Centers for Medicare & Medicaid Services

Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual

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Centers for Medicare & Medicaid Services'
Long-Term Care Facility
Resident Assessment Instrument (RAI)
User's Manual
October 2019
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The *Long-Term Care Facility Resident Assessment Instrument User's Manual* for Version 3.0 is published by the Centers for Medicare & Medicaid Services (CMS) and is a public document. It may be copied freely, as our goal is to disseminate information broadly to facilitate accurate and effective resident assessment practices in long-term care facilities.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. (Note: The RAI mandated by OBRA is exempt from this requirement.) The valid OMB control number for the Medicare Prospective Payment System SNF and Swing Bed information collection is 0938-1140 and forms have been approved through January 30, 2020. The times required to complete the information collection for the item sets are as follows:

Item Set	Estimated response time
NP	51 minutes
NOD	39 minutes
NO/SO	26.52 minutes
NSD	34.17 minutes
NS/SS	14.03 minutes

These times are estimated per response, including completion, encoding, and transmission of the information collection.

If you have comments concerning the accuracy of the time estimates or suggestions for improving these forms, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

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- American Association of Nurse Assessment Coordinators
- American Health Care Association
- American Health Information Management Association
- American Hospital Association
- American Medical Directors Association
- American Nurses Association
- Association of Health Facility Survey Agencies – RAI Panel
- Commonwealth Fund
- interRAI
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- Leading Age
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Questions regarding information presented in this Manual should be directed to your State's RAI Coordinator. Please continue to check our web site for more information at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html.

The MDS instrument has also been adapted for use by non-critical access hospitals with a swing bed agreement. They are required to complete the MDS for reimbursement under SNF PPS.

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

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

(1) the assessment accurately reflects the resident's status

(2) a registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals

(3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts.

Nursing homes are left to determine

(1) who should participate in the assessment process

(2) how the assessment process is completed

that the increased clarity of the information documented about a resident makes tracking care and outcomes easier to accomplish.

The purpose of this manual is to offer clear guidance, through instruction and example, for the effective use of the RAI, and thereby help nursing home staff achieve the benefits listed above.

In keeping with objectives set forth in the Institute of Medicine (IOM) study completed in 1986 (Committee on Nursing Home Regulation, IOM) that made recommendations to improve the quality of care in nursing homes, the RAI provides each resident with a standardized, comprehensive and reproducible assessment. This tool assesses a resident's ability to perform daily life functions, identifies significant impairments in a resident's functional capacity, and provides opportunities for direct resident interview. In essence, with an accurate RAI completed periodically, caregivers have a genuine and consistent recorded "look" at the resident and can attend to that resident's needs with realistic goals in hand.

Furthermore, with the consistent application of item definitions, the RAI ensures standardized communication both within the nursing home and between facilities (e.g., other long-term care facilities or hospitals). Basically, when everyone is speaking the same language, the opportunity for misunderstanding or error is diminished considerably.

1.5 MDS 3.0

In response to changes in nursing home care, resident characteristics, advances in resident assessment methods, and provider and consumer concerns about the performance of the MDS 2.0, the Centers for Medicare & Medicaid Services (CMS) contracted with the RAND Corporation and Harvard University to draft revisions and nationally test the MDS Version 3.0. Following is a synopsis of the goals and key findings as reported in the *Development & Validation of a Revised Nursing Home Assessment Tool: MDS 3.0* final report (Saliba and Buchanan, 2008).

Goals

The goals of the MDS 3.0 revision are to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, increase user satisfaction, and increase the resident's voice by introducing more resident interview items. Providers, consumers, and other technical experts in nursing home care requested that MDS 3.0 revisions focus on improving the tool's clinical utility, clarity, and accuracy. CMS also wanted to increase the usability of the instrument while maintaining the ability to use MDS data for quality measure reporting and Medicare SNF PPS reimbursement *(via Patient Driven Payment Model [PDPM] classification).*

In addition to improving the content and structure of the MDS, the RAND/Harvard team also aimed to improve user satisfaction. User attitudes are key determinants of quality improvement implementation. Negative user attitudes toward the MDS are often cited as a reason that nursing homes have not fully implemented the information from the MDS into targeted care planning.

Methods

To address many of the issues and challenges previously identified and to provide an empirical foundation for examining revisions to the MDS before they were implemented, the RAND/Harvard team engaged in a careful iterative process that incorporated provider and consumer input, expert consultation, scientific advances in clinical knowledge about screening and assessment, CMS experience, and intensive item development and testing by a national Veterans Health Administration (VHA) consortium. This process allowed the final national testing of MDS 3.0 to include well-developed and tested items.

The national validation and evaluation of the MDS 3.0 included 71 community nursing homes (3,822 residents) and 19 VHA nursing homes (764 residents), regionally distributed throughout the United States. The evaluation was designed to test and analyze inter-rater agreement (reliability) between gold-standard (research) nurses and between nursing home and gold-standard nurses, validity of key sections, response rates for interview items, anonymous feedback on changes from participating nurses, and time to complete the MDS assessment. In addition, the national test design allowed comparison of item distributions between MDS 3.0 and MDS 2.0 and thus facilitated mapping into payment cells (Saliba and Buchanan, 2008).

Key Findings for MDS 3.0

- Improved Resident Input
- Improved Accuracy and Reliability
- Increased Efficiency
- Improved Staff Satisfaction and Perception of Clinical Utility

Improvements incorporated in MDS 3.0 produce a more efficient assessment instrument: better quality information was obtained in less time. Such gains should improve identification of resident needs and enhance resident-focused care planning. In addition, inclusion of items recognized in other care settings is likely to enhance communication among providers. These significant gains reflect the cumulative effect of changes across the tool, including:

- use of more valid items,
- direct inclusion of resident reports, and
- improved clarity of retained items.

1.6 Components of the MDS

The MDS is completed for all residents in Medicare- or Medicaid-certified nursing homes and *residents in a PPS stay in* non-critical access hospitals with Medicare swing bed agreements. The mandated assessment schedule is discussed in Chapter 2. States may also establish additional MDS requirements. For specific information on State requirements, please contact your State RAI Coordinator (see Appendix B).

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

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

2.1 Introduction to the Requirements for the RAI

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

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

MDS assessments are also required for Medicare payment (Skilled Nursing Facility (SNF) PPS) purposes under Medicare Part A (described in detail in Section 2.9) or for the SNF Quality Reporting Program (QRP) required under the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act).

It is important to note that when the OBRA and PPS assessment time frames coincide, one assessment may be used to satisfy both requirements. In such cases, the most stringent requirement for MDS completion must be met. Therefore, it is imperative that nursing home staff fully understand the requirements for both types of assessments in order to avoid unnecessary duplication of effort and to remain in compliance with both OBRA and PPS requirements. (Refer to Sections 2.10 and 2.11 for combining OBRA and PPS assessments).

2.2 CMS Designation of the RAI for Nursing Homes

Federal regulatory requirements at 42 CFR 483.20(b)(1) and 483.20(c) require facilities to use an RAI that has been specified by CMS. The Federal requirement also mandates facilities to encode and electronically transmit MDS 3.0 data. (Detailed submission requirements are located in Chapter 5.)

While states must use all Federally required MDS 3.0 items, they have some flexibility in adding optional Section S items.

- CMS' specified RAI covers the core items included on the instrument, the wording and sequencing of those items, and all definitions and instructions for the RAI.
- CMS' specified RAI does not include characteristics related to formatting (e.g., print type, color coding, or changes such as printing triggers on the assessment form).
- All comprehensive RAIs specified by CMS must include at least the CMS MDS Version 3.0 (with or without optional Section S) and use of the Care Area Assessment (CAA) process (including Care Area Triggers (CATs) and the CAA Summary (Section V).
- If allowed by the State, facilities may have some flexibility in form design (e.g., print type, color, shading, integrating triggers) or use a computer-generated printout of the RAI as long as the State can ensure that the facility's RAI in the resident's record accurately and completely represents the CMS-specified RAI in accordance with 42 CFR 483.20(b). This applies to either pre-printed forms or computer-generated printouts.
- Facility assessment systems must always be based on the MDS (i.e., both item terminology and definitions). However, facilities may insert additional items within automated assessment programs, but must be able to "extract" and print the MDS in a manner that replicates CMS' specified RAI (i.e., using the exact wording and sequencing of items as is found on the RAI specified by CMS).

Additional information about CMS specification of the RAI and variations in format can be found in Sections 4145.1–4145.7 of the CMS State Operations Manual (SOM) which can be found here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c04.pdf. For more information about your State's assessment requirements, contact your State RAI coordinator (see Appendix B).

2.3 Responsibilities of Nursing Homes for Completing Assessments

The requirements for the RAI are found at 42 CFR 483.20 and are applicable to all residents in Medicare and/or Medicaid certified long-term care facilities. The requirements are applicable regardless of age, diagnosis, length of stay, payment source or payer source. Federal RAI requirements are not applicable to individuals residing in non-certified units of long-term care facilities or licensed-only facilities. This does not preclude a State from mandating the RAI for residents who live in these units. Please contact your State RAI Coordinator for State requirements.

An RAI (MDS, CAA process, and Utilization Guidelines) must be completed for any resident residing in the facility, including:

- **All residents** of Medicare (Title 18) skilled nursing facilities (SNFs) or Medicaid (Title 19) nursing facilities (NFs). This includes certified SNFs or NFs in hospitals, regardless of payment source.
- **Hospice residents:** When a SNF or NF is the hospice resident's residence for purposes of the hospice benefit, the facility must comply with the Medicare or Medicaid participation requirements, meaning the resident must be assessed using the RAI, have a care plan and

be provided with the services required under the plan of care. This can be achieved through cooperation of both the hospice and long-term care facility staff (including participation in completing the RAI and care planning) with the consent of the resident.

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

Skilled Nursing Facility Quality Reporting Program: The IMPACT Act of 2014 established the SNF QRP. Amending Section 1888(e) of the Social Security Act, the IMPACT Act mandates that SNFs are to collect and report on standardized resident assessment data. Failure to report such data results in a 2 percent reduction in the SNF's market basket percentage for the applicable fiscal year. Data collected for the SNF QRP is submitted through the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system as it currently is for other MDS assessments.

- Additional information regarding the IMPACT Act and associated quality measures may be found on CMS's website at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-Measures.html.

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

- **Newly Certified Nursing Homes:**
  - Nursing homes must admit residents and operate in compliance with certification requirements before a certification survey can be conducted.
  - Nursing homes must meet specific requirements, 42 Code of Federal Regulations, Part 483 (Requirements for States and Long Term Care Facilities, Subpart B), in order to participate in the Medicare and/or Medicaid programs.
  - The completion and submission of OBRA and/or PPS assessments are a requirement for Medicare and/or Medicaid long-term care facilities. However, even though OBRA does not apply until the provider is certified, facilities are required to conduct and complete resident assessments prior to certification as if the beds were already certified.*
  - Prior to certification, although the facility is conducting and completing assessments, these assessments are not technically OBRA required, but are required to demonstrate compliance with certification requirements. Since the data on these pre-certification assessments was collected and completed with an ARD/target date prior to the certification date of the facility, CMS does not have the authority to receive this into the QIES ASAP system. Therefore, these assessments cannot be submitted to the QIES ASAP system.
  - Assuming a survey is completed where the nursing home has been determined to be in substantial compliance, the facility will be certified effective the last day of the survey and can begin to submit OBRA and PPS required assessments to the QIES ASAP system.
    - For OBRA assessments, the assessment schedule is determined from the resident's actual date of admission. Please note, if a facility completes an Admission assessment prior to the certification date, there is no need to do another Admission assessment. The facility will simply continue with the next expected assessment according to the OBRA schedule, using the actual admission date as Day 1. Since the first assessment submitted will not be an Entry or OBRA Admission assessment, but a Quarterly, OBRA Discharge, etc., the facility may receive a sequencing warning message, but should still submit the required assessment.
    - **For PPS assessments, please note that Medicare cannot be billed for any care provided prior to the certification date.** Therefore, the facility must use the certification date as Day 1 of the covered Part A stay when establishing the Assessment Reference Date (ARD) for the Medicare Part A SNF PPS assessments.

- *NOTE: Even in situations where the facility's certification date is delayed due to the need for a resurvey, the facility must continue conducting and completing resident assessments according to the original schedule.

- **Adding Certified Beds:**
  - If the nursing home is already certified and is just adding additional certified beds, the procedure for changing the number of certified beds is different from that of the initial certification.
  - Medicare and Medicaid residents should not be placed in a bed until the facility has been notified that the bed has been certified.
- **Change in Ownership:** There are two types of change in ownership transactions:
  - The more common situation requires the new owner to assume the assets and liabilities of the prior owner and retain the current CCN number. In this case:
    - The assessment schedule for existing residents continues, and the facility continues to use the existing provider number.
    - Staff with QIES user IDs continue to use the same QIES user IDs.
    - **Example:** if the Admission assessment was done 10 days prior to the change in ownership, the next OBRA assessment would be due no later than 92 days after the ARD (A2300) of the Admission assessment and would be submitted using the existing provider number. If the resident is in a Part A stay, and the 5-Day PPS assessment was combined with the OBRA Admission assessment, the next PPS assessment could be an Interim Payment Assessment (IPA), if the provider chooses to complete one, and would also be submitted under the existing provider number.
  - There are also situations where the new owner does not assume the assets and liabilities of the previous owner. In these cases:
    - The beds are no longer certified.
    - There are no links to the prior provider, including sanctions, deficiencies, resident assessments, Quality Measures, debts, provider number, etc.
    - The previous owner would complete an OBRA Discharge assessment - return not anticipated, thus code A0310F = 10, A2000 = date of ownership change, and A2100 = 02 for those residents who will remain in the facility.
    - The new owner would complete an Admission assessment and Entry tracking record for all residents, thus code A0310F = 01, A1600 = date of ownership change, A1700 = 1 (admission), and A1800 = 02.
    - Staff who worked for the previous owner **cannot** use their previous QIES user IDs to submit assessments for the new owner as this is now a new facility. They **must** register for new user IDs for the new facility.
    - Compliance with OBRA regulations, including the MDS requirements, is expected at the time of survey for certification of the facility with a new owner. See information above regarding newly certified nursing homes.

- **Resident Transfers:**
  - When transferring a resident, the transferring facility must provide the new facility with necessary medical records, including appropriate MDS assessments, to support the continuity of resident care.
  - When admitting a resident from another nursing home, regardless of whether or not it is a transfer within the same chain, a new Admission assessment must be done within 14 days. The MDS schedule then starts with the new Admission assessment and, if applicable, a 5-Day assessment.
  - The admitting facility should look at the previous facility's assessment in the same way they would review other incoming documentation about the resident for the purpose of understanding the resident's history and promoting continuity of care. However, the admitting facility must perform a new Admission assessment for the purpose of planning care within that facility to which the resident has been transferred.
  - When there has been a transfer of residents as a result of a natural disaster(s) (e.g., flood, earthquake, fire) with an **anticipated return** to the facility, the evacuating facility should contact their Regional Office, State agency, and Medicare Administrative Contractor (MAC) for guidance.
  - When there has been a transfer as a result of a natural disaster(s) (e.g., flood, earthquake, fire) and it has been determined that the resident will not return to the evacuating facility, the evacuating provider will discharge the resident **return not anticipated** and the receiving facility will admit the resident, with the MDS cycle beginning as of the admission date to the receiving facility. For questions related to this type of situation, providers should contact their Regional Office, State agency, and MAC for guidance.
  - More information on emergency preparedness can be found at: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html.

2.4 Responsibilities of Nursing Homes for Reproducing and Maintaining Assessments

The Federal regulatory requirement at 42 CFR 483.20(d) requires nursing homes to maintain all resident assessments completed within the previous 15 months in the resident's active clinical record. This requirement applies to all MDS assessment types regardless of the form of storage (i.e., electronic or hard copy).

- The 15-month period for maintaining assessment data may not restart with each readmission to the facility:
  - When a resident is **discharged return anticipated** and the resident **returns to the facility within 30 days**, the facility must copy the previous RAI and transfer that copy to the new record. The15-month requirement for maintenance of the RAI data must be adhered to.
  - When a resident is **discharged return anticipated and does not return within 30 days** or **discharged return not anticipated**, facilities may develop their own specific

policies regarding how to handle return situations, whether or not to copy the previous RAI to the new record.

— In cases where the resident returns to the facility after a long break in care (i.e., 15 months or longer), staff may want to review the older record and familiarize themselves with the resident history and care needs. However, the decision on retaining the prior stay record in the active clinical record is a matter of facility policy and is not a CMS requirement.

- After the 15-month period, RAI information may be thinned from the active clinical record and stored in the medical records department, provided that it is easily retrievable if requested by clinical staff, State agency surveyors, CMS, or others as authorized by law. The **exception** is that demographic information (items A0500-A1600) from the most recent Admission assessment must be maintained in the active clinical record until the resident is discharged return not anticipated or is discharged return anticipated but does not return within 30 days.
- Nursing homes may use electronic signatures for clinical record documentation, including the MDS, when permitted to do so by State and local law and when authorized by the facility's policy. Use of electronic signatures for the MDS does not require that the entire clinical record be maintained electronically. Facilities must have written policies in place to ensure proper security measures are in place to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.
- Nursing homes also have the option for a resident's clinical record to be maintained electronically rather than in hard copy. This also applies to portions of the clinical record such as the MDS. Maintenance of the MDS electronically does not require that the entire clinical record also be maintained electronically, nor does it require the use of electronic signatures.
- In cases where the MDS is maintained electronically without the use of electronic signatures, nursing homes must maintain, at a minimum, hard copies of signed and dated CAA(s) completion (items V0200B-C), correction completion (items X1100A-E), and assessment completion (items Z0400-Z0500) data that is resident-identifiable in the resident's active clinical record.
- Nursing homes must ensure that proper security measures are implemented via facility policy to ensure the privacy and integrity of the record.
- Nursing homes must also ensure that clinical records, regardless of form, are maintained in a centralized location as deemed by facility policy and procedure (e.g., a facility with five units may maintain all records in one location or by unit or a facility may maintain the MDS assessments and care plans in a separate binder). Nursing homes must also ensure that clinical records, regardless of form, are easily and readily accessible to staff (including consultants), State agencies (including surveyors), CMS, and others who are authorized by law and need to review the information in order to provide care to the resident. Resident specific information must also be available to the individual resident.
- Nursing homes that are not capable of maintenance of the MDS electronically must adhere to the current requirement that either a handwritten **or** a computer-generated copy be maintained in the active clinical record for 15 months following the final completion

date for all assessments and correction requests. This includes all MDS records, including the CAA Summary, Quarterly assessment records, Identification Information, Entry and Death in Facility tracking records and MDS Correction Requests (including signed attestation).

