direct supervision) and treatment plan, (2) documented in the resident's medical record, and (3) care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective. Therapy treatment may occur either inside or outside of the facility.
- In the case of an interrupted stay, code medically necessary therapies that occurred during the entire current Medicare Part A PPS stay that meet the above-noted criteria.
- **For definitions of the types of therapies listed in this section, please refer to the Glossary in Appendix A.**

O0425: Part A Therapies (cont.)

Steps for Assessment

1. Complete only if A0310H (Is this a SNF Part A PPS Discharge Assessment?) = 1, Yes.
2. Review the resident's medical record (e.g., rehabilitation therapy evaluation and treatment records) and consult with each of the qualified care providers to collect the information required for this item.

NOTE: The look-back period for these items is the entire SNF Part A stay, starting at Day 1 of the Part A stay and finishing on the last day of the Part A stay. Once reported on the MDS, CMS grouping software will calculate the percentage of group and concurrent therapy, combined, provided to each resident as a percentage of all therapies provided to that resident, by discipline. If the combined amount of group and concurrent therapy provided, by discipline, exceeds 25 percent, then this would be deemed as non-compliance and a warning message would be received on the Final Validation Report.

Providers should follow the steps outlined below for calculating compliance with the concurrent/group therapy limit:

- Step 1: Total Therapy Minutes, by discipline (O0425X1 + O0425X2 + O0425X3)
- Step 2: Total Concurrent and Group Therapy Minutes, by discipline (O0425X2 + O0425X3)
- Step 3: Concurrent/Group Ratio (Step 2 result/Step 1 result)
- Step 4: If Step 3 result is greater than 0.25, then the provider is non-compliant

O0425: Part A Therapies (cont.)

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 during the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). **Enter 0** if none were provided. Individual services are provided by one therapist or assistant to one resident at a time. (For detailed definitions and examples of individual therapy, refer to O0390 above.)
- **Concurrent minutes**—Enter the total number of minutes of therapy that were provided on a concurrent basis during the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). **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 detailed definitions and examples of concurrent therapy, refer to item O0390 above.)
- **Group minutes**—Enter the total number of minutes of therapy that were provided in a group during the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). **Enter 0** if none were provided. Group therapy is defined for Part A as the treatment of two to six 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 detailed definitions and examples of group therapy, refer to item O0390 above.)
- **Co-treatment minutes**—Enter the total number of minutes each discipline of therapy was administered to the resident in co-treatment sessions during the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). Skip the item if none were provided. (For detailed definitions and examples of co-treatment, refer to item O0390 above.)
- **Speech-Language Pathology Days**—Enter the number of days speech-language pathology therapy services were provided over the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). 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 during the stay. If the total number of minutes (individual plus concurrent plus group) during the stay is 0, skip this item and leave blank.

O0425: Part A Therapies (cont.)

- **Occupational Therapy Days**—Enter the number of days occupational therapy services were provided over the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). 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 during the stay. If the total number of minutes (individual plus concurrent plus group) during the stay is 0, skip this item and leave blank.
- **Physical Therapy Days**—Enter the number of days physical therapy services were provided over the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). 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 during the stay. If the total number of minutes (individual plus concurrent plus group) during the stay is 0, skip this item and leave blank.

Coding Tips and Special Populations

- For detailed descriptions of how to code minutes of therapy and explanation of skilled versus nonskilled therapy services, co-treatment, therapy aides and students, please refer to these topic headings in the discussion of item O0390 above.

Modes of Therapy

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

Individual Therapy

For a detailed definition and example of individual therapy, please refer to the discussion of item O0390 above.

O0425: Part A Therapies (cont.)

Concurrent Therapy

For a detailed definition and example of concurrent therapy, please refer to the discussion of item O0390 above.

Group Therapy

For a detailed definition and example of group therapy, please refer to the discussion of item O0390 above.

Therapy Modalities

For a detailed definition and explanation of therapy modalities, please refer to the discussion of item O0390 above.

General Coding Example:

Following a bilateral knee replacement, Resident G was admitted to the skilled nursing facility in stable condition for rehabilitation therapy on Sunday 10/06/19 under Part A skilled nursing facility coverage. While in the hospital, they exhibited some short-term memory difficulties specifically affecting orientation. They were non-weight bearing, had reduced range of motion, and had difficulty with ADLs. They were referred to SLP, OT, and PT with the long-term goal of returning home with their spouse. Their initial SLP evaluation was performed on 10/06/19, and the OT and PT initial evaluations were done on 10/07/19. They were in the SNF for 14 days and were discharged home on 10/19/2019. Resident G received the following rehabilitation services during their stay in the SNF.