- All State licensure and State practice regulations continue to apply to Medicare and/or Medicaid certified facilities. Where State law is more restrictive than Federal requirements, the provider needs to apply the State law standard.
- In the future, facilities may be required to conform to a CMS electronic signature standard should CMS adopt one.

2.5 Assessment Types and Definitions

In order to understand the requirements for conducting assessments of nursing home residents, it is first important to understand some of the concepts and definitions associated with MDS assessments. Concepts and definitions for assessments are only introduced in this section. Detailed instructions are provided throughout the rest of this chapter.

Admission refers to the date a person enters the facility and is admitted as a resident. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether admission occurs at 12:00 a.m. or 11:59 p.m., this date is considered the 1st day of admission. Completion of an OBRA Admission assessment must occur in any of the following admission situations:

- when the resident has never been admitted to this facility before; OR
- when the resident has been in this facility previously and was discharged return not anticipated; OR
- when the resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge (see Discharge assessment below).

Assessment Combination refers to the use of one assessment to satisfy both OBRA and PPS assessment requirements when the time frames coincide for both required assessments. In such cases, the most stringent requirement of the two assessments for MDS completion must be met. Therefore, it is imperative that nursing home staff fully understand the requirements for both types of assessments in order to avoid unnecessary duplication of effort and to remain in compliance with both OBRA and PPS requirements. Sections 2.10 and 2.11 provide more detailed information on combining PPS and OBRA assessments. In addition, when all requirements for both are met, one assessment may satisfy two OBRA assessment requirements, such as Admission and OBRA Discharge assessment.

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

- For OBRA-required Comprehensive assessments, assessment completion is defined as completion of the CAA process in addition to the MDS items, meaning that the RN

assessment coordinator has signed and dated both the MDS (item Z0500) and CAA(s) (item V0200B) completion attestations. Since a Comprehensive assessment includes completion of both the MDS and the CAA process, the assessment timing requirements for a comprehensive assessment apply to both the completion of the MDS and the CAA process.

- For non-comprehensive and Discharge assessments, assessment completion is defined as completion of the MDS only, meaning that the RN assessment coordinator has signed and dated the MDS (item Z0500) completion attestation.

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

Assessment Reference Date (ARD) refers to the last day of the observation (or "look back") period that the assessment covers for the resident. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. The facility is required to set the ARD on the MDS Item Set or in the facility software within the required time frame of the assessment type being completed. This concept of setting the ARD is used for all assessment types (OBRA and PPS) and varies by assessment type and facility determination. Most of the MDS 3.0 items have a 7-day look back period. If a resident has an ARD of July 1, 2011, then all pertinent information starting at 12:00 a.m. on June 25th and ending on July 1st at 11:59 p.m. should be included for MDS 3.0 coding.

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

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

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

- For OBRA-required assessments, regulatory requirements for each assessment type dictate assessment timing, the schedule for which is established with the Admission (comprehensive) assessment when the ARD is set by the RN assessment coordinator and the Interdisciplinary Team (IDT).
- Assuming the resident did not experience a significant change in status, was not discharged, and did not have a Significant Correction to Prior Comprehensive assessment (SCPA) completed, assessment scheduling would then move through a cycle of three Quarterly assessments followed by an Annual (comprehensive) assessment.

- This cycle (Comprehensive assessment – Quarterly assessment – Quarterly assessment – Quarterly assessment – Comprehensive assessment) would repeat itself annually for the resident who: 1) the IDT determines the criteria for a Significant Change in Status Assessment (SCSA) has not occurred, 2) an uncorrected significant error in prior comprehensive or Quarterly assessment was not determined, and 3) was not discharged with return not anticipated.
- OBRA assessments may be scheduled early if a nursing home wants to stagger due dates for assessments. As a result, more than three OBRA Quarterly assessments may be completed on a particular resident in a given year, or the Annual may be completed early to ensure that regulatory time frames between assessments are met. However, States may have more stringent restrictions.
- When a resident does have an SCSA or SCPA completed, the assessment resets the assessment timing/scheduling. The next Quarterly assessment would be scheduled within 92 days after the ARD of the SCSA or SCPA, and the next comprehensive assessment would be scheduled within 366 days after the ARD of the SCSA or SCPA.

Assessment Transmission refers to the electronic transmission of submission files to the QIES ASAP system using the Medicare Data Communication Network (MDCN). Chapter 5 and the CMS MDS 3.0 web site provide more detailed information.

Comprehensive MDS assessments include both the completion of the MDS as well as completion of the CAA process and care planning. Comprehensive MDSs include Admission, Annual, SCSA, and SCPA.

Death in Facility refers to when the resident dies in the facility or dies while on a leave of absence (LOA) (see LOA definition). The facility must complete a Death in Facility tracking record. No Discharge assessment is required.

Discharge refers to the date a resident leaves the facility or the date the resident's Medicare Part A stay ends but the resident remains in the facility. A day begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether discharge occurs at 12:00 a.m. or 11:59 p.m., this date is considered the actual date of discharge. There are three types of discharges: two are OBRA required—return anticipated and return not anticipated; the third is Medicare required—Part A PPS Discharge. A Discharge assessment is required with all three types of discharges. Section 2.6 provides detailed instructions regarding return anticipated and return not anticipated types, and Section 2.8 provides detailed instructions regarding the Part A PPS Discharge type. Any of the following situations warrant a Discharge assessment, regardless of facility policies regarding opening and closing clinical records and bed holds:

- Resident is discharged from the facility to a private residence (as opposed to going on an LOA);
- Resident is admitted to a hospital or other care setting (regardless of whether the nursing home discharges or formally closes the record);
- Resident has a hospital observation stay greater than 24 hours, regardless of whether the hospital admits the resident.

- Resident is transferred from a Medicare- and/or Medicaid-certified bed to a non-certified bed.
- Resident's Medicare Part A stay ends, but the resident remains in the facility.

Discharge Assessment refers to an assessment required on resident discharge from the facility, or when a resident's Medicare Part A stay ends, but the resident remains in the facility (unless it is an instance of an interrupted stay, as defined below). This assessment includes clinical items for quality monitoring as well as discharge tracking information.

Entry is a term used for both an admission and a reentry and requires completion of an Entry tracking record.

Entry and Discharge Reporting MDS assessments and tracking records that include a select number of items from the MDS used to track residents and gather important quality data at transition points, such as when they enter a nursing home, leave a nursing home, or when a resident's Medicare Part A stay ends, but the resident remains in the facility. Entry/Discharge reporting includes Entry tracking record, OBRA Discharge assessments, Part A PPS Discharge assessment, and Death in Facility tracking record.

Interdisciplinary Team (IDT[1]) is a group of professional disciplines that combine knowledge, skills, and resources to provide the greatest benefit to the resident.

Interrupted Stay is a Medicare Part A SNF stay in which a resident is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay) and subsequently resumes SNF care in the **same** SNF for a Medicare Part A-covered stay during the interruption window.

Interruption Window is a 3-day period, starting with the calendar day of Part A discharge and including the 2 immediately following calendar days. In other words, if a resident in a Medicare Part A SNF stay is discharged from Part A, the resident must resume Part A services, or return to the **same** SNF (if physically discharged) to resume Part A services, by 11:59 p.m. at the end of the third calendar day after their Part A-covered stay ended. The interruption window begins with the first non-covered day following a Part A-covered stay and ends at 11:59 p.m. on the third consecutive non-covered day following a Part A-covered SNF stay. If these conditions are met, the subsequent stay is considered a continuation of the previous Medicare Part A-covered stay for the purposes of both the variable per diem schedule and PPS assessment completion.

Examples of when there **is** an Interrupted Stay:

- If a resident is discharged from Part A, **remains in the facility, and resumes Part A within the 3-day interruption window**, this is an interrupted stay and no Part A PPS

[1] 42 CFR 483.21(b)(2) A comprehensive care plan must be (ii) Prepared by an interdisciplinary team, that includes but is not limited to - the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of food and nutrition services staff, and other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident, and, to the extent practicable, the participation of the resident and the resident's representative(s).

Discharge or OBRA Discharge is completed, nor is a 5-Day or Entry Tracking record required when Part A resumes.

- If a resident is discharged from Part A, **leaves the facility, and resumes Part A within the 3-day interruption window**, this is an interrupted stay and only an OBRA Discharge is required. An Entry Tracking record is required on reentry, but no 5-Day is required.

Examples of when there is **no** Interrupted Stay:

- If a resident is discharged from Part A, **remains in the facility, and does not resume Part A within the 3-day interruption window**, it is **not** an interrupted stay. Therefore, a Part A PPS Discharge and a 5-Day assessment are both required (as long as resumption of Part A occurs within the 30-day window allowed by Medicare).
- If a resident is discharged from Part A, **leaves the facility, and does not resume Part A within the 3-day interruption window**, it is not an interrupted stay and the Part A PPS Discharge and OBRA Discharge are both required and may be combined (see Part A PPS Discharge assessment in Section 2.5). Any return to the facility in this instance would be considered a new entry—that means that an Entry Tracking record, OBRA admission and/or 5-Day assessment would be required.

Item Set refers to the MDS items that are active on a particular assessment type or tracking form. There are 9 different item subsets for nursing homes and 5 for swing bed providers as follows:

- Nursing Home
  - **Comprehensive (NC[2]) Item Set.** This is the set of items active on an OBRA Comprehensive assessment (Admission, Annual, SCSA, and SCPA). This item set is used whether the OBRA Comprehensive assessment is standalone or combined with any other assessment (PPS assessment and/or Discharge assessment).
  - **Quarterly (NQ) Item Set.** This is the set of items active on an OBRA Quarterly assessment (including Significant Correction of Prior Quarterly assessment [SCQA]). This item set is used for a standalone Quarterly assessment or a Quarterly assessment combined with any type of PPS assessment and/or Discharge assessment.
  - **PPS (NP) Item Set.** This is the set of items active on a 5-Day PPS assessment.
  - **Interim Payment Assessment (IPA) Item Set.** This is the set of items active on an Interim Payment Assessment and used for PPS payment purposes. This is a standalone assessment.
  - **Discharge (ND) Item Set.** This is the set of items active on a standalone OBRA Discharge assessment (either return anticipated or not anticipated) to be used when a resident is physically discharged from the facility.
  - **Part A PPS Discharge (NPE) Item Set.** This is the set of items active on a standalone nursing home Part A PPS Discharge assessment for the purposes of the

2 The codes in parentheses are the item set codes (ISCs) used in the data submission specifications.

SNF QRP. It is completed when the resident's Medicare Part A stay ends, but the resident remains in the facility.

- **Tracking (NT) Item Set.** This is the set of items active on an Entry Tracking Record or a Death in Facility Tracking Record.
- **Optional State Assessment (OSA).** This is the set of items that may be required by a State Medicaid agency to calculate the RUG III or RUG IV HIPPS code. This is not a Federally required assessment; rather, it is required at the discretion of the State Agency for payment purposes. This is a standalone assessment.
- **Inactivation Request (XX) Item Set.** This is the set of items active on a request to inactivate a record in the QIES ASAP system.

- Swing Beds
  - **PPS (SP) Item Set.** This is the set of items active on a 5-Day PPS assessment.
  - **Discharge (SD) Item Set.** This is the set of items active on a standalone Swing Bed Discharge assessment (either return anticipated or not anticipated).
  - **Interim Payment Assessment (IPA) Item Set.** This is the set of items active on an Interim Payment Assessment and used for PPS payment purposes. This is a standalone assessment.
  - **Tracking (ST) Item Set.** This is the set of items active on an Entry Tracking Record or a Death in Facility Tracking Record.
  - **Inactivation (XX) Item Set.** This is the set of items active on a request to inactivate a record in the QIES ASAP system.

Printed layouts for the item sets are available in Appendix H of this manual.

The item set for a particular MDS record is completely determined by the Type of Provider, item A0200 (indicating nursing home or swing bed), and the reason for assessment items (A0310A, A0310B, A0310F, and A0310H). Item set determination is complicated and standard MDS software from CMS and private vendors will automatically make this determination. Section 2.14 of this chapter provides manual lookup tables for determining the item set when automated software is unavailable.

Item Set Codes are those values that correspond to the OBRA-required and PPS assessments represented in items A0310A, A0310B, A0310F, and A0310H of the MDS 3.0. They will be used to reference assessment types throughout the rest of this chapter.

Leave of Absence (LOA), which does not require completion of either a Discharge assessment or an Entry tracking record, occurs when a resident has a:

- Temporary home visit of at least one night; or
- Therapeutic leave of at least one night; or
- Hospital observation stay less than 24 hours and the hospital does not admit the resident.

Providers should refer to Chapter 6 and their State LOA policy for further information, if applicable.

Upon return, providers should make appropriate documentation in the medical record regarding any changes in the resident. If there are changes noted, they should be documented in the medical record.

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

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

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

Tracking records

- Entry
- Death in facility

Assessments

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

PPS Assessments provide information about the clinical condition of beneficiaries receiving Part A SNF-level care in order to be reimbursed under the SNF PPS for both SNFs and Swing Bed providers. These assessments are coded on the MDS 3.0 in items A0310B (PPS Assessment) and A0310H (Is this a Part A PPS Discharge Assessment?). They include:

- 5-Day assessment
- Interim Payment Assessment (IPA)

- Part A PPS Discharge Assessment

Reentry refers to the situation when all three of the following occurred prior to this entry: the resident was previously in this facility **and** was discharged return anticipated **and** returned within 30 days of discharge. Upon the resident's return to the facility, the facility is required to complete an Entry tracking record. In determining if the resident returned to the facility within 30 days, the day of discharge from the facility is not counted in the 30 days. For example, a resident who is discharged return anticipated on December 1 would need to return to the facility by December 31 to meet the "within 30 days" requirement.

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

2.6 Required OBRA Assessments for the MDS

If the assessment is being used for OBRA requirements, the OBRA reason for assessment must be coded in items A0310A and A0310F (Entry/discharge reporting). PPS reasons for assessment are described later in this chapter (Section 2.9) while the OBRA reasons for assessment are described below.

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

RAI OBRA-required Assessment Summary

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look Back) Consists Of	14-day Observation Period (Look Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Admission (Comprehensive)	A0310A = 01	14th calendar day of the resident's admission (admission date + 13 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day of the resident's admission (admission date + 13 calendar days)	14th calendar day of the resident's admission (admission date + 13 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (Initial) 42 CFR 483.20 (b)(2)(i) (by the 14th day)	May be combined with any OBRA assessment; 5-Day or Part A PPS Discharge Assessment
Annual (Comprehensive)	A0310A = 03	ARD of previous OBRA comprehensive assessment + 366 calendar days **AND** ARD of previous OBRA Quarterly assessment + 92 calendar days	ARD + 6 previous calendar days	ARD +13 previous calendar days	ARD + 14 calendar days	ARD + 14 calendar days	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(iii) (every 12 months)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Significant Change in Status (SCSA) (Comprehensive)	A0310A = 04	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(ii) (within 14 days)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment

(continued)

RAI OBRA-required Assessment Summary (cont.)

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look Back) Consists Of	14-day Observation Period (Look Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Significant Correction to Prior Comprehensive (SCPA) (Comprehensive)	A0310A = 05	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20(f)(3)(iv)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Quarterly (Non-Comprehensive)	A0310A = 02	ARD of previous OBRA assessment of any type + 92 calendar days	ARD + 6 previous calendar days	ARD + 13 previous calendar days	ARD + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days	42 CFR 483.20(c) (every 3 months)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Significant Correction to Prior Quarterly (SCQA) (Non-Comprehensive)	A0310A = 06	14th day after determination that significant error in prior quarterly assessment occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th day after determination that significant error in prior quarterly assessment occurred (determination date + 14 calendar days)	N/A	N/A	MDS Completion Date + 14 calendar days	42 CFR 483.20(f)(3)(v)	May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Discharge Assessment – return not anticipated (Non-Comprehensive)	A0310F = 10	N/A	N/A	N/A	Discharge Date + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days		May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment

(continued)

RAI OBRA-required Assessment Summary (cont.)

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look Back) Consists Of	14-day Observation Period (Look Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Discharge Assessment – return anticipated (Non-Comprehensive)	A0310F = 11	N/A	N/A	N/A	Discharge Date + 14 calendar days	N/A	N/A	MDS Completion Date + 14 calendar days		May be combined with any OBRA or 5-Day or Part A PPS Discharge Assessment
Entry tracking record	A0310F = 01	N/A	N/A	N/A	Entry Date + 7 calendar days			Entry Date + 14 calendar days		May not be combined with another assessment
Death in facility tracking record	A0310F = 12	N/A	N/A	N/A	Discharge (death) Date + 7 calendar days	N/A	N/A	Discharge (death) Date +14 calendar days		May not be combined with another assessment

Comprehensive Assessments

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

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

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

Assessment Management Requirements and Tips for Comprehensive Assessments:

- The ARD (item A2300) is the last day of the observation/look back period, and day 1 for purposes of counting back to determine the beginning of observation/look back periods. For example, if the ARD is set for day 14 of a resident's admission, then the beginning of the observation period for MDS items requiring a 7-day observation period would be day 8 of admission (ARD + 6 previous calendar days), while the beginning of the observation period for MDS items requiring a 14-day observation period would be day 1 of admission (ARD + 13 previous calendar days).
- The nursing home may not complete a Significant Change in Status Assessment until after an OBRA Admission assessment has been completed.
- If a resident had an OBRA Admission assessment completed and then goes to the hospital (discharge return anticipated and returns within 30 days) and returns during an assessment period and most of the assessment was completed prior to the hospitalization, then the nursing home may wish to continue with the original assessment, provided the resident does not meet the criteria for an SCSA. In this case, the ARD remains the same and the assessment must be completed by the completion dates required of the assessment type based on the time frame in which the assessment was started. Otherwise, the assessment should be reinitiated with a new ARD and completed within 14 days after re-entry from the hospital. The portion of the resident's assessment that was previously completed should be stored on the resident's record with a notation that the assessment was reinitiated because the resident was hospitalized.
- If a resident is discharged prior to the completion deadline for the assessment, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record.[3] In closing the record, the nursing home should note why the RAI was not completed.

[3] The RAI is considered part of the resident's clinical record and is treated as such by the RAI Utilization Guidelines, e.g., portions of the RAI that are "started" must be saved.

- If a resident dies prior to the completion deadline for the assessment, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record.[4] In closing the record, the nursing home should note why the RAI was not completed.
- If a significant change in status is identified in the process of completing any OBRA assessment except Admission and SCSAs, code and complete the assessment as a comprehensive SCSA instead.
- The nursing home may combine a comprehensive assessment with a Discharge assessment.
- In the process of completing any OBRA comprehensive assessment except an Admission and an SCPA, if it is identified that an uncorrected significant error occurred in a previous assessment that has already been submitted and accepted into the QIES ASAP system, and has not already been corrected in a subsequent comprehensive assessment, code and complete the assessment as a comprehensive SCPA instead. A correction request for the erroneous assessment should also be completed and submitted. See the section on SCPAs for detailed information on completing an SCPA, and Chapter 5 for detailed information on processing corrections.
- In the process of completing any assessment except an Admission, if it is identified that a non-significant (minor) error occurred in a previous assessment, continue with completion of the assessment in progress and also submit a correction request for the erroneous assessment as per the instructions in Chapter 5.
- The MDS must be transmitted (submitted and accepted into the QIES ASAP system) electronically no later than 14 calendar days after the care plan completion date (V0200C2 + 14 calendar days).
- The ARD of an assessment drives the due date of the next assessment. The next comprehensive assessment is due within 366 days after the ARD of the most recent comprehensive assessment.
- May be combined with a 5-Day assessment or SNF Part A PPS Discharge assessment (see Sections 2.10 and 2.11 for details) or any Discharge assessment type.

OBRA-required comprehensive assessments include the following types, which are numbered according to their MDS 3.0 assessment code (item A0310A).

01. Admission Assessment (A0310A = 01)

The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if:

[4] The RAI is considered part of the resident's clinical record and is treated as such by the RAI Utilization Guidelines, e.g., portions of the RAI that are "started" must be saved.

- this is the resident's first time in this facility, OR
- the resident has been admitted to this facility and was discharged return not anticipated, OR
- the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge.

Assessment Management Requirements and Tips for Admission Assessments:

- Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the actual date of admission, regardless of whether admission occurs at 12:00 a.m. or 11:59 p.m., is considered day "1" of admission.
- The ARD (item A2300) must be set no later than day 14, counting the date of admission as day 1. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. For example, if a resident is admitted at 8:30 a.m. on Wednesday (day 1), a completed RAI is required by the end of the day Tuesday (day 14).
- Federal statute and regulations require that residents are assessed promptly upon admission (but no later than day 14) and the results are used in planning and providing appropriate care to attain or maintain the highest practicable well-being. This means it is imperative for nursing homes to assess a resident upon the individual's admission. The IDT may choose to start and complete the Admission comprehensive assessment at any time prior to the end of day 14. Nursing homes may find early completion of the MDS and CAA(s) beneficial to providing appropriate care, particularly for individuals with short lengths of stay when the assessment and care planning process is often accelerated.
- The MDS completion date (item Z0500B) must be no later than day 14. This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- The CAA(s) completion date (item V0200B2) must be no later than day 14.
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).
- For a resident who goes in and out of the facility on a relatively frequent basis and return is expected within the next 30 days, the resident may be discharged with return anticipated. This status **requires** an Entry tracking record **each time** the resident returns to the facility and an OBRA Discharge assessment **each time** the resident is discharged.
- The nursing home may combine the Admission assessment with a Discharge assessment when applicable.

02. Annual Assessment (A0310A = 03)

The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless an SCSA or an SCPA has been completed since the most recent comprehensive assessment was completed. Its completion dates (MDS/CAA(s)/care plan) depend on the most recent comprehensive and past assessments' ARDs and completion dates.

Assessment Management Requirements and Tips for Annual Assessments:

- The ARD (item A2300) must be set within 366 days after the ARD of the previous OBRA comprehensive assessment (ARD of previous comprehensive assessment + 366 calendar days) AND within 92 days since the ARD of the previous OBRA Quarterly or SCQA (ARD of previous OBRA Quarterly assessment + 92 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- The CAA(s) completion date (item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days). This date may be the same as the MDS completion date, but not earlier than.
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).

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

The SCSA is a comprehensive assessment for a resident that must be completed when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline. It can be performed at any time after the completion of an Admission assessment, and its completion dates (MDS/CAA(s)/care plan) depend on the date that the IDT's determination was made that the resident had a significant change.

A **"significant change"** is a major decline or improvement in a resident's status that:

1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting";
2. Impacts more than one area of the resident's health status; and
3. Requires interdisciplinary review and/or revision of the care plan.

A significant change differs from a significant error because it reflects an actual significant change in the resident's health status and NOT incorrect coding of the MDS.

A significant change may require referral for a Preadmission Screening and Resident Review (PASRR) evaluation if a mental illness, intellectual disability (ID), or related condition is present or is suspected to be present.

Assessment Management Requirements and Tips for Significant Change in Status Assessments:

- When a resident's status changes and it is not clear whether the resident meets the SCSA guidelines, the nursing home may take up to 14 days to determine whether the criteria are met.

- After the IDT has determined that a resident meets the significant change guidelines, the nursing home should document the initial identification of a significant change in the resident's status in the clinical record.
- An SCSA is appropriate when:
  - There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and
  - The resident's condition is not expected to return to baseline within two weeks.
  - For a resident who goes in and out of the facility on a relatively frequent basis and reentry is expected within the next 30 days, the resident may be discharged with return anticipated. This status requires an Entry tracking record each time the resident returns to the facility and an OBRA Discharge assessment each time the resident is discharged. However, if the IDT determines that the resident would benefit from an SCSA during the intervening period, the staff must complete an SCSA. This is only allowed when the resident has had an OBRA Admission assessment completed and submitted prior to discharge return anticipated (and resident returns within 30 days) or when the OBRA Admission assessment is combined with the discharge return anticipated assessment (and resident returns within 30 days).
- An SCSA may **not** be completed prior to an OBRA Admission assessment.
- An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving his/her highest practicable well-being at whatever stage of the disease process the resident is experiencing.
- If a resident is admitted on the hospice benefit (i.e., the resident is coming into the facility having already elected hospice), or elects hospice on or prior to the ARD of the Admission assessment, the facility should complete the Admission assessment, checking the Hospice Care item, O0100K. Completing an Admission assessment followed by an SCSA is not required. Where hospice election occurs after the Admission assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice election so that only the Admission assessment is required. In such situations, an SCSA is not required.
- An SCSA is required to be performed when a resident is receiving hospice services and then decides to discontinue those services (known as revoking of hospice care). The ARD must be within 14 days from one of the following: 1) the effective date of the hospice

election revocation (which can be the same or later than the date of the hospice election revocation statement, but not earlier than); 2) the expiration date of the certification of terminal illness; or 3) the date of the physician's or medical director's order stating the resident is no longer terminally ill.

- If a resident is admitted on the hospice benefit but decides to discontinue it prior to the ARD of the Admission assessment, the facility should complete the Admission assessment, checking the Hospice Care item, O0100K. Completing an Admission assessment followed by an SCSA is not required. Where hospice revocation occurs after the Admission assessment ARD but prior to its completion, facilities may choose to adjust the ARD to the date of hospice revocation so that only the Admission assessment is required. In such situations, an SCSA is not required.
- The ARD must be less than or equal to 14 days after the IDT's determination that the criteria for an SCSA are met (determination date + 14 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met. This date may be earlier than or the same as the CAA(s) completion date, but not later than.
- When an SCSA is completed, the nursing home must review all triggered care areas compared to the resident's previous status. If the CAA process indicates no change in a care area, then the prior documentation for the particular care area may be carried forward, and the nursing home should specify where the supporting documentation can be located in the medical record.
- The CAA(s) completion date (item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for an SCSA were met. This date may be the same as the MDS completion date, but not earlier than MDS completion.
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).

Guidelines for Determining a Significant Change in a Resident's Status: Note: this is not an exhaustive list

The final decision regarding what constitutes a significant change in status must be based upon the judgment of the IDT. MDS assessments are not required for minor or temporary variations in resident status - in these cases, the resident's condition is expected to return to baseline within 2 weeks. However, staff must note these transient changes in the resident's status in the resident's record and implement necessary assessment, care planning, and clinical interventions, even though an MDS assessment is not required.

Some Guidelines to Assist in Deciding If a Change Is Significant or Not:

- A condition is defined as "self-limiting" when the condition will normally resolve itself without further intervention or by staff implementing standard disease-related clinical interventions. If the condition has not resolved within 2 weeks, staff should begin an SCSA. This time frame may vary depending on clinical judgment and resident needs. For

example, a 5% weight loss for a resident with the flu would not normally meet the requirements for an SCSA. In general, a 5% weight loss may be an expected outcome for a resident with the flu who experienced nausea and diarrhea for a week. In this situation, staff should monitor the resident's status and attempt various interventions to rectify the immediate weight loss. If the resident did not become dehydrated and started to regain weight after the symptoms subsided, a comprehensive assessment would not be required.

- An SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. In this example, a resident with a 5% weight loss in 30 days would not generally require an SCSA unless a second area of decline accompanies it. Note that this assumes that the care plan has already been modified to actively treat the weight loss as opposed to continuing with the original problem, "potential for weight loss." This situation should be documented in the resident's clinical record along with the plan for subsequent monitoring and, if the problem persists or worsens, an SCSA may be warranted.
- **If there is only one change**, staff may still decide that the resident would benefit from an SCSA. It is important to remember that each resident's situation is unique, and the IDT must make the decision as to whether or not the resident will benefit from an SCSA. Nursing homes must document a rationale, in the resident's medical record, for completing an SCSA that does not meet the criteria for completion.
- An SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL decline or improvement).
- An SCSA would not be appropriate in situations where the resident has stabilized but is expected to be discharged in the immediate future. The nursing home has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning.
- **Decline in two or more of the following:**
  - Resident's decision-making ability has changed;
  - Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-9©), e.g., increase in the number of areas where behavioral symptoms are coded as being present and/or the frequency of a symptom increases for items in Section E (Behavior);
  - Changes in frequency or severity of behavioral symptoms of dementia that indicate progression of the disease process since the last assessment;
  - Any decline in an ADL physical functioning area (at least 1) where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment and does not reflect normal fluctuations in that individual's functioning;
  - Resident's incontinence pattern changes or there was placement of an indwelling catheter;
  - Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days);

- Emergence of a new pressure ulcer at Stage 2 or higher, a new unstageable pressure ulcer/injury, a new deep tissue injury or worsening in pressure ulcer status;
- Resident begins to use a restraint of any type when it was not used before; and/or
- Emergence of a condition/disease in which a resident is judged to be unstable.

- **Improvement in two or more of the following:**
  - Any improvement in an ADL physical functioning area (at least 1) where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment and does not reflect normal fluctuations in that individual's functioning;
  - Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases;
  - Resident's decision making improves;
  - Resident's incontinence pattern improves.

Examples (SCSA):

1. Mr. T no longer responds to verbal requests to alter his screaming behavior. It now occurs daily and has neither lessened on its own nor responded to treatment. He is also starting to resist his daily care, pushing staff away from him as they attempt to assist with his ADLs. This is a significant change, and an SCSA is required, since there has been deterioration in the behavioral symptoms to the point where it is occurring daily and new approaches are needed to alter the behavior. Mr. T's behavioral symptoms could have many causes, and an SCSA will provide an opportunity for staff to consider illness, medication reactions, environmental stress, and other possible sources of Mr. T's disruptive behavior.

2. Mrs. T required minimal assistance with ADLs. She fractured her hip and upon return to the facility requires extensive assistance with all ADLs. Rehab has started and staff is hopeful she will return to her prior level of function in 4-6 weeks.

3. Mrs. G has been in the nursing home for 5 weeks following an 8-week acute hospitalization. On admission she was very frail, had trouble thinking, was confused, and had many behavioral complications. The course of treatment led to steady improvement and she is now stable. She is no longer confused or exhibiting inappropriate behaviors. The resident, her family, and staff agree that she has made remarkable progress. An SCSA is required at this time. The resident is not the person she was at admission - her initial problems have resolved and she will be remaining in the facility. An SCSA will permit the interdisciplinary team to review her needs and plan a new course of care for the future.

Guidelines for When a Change in Resident Status Is Not Significant: Note: this is not an exhaustive list

- Discrete and easily reversible cause(s) documented in the resident's record and for which the IDT can initiate corrective action (e.g., an anticipated side effect of introducing a psychoactive medication while attempting to establish a clinically effective dose level. Tapering and monitoring of dosage would not require an SCSA).

- Short-term acute illness, such as a mild fever secondary to a cold from which the IDT expects the resident to fully recover.
- Well-established, predictable cyclical patterns of clinical signs and symptoms associated with previously diagnosed conditions (e.g., depressive symptoms in a resident previously diagnosed with bipolar disease would not precipitate an SCSA).
- Instances in which the resident continues to make steady progress under the current course of care. Reassessment is required only when the condition has stabilized.
- Instances in which the resident has stabilized but is expected to be discharged in the immediate future. The facility has engaged in discharge planning with the resident and family, and a comprehensive reassessment is not necessary to facilitate discharge planning.

Guidelines for Determining the Need for an SCSA for Residents with Terminal Conditions:
Note: this is not an exhaustive list

The key in determining if an SCSA is required for individuals with a terminal condition is whether or not the change in condition is an expected, well-defined part of the disease course and is consequently being addressed as part of the overall plan of care for the individual.

- If a terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration and the criteria are met for an SCSA, an SCSA is required.
- If a resident elects the Medicare Hospice program, it is important that the two separate entities (nursing home and hospice program staff) coordinate their responsibilities and develop a care plan reflecting the interventions required by both entities. The nursing home and hospice plans of care should be reflective of the current status of the resident.

Examples (SCSA):

1. Mr. M has been in this nursing home for two and one-half years. He has been a favorite of staff and other residents, and his daughter has been an active volunteer on the unit. Mr. M is now in the end stage of his course of chronic dementia, diagnosed as probable Alzheimer's. He experiences recurrent pneumonias and swallowing difficulties, his prognosis is guarded, and family members are fully aware of his status. He is on a special dementia unit, staff has detailed palliative care protocols for all such end stage residents, and there has been active involvement of his daughter in the care planning process. As changes have occurred, staff has responded in a timely, appropriate manner. In this case, Mr. M's care is of a high quality, and as his physical state has declined, there is no need for staff to complete a new MDS assessment for this bedfast, highly dependent terminal resident.

2. Mrs. K came into the nursing home with identifiable problems and has steadily responded to treatment. Her condition has improved over time and has recently hit a plateau. She will be discharged within 5 days. The initial RAI helped to set goals and start her care. The course of care provided to Mrs. K was modified as necessary to ensure continued improvement. The IDT's treatment response reversed the causes of the resident's condition. An assessment need

not be completed in view of the imminent discharge. Remember, facilities have 14 days to complete an assessment once the resident's condition has stabilized, and if Mrs. K. is discharged within this period, a new assessment is not required. If the resident's discharge plans change, or if she is not discharged, an SCSA is required by the end of the allotted 14-day period.

3. Mrs. P, too, has responded to care. Unlike Mrs. K, however, she continues to improve. Her discharge date has not been specified. She is benefiting from her care and full restoration of her functional abilities seems possible. In this case, treatment is focused appropriately, progress is being made, staff is on top of the situation, and there is nothing to be gained by requiring an SCSA at this time. However, if her condition was to stabilize and her discharge was not imminent, an SCSA would be in order.

Guidelines for Determining When a Significant Change Should Result in Referral for a Preadmission Screening and Resident Review (PASRR) Level II Evaluation:

- If an SCSA occurs for an individual *known* or *suspected* to have a mental illness, intellectual disability, or related condition (as defined by 42 CFR 483.102), a referral to the State Mental Health or Intellectual Disability/Developmental Disabilities Administration authority (SMH/ID/DDA) for a possible Level II PASRR evaluation must promptly occur as required by Section 1919(e)(7)(B)(iii) of the Social Security Act.[5]
- PASRR is not a requirement of the resident assessment process but is an OBRA provision that is required to be coordinated with the resident assessment process. This guideline is intended to help facilities coordinate PASRR with the SCSA — the guideline does not require any actions to be taken in completing the SCSA itself.
- Facilities should look to their state PASRR program requirements for specific procedures. PASRR contact information for the SMH/ID/DDA authorities and the State Medicaid Agency is available at http://www.cms.gov/.
- The nursing facility must provide the SMH/ID/DDA authority with referrals as described below, independent of the findings of the SCSA. PASRR Level II is to function as an independent assessment process for this population with special needs, in parallel with the facility's assessment process. Nursing facilities should have a low threshold for referral to the SMH/ID/DDA, so that these authorities may exercise their expert judgment about when a Level II evaluation is needed.
- Referral should be made as soon as the criteria indicating such are evident — the facility should not wait until the SCSA is complete.

[5] The statute may also be referenced as 42 U.S.C. 1396r(e)(7)(B)(iii). Note that as of this revision date the statute supersedes Federal regulations at 42 CFR 483.114(c), which still reads as requiring annual resident review. The regulation has not yet been updated to reflect the statutory change to resident review upon significant change in condition.

Referral for Level II Resident Review Evaluations Is Required for Individuals Previously Identified by PASRR to Have Mental Illness, Intellectual Disability/Developmental Disability, or a Related Condition in the Following Circumstances:
Note: this is not an exhaustive list

- A resident who demonstrates increased behavioral, psychiatric, or mood-related symptoms.
- A resident with behavioral, psychiatric, or mood related symptoms that have not responded to ongoing treatment.
- A resident who experiences an improved medical condition—such that the resident's plan of care or placement recommendations may require modifications.
- A resident whose significant change is physical, but with behavioral, psychiatric, or mood-related symptoms, or cognitive abilities, that may influence adjustment to an altered pattern of daily living.
- A resident who indicates a preference (may be communicated verbally or through other forms of communication, including behavior) to leave the facility.
- A resident whose condition or treatment is or will be significantly different than described in the resident's most recent PASRR Level II evaluation and determination. (Note that a referral for a possible new Level II PASRR evaluation is required whenever such a disparity is discovered, whether or not associated with an SCSA.)

Example (PASRR & SCSA):

1. Mr. L has a diagnosis of serious mental illness, but his primary reason for admission was rehabilitation following a hip fracture. Once the hip fracture resolves and he becomes ambulatory, even if other conditions exist for which Mr. L receives medical care, he should be referred for a PASRR evaluation to determine whether a change in his placement or services is needed.

Referral for Level II Resident Review Evaluations Is Also Required for Individuals Who May Not Have Previously Been Identified by PASRR to Have Mental Illness, Intellectual Disability/Developmental Disability, or a Related Condition in the Following Circumstances:
Note: this is not an exhaustive list

- A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a diagnosis of mental illness as defined under 42 CFR 483.100 (where dementia is not the primary diagnosis).
- A resident whose intellectual disability as defined under 42 CFR 483.100, or related condition as defined under 42 CFR 435.1010 was not previously identified and evaluated through PASRR.
- A resident transferred, admitted, or readmitted to a NF following an inpatient psychiatric stay or equally intensive treatment.

04. Significant Correction to Prior Comprehensive Assessment (SCPA) (A0310A = 05)

The SCPA is a comprehensive assessment for an existing resident that must be completed when the IDT determines that a resident's prior comprehensive assessment contains a significant error. It can be performed at any time after the completion of an Admission assessment, and its ARD and completion dates (MDS/CAA(s)/care plan) depend on the date the determination was made that the significant error exists in a comprehensive assessment.