Speech-language pathology services that were provided over the SNF stay:

- Individual cognitive training; six sessions for 45 minutes each day.
- Discharged from SLP services on 10/14/2019.

Coding: O0425A1 would be **coded 270**; O0425A2 would be **coded 0**; O0425A3 would be **coded 0**; O0425A4 would be **coded 0**; O0425A5 would be **coded 6**.

Rationale: Individual minutes totaled 270 over the stay (45 minutes $\times$ 6 days); concurrent minutes totaled 0 over the stay ($0 \times 0 = 0$); and group minutes totaled 0 over the stay ($0 \times 0 = 0$). Therapy was provided 6 days of the stay.

Occupational therapy services that were provided over the SNF stay:

- Individual ADL activities daily for 30 minutes each starting 10/08/19.
- Co-treatment: seating and transferring with PT; three sessions for the following times: 23 minutes, 18 minutes, and 12 minutes.
- Balance/coordination activities: 10 sessions for 20 minutes each session in a group.

O0425: Part A Therapies (cont.)

- Discharged from OT services on 10/19/19.
Coding: O0425B1 would be **coded 413**, O0425B2 would be **coded 0**, O0425B3 would be **coded 200**, O0425B4 would be **coded 53**, O0425B5 would be **coded 12**.
Rationale: Individual minutes (including 53 co-treatment minutes) totaled 413 over the stay $[(30 \times 12) + 53 = 413]$; concurrent minutes totaled 0 over the stay $(0 \times 0 = 0)$; and group minutes totaled 200 over the stay $(20 \times 10 = 200)$. Therapy was provided 12 days of the stay.

Physical therapy services that were provided over the stay:

- Individual mobility training daily for 45 minutes per session starting 10/07/19.
- Group mobility training for 30 minutes Tuesdays, Wednesdays, and Fridays.
- Co-treatment seating and transferring for three sessions with OT for 7 minutes, 22 minutes, and 18 minutes.
- Concurrent therapeutic exercises Monday–Friday for 20 minutes each day.
- Discharged from PT services on 10/19/19.
Coding: O0425C1 would be **coded 632**, O0425C2 would be **coded 200**, O0425C3 would be **coded 180**, O0425C4 would be **coded 47**, O0425C5 would be **coded 13**.
Rationale: Individual minutes (including 47 co-treatment minutes) totaled 632 over the stay $[(45 \times 13) + (7 + 22 + 18) = 632]$; concurrent minutes totaled 200 over the stay $(20 \times 10 = 200)$; and group minutes totaled 180 over the stay $(30 \times 6 = 180)$. Therapy was provided 13 days of the stay.

O0430: Distinct Calendar Days of Part A Therapy

O0430. Distinct Calendar Days of Part A Therapy

Complete only if A0310H = 1

Enter Number of Days

--	--	--

Record the number of **calendar days** that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for **at least 15 minutes** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Item Rationale

To record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes during the Part A SNF stay.

Coding Instructions

Enter the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes during the SNF Part A stay (i.e., from the date in A2400B through the date in A2400C). If a resident receives more than one therapy discipline on a given calendar day, this may only count for one calendar day for purposes of coding item O0430. Consider the following example:

Example: Resident T was admitted to the SNF on Sunday 10/06/18 and discharged on Saturday 10/26/18. They received 60 minutes of physical therapy every Monday, Wednesday, and Friday during the SNF stay. Resident T also received 45 minutes of occupational therapy every Monday, Tuesday, and Friday during the stay. Given the therapy services received by Resident T during the stay, item **O0430 would be coded as 12** because therapy services were provided for at least 15 minutes on 12 distinct calendar days during the stay (i.e., every Monday, Tuesday, Wednesday, and Friday).

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)

Technique	
↓	Number of Days
☐	A. Range of motion (passive)
☐	B. Range of motion (active)
☐	C. Splint or brace assistance
Training and Skill Practice In:	
↓	Number of Days
☐	D. Bed mobility
☐	E. Transfer
☐	F. Walking
☐	G. Dressing and/or grooming
☐	H. Eating and/or swallowing
☐	I. Amputation/prostheses care
☐	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/injuries.