A **"significant error"** is an error in an assessment where:

1. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment and/or results in an inappropriate plan of care; and
2. The error has not been corrected via submission of a more recent assessment.

A significant error differs from a significant change because it reflects incorrect coding of the MDS and NOT an actual significant change in the resident's health status.

Assessment Management Requirements and Tips for Significant Correction to Prior Comprehensive Assessments:

- Nursing homes should document the initial identification of a significant error in an assessment in the clinical record.
- An SCPA is appropriate when:
  - the erroneous comprehensive assessment has been completed and transmitted/submitted into the QIES ASAP system; and
  - there is not a more current assessment in progress or completed that includes a correction to the item(s) in error.
- The ARD must be within 14 days after the determination that a significant error in the prior comprehensive assessment occurred (determination date + 14 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after the determination was made that a significant error occurred. This date may be earlier than or the same as the CAA(s) completion date, but not later than the CAA(s) completion date.
- The CAA(s) completion date (item V0200B2) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no more than 14 days after the determination was made that a significant error occurred. This date may be the same as the MDS completion date, but not earlier than the MDS completion date.
- The care plan completion date (item V0200C2) must be no later than 7 calendar days after the CAA(s) completion date (item V0200B2) (CAA(s) completion date + 7 calendar days).

Non-Comprehensive Assessments and Entry and Discharge Reporting

OBRA-required non-comprehensive MDS assessments include a select number of MDS items, but **not** completion of the CAA process and care planning. The OBRA non-comprehensive assessments include:

- Quarterly Assessment
- Significant Correction to Prior Quarterly Assessment
- Discharge Assessment – Return not Anticipated
- Discharge Assessment – Return Anticipated

The Quarterly assessments, OBRA Discharge assessments and SCQAs are not required for Swing Bed residents. However, Swing Bed providers are required to complete the Swing Bed Discharge item set (SD).

Tracking records include a select number of MDS items and are required for **all** residents in the nursing home and swing bed facility. They include:

- Entry Tracking Record
- Death in Facility Tracking Record

Assessment Management Requirements and Tips for Non-Comprehensive Assessments:

- The ARD is considered the last day of the observation/look back period, therefore it is day 1 for purposes of counting back to determine the beginning of observation/look back periods. For example, if the ARD is set for March 14, then the beginning of the observation period for MDS items requiring a 7-day observation period would be March 8 (ARD + 6 previous calendar days), while the beginning of the observation period for MDS items requiring a 14-day observation period would be March 1 (ARD + 13 previous calendar days).
- If a resident goes to the hospital (discharge return anticipated and returns within 30 days) and returns during the assessment period and most of the assessment was completed prior to the hospitalization, then the nursing home may wish to continue with the original assessment, provided the resident does not meet the criteria for an SCSA.

  For example:

  — Resident A has a Quarterly assessment with an ARD of March 20th. The facility staff finished most of the assessment. The resident is discharged (return anticipated) to the hospital on March 23rd and returns on March 25th. Review of the information from the discharging hospital reveals that there is not any significant change in status for the resident. Therefore, the facility staff continues with the assessment that was not fully completed before discharge and may complete the assessment by April 3rd (which is day 14 after the ARD).

  — Resident B also has a Quarterly assessment with an ARD of March 20th. She goes to the hospital on March 20th and returns March 30th. While there is no significant

change the facility decides to start a new assessment and sets the ARD for April 2nd and completes the assessment.

- If a resident is discharged during this assessment process, then whatever portions of the RAI that have been completed must be maintained in the resident's discharge record.[6] In closing the record, the nursing home should note why the RAI was not completed.
- If a resident dies during this assessment process, completion of the assessment is not required. Whatever portions of the RAI that have been completed must be maintained in the resident's medical record.[6] When closing the record, the nursing home should document why the RAI was not completed.
- If a significant change in status is identified in the process of completing any assessment except Admission and SCSAs, code and complete the assessment as a comprehensive SCSA instead.
- In the process of completing any assessment except an Admission and an SCPA, if it is identified that a significant error occurred in a previous comprehensive assessment that has already been submitted and accepted into the QIES ASAP system and has not already been corrected in a subsequent comprehensive assessment, code and complete the assessment as a comprehensive SCPA instead. A correction request for the erroneous comprehensive assessment should also be completed and submitted. See the section on SCPAs for detailed information on completing an SCPA, and Chapter 5 for detailed information on processing corrections.
- In the process of completing any assessment except an Admission, if it is identified that a non-significant (minor) error occurred in a previous assessment, continue with completion of the assessment in progress and also submit a correction request for the erroneous assessment as per the instructions in Chapter 5.
- The ARD of an assessment drives the due date of the next assessment. The next non-comprehensive assessment is due within 92 days after the ARD of the most recent OBRA assessment (ARD of previous OBRA assessment - Admission, Annual, Quarterly, Significant Change in Status, or Significant Correction assessment - + 92 calendar days).
- While the CAA process is not required with a non-comprehensive assessment (Quarterly, SCQA), nursing homes are still required to review the information from these assessments, and review and revise the resident's care plan.
- The MDS must be transmitted (submitted and accepted into the QIES ASAP system) electronically no later than 14 calendar days after the MDS completion date (Z0500B + 14 calendar days).
- Non-comprehensive assessments may be combined with a 5-Day assessment or SNF Part A PPS Discharge Assessment (see Sections 2.10 and 2.11 for details).

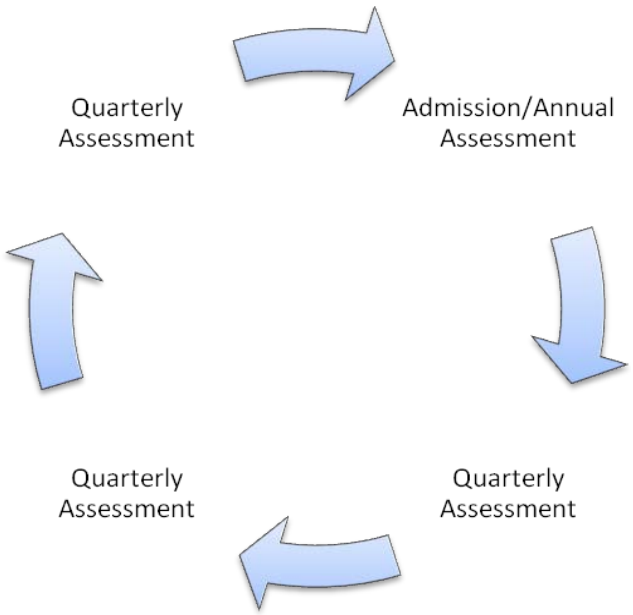
[6] The RAI is considered part of the resident's clinical record and is treated as such by the RAI Utilization Guidelines, e.g., portions of the RAI that are "started" must be saved.

05. Quarterly Assessment (A0310A = 02)

The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type.

Assessment Management Requirements and Tips:

- Federal requirements dictate that, at a minimum, three Quarterly assessments be completed in each 12-month period. Assuming the resident does not have an SCSA or SCPA completed and was not discharged from the nursing home, a typical 12-month OBRA schedule would look like this:



- OBRA assessments may be scheduled early if a nursing home wants to stagger due dates for assessments. As a result, more than three OBRA Quarterly assessments may be completed on a particular resident in a given year, or the Annual assessment may be completed early to ensure that the regulatory time frames are met. However, States may have more stringent restrictions.
- The ARD must be within 92 days after the ARD of the previous OBRA assessment (Quarterly, Admission, SCSA, SCPA, SCQA, or Annual assessment + 92 calendar days).
- The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days).

06. Significant Correction to Prior Quarterly Assessment (SCQA) (A0310A = 06)

The SCQA is an OBRA non-comprehensive assessment that must be completed when the IDT determines that a resident's prior Quarterly assessment contains a significant error. It can be performed at any time after the completion of a Quarterly assessment, and the ARD (item A2300) and completion dates (item Z0500B) depend on the date the determination was made that there is a significant error in a previous Quarterly assessment.

A **"significant error"** is an error in an assessment where:

1. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment; and
2. The error has not been corrected via submission of a more recent assessment.

A significant error differs from a significant change because it reflects incorrect coding of the MDS and NOT an actual significant change in the resident's health status.

Assessment Management Requirements and Tips:

- Nursing homes should document the initial identification of a significant error in an assessment in the clinical record.
- An SCQA is appropriate when:
  - the erroneous Quarterly assessment has been completed (MDS completion date, item Z0500B) and transmitted/submitted into the QIES ASAP system; and
  - there is not a more current assessment in progress or completed that includes a correction to the item(s) in error.
- The ARD must be less than or equal to 14 days after the determination that a significant error in the prior Quarterly has occurred (determination date + 14 calendar days). The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days) and no later than 14 days after determining that the significant error occurred.

Tracking Records and Discharge Assessments (A0310F)

OBRA-required tracking records and assessments consist of the Entry tracking record, the Discharge assessments, and the Death in Facility tracking record. These include the completion of a select number of MDS items in order to track residents when they enter or leave a facility. They do not include completion of the CAA process and care planning. The Discharge assessments include items for quality monitoring. Entry and discharge reporting is required for residents in Swing Beds or those in respite care.

If the resident has one or more admissions to the hospital before the Admission assessment is completed, the nursing home should continue to submit OBRA Discharge assessments and Entry tracking records every time until the resident is in the nursing home long enough to complete the comprehensive Admission assessment.

OBRA-required Tracking Records and Discharge Assessments include the following types (item A0310F):

07. Entry Tracking Record (Item A0310F = 01)

There are two types of entries – admission and reentry.

Admission (Item A1700 = 1)

- Entry tracking record is coded an Admission every time a resident:
  - is admitted for the first time to this facility; or
  - is readmitted after a discharge return not anticipated; or
  - is readmitted after a discharge return anticipated when return was not within 30 days of discharge.

Example (Admission):

1. Mr. S. was admitted to the nursing home on February 5, 2011 following a stroke. He regained most of his function and returned to his home on March 29, 2011. He was discharged return not anticipated. Five months later, Mr. S. underwent surgery for a total knee replacement. He returned to the nursing home for rehabilitation therapy on August 27, 2011. Code the Entry tracking record for the August 27, 2011 return as follows:

   A0310F = 01
   A1600 = 08-27-2011
   A1700 = 1

Reentry (Item A1700 = 2)

- Entry tracking record is coded Reentry every time a person:
  - is readmitted to this facility, **and** was discharged return anticipated from this facility, **and** returned within 30 days of discharge. See Section 2.5, Reentry, for greater detail.

Example (Reentry):

1. Mr. W. was admitted to the nursing home on April 11, 2011. Four weeks later he became very short of breath during lunch. The nurse assessed him and noted his lung sounds were not clear. His breathing became very labored. He was discharged return anticipated and admitted to the hospital on May 9, 2011. On May 18, 2011, Mr. W. returned to the facility. Code the Entry tracking record for the May 18, 2011 return, as follows:

   A0310F = 01
   A1600 = 05-18-2011
   A1700 = 2

Assessment Management Requirements and Tips for Entry Tracking Records:

- The Entry tracking record is the first item set completed for all residents.
- Must be completed every time a resident is admitted (admission) or readmitted (reentry) into a nursing home (or swing bed facility), including upon return if a resident in a Medicare Part A stay is discharged from the facility and does not resume Part A within the same facility within the 3-day interruption window (see Interrupted Stay in Section 2.5, Assessment Types and Definitions above).
- Must be completed for a respite resident every time the resident enters the facility.
- Must be completed within 7 days after the admission/reentry.
- Must be submitted no later than the 14th calendar day after the entry (entry date (A1600) + 14 calendar days).
- Required in addition to the initial Admission assessment or other OBRA or PPS assessments that might be required.
- Contains administrative and demographic information.
- Is a standalone tracking record.
- May **not** be combined with an assessment.

08. Death in Facility Tracking Record (A0310F = 12)

- Must be completed when the resident dies in the facility or when on LOA.
- Must be completed within 7 days after the resident's death, which is recorded in item A2000, Discharge Date (A2000 + 7 calendar days).
- Must be submitted within 14 days after the resident's death, which is recorded in item A2000, Discharge Date (A2000 + 14 calendar days).
- Consists of demographic and administrative items.
- May not be combined with any type of assessment.

Example (Death in Facility):

1. Mr. W. was admitted to the nursing home for hospice care due to a terminal illness on September 9, 2011. He passed away on November 13, 2011. Code the November 13, 2011 Death in Facility tracking record as follows:

   A0310F = 12
   A2000 = 11-13-2011
   A2100 = 08

OBRA Discharge Assessments (A0310F)

OBRA Discharge assessments consist of discharge return anticipated and discharge return not anticipated.

09. Discharge Assessment–Return Not Anticipated (A0310F = 10)

- Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days.
- Must be completed (item Z0500B) within 14 days after the discharge date (A2000 + 14 calendar days).
- Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).
- Consists of demographic, administrative, and clinical items.
- If the resident returns, the Entry tracking record will be coded A1700 = 1, Admission. The OBRA schedule for assessments will start with a new Admission assessment. If the resident's stay will be covered by Medicare Part A, the provider must determine whether the interrupted stay policy applies. Refer to Section 2.9 for instructions on the PPS assessments.

Examples (Discharge-return not anticipated):

1. Mr. S. was admitted to the nursing home on February 5, 2011 following a stroke. He regained most of his function and was discharged return not anticipated to his home on March 29, 2011. Code the March 29, 2011 OBRA Discharge assessment as follows:

   A0310F = 10
   A2000 = 03-29-2011
   A2100 = 01

2. Mr. K. was transferred from a Medicare-certified bed to a non-certified bed on December 12, 2013 and plans to remain long term in the facility. Code the December 12, 2013 Discharge assessment as follows:

   A0310F = 10
   A2000 = 12-12-2013
   A2100 = 02

10. OBRA Discharge Assessment–Return Anticipated (A0310F = 11)

- Must be completed when the resident is discharged from the facility and the resident is expected to return to the facility within 30 days.
- For a resident discharged to a hospital or other setting (such as a respite resident) who comes in and out of the facility on a relatively frequent basis and reentry can be expected, the resident is discharged return anticipated unless it is known on discharge that he or she will not return within 30 days. This status requires an Entry tracking record each time the resident returns to the facility and an OBRA Discharge assessment each time the resident is discharged.
- Must be completed (item Z0500B) within 14 days after the discharge date (item A2000) (i.e., discharge date (A2000) + 14 calendar days).

- Must be submitted within 14 days after the MDS completion date (item Z0500B) (i.e., MDS completion date (Z0500B) + 14 calendar days).
- Consists of demographic, administrative, and clinical items.
- When the resident returns to the nursing home, the IDT must determine if criteria are met for an SCSA (only when the OBRA Admission assessment was completed prior to discharge).
  - If criteria are met, complete an SCSA.
  - If criteria are not met, continue with the OBRA schedule as established prior to the resident's discharge.
- If an interrupted stay occurs, an SCSA should be completed if clinically indicated.
- If an SCSA is not indicated and an OBRA assessment was due while the resident was in the hospital, the facility has 13 days after reentry to complete the assessment (this does not apply to Admission assessment).
- When a resident had a prior OBRA Discharge assessment completed indicating that the resident was expected to return (A0310F = 11) to the facility, but later learned that the resident will not be returning to the facility, there is no Federal requirement to inactivate the resident's record nor to complete another OBRA Discharge assessment. Please contact your State RAI Coordinator for specific State requirements.

Example (Discharge-return anticipated):

1. Ms. C. was admitted to the nursing home on May 22, 2011. She tripped while at a restaurant with her daughter. She was discharged return anticipated and admitted to the hospital on May 31, 2011. Code the May 31, 2011 OBRA Discharge assessment as follows:

   A0310F = 11
   A2000 = 05-31-2011
   A2100 = 03

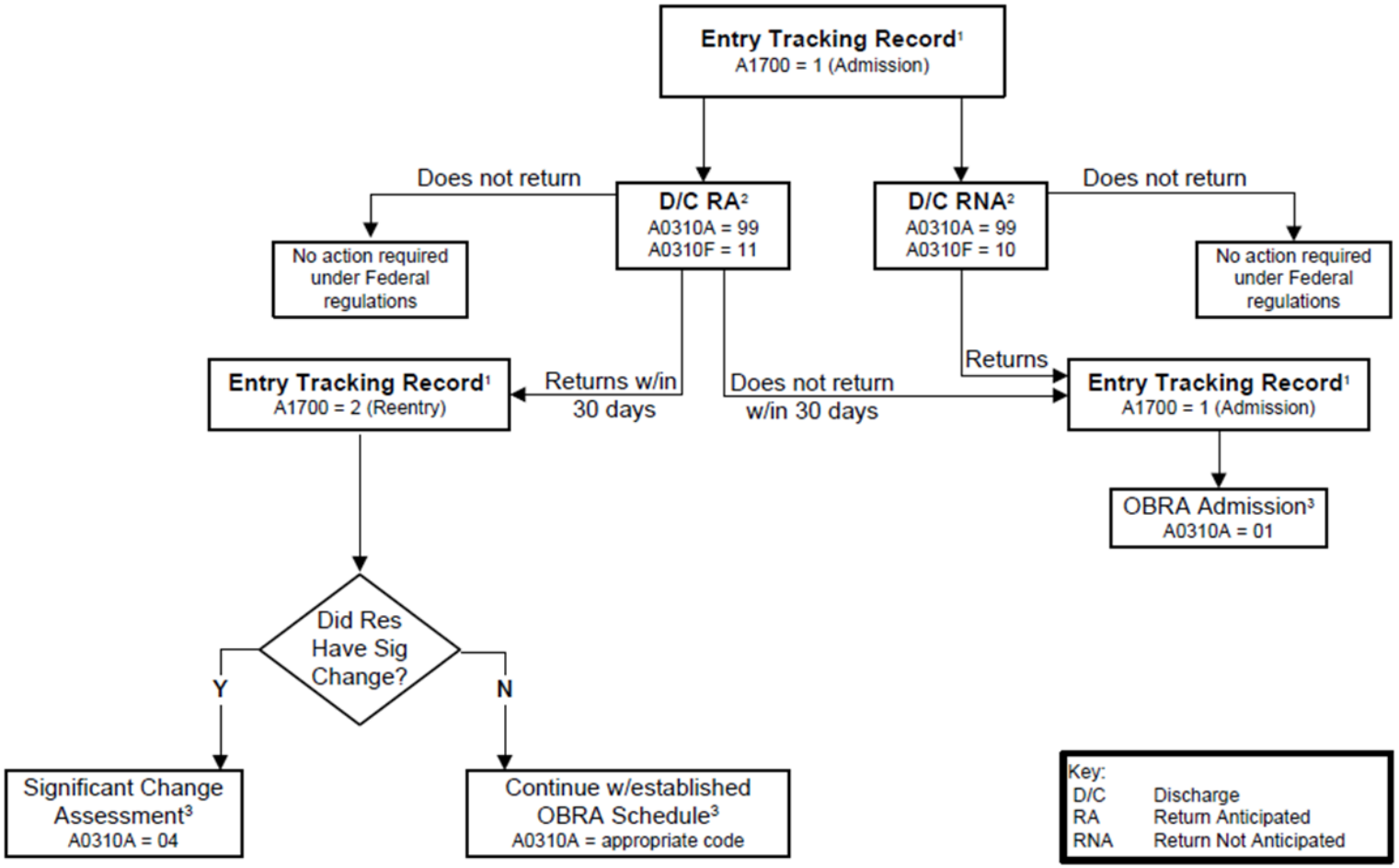
Assessment Management Requirements and Tips for OBRA Discharge Assessments:

- Must be completed when the resident is discharged from the facility (see definition of Discharge in Section 2.5, Assessment Types and Definitions).
- Must be completed when the resident is admitted to an acute care hospital.
- Must be completed when the resident has a hospital observation stay greater than 24 hours.
- Must be completed if a resident in a Medicare Part A stay is discharged from the facility regardless of whether the resident resumes Part A within the 3-day interruption window (see Interrupted Stay, Section 2.5, Assessment Types and Definitions above).
- Must be completed on a respite resident every time the resident is discharged from the facility.
- May be combined with another OBRA-required assessment when requirements for all assessments are met.

- May be combined with a 5-Day or Part A PPS Discharge Assessment when requirements for all assessments are met.
- For an OBRA Discharge assessment, the ARD (item A2300) is not set prospectively as with other assessments. The ARD (item A2300) for an OBRA Discharge assessment is always equal to the Discharge date (item A2000) and may be coded on the assessment any time during the OBRA Discharge assessment completion period (i.e., Discharge date (A2000) + 14 calendar days).
- The use of the dash, "-", is appropriate when the staff are unable to determine the response to an item, including the interview items. In some cases, the facility may have already completed some items of the assessment and should record those responses or may be in the process of completing an assessment. The facility may combine the OBRA Discharge assessment with another assessment(s) when requirements for all assessments are met.
- For **unplanned discharges**, the facility should complete the OBRA Discharge assessment to the best of its abilities.
  - An unplanned discharge includes, for example:
    - Acute-care transfer of the resident to a hospital or an emergency department in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation; or
    - Resident unexpectedly leaving the facility against medical advice; or
    - Resident unexpectedly deciding to go home or to another setting (e.g., due to the resident deciding to complete treatment in an alternate setting).
- Nursing home bed hold status and opening and closing of the medical record have no effect on these requirements.

The following chart details the sequencing and coding of Tracking records and OBRA Discharge assessments.

Entry, OBRA Discharge, and Reentry Algorithms



[1]A0310A = 99 A0310B = 99 A0310E = 0 A0310F = 01

[2]A0310B – E = appropriate code [3]A0310B – F = appropriate code

When A1700 = 1, the first OBRA assessment should be an admission assessment unless D/C prior to completion.

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

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

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

CAA(s) Completion

- Is required for OBRA-required comprehensive assessments. They are not required for non-comprehensive assessments, PPS assessments, Discharge assessments, or Tracking records.
- After completing the MDS portion of the comprehensive assessment, the next step is to further identify and evaluate the resident's strengths, problems, and needs through use of the CAA process (described in detail in Chapter 3, Section V, and Chapter 4 of this manual) and through further investigation of any resident-specific issues not addressed in the RAI/CAA process.
- The CAA(s) completion date (item V0200B2) must be either later than or the same date as the MDS completion date (item Z0500B). In no event should either date be later than the established time frames as described in Section 2.6.
- It is important to note that for an Admission assessment, the resident enters the nursing home with a set of physician-based treatment orders. Nursing home staff should review these orders and begin to assess the resident and to identify potential care issues/ problems. Within 48 hours of admission to the facility, the facility must develop and implement a Baseline Care Plan for the resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of care (42 CFR §483.21(a)). In many cases, interventions to meet the resident's needs will already have been implemented to address priority issues prior to completion of the final care plan. At this time, many of the resident's problems in the 20 care areas will have been identified, causes will have been considered, and a baseline care plan initiated. However, a final CAA(s) review and associated documentation are still required no later than the 14th calendar day of admission (admission date plus 13 calendar days).
- Detailed information regarding each CAA and the CAA process appears in Chapter 4 of this manual.

Care Plan Completion

- Care plan completion based on the CAA process is required for OBRA-required comprehensive assessments. It is not required for non-comprehensive assessments (Quarterly, SCQA), PPS assessments, Discharge assessments, or Tracking records. However, the resident's care plan must be reviewed after each assessment, as required by §483.20, except discharge assessments, and revised based on changing goals, preferences and needs of the resident and in response to current interventions.
- After completing the MDS and CAA portions of the comprehensive assessment, the next step is to evaluate the information gained through both assessment processes in order to identify problems, causes, contributing factors, and risk factors related to the problems. Subsequently, the IDT must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's goals, preferences, strengths, problems, and needs (described in detail in Chapter 4 of this manual).
- The care plan completion date (item V0200C2) must be either later than or the same date as the CAA completion date (item V0200B2), but no later than 7 calendar days after the CAA completion date. The MDS completion date (item Z0500B) must be earlier than or the same date as the care plan completion date. In no event should either date be later than the established time frames as described in Section 2.6.
- For Annual assessments, SCSAs, and SCPAs, the process is basically the same as that described with an Admission assessment. In these cases, however, the care plan will already be in place. Review of the CAA(s) when the MDS is complete for these assessment types should raise questions about the need to modify or continue services and result in either the continuance or revision of the existing care plan. A new care plan does not need to be developed after each Annual assessment, SCSA, or SCPA.
- Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.
- Detailed information regarding the care planning process appears in Chapter 4 of this manual.

2.8 Skilled Nursing Facility Prospective Payment System Assessment Schedule

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

Assessment Window

The PPS 5-Day assessment has defined days within which the Assessment Reference Date (ARD) must be set. The ARD must be a day within the prescribed window of Days 1 through 8

of the Part A stay and must be set on the MDS form itself or in the facility software before this window has passed.

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

Scheduled PPS Assessment

The PPS-required standard assessment is the 5-Day assessment, which has a predetermined time period for setting the ARD. The SNF provider must set the ARD on days 1–8 to assure compliance with the SNF PPS PDPM requirements.

Unscheduled PPS Assessments

There are situations when a SNF provider may complete an assessment after the 5-Day assessment. This assessment is an unscheduled assessment called the Interim Payment Assessment (IPA). When deemed appropriate by the provider, this assessment may be completed to capture changes in the resident's status and condition.

Tracking Records and Discharge Assessments Reporting

Tracking records and Discharge assessments reporting are required on **all** residents in the SNF and swing bed facilities. Tracking records and standalone Discharge assessments do not impact payment.

Part A PPS Discharge Assessment (A0310H)

The Part A PPS Discharge assessment contains data elements used to calculate current and future SNF QRP quality measures under the IMPACT Act. The IMPACT Act directs the Secretary to specify quality measures on which Post-Acute Care (PAC) providers (which includes SNFs) are required to submit standardized resident assessment data. Section 1899B(2)(b)(1)(A)(B) of the Act delineates that resident assessment data must be submitted with respect to a resident's admission into and discharge from a SNF setting.

- Per current requirements, the OBRA Discharge assessment is used when the resident is physically discharged from the facility. The Part A PPS Discharge assessment is **completed when a resident's Medicare Part A stay ends, but the resident remains in the facility (unless it is an instance of an interrupted stay)**. Item A0310H, "Is this a Part A PPS Discharge Assessment?" identifies whether or not the discharge is a Part A PPS Discharge assessment for the purposes of the SNF QRP (see Chapter 3, Section A for further details and coding instructions). The Part A PPS Discharge assessment can also be combined with the OBRA Discharge assessment when a resident receiving services under SNF Part A PPS has a Discharge Date (A2000) that occurs **on the day of or one day after** the End Date of Most Recent Medicare Stay (A2400C), because in this instance, both the OBRA and Part A PPS Discharge assessments would be required.

Part A PPS Discharge Assessment (A0310H = 1):

- For the Part A PPS Discharge assessment, the ARD (item A2300) is not set prospectively as with other assessments. The ARD (A2300) for a **standalone** Part A PPS Discharge assessment is always equal to the End Date of the Most Recent Medicare Stay (A2400C). The ARD may be coded on the assessment any time during the assessment completion period (i.e., End Date of Most Recent Medicare Stay (A2400C) + 14 calendar days).
- If the resident's Medicare Part A stay ends and the resident is physically discharged from the facility, an OBRA Discharge assessment is required.
- If the End Date of the Most Recent Medicare Stay (A2400C) **occurs on the day of or one day before** the Discharge Date (A2000), the OBRA Discharge assessment and Part A PPS Discharge assessment are both required and may be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000). The Part A PPS Discharge assessment may be combined with most OBRA-required assessments when requirements for all assessments are met (please see Section 2.10 Combining PPS Assessments and OBRA Assessments).
- Must be completed (item Z0500B) within 14 days after the End Date of Most Recent Medicare Stay (A2400C + 14 calendar days).
- Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).
- Consists of demographic, administrative, and clinical items.
- If the resident's Medicare Part A stay ends and the resident subsequently returns to a skilled level of care and Medicare Part A benefits do not resume within 3 days, the PPS schedule starts again with a 5-Day assessment. If the Medicare Part A stay does resume within the 3-day interruption window, then this is an interrupted stay (see below).
- If the resident leaves the facility for an interrupted stay, no Part A PPS Discharge Assessment is required when the resident leaves the building at the outset of the interrupted stay; however, an OBRA Discharge record is required if the discharge criteria are met (see Section 2.5). If the resident returns to the facility within the interruption window, as defined above, an Entry tracking form is required; however, no new 5-Day assessment is required.

The following chart summarizes the PPS assessments, tracking records, and discharge assessments:

PPS Assessments, Tracking Records, and Discharge
Assessment Reporting Schedule for SNFs and Swing Bed Facilities

Assessment Type/ Item Set for PPS	Assessment Reference Date (ARD) Can be Set on Any of Following Days	Billing Cycle Used by the Business Office	Special Comment
5-Day A0310B = 01	Days 1-8	Sets payment rate for the entire stay (unless an IPA is completed. See below.)	• See Section 2.12 for instructions involving beneficiaries who transfer or expire day 8 or earlier. • CAAs must be completed only if the 5-Day assessment is dually coded as an OBRA Admission, Annual, SCSA or SCPA.
Interim Payment Assessment (IPA) A0310B = 08	Optional	Sets payment for remainder of the stay beginning on the ARD.	• Optional assessment. • Does not reset variable per diem adjustment schedule. • May not be combined with another assessment.
Part A PPS Discharge Assessment A0310H = 1	End date of most recent Medicare Stay (A2400C)	N/A	• Completed when the resident's Medicare Part A stay ends, but the resident remains in the facility, or can be combined with an OBRA Discharge assessment if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000).

2.9 MDS PPS Assessments for SNFs

The MDS has been constructed to identify the OBRA Reasons for Assessment and the SNF PPS Reasons for Assessment in items A0310A and A0310B respectively. If the assessment is being used for reimbursement under the SNF PPS, the PPS Reason for Assessment must be coded in item A0310B. The OBRA Reason for Assessment is described earlier in this section while the PPS assessments are described below. A SNF provider may combine assessments to meet both OBRA and PPS requirements. When combining assessments, all completion deadlines and other requirements for both types of assessments must be met. If all requirements cannot be met, the assessments must be completed separately. The relationship between OBRA and PPS assessments is discussed below and in more detail in Sections 2.10 and 2.11.

PPS Assessments for a Medicare Part A Stay

01. 5-Day Assessment

- ARD (item A2300) must be set for Days 1 through 8 of the Part A SNF covered stay.
- Must be completed (item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment for entire PPS stay (except in cases when an IPA is completed).
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (item Z0500B) (completion + 14 days).
- If combined with the OBRA Admission assessment, the assessment must be completed by the end of day 14 of admission (admission date plus 13 calendar days).

- Is the first PPS-required assessment to be completed when the resident is first admitted for a SNF Part A stay.
- Is the first PPS-required assessment to be completed when the resident is re-admitted to the facility for a Part A stay following a discharge assessment – return not anticipated or if the resident returns more than 30 days after a discharge assessment-return anticipated.
- A 5-Day assessment is not required at the time when a resident returns to a Part A-covered stay following an interrupted stay, regardless of the reason for the interruption (facility discharge, resident no longer skilled, payer change, etc.).
- If a resident changes payers from Medicare Advantage to Medicare Part A, the SNF must complete a 5-Day assessment with the ARD set for one of days 1 through 8 of the Medicare Part A stay, with the resident's first day covered by Medicare Part A serving as Day 1, unless it is a case of an interrupted stay.

02. Interim Payment Assessment

- Optional assessment.
- ARD (item A2300) may be set for any day of the SNF PPS stay, beyond the ARD of the 5-Day assessment.
- Must be completed (item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Authorizes payment for remainder of the PPS stay, beginning on the ARD.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (item Z0500B) (completion + 14 days).
- The ARD for an IPA may not precede that of the 5-Day assessment.
- May not be combined with any other assessments (PPS or OBRA).

03. Part A PPS Discharge Assessment

- See definition provided in Section 2.8, Part A PPS Discharge Assessment (A0310H = 1).

2.10 Combining PPS Assessments and OBRA Assessments[7]

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

- The OBRA standards are designated by the reason selected in item A0310A, **Federal OBRA Reason for Assessment**, and item A0130F, **Entry/Discharge Reporting** and are required for all residents.
- The PPS standards are designated by the reason selected in item A0310B, **PPS Assessment** and item A0310H, **Is this a SNF Part A PPS Discharge Assessment?**
- When the OBRA and PPS assessment time frames coincide (except the IPA), one assessment may be used to satisfy both requirements. PPS and OBRA assessments (except

[7] OBRA assessments do not apply to Swing Bed providers; however, Swing Bed providers are required to complete the Entry Tracking record, Swing Bed PPS (SP), Swing Bed Discharge (SD) assessment, and Death in Facility Tracking record.

the IPA) may be combined when the ARD windows overlap allowing for a common assessment reference date. When combining the OBRA and PPS assessments, the most stringent requirements for ARD, item set, and CAA completion requirements must be met. For example, the skilled nursing facility staff must be very careful in selecting the ARD for an OBRA Admission assessment combined with a 5-Day assessment. For the OBRA Admission, the ARD must be set between days 1 and 14 counting the date of admission as day 1. For the 5-Day, the ARD must be set for days 1 through 8. However, when combining a 5-Day assessment with the OBRA Admission assessment, the use of the latter end of the OBRA Admission ARD window would cause the 5-Day assessment to be considered late. To assure the assessment meets both standards, an ARD of a day between Day 1 and 8 would have to be chosen in this situation. In addition, the completion standards must be met. While a PPS assessment can be completed within 14 days after the ARD when it is not combined with an OBRA assessment, the CAA completion date for the OBRA Admission assessment (item V0200B2) must be day 14 or earlier. With the combined OBRA Admission/ 5-Day assessment, completion by day 14 would be required. Finally, when combining a PPS assessment with an OBRA assessment, the SNF staff must ensure that all required items are completed.

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

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

Item Sets by Assessment Type for Skilled Nursing Facilities

	Comprehensive Item Sets	Quarterly and PPS* Item Sets	Other Assessments and Tracking Records/Item Sets
Standalone Assessment Types	• OBRA Admission • Annual • Significant Change in Status (SCSA) • Significant Correction to Prior Comprehensive (SCPA)	• Quarterly • Significant Correction to Prior Quarterly • 5-Day	• Entry Tracking Record • OBRA Discharge assessments • Death in Facility Tracking Record • Part A PPS Discharge • Interim Payment Assessment (IPA)
Combined Assessment Types	• OBRA Admission and 5-Day • Annual and 5-Day • SCSA and 5-Day • SCPA and 5-Day • Any OBRA comprehensive and any Discharge	• Quarterly and 5-Day • Significant Correction to Prior Quarterly and 5-Day • 5-Day and any Discharge • Significant Correction to Prior Quarterly and any Discharge	• OBRA Discharge assessment and Part A PPS Discharge Assessment

*Nursing home-based SNFs must check with their State Agency to determine if the state requires additional items to be completed for the required OBRA Quarterly and PPS assessments.

Item Sets by Assessment Type for Swing Bed Providers

	Swing Bed PPS/Item Set	Other Assessments/Tracking Item Sets for Swing Bed Providers
Assessment Type	• (SP) Swing Bed PPS assessment	• Entry Tracking record • Death in Facility Tracking record • (SD) Swing Bed Discharge • Interim Payment Assessment (IPA)
Assessment Type Combinations	• (SP) Swing Bed PPS assessment and (SD) Swing Bed Discharge	• N/A

Tracking records (Entry and Death in Facility) and the Interim Payment Assessment can never be combined with other assessments.

2.11 PPS and OBRA Assessment Combinations

Below are some of the allowed possible assessment combinations. A provider may choose to combine more than two assessment types when all requirements are met. The coding of items in A0310 will provide the item set that the facility is required to complete. For SNFs that use a paper format to collect MDS data, the provider must ensure that the item set selected meets the requirements of all assessments coded in item A0310 (see Section 2.14).

5-Day Assessment and OBRA Admission Assessment

- Comprehensive item set.
- ARD (item A2300) must be set for days 1 through 8 of the Part A SNF stay.
- Must be completed (item Z0500B) by the end of day 14 of the stay (admission date plus 13 calendar days).
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

5-Day Assessment and OBRA Quarterly Assessment

- Quarterly item set.
- ARD (item A2300) must be set for days 1 through 8 of the Part A SNF stay.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

5-Day Assessment and Annual Assessment

- Comprehensive item set.
- ARD (item A2300) must be set for days 1 through 8 of the Part A SNF stay.
- See Section 2.6 for OBRA Annual assessment completion requirements.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

5-Day Assessment and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (item A2300) must be set for days 1 through 8 of the Part A SNF stay.
- Must be completed (item Z0500B) within 14 days after the determination that the criteria are met for a Significant Change in Status assessment.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

5-Day Assessment and Significant Correction to Prior Comprehensive Assessment

- Comprehensive item set.
- ARD (item A2300) must be set for days 1 through 8 of the Part A SNF stay.
- Must be completed (item Z0500B) within 14 days after the determination that an uncorrected significant error in the prior comprehensive assessment has occurred.
- See Section 2.7 and Chapter 4 for requirements for CAA process and care plan completion.

5-Day Assessment and Significant Correction to Prior Quarterly Assessment

- See 5-Day assessment and OBRA Quarterly Assessment.