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 they are admitted to the facility with restorative needs, but are 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.

O0500: Restorative Nursing Programs (cont.)

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:
 - Measurable objective and interventions must be documented in the care plan and in the medical record. If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this reassessment should be documented in the resident's medical record.
 - Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record. When not contraindicated by state practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established.
 - Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity.
 - A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a restorative nursing program. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents. Restorative nursing does not require a physician's order. Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In situations where such services do not actually require the involvement of a qualified therapist, the services may not be coded as therapy in item O0390, Therapy Services, or O0425, Part A Therapies, because the specific interventions are considered restorative nursing services (see items O0390, Therapy Services, and O0425, Part A Therapies). The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.
 - This category does not include groups with more than four residents per supervising helper or caregiver.

O0500: Restorative Nursing Programs (cont.)

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 O0390A or O0425A, **Occupational Therapy** item O0390B or O0425B, and **Physical Therapy** item O0390C or O0425C.
- 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.

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.

O0500: Restorative Nursing Programs (cont.)

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 themselves 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.

- **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.

O0500: Restorative Nursing Programs (cont.)

- **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 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.

O0500: Restorative Nursing Programs (cont.)

Examples

1. Resident V has lost range of motion in their right arm, wrist, and hand due to a cerebrovascular accident (CVA) experienced several years ago. They have moderate to severe loss of cognitive decision-making skills and memory. To avoid further ROM loss and contractures to their 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 their right arm, wrist, and hand three times per day. The nurse's aides and Resident V's spouse 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 Resident 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 Resident V's affected extremity when bathing and dressing them.

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. Resident R's right shoulder ROM has decreased slightly over the past week. Upon examination and X-ray, their physician diagnosed them with right shoulder impingement syndrome. Resident R was given exercises to perform on a daily basis to help improve their right shoulder ROM. After initial training in these exercises by the physical therapist, Resident R and the nursing staff were provided with instructions on how to cue and sometimes actively assist Resident R when they cannot make the full ROM required by the exercises on their own. Their 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 Resident R's medical record. The nursing staff cued and sometimes actively assisted Resident 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. Resident 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, they had difficulty moving themselves in bed and were dependent for transfers. To prevent further deterioration and increase their independence, the nursing staff implemented a plan on the second day following admission to teach them how to move themselves in bed and transfer from bed to chair using a trapeze, the bed rails, and a transfer board. The plan was documented in Resident 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 Resident K has been receiving training and skill practice for bed mobility for 20 minutes a day and transferring for 25 minutes a day, their endurance and strength have improved, and they require only substantial/maximal 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) and **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. Resident D is receiving training and skill practice in walking using a quad cane. Together, Resident D and the nursing staff have set progressive walking distance goals. The nursing staff has received instruction on how to provide Resident D with the instruction and guidance they need to achieve the goals. They have three scheduled times each day where they learn how to walk with their 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. Resident J had a CVA less than a year ago resulting in left-sided hemiplegia. Resident J has a strong desire to participate in their own care. Although they cannot dress themselves independently, they are capable of participating in this activity of daily living. Resident J's overall care plan goal is to maximize their independence in ADLs. A plan, documented on the care plan, has been developed to assist Resident J in how to maintain the ability to put on and take off their shirt with no physical assistance from the staff. All of their shirts have been adapted for front closure with hook and loop fasteners. The nursing assistants have been instructed in how to verbally guide Resident J as they put on and takes off their shirt to enhance their efficiency and maintain their level of function. It takes approximately 20 minutes per day for Resident J to complete this task (dressing and undressing).

Coding: **Dressing and/or grooming** item (O0500G) would be **coded 7**.

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

O0500: Restorative Nursing Programs (cont.)

6. Resident W's cognitive status has been deteriorating progressively over the past several months. Despite deliberate nursing restoration attempts to promote their independence in feeding themselves, they will not eat unless they are fed.

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

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

7. Resident E has Amyotrophic Lateral Sclerosis. They no longer have the ability to speak or even to nod their head "yes" or "no." Their cognitive skills remain intact, they can spell, and they can move their eyes in all directions. The speech-language pathologist taught both Resident E and the nursing staff to use a communication board so that Resident 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 Resident E's bed that they are to provide them with the board to enable Resident E to communicate with them. This is also documented in Resident E's care plan. Because the teaching and practice using the communication board had been completed 2 weeks ago and Resident E is able to use the board to communicate successfully, they no longer receive 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.