5-Day Assessment and OBRA Discharge Assessment

- PPS item set.
- ARD (item A2300) must be set for the day of discharge (item A2000) **and** the date of discharge must fall within the allowed window of the 5-Day as described earlier in Section 2.9.
- Must be completed (item Z0500B) within 14 days after the ARD.

5-Day Assessment and Part A PPS Discharge Assessment

- PPS item set.
- ARD (item A2300) must be set for the last day of the Medicare Part A Stay (A2400C) **and** the last day of the Medicare Part A stay must fall within the allowed window of the 5-Day assessment as described earlier in Section 2.9.
- Must be completed (item Z0500B) within 14 days after the ARD.

2.12 Factors Impacting SNF PPS Assessment Scheduling[8]

Resident Expires Before or On the Eighth Day of SNF Stay

If the beneficiary dies in the SNF or while on a leave of absence before or on the eighth day of the covered SNF stay, the provider should prepare a 5-Day assessment as completely as possible and submit the assessment as required. If there is not a PPS assessment in the QIES ASAP system, the provider must bill the default rate for any Medicare days. The provider must also complete a Death in Facility Tracking Record (see Section 2.6 for greater detail).

Resident Transfers or Is Discharged Before or On the Eighth Day of SNF Stay

If the beneficiary is discharged from the SNF or the Medicare Part A stay ends (e.g., transferred to another payer source) before or on the eighth day of the covered SNF stay, the provider should prepare a 5-Day assessment as completely as possible and submit the assessment as required. If there is not a PPS assessment in the QIES ASAP system, the provider must bill the default rate for any Medicare days.

When the Medicare Part A stay ends on or before the eighth day of the covered SNF stay, and the beneficiary remains in the facility, a Part A PPS Discharge assessment is required.

When the beneficiary is discharged from the SNF, the provider must also complete an OBRA Discharge assessment, but if the Medicare Part A stay ends on or before the eighth day of the covered SNF stay and the beneficiary is physically discharged from the facility the day of or the day after the Part A stay ends, the Part A PPS and OBRA Discharge assessments may be combined. (See Sections 2.10 and 2.11 for details on combining a PPS assessment with a Discharge assessment.)

Resident Is Admitted to an Acute Care Facility and Returns

If a Medicare Part A resident is admitted to an acute care facility and later returns to the SNF to resume Part A coverage, the resident requires a new 5-Day assessment, unless it is an instance of an interrupted stay. If it is a case of an interrupted stay (i.e., the resident returns to the SNF and resumes Part A services in the same SNF within the 3-day interruption window), then no PPS assessment is required upon reentry, only an Entry tracking form. An IPA may be completed, if deemed appropriate.

Resident Is Sent to Acute Care Facility, Not in SNF over Midnight, and Is Not Admitted to Acute Care Facility

If a resident is out of the facility over a midnight, but for less than 24 hours, and is not admitted to an acute care facility, a new 5-Day PPS assessment is not required, though an IPA may be completed, if deemed appropriate. However, there are payment implications: the day preceding the midnight on which the resident was absent from the nursing home is not a covered Part A day. This is known as the "midnight rule." For example, if the resident goes to the emergency room at 10 p.m. Wednesday, day 22 of his Part A stay, and returns at 3 a.m. the next day, Wednesday is not billable to Part A. As a result, the day of his return to the SNF, Thursday,

[8] These requirements/policies also apply to swing bed providers.

becomes day 22 of his Part A stay. This means that this day is skipped for purposes of the variable per diem adjustment, described in Chapter 6.

Resident Takes a Leave of Absence from the SNF

If a resident is out of the facility for a Leave of Absence (LOA) as defined on page 2-13 in this chapter, there may be payment implications. For example, if a resident leaves a SNF at 6:00 p.m. on Wednesday, which is Day 27 of the resident's stay and returns to the SNF on Thursday at 9:00 a.m., then Wednesday becomes a non-billable day and Thursday becomes Day 27 of the resident's stay.

If the beneficiary experiences a leave of absence during part of the assessment observation period, the facility may include services furnished during the beneficiary's temporary absence (when permitted under MDS coding guidelines; see Chapter 3).

Resident Discharged from Part A Skilled Services and from the Facility and Returns to SNF Part A Skilled Level Services

In the situation when a beneficiary is discharged from Medicare Part A and is physically discharged from the facility, but returns to resume SNF Part A skilled services after the interruption window has closed, the OBRA Discharge and Part A PPS Discharge must be completed and can be combined (see Part A PPS Discharge in Section 2.5).

On return to the facility, this is considered a new Part A stay (as long as resumption of Part A occurs within the 30-day window allowed by Medicare), and a new 5-Day and Entry Tracking record must be completed. If the resident was discharged return anticipated, no OBRA assessment is required. However, if the resident was discharged return not anticipated, the facility must complete a new OBRA Admission assessment. See Chapter 6, Section 6.7 for greater detail to determine whether or not the resident is eligible for Part A SNF coverage.

However, in the case of an interrupted stay, that is, if a resident **leaves the facility and resumes Part A within the 3-day interruption window**, only an OBRA Discharge is required. An Entry Tracking record is required on reentry, but no 5-Day is required. If the resident was discharged return anticipated, no OBRA assessment is required. However, if the resident was discharged return not anticipated, the facility must complete a new OBRA Admission assessment.

The beneficiary should be assessed to determine if there was a significant change in status.

Resident Discharged from Part A Skilled Services Is Not Physically Discharged from the Skilled Nursing Facility

In the situation when a resident's Medicare Part A stay ends, but the resident is not physically discharged from the facility, remaining in a Medicare and/or Medicaid certified bed with another payer source, the facility must continue with the OBRA schedule from the beneficiary's original date of admission (item A1900) and must also complete a Part A PPS Discharge assessment.

If Part A benefits resume, there is no reason to change the OBRA schedule; the PPS schedule would start again with a 5-Day assessment, MDS item A0310B = 01, **unless** it is a case of an

interrupted stay—that is, if the resident is discharged from Part A, remains in the facility, and resumes Part A **within the 3-day interruption window**, no Part A PPS Discharge is completed, nor is a 5-Day required when Part A resumes.

Delay in Requiring and Receiving Skilled Services

There are instances when the beneficiary does not require SNF level of care services when initially admitted to the SNF. See Chapter 6, Section 6.7.

Non-Compliance with the PPS Assessment Schedule

According to Part 42 Code of Federal Regulation (CFR) Section 413.343, an assessment that does not have its ARD within the prescribed ARD window will be paid at the default rate for the number of days the ARD is out of compliance. Frequent late assessment scheduling practices or missed assessments may result in additional review. The default rate takes the place of the otherwise applicable Federal rate. It is equal to the rate paid for the Health Insurance Prospective Payment System (HIPPS) code reflecting the lowest acuity level for each PDPM component and would generally be lower than the Medicare rate payable if the SNF had submitted an assessment in accordance with the prescribed assessment schedule.

Late PPS Assessment

If the SNF fails to set the ARD within the defined ARD window for a 5-Day assessment, and the resident is still on Part A, the SNF must complete a late assessment. The ARD can be no earlier than the day the error was identified.

The SNF will bill the default rate for the number of days that the assessment is out of compliance. This is equal to the number of days between the day following the last day of the available ARD window and the late ARD (including the late ARD). **The SNF would then bill the HIPPS code established by the late assessment for the remainder of the SNF stay, unless the SNF chooses to complete an IPA.** For example, a 5-Day assessment with an ARD of Day 11 is out of compliance for 3 days and therefore would be paid at the default rate for Days 1 through 3 of the Part A stay and the HIPPS code from the late 5-Day assessment for the remainder of the Part A stay, unless an IPA is completed.

Missed PPS Assessment

If the SNF fails to set the ARD of a 5-Day assessment prior to the end of the last day of the ARD window, and the resident was already discharged from Medicare Part A when this error is discovered, the provider cannot complete an assessment for SNF PPS purposes and the days cannot be billed to Part A.

Errors on a PPS Assessment

To correct an error on an MDS that has been submitted to the QIES ASAP system, the SNF must follow the normal MDS correction procedures (see Chapter 5).

2.13 Expected Order of MDS Records

The MDS records for a nursing home resident are expected to occur in a specific order. For example, the first record for a resident is expected to be an Entry record with entry type (item A1700) indicating admission, and the next record is expected to be an Admission assessment, a

5-Day assessment, a Discharge assessment, or Death in Facility tracking record. The QIES ASAP system will issue a warning when an unexpected record is submitted. Examples include an assessment record after a discharge (an entry is expected) or any record after a Death in Facility tracking record.

The target date, rather than the submission date, is used to determine the order of records. The target date is the Assessment Reference Date (item A2300) for assessment records, the Entry Date (item A1600) for entry records, and the Discharge Date (item A2000) for discharge or Death in facility records. In the following table, the prior record is represented in the columns and the next (subsequent) record is represented in the rows. A "no" has been placed in a cell when the next record is not expected to follow the prior record; the QIES ASAP system will issue a record order warning for record combinations that contain a "no." A "yes" indicates that the next record is expected to follow the prior record; a record order warning will ***not*** be issued for these combinations. Note that there are not any QIES ASAP record order warnings produced for Swing Bed MDS records.

Expected Order of MDS Records

	Prior Record									
Next Record	**Entry**	**OBRA Admission**	**OBRA Annual**	**OBRA Quarterly**	**5-Day**	**IPA**	**OBRA Discharge**	**Part A PPS Discharge**	**Death in facility**	**No prior record**
Entry	no	no	no	no	no	no	yes	no	no	yes
OBRA Admission	yes	no	no	no	yes	yes	no	yes	no	no
OBRA Annual	yes	no	no	yes	yes	yes	no	yes	no	no
OBRA Quarterly, sign. change, sign correction	yes	yes	yes	yes	yes	yes	no	yes	no	no
5-Day	yes	yes	yes	yes	no	no	no	yes	no	no
IPA	yes	yes	yes	yes	yes	yes	no	no	no	no
OBRA Discharge	yes	yes	yes	yes	yes	yes	no	yes	no	no
Part A PPS Discharge	yes	yes	yes	yes	yes	yes	no	no	no	no
Death in facility	yes	yes	yes	yes	yes	yes	no	yes	no	no

Note: "No" indicates that the record sequence is not expected; record order warnings will be issued for these combinations.
"Yes" indicates expected record sequences; no record order warning will be issued for these combinations.

2.14 Determining the Item Set for an MDS Record

The item set for a particular MDS record is completely determined by the reason for assessment items (A0310A, A0310B, A0310F, and A0310H). Item set determination is complicated and standard MDS software from CMS and private vendors will automatically make this determination. This section provides manual lookup tables for determining the item set when automated software is unavailable.

The first lookup table is for nursing home records. The first 4 columns are entries for the reason for assessment (RFA) items A0310A, A0310B, A0310F, and A0310H. To determine the item set for a record, locate the row that includes the values of items A0310A, A0310B, A0310F, and A0310H for that record. When the row is located, then the item set is identified in the item set code (ISC) and Description columns for that row. If the combination of items A0310A, A0310B, A0310F, and A0310H values for the record cannot be located in any row, then that combination of RFAs is not allowed and any record with that combination will be rejected by the QIES ASAP system.

Nursing Home Item Set Code (ISC) Reference Table

OBRA RFA (A0310A)	PPS RFA (A0310B)	Entry/ Discharge (A0310F)	Part A PPS Discharge (A0310H)	ISC	Description
01, 03, 04, 05	01, 99	10, 11, 99	0, 1	NC	Comprehensive
02, 06	01, 99	10, 11, 99	0, 1	NQ	Quarterly
99	01	10, 11, 99	0, 1	NP	PPS
99	08	99	0	IPA	PPS (Optional)
99	99	10, 11	0, 1	ND	OBRA Discharge
99	99	01, 12	0	NT	Tracking
99	99	99	1	NPE	Part A PPS Discharge

Consider examples of the use of this table. If items A0310A = 01, A0310B = 99, item A0310F = 99, and A0310H = 0 (a standalone OBRA Admission assessment), then these values are matched in row 1 and the item set is an OBRA comprehensive assessment (NC). The same row would be selected if item A0310F is changed to 10 (Admission assessment combined with a return not anticipated Discharge assessment). The item set is again an OBRA comprehensive assessment (NC). If items A0310A = 99, A0310B = 99, item A0310F = 12, and A0310H = 0 (a Death in Facility tracking record), then these values are matched in the second to last row and the item set is a tracking record (NT). Finally, if items A0310A = 99, A0310B = 99, A0310F = 99, and A0310H = 0, then no row matches these entries, and the record is invalid and would be rejected.

There are two additional item sets not listed in the above table. The first item set is for inactivation request records. This is the set of items active on a request to inactivate a record in the QIES ASAP system. An inactivation request is indicated by A0050 = 3. The item set for this type of record is "Inactivation" with an ISC code of XX. The second item set is not a Federally required assessment; rather, it is required at the discretion of the State Agency for payment purposes. This is the set of items required to calculate the RUG III or RUG IV HIPPS code.

The item set for this type of record is the "Optional State Assessment" with an ISC code of OSA and is indicated by coding A0300 = 1.

The next lookup table is for swing bed records. The first 4 columns are entries for the reason for assessment (RFA) items A0310A, A0310B, A0310F, and A0310H. To determine the item set for a record, locate the row that includes the values of items A0310A, A0310B, A0310F, and A0310H for that record. When the row is located, then the item set is identified in the ISC and Description columns for that row. If the combination of A0310A, A0310B, A0310F, and A0310H values for the record cannot be located in any row, then that combination of RFAs is not allowed and any record with that combination will be rejected by the QIES ASAP system.

Swing Bed Item Set Code (ISC) Reference Table

OBRA RFA (A0310A)	PPS RFA (A0310B)	Entry/ Discharge (A0310F)	Part A Discharge (A0310H)	ISC	Description
99	01	10, 11, 99	0, 1	SP	PPS
99	08	99	0	IPA	PPS (Optional)
99	99	10, 11	0, 1	SD	Discharge
99	99	01, 12	0	ST	Tracking

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

CHAPTER 3: OVERVIEW TO THE ITEM-BY-ITEM GUIDE TO THE MDS 3.0

This chapter provides item-by-item coding instructions for all required sections and items in the MDS Version 3.0 item sets. The goal of this chapter is to facilitate the accurate coding of the MDS resident assessment and to provide assessors with the rationale and resources to optimize resident care and outcomes.

3.1 Using this Chapter

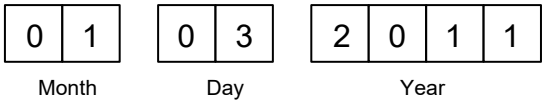
Throughout this chapter, MDS assessment sections are presented using a standard format for ease of review and instruction. In addition, screenshots of each section are available for illustration purposes. Note: There are images imbedded in this manual and if you are using a screen reader to access the content contained in the manual you should refer to the MDS 3.0 item set to review the referenced information. The order of the sections is as follows:

- **Intent.** The reason(s) for including this set of assessment items in the MDS.
- **Item Display.** To facilitate accurate resident assessment using the MDS, each assessment section is accompanied by screenshots, which display the item from the MDS 3.0 item set.
- **Item Rationale.** The purpose of assessing this aspect of a resident's clinical or functional status.
- **Health-related Quality of Life.** How the condition, impairment, improvement, or decline being assessed can affect a resident's quality of life, along with the importance of staff understanding the relationship of the clinical or functional issue related to quality of life.
- **Planning for Care.** How assessment of the condition, impairment, improvement, or decline being assessed can contribute to appropriate care planning.
- **Steps for Assessment.** Sources of information and methods for determining the correct response for coding each MDS item.
- **Coding Instructions.** The proper method of recording each response, with explanations of individual response categories.
- **Coding Tips and Special Populations.** Clarifications, issues of note, and conditions to be considered when coding individual MDS items.
- **Examples.** Case examples of appropriate coding for most, if not all, MDS sections/items.

Additional layout issues to note include (1) the  symbol is displayed in all MDS 3.0 sections/items that require a resident interview, and (2) important definitions are highlighted in the columns, and these and other definitions of interest may be found in the glossary.

directed (e.g., item B0100, **Comatose**, directs the assessor to skip to item G0110, **Activities of Daily Living Assistance**, if B0100 is answered **code 1, yes.** The intervening items from B0200-F0800 would not be coded (i.e. left blank). If B0100 was recorded as **code 0, no,** then the assessor would continue to code the MDS at the next item, B0200).

- Use a check mark for boxes where the instructions state to "check all that apply," if specified condition is met; otherwise these boxes remain blank (e.g., F0800, **Staff Assessment of Daily and Activity Preferences**, boxes A-Z).
- Use a numeric response (a number or pre-assigned value) for blank boxes (e.g., *M1030, **Number of Venous and Arterial Ulcers***).
- When completing hard copy forms to be used for data entry, capital letters may be easiest to read. Print legibly.
- When recording month, day, and year for dates, enter two digits for the month and the day and four digits for the year. For example, the third day of January in the year 2011 is recorded as:



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

SECTION A: IDENTIFICATION INFORMATION

Intent: The intent of this section is to obtain key information to uniquely identify each resident, the home in which he or she resides, and the reasons for assessment.

A0050: Type of Record

A0050. Type of Record	
Enter Code ☐	1. **Add new record** → Continue to A0100, Facility Provider Numbers 2. **Modify existing record** → Continue to A0100, Facility Provider Numbers 3. **Inactivate existing record** → Skip to X0150, Type of Provider

Coding Instructions for A0050, Type of Record

- **Code 1, Add new record:** if this is a **new record** that has not been previously submitted and accepted in the QIES ASAP system. If this item is **coded as 1**, continue to A0100 Facility Provider Numbers.

  If there is an existing database record for the same resident, the same facility, the same reasons for assessment/tracking, and the same date (assessment reference date, entry date, or discharge date), then the current record is a duplicate and not a new record. In this case, the submitted record will be rejected and not accepted in the QIES ASAP system and a "fatal" error will be reported to the facility on the Final Validation Report.

- **Code 2, Modify existing record:** if this is a **request to modify** the MDS items for a record that already has been submitted and accepted in the *Quality Improvement and Evaluation System (*QIES*) Assessment Submission and Processing (*ASAP*)* system.

  If this item is **coded as 2**, continue to A0100, Facility Provider Numbers.

  When a modification request is submitted, the QIES ASAP system will take the following steps:

  1. The system will attempt to locate the existing record in the QIES ASAP system for this facility with the resident, reasons for assessment/tracking, and date (Assessment Reference Date (ARD), entry date, or discharge date) indicated in subsequent Section X items.

  2. If the existing record is not found, the submitted modification record will be rejected and not accepted in the QIES ASAP system. A "fatal" error will be reported to the facility on the Final Validation Report.

  3. If the existing record is found, then the items in all sections of the submitted modification record will be edited. If there are any fatal errors, the modification record will be rejected and not accepted in the QIES ASAP system. The "fatal" error(s) will be reported to the facility on the Final Validation Report.

  4. If the modification record passes all the edits, it will replace the prior record being modified in the QIES ASAP system. The prior record will be moved to a history file in the QIES ASAP system.

A0050: Type of Record (cont.)

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

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

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

  1. The system will attempt to locate the existing record in the QIES ASAP system for this facility with the resident, reasons for assessment/tracking, and date (ARD, entry date, or discharge date) indicated in subsequent Section X items.

  2. If the existing record is not found in the QIES ASAP system, the submitted inactivation request will be rejected and a "fatal" error will be reported to the facility on the Final Validation Report.

  3. All items in Section X of the submitted record will be edited. If there are any fatal errors, the current inactivation request will be rejected and no record will be inactivated in the QIES ASAP system.

  4. If the existing record is found, it will be removed from the active records in the QIES ASAP system and moved to a history file.

Identification of Record to be Modified/Inactivated

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

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

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

A0100: Facility Provider Numbers

A0100. Facility Provider Numbers	
	A. National Provider Identifier (NPI): ☐☐☐☐☐☐☐☐☐☐ B. CMS Certification Number (CCN): ☐☐☐☐☐☐☐☐☐☐☐☐ C. State Provider Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Item Rationale

- Allows the identification of the facility submitting the assessment.

Coding Instructions

- Enter the facility provider numbers:
  - A. National Provider Identifier (NPI).
  - B. CMS Certification Number (CCN) – *If A0410 = 3 (federal required submission), then A0100B (facility CCN) must not be blank.*
  - C. State Provider Number (optional). This number is assigned by the *State survey agency* and provided to the intermediary. When known, enter the State Provider Number in A0100C. Completion of this is not required; however, your State may require the completion of this item.

DEFINITIONS

NATIONAL PROVIDER IDENTIFIER (NPI)
A unique Federal number that identifies providers of health care services. The NPI applies to the nursing home for all of its residents.

CMS CERTIFICATION NUMBER (CCN)
Replaces the term "Medicare/Medicaid Provider Number" in survey, certification, and assessment-related activities.

STATE PROVIDER NUMBER
Medicaid Provider Number established by a state.

A0200: Type of Provider

A0200. Type of Provider	
Enter Code ☐	Type of provider 1. Nursing home (SNF/NF) 2. Swing Bed

Item Rationale

- Allows designation of type of provider.

Coding Instructions

- **Code 1, nursing home (SNF/NF):** if a Medicare skilled nursing facility (SNF) or Medicaid nursing facility (NF).
- **Code 2, swing bed:** if a hospital with swing bed approval.

DEFINITION

SWING BED
A rural hospital with less than 100 beds that participates in the Medicare program that has CMS approval to provide post-hospital SNF care. The hospital may use its beds, as needed, to provide either acute or SNF care.

A0300: Optional State Assessment

A0300. Optional State Assessment	
Enter Code ☐	**A. Is this assessment for state payment purposes only?** 0. **No** 1. **Yes**
Enter Code ☐	**B. Assessment type** 1. **Start of therapy** assessment 2. **End of therapy** assessment 3. **Both Start and End of therapy** assessment 4. **Change of therapy** assessment 5. **Other payment** assessment

Item Rationale

- *Allows for collection of data required for state payment reimbursement.*

Coding Instructions for A0300, Optional State Assessment

- *Enter the code identifying whether this is an optional payment assessment. This assessment is not required by CMS but may be required by your state.*
- *If the assessment is being completed for state-required payment purposes, complete items A0300A and A0300B.*

Coding Instructions for A0300A, Is this assessment for state payment purposes only?

- *Enter the value indicating whether your state requires this assessment for payment.*

  0. *No*
  1. *Yes*

Coding Tips and Special Populations

- *This assessment is optional, as it is not federally required; however, it may be required by your state.*
- *For questions regarding completion of this assessment, please contact your State agency.*
- *This must be a standalone assessment (i.e., cannot be combined with any other type of assessment).*
- *The responses to the items in this assessment are used to calculate the case mix group Health Insurance Prospective Payment System (HIPPS) code for state payment purposes.*
- *If your state does not require this record for state payment purposes, enter a value of "0" (No). If your state requires this record for state payment purposes, enter a value of "1" (Yes) and proceed to item A0300B, Assessment Type.*

A0300: Optional State Assessment (cont.)

Coding Instructions for A0300B, Assessment Type

- *Enter the number corresponding to the reason for completing this state assessment.*

  1. *Start of therapy assessment*
  2. *End of therapy assessment*
  3. *Both Start and End of therapy assessment*
  4. *Change of therapy assessment*
  5. *Other payment assessment*

A0310: Type of Assessment

For Comprehensive, Quarterly, and PPS Assessments, Entry and OBRA Discharge Records, and Part A PPS Discharge Assessment.

A0310. Type of Assessment	
Enter Code ☐☐	**A. Federal OBRA Reason for Assessment** 01. **Admission** assessment (required by day 14) 02. **Quarterly** review assessment 03. **Annual** assessment 04. **Significant change in status** assessment 05. **Significant correction** to **prior comprehensive** assessment 06. **Significant correction** to **prior quarterly** assessment 99. **None of the above**
Enter Code ☐☐	**B. PPS Assessment** **PPS Scheduled Assessment for a Medicare Part A Stay** 01. **5-day** scheduled assessment **PPS Unscheduled Assessment for a Medicare Part A Stay** 08. **IPA** - Interim Payment Assessment **Not PPS Assessment** 99. **None of the above**
Enter Code ☐	**E. Is this assessment the first assessment** (OBRA, Scheduled PPS, or Discharge) **since the most recent admission/entry or reentry?** 0. **No** 1. **Yes**
Enter Code ☐☐	**F. Entry/discharge reporting** 01. **Entry** tracking record 10. **Discharge** assessment-**return not anticipated** 11. **Discharge** assessment-**return anticipated** 12. **Death in facility** tracking record 99. **None of the above**
Enter Code ☐	**G. Type of discharge** - Complete only if A0310F = 10 or 11 1. **Planned** 2. **Unplanned**
Enter Code ☐	**G1. Is this a SNF Part A Interrupted Stay?** 0. **No** 1. **Yes**
Enter Code ☐	**H. Is this a SNF Part A PPS Discharge Assessment?** 0. **No** 1. **Yes**

Item Rationale

- Allows identification of needed assessment content.

A0310: Type of Assessment (cont.)

Coding Instructions for A0310, Type of Assessment

Enter the code corresponding to the reason or reasons for completing this assessment.

If the assessment is being completed for both Omnibus Budget Reconciliation Act (OBRA)–required clinical reasons (A0310A) and Prospective Payment System (PPS) reasons (A0310B), all requirements for both types of assessments must be met. See Chapter 2 on assessment schedules for details of these requirements.

Coding Instructions for A0310A, Federal OBRA Reason for Assessment

- Document the reason for completing the assessment, using the categories of assessment types. For detailed information on the requirements for scheduling and timing of the assessments, see Chapter 2 on assessment schedules.
- Enter the number corresponding to the OBRA reason for assessment. This item contains 2 digits. For codes 01-06, enter "0" in the first box and place the correct number in the second box. If the assessment is not coded 01-06, enter code "99".

01. Admission assessment (required by day 14)
02. Quarterly review assessment
03. Annual assessment
04. Significant change in status assessment
05. Significant correction to prior comprehensive assessment
06. Significant correction to prior quarterly assessment
99. None of the above

Coding Tips and Special Populations

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

A0310: Type of Assessment (cont.)

Coding Instructions for A0310B, PPS Assessment

- Enter the number corresponding to the PPS reason for completing this assessment. This item contains 2 digits. For codes 01 *and 08*, enter "0" in the first box and place the correct number in the second box. If the assessment is not coded as 01 *or 08*, enter code "99."
- See Chapter 2 on assessment schedules for detailed information on the timing of the assessments.

DEFINITION

PROSPECTIVE PAYMENT SYSTEM (PPS)
Method of reimbursement in which Medicare payment is made based on the classification system of that service.

PPS Scheduled Assessment for Medicare Part A Stay

01. 5-day scheduled assessment

PPS Unscheduled Assessment for Medicare Part A Stay

08. IPA-Interim Payment Assessment

Not PPS Assessment

99. None of the above

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

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

Coding Tips and Special Populations

- A0310E = 0 for:
  - Entry or Death in Facility tracking records (A0310F = 01 or 12);
  - A standalone Part A PPS Discharge assessment (A0310A = 99, A0310B = 99, A0310F = 99, and A0310H = 1); or
  - *An Interim Payment Assessment* (A0310A = 99, A0310B = 0*8*, A0310F = 99, *and A0310H=0*).
- A0310E = 1 on the first OBRA, Scheduled PPS or OBRA Discharge assessment that is completed and submitted once a facility obtains CMS certification. Note: the first submitted assessment may not be *an OBRA* Admission assessment.

A0310: Type of Assessment (cont.)

Coding Instructions for A0310F, Federal OBRA & PPS Entry/Discharge Reporting

- Enter the number corresponding to the reason for completing this assessment or tracking record. This item contains 2 digits. For code 01, enter "0" in the first box and place "1" in the second box. If the assessment is not coded as "01" or "10 or "11" or "12," enter "99":

  01. Entry tracking record
  10. Discharge assessment-return not anticipated
  11. Discharge assessment-return anticipated
  12. Death in facility tracking record
  99. None of the above

Coding Instructions for A0310G, Type of Discharge (complete only if A0310F = 10 or 11)

- *Enter the number corresponding to the type of discharge.*
- **Code 1:** if type of discharge is a planned discharge.
- **Code 2:** if type of discharge is an unplanned discharge.

DEFINITION

Part A PPS Discharge Assessment
A discharge assessment developed to inform current and future *Skilled Nursing Facility Quality Reporting Program (*SNF QRP*)* measures and the calculation of these measures. The Part A PPS Discharge assessment is completed when a resident's Medicare Part A stay ends, but the resident remains in the facility; or may be combined with an OBRA Discharge if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000).

A0310: Type of Assessment (cont.)

Enter Code	G1. Is this a SNF Part A Interrupted Stay? 0. No 1. Yes

Coding Instructions for A0310G1, Is this a SNF Part A Interrupted Stay?

- ***Code 0, no:*** *if the resident was discharged from SNF care (i.e., from a Medicare Part A-covered stay) but* ***did not*** *resume SNF care in the same SNF within the interruption window.*
- ***Code 1, yes:*** *if the resident was discharged from SNF care (i.e., from a Medicare Part A-covered stay) but did resume SNF care in the same SNF within the interruption window.*

Coding Tips

- *Item A0310G1 indicates whether or not an interrupted stay occurred.*
- *The interrupted stay policy applies to residents who either leave the SNF, then return to the same SNF within the interruption window, or to residents who are discharged from Part A-covered services and remain in the SNF, but then resume a Part A-covered stay within the interruption window.*

DEFINITIONS

Interrupted Stay
Is a Medicare Part A SNF stay in which a resident is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay) and subsequently resumes SNF care in the ***same*** *SNF for a Medicare Part A-covered stay during the interruption window.*

Interruption Window
Is a 3-day period, starting with the calendar day of Part A discharge and including the 2 immediately following calendar days. In other words, if a resident in a Medicare Part A SNF stay is discharged from Part A, the resident must resume Part A services, or return to the ***same*** *SNF (if physically discharged) to resume Part A services, by 11:59 p.m. at the end of the third calendar day after their Part A-covered stay ended. The interruption window begins with the first non-covered day following a Part A-covered stay and ends at 11:59 p.m. on the third consecutive non-covered day following a Part A-covered SNF stay. If these conditions are met, the subsequent stay is considered a continuation of the previous Medicare Part A-covered stay for the purposes of both the variable per diem schedule and PPS assessment completion.*

A0310: Type of Assessment (cont.)

- *The following is a list of examples of an interrupted stay when the resident leaves the SNF and then returns to the same SNF to resume Part A-covered services within the interruption window. Examples include, but are not limited to, the following:*
    - *Resident transfers to an acute care setting for evaluation or treatment due to a change in condition and returns to the same SNF within the interruption window.*
    - *Resident transfers to a psychiatric facility for evaluation or treatment and returns to the same SNF within the interruption window.*
    - *Resident transfers to an outpatient facility for a procedure or treatment and returns to the same SNF within the interruption window.*
    - *Resident transfers to an assisted living facility or a private residence with home health services and returns to the same SNF within the interruption window.*
    - *Resident leaves against medical advice and returns to the same SNF within the interruption window.*
- *The following is a list of examples of an interrupted stay when the resident under a Part A-covered stay remains in the facility but the stay stops being covered under the Part A PPS benefit, and then resumes Part A-covered services in the SNF within the interruption window. Examples include, but are not limited to, the following:*
    - *Resident elects the hospice benefit, thereby declining the SNF benefit, and then revokes the hospice benefit and resumes SNF-level care within the interruption window.*
    - *Resident refuses to participate in rehabilitation and has no other daily skilled need; this ends the Part A coverage. Within the interruption window, the resident decides to engage in the planned rehabilitation regime and Part A coverage resumes.*
    - *Resident changes payer sources from Medicare Part A to an alternate payer source (i.e., hospice, private pay or private insurance) and then wishes to resume their Medicare Part A stay, at the same SNF, within the interruption window.*
- *If a resident is discharged from SNF care, remains in the SNF, and resumes a Part A-covered stay in the SNF within the interruption window, this is an interrupted stay. No discharge assessment (OBRA or Part A PPS) is required, nor is an Entry Tracking Record or 5-Day required on resumption.*
- *If a resident leaves the SNF and returns to resume Part A-covered services in the **same** SNF within the interruption window, this is an interrupted stay. Although this situation does not end the resident's Part A PPS stay, the resident left the SNF, and therefore an OBRA Discharge assessment is required. On return to the SNF, no 5-Day would be required. An OBRA Admission **would** be required if the resident was discharged return **not** anticipated. If the resident was discharged return anticipated, no new OBRA Admission would be required.*

A0310: Type of Assessment (cont.)

- *When an interrupted stay occurs, a 5-Day PPS assessment is not required upon reentry or resumption of SNF care in the same SNF, because an interrupted stay does not end the resident's Part A PPS stay.*
- *If a resident is discharged from SNF care, remains in the SNF and **does not** resume Part A-covered services within the interruption window, an interrupted stay did **not** occur. In this situation, a Part A PPS Discharge is required. If the resident qualifies and there is a resumption of Part A services within the 30-day window allowed by Medicare, a 5-Day would be required as this would be considered a **new** Part A stay. The OBRA schedule would continue from the resident's original date of admission (item A1900).*
- *If a resident leaves the SNF and **does not** return to resume Part A-covered services in the **same** SNF within the interruption window, an interrupted stay did **not** occur. In this situation, both the Part A PPS and OBRA Discharge assessments are required (and may be combined). If the resident returns to the same SNF, this would be considered a **new** Part A stay. An Entry Tracking record and 5-Day would be required on return. An OBRA Admission **would** be required if the resident was discharged return **not** anticipated. If the resident was discharged return anticipated, no new OBRA Admission would be required.*
- *The OBRA assessment schedule is unaffected by the interrupted stay policy. Please refer to Chapter 2 for guidance on OBRA assessment scheduling requirements.*

Coding Instructions for A0310H, Is this a Part A PPS Discharge Assessment?

- **Code 0, no:** if this is not a Part A PPS Discharge assessment.
- **Code 1, yes:** if this is a Part A PPS Discharge assessment.
- A Part A PPS Discharge assessment (NPE Item Set) is required under the Skilled Nursing Facility Quality Reporting Program (SNF QRP) when the resident's Medicare Part A stay ends (as documented in A2400C, End Date of Most Recent Medicare Stay) but the resident remains in the facility.
- If the End Date of the Most Recent Medicare Stay (A2400C) occurs on the day of or one day before the Discharge Date (A2000), the OBRA Discharge assessment and Part A PPS Discharge assessment are **both required** and may be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000).

A0410: Unit Certification or Licensure Designation

A0410. Unit Certification or Licensure Designation	
Enter Code ☐	1. Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State 2. Unit is neither Medicare nor Medicaid certified but MDS data is required by the State 3. Unit is Medicare and/or Medicaid certified

Item Rationale

- In coding this item, the facility must consider its Medicare and/or Medicaid status as well as the state's authority to collect MDS records. State regulations may require submission of MDS data to the QIES ASAP system or directly to the state for residents residing in licensed-only beds.
- Nursing homes must be certain they are submitting MDS assessments to the QIES ASAP system for those residents who are on a Medicare and/or Medicaid certified unit. *Swing bed facilities must be certain that they are submitting MDS assessments only for those residents whose stay is covered by Medicare Part A benefits.* For those residents who are in licensed-only beds, nursing homes must be certain they are submitting MDS assessments either to QIES ASAP or directly to the state in accordance with state requirements.
- Payer source is not the determinant by which this item is coded. This item is coded solely according to the authority CMS has to collect MDS data for residents who are on a Medicare and/or Medicaid certified unit and the authority that the state may have to collect MDS data under licensure. Consult Chapter 5, page 5-1 of this Manual for a discussion of what types of records should be submitted to the QIES ASAP system.

Steps for Assessment

1. Ask the nursing home administrator or representative which units in the nursing home are Medicare certified, Medicaid certified or dually certified (Medicare/Medicaid).

2. If some or all of the units in the nursing home are neither Medicare nor Medicaid certified, ask the nursing home administrator or representative if there are units that are state licensed and if the state requires MDS submission for residents on that unit.

3. Identify all units in the nursing home that are not certified or licensed by the state, if any.

A0410: Unit Certification or Licensure Designation (cont.)

Coding Instructions

- **Code 1, Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State:** if the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, and *neither CMS nor* the state ha*s* authority to collect MDS information for residents on this unit, the facility may not submit MDS records to QIES ASAP. If any records are submitted under this certification designation, they will be rejected by the QIES ASAP system.
- **Code 2, Unit is neither Medicare nor Medicaid certified but MDS data is required by the State:** if the nursing home resident is on a unit that is neither Medicare nor Medicaid certified, but the state has authority under state licensure to collect MDS information for residents on such units, the facility should submit the resident's MDS records per the state's requirement to QIES ASAP or directly to the state.

  Note that this certification designation does not apply to swing-bed facilities. Assessments for swing-bed residents on which A0410 is coded "2" will be rejected by the QIES ASAP system.
- **Code 3, Unit is Medicare and/or Medicaid certified:** if the resident is on a Medicare and/or Medicaid certified unit, regardless of payer source (i.e., even if the resident is private pay or has his/her stay covered under Medicare Advantage, Medicare HMO, private insurance, etc.), the facility is required to submit MDS records (OBRA and SNF PPS only) to QIES ASAP for these residents. Consult Chapter 5, page 5-1 of this Manual for a discussion of what types of records should be submitted to the QIES ASAP system.

A0500: Legal Name of Resident

A0500. Legal Name of Resident		
	A. First name:	B. Middle initial:
	C. Last name:	D. Suffix:

Item Rationale

- Allows identification of resident.
- Also used for matching each of the resident's records.

Steps for Assessment

1. Ask resident, family, significant other, guardian, or legally authorized representative.

DEFINITION

LEGAL NAME
Resident's name as it appears on the Medicare card. If the resident is not enrolled in the Medicare program, use the resident's name as it appears on a Medicaid card or other government-issued document.

A0500: Legal Name of Resident (cont.)

2. Check the resident's name on his or her Medicare card, or if not in the program, check a Medicaid card or other government-issued document.

Coding Instructions

Use printed letters. Enter in the following order:

A. First Name

B. Middle Initial (if the resident has no middle initial, leave Item A0500B blank; if the resident has two or more middle names, use the initial of the first middle name)

C. Last Name

D. Suffix (e.g., Jr./Sr.)

A0600: Social Security and Medicare Numbers

A0600. Social Security and Medicare Numbers

A. Social Security Number: ☐☐☐ – ☐☐ – ☐☐☐☐

B. Medicare number: ☐☐☐☐☐☐☐☐☐☐☐☐

Item Rationale

- Allows identification of the resident.
- Allows records for resident to be matched in system.

Coding Instructions

- Enter the Social Security Number (SSN) in A0600A, one number per space starting with the leftmost space. If no *SSN* is available for the resident (e.g., if the resident is a recent immigrant or a child) the item may be left blank. *Note: A valid SSN should be submitted in A0600A whenever it is available so that resident matching can be performed as accurately as possible.*
- Enter Medicare number in A0600B exactly as it appears on the resident's documents.
- For PPS assessments (A0310B = 01 *or 08*), the Medicare number (A0600B) must be present (i.e., may not be left blank).
- A0600B *must* be a Medicare number.

DEFINITIONS

SOCIAL SECURITY NUMBER
A tracking number assigned to an individual by the U.S. Federal government for taxation, benefits, and identification purposes.

MEDICARE NUMBER
An identifier assigned to an individual for participation in national health insurance program. The Medicare Health Insurance identifier *is* different from the resident's Social Security Number (SSN) and may contain both letters and numbers.

A0700: Medicaid Number

A0700. **Medicaid Number** - Enter "+" if pending, "N" if not a Medicaid recipient
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Item Rationale

- Assists in correct resident identification.

Coding Instructions

- Record this number if the resident is a Medicaid recipient.
- Enter one number *or letter* per box beginning in the leftmost box.
- Recheck the number to make sure you have entered the digits correctly.
- Enter a "+" in the leftmost box if the number is pending. If you are notified later that the resident does have a Medicaid number, just include it on the next assessment.
- If not applicable because the resident is not a Medicaid recipient, enter "N" in the leftmost box.

Coding Tips and Special Populations

- To obtain the Medicaid number, check the resident's Medicaid card, admission or transfer records, or medical record.
- Confirm that the resident's name on the MDS matches the resident's name on the Medicaid card.
- It is not necessary to process an MDS correction to add the Medicaid number on a prior assessment. However, a correction may be a State-specific requirement.

A0800: Gender

A0800. **Gender**	
Enter Code ☐	1. **Male** 2. **Female**

Item Rationale

- Assists in correct identification.
- Provides demographic gender specific health trend information.

Coding Instructions

- **Code 1:** if resident is male.
- **Code 2:** if resident is female.

Coding Tips and Special Populations

- Resident gender on the MDS *must* match what is in the Social Security system.

A0900: Birth Date

A0900. Birth Date	
	Month – Day – Year

Item Rationale

- Assists in correct identification.
- Allows determination of age.

Coding Instructions

- Fill in the boxes with the appropriate birth date. If the complete birth date is known, do not leave any boxes blank. If the month or day contains only a single digit, fill the first box in with a "0." For example: January 2, 1918, should be entered as 01-02-1918.
- Sometimes, only the birth year or the birth year and birth month will be known. These situations are handled as follows:
  - If only the birth year is known (e.g., 1918), then enter the year in the "year" portion of A0900, and leave the "month" and "day" portions blank. If the birth year and birth month are known, but the day of the month is not known, then enter the year in the "year" portion of A0900, enter the month in the "month" portion of A0900, and leave the "day" portion blank.

A1000: Race/Ethnicity

A1000. Race/Ethnicity	
↓ Check all that apply	
☐	A. American Indian or Alaska Native
☐	B. Asian
☐	C. Black or African American
☐	D. Hispanic or Latino
☐	E. Native Hawaiian or Other Pacific Islander
☐	F. White

Item Rationale

- This item uses the common uniform language approved by the Office of Management and Budget (OMB) to report racial and ethnic categories. The categories in this classification are social-political constructs and should not be interpreted as being scientific or anthropological in nature.
- Provides demographic race/ethnicity specific health trend information.
- These categories are NOT used to determine eligibility for participation in any Federal program.

A1000: Race/Ethnicity (cont.)

Steps for Assessment: Interview Instructions

1. Ask the resident to select the category or categories that most closely correspond to his or her race/ethnicity from the list in A1000.

    - Individuals may be more comfortable if this and the preceding question are introduced by saying, "We want to make sure that all our residents get the best care possible, regardless of their race or ethnic background. We would like you to tell us your ethnic and racial background so that we can review the treatment that all residents receive and make sure that everyone gets the highest quality of care" (Baker et al., 2005).

2. If the resident is unable to respond, ask a family member or significant other.

3. Category definitions are provided to resident or family only if requested by them in order to answer the item.

4. Respondents should be offered the option of selecting one or more racial designations.

5. Only if the resident is unable to respond and no family member or significant other is available, observer identification or medical record documentation may be used.

Coding Instructions

Check all that apply.

- Enter the race or ethnic category or categories the resident, family or significant other uses to identify him or her.

DEFINITIONS

RACE/ETHNICITY

AMERICAN INDIAN OR ALASKA NATIVE
A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

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

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

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

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

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

A1100: Language

A1100. Language

Enter Code ☐

A. Does the resident need or want an interpreter to communicate with a doctor or health care staff?

0. **No** → Skip to A1200, Marital Status
1. **Yes** → Specify in A1100B, Preferred language
9. **Unable to determine** → Skip to A1200, Marital Status

B. Preferred language:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Item Rationale

Health-related Quality of Life

- Inability to make needs known and to engage in social interaction because of a language barrier can be very frustrating and can result in isolation, depression, and unmet needs.
- Language barriers can interfere with accurate assessment.

Planning for Care

- When a resident needs or wants an interpreter, the nursing home should ensure that an interpreter is available.
- An alternate method of communication also should be made available to help to ensure that basic needs can be expressed at all times, such as a communication board with pictures on it for the resident to point to (if able).
- Identifies residents who need interpreter services in order to answer interview items or participate in consent process.

Steps for Assessment

1. Ask the resident if he or she needs or wants an interpreter to communicate with a doctor or health care staff.
2. If the resident is unable to respond, a family member or significant other should be asked.
3. If neither source is available, review record for evidence of a need for an interpreter.
4. If an interpreter is wanted or needed, ask for preferred language.
5. It is acceptable for a family member or significant other to be the interpreter if the resident is comfortable with it and if the family member or significant other will translate exactly what the resident says without providing his or her interpretation.

Coding Instructions for A1100A

- **Code 0, no:** if the resident (or family or medical record if resident unable to communicate) indicates that the resident does not want or need an interpreter to communicate with a doctor or health care staff. Skip to A1200, Marital Status.
- **Code 1, yes:** if the resident (or family or medical record if resident unable to communicate) indicates that he or she needs or wants an interpreter to communicate with a doctor or health care staff. Specify preferred language. Proceed to 1100B and enter the resident's preferred language.
- **Code 9, unable to determine:** if no source can identify whether the resident wants or needs an interpreter. Skip to A1200, Marital Status.

A1100: Language (cont.)

Coding Instructions for A1100B

- Enter the preferred language the resident primarily speaks or understands after interviewing the resident and family, observing the resident and listening, and reviewing the medical record.

Coding Tips and Special Populations

- An organized system of signing such as American Sign Language (ASL) can be reported as the preferred language if the resident needs or wants to communicate in this manner.

A1200: Marital Status

A1200. Marital Status	
Enter Code ☐	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced

Item Rationale

- Allows understanding of the formal relationship the resident has and can be important for care and discharge planning.
- Demographic information.

Steps for Assessment

1. Ask the resident about his or her marital status.
2. If the resident is unable to respond, ask a family member or other significant other.
3. If neither source can report, review the medical record for information.

Coding Instructions

- Choose the answer that best describes the current marital status of the resident and enter the corresponding number in the code box:

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

A1300: Optional Resident Items

A1300. Optional Resident Items

A. Medical record number:

B. Room number:

C. Name by which resident prefers to be addressed:

D. Lifetime occupation(s) - put "/" between two occupations:

Item Rationale

- Some facilities prefer to include the nursing home medical record number on the MDS to facilitate tracking.
- Some facilities conduct unit reviews of MDS items in addition to resident and nursing home level reviews. The unit may be indicated by the room number.
- Preferred name and lifetime occupation help nursing home staff members personalize their interactions with the resident.
- Many people are called by a nickname or middle name throughout their life. It is important to call residents by the name they prefer in order to establish comfort and respect between staff and resident. Also, some cognitively impaired or hearing impaired residents might have difficulty responding when called by their legal name, if it is not the name most familiar to them.
- Others may prefer a more formal and less familiar address. For example, a physician might appreciate being referred to as "Doctor."
- Knowing a person's lifetime occupation is also helpful for care planning and conversation purposes. For example, a carpenter might enjoy pursuing hobby shop activities.
- These are optional items because they are not needed for CMS program function.

Coding Instructions for A1300A, Medical Record Number

- Enter the resident's medical record number (from the nursing home medical record, admission office or Health Information Management Department) if the nursing home chooses to exercise this option.

Coding Instructions for A1300B, Room Number

- Enter the resident's room number if the nursing home chooses to exercise this option.

Coding Instructions for A1300C, Name by Which Resident Prefers to Be Addressed

- Enter the resident's preferred name. This field captures a preferred nickname, middle name, or title that the resident prefers staff use.
- Obtained from resident self-report or family or significant other if resident is unable to respond.

A1300: Optional Resident Items (cont.)

Coding Instructions for A1300D, Lifetime Occupation(s)

- Enter the job title or profession that describes the resident's main occupation(s) before retiring or entering the nursing home. When two occupations are identified, place a slash (/) between each occupation.
- The lifetime occupation of a person whose primary work was in the home should be recorded as "homemaker." For a resident who is a child or an intellectually disabled/developmentally disabled adult resident who has never had an occupation, record as "none."

A1500: Preadmission Screening and Resident Review (PASRR)

A1500. Preadmission Screening and Resident Review (PASRR) Complete only if A0310A = 01, 03, 04, or 05	
Enter Code ☐	**Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?** 0. **No** → Skip to A1550, Conditions Related to ID/DD Status 1. **Yes** → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions 9. **Not a Medicaid-certified unit** → Skip to A1550, Conditions Related to ID/DD Status

Item Rationale

Health-related Quality of Life

- All individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), developmental disability (DD), or related conditions (please contact your local State Medicaid Agency for details regarding PASRR requirements and exemptions).
- Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State.
- A resident with MI or ID/DD must have a Resident Review (RR) conducted when there is a significant change in the resident's physical or mental condition. Therefore, when *an SCSA* is completed for a resident with MI or ID/DD, the nursing home is required to notify the State mental health authority, intellectual disability or developmental disability authority (depending on which operates in their State) in order to notify them of the resident's change in status. Section 1919(e)(7)(B)(iii) of the Social Security Act requires the notification or referral for a significant change.[1]

[1] The statute may also be referenced as 42 USC 1396r(e)(7)(B)(iii). Note that as of this revision date the statute supersedes Federal regulations at 42 CFR 483.114(c), which still reads as requiring annual resident review. The regulation has not yet been updated to reflect the statutory change to resident review upon significant change in condition.

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

- Each State Medicaid Agency might have specific processes and guidelines for referral, and which types of significant changes should be referred. Therefore, facilities should become acquainted with their own State requirements.
- Please see https://www.medicaid.gov/medicaid/ltss/institutional/pasrr/index.html for CMS information on PASRR.

Planning for Care

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

Steps for Assessment

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

Coding Instructions

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

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

- **Code 1, yes:** if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.
- **Code 9, not a Medicaid-certified unit:** if bed is not in a Medicaid-certified nursing home. Skip to A1550, Conditions Related to ID/DD Status. The PASRR process does not apply to nursing home units that are not certified by Medicaid (unless a State requires otherwise) and therefore the question is not applicable.
  - Note that the requirement is based on the certification of the part of the nursing home the resident will occupy. In a nursing home in which some parts are Medicaid certified and some are not, this question applies when a resident is admitted, or transferred to, a Medicaid certified part of the building.

A1510: Level II Preadmission Screening and Resident Review (PASRR) Conditions

A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions Complete only if A0310A = 01, 03, 04, or 05	
↓ Check all that apply	
☐	A. Serious mental illness
☐	B. Intellectual Disability
☐	C. Other related conditions

Steps for Assessment

1. Complete if A0310A = 01, 03, 04 or 05 (Admission assessment, Annual assessment, *SCSA*, Significant Correction to Prior Comprehensive Assessment).

2. Check all that apply.

Coding Instructions

- **Code A, Serious mental illness:** if resident has been diagnosed with a serious mental illness.
- **Code B, Intellectual Disability:** if resident has been diagnosed with intellectual disability/developmental disability.
- **Code C, Other related conditions:** if resident has been diagnosed with other related conditions.

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

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

Item Rationale

- To document conditions associated with intellectual or developmental disabilities.

Steps for Assessment

1. If resident is 22 years of age or older on the *ARD*, complete only if A0310A = 01 (Admission assessment).

2. If resident is 21 years of age or younger on the *ARD*, complete if A0310A = 01, 03, 04, or 05 (Admission assessment, Annual assessment, *SCSA*, Significant Correction to Prior Comprehensive Assessment).

Coding Instructions

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

DEFINITIONS

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

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

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

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

- **Code E:** if an ID/DD condition is present but the resident does not have any of the specific conditions listed.
- **Code Z:** if ID/DD condition is not present.

DEFINITION

OTHER ORGANIC CONDITION RELATED TO ID/DD

Examples of diagnostic conditions include congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macroencephaly, meningomyelocele, congenital hydrocephalus, etc.

A1600–A1800: Most Recent Admission/Entry or Reentry into this Facility

Most Recent Admission/Entry or Reentry into this Facility

A1600. Entry Date

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A1700. Type of Entry

Enter Code ☐

1. **Admission**
2. **Reentry**

A1800. Entered From

Enter Code ☐☐

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **ID/DD facility**
07. **Hospice**
09. **Long Term Care Hospital** (LTCH)
99. **Other**

A1600: Entry Date

Most Recent Admission/Entry or Reentry into this Facility	
A1600. Entry Date	
	☐☐ – ☐☐ – ☐☐☐☐ Month – Day – Year

Item Rationale

- To document the date of admission/entry or reentry into the facility.

Coding Instructions

- Enter the most recent date of admission/entry or reentry to this facility. Use the format: Month-Day-Year: XX-XX-XXXX. For example, October 12, 2010, would be entered as 10-12-2010.

DEFINITION

ENTRY DATE
The initial date of admission to the facility, or the date the resident most recently returned to your facility after being discharged.

A1700: Type of Entry

A1700. Type of Entry	
Enter Code ☐	1. **Admission** 2. **Reentry**

Item Rationale

- Captures whether date in A1600 is an admission/entry or reentry date.

Coding Instructions

- **Code 1, admission:** when one of the following occurs:
  1. resident has never been admitted to this facility before; OR
  2. resident has been in this facility previously and was discharged return not anticipated; OR
  3. resident has been in this facility previously and was discharged return anticipated and did not return within 30 days of discharge.
- **Code 2, reentry:** when all three of the following occurred prior to this entry; the resident was:
  1. admitted to this facility, AND
  2. discharged return anticipated, AND
  3. returned to facility within 30 days of discharge.

A1800: Entered From

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

Item Rationale

- Understanding the setting that the individual was in immediately prior to facility admission/entry or reentry informs care planning and may also inform discharge planning and discussions.
- Demographic information.

Steps for Assessment

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

Coding Instructions

Enter the 2-digit code that corresponds to the location or program the resident was admitted from for this admission/entry or reentry.

- **Code 01, community (private home/apt, board/care, assisted living, group home):** if the resident was admitted from a private home, apartment, board and care, assisted living facility or group home.
- **Code 02, another nursing home or swing bed:** if the resident was admitted from an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds.
- **Code 03, acute hospital:** if the resident was admitted from an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons.

DEFINITIONS

PRIVATE HOME OR APARTMENT
Any house, condominium, or apartment in the community whether owned by the resident or another person. Also included in this category are retirement communities and independent housing for the elderly.

BOARD AND CARE/ ASSISTED LIVING/ GROUP HOME
A non-institutional community residential setting that includes services of the following types: home health services, homemaker/ personal care services, or meal services.

A1800: Entered From (cont.)

- **Code 04, psychiatric hospital:** if the resident was admitted from an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill residents.
- **Code 05, inpatient rehabilitation facility (IRF):** if the resident was admitted from an institution that is engaged in providing, under the supervision of physicians, services for the rehabilitation of injured, disabled, or sick persons. Includes IRFs that are units within acute care hospitals.
- **Code 06, ID/DD facility:** if the resident was admitted from an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who have intellectual or developmental disabilities.
- **Code 07, hospice:** if the resident was admitted from a program for terminally ill persons where an array of services is necessary 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. Includes community-based or inpatient hospice programs.
- **Code 09, long term care hospital (LTCH):** if the resident was admitted from a hospital that is certified under Medicare as a short-term, acute-care hospital which has been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under §1886(d)(1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.
- **Code 99, other:** if the resident was admitted from none of the above.

Coding Tips and Special Populations

- If an individual was enrolled in a home-based hospice program enter **07, Hospice**, instead of **01, Community**.

A1900: Admission Date (Date this episode of care in this facility began)

A1900. Admission Date (Date this episode of care in this facility began)	
	Month – Day – Year

Item Rationale

- To document the date this episode of care in this facility began.

Coding Instructions

- Enter the date this episode of care in this facility began. Use the format: Month-Day-Year: XX-XX-XXXX. For example, October 12, 2010, would be entered as 10-12-2010.
- The Admission Date may be the same as the Entry Date (A1600) for the entire stay (i.e., if the resident is never discharged).

A1900: Admission Date (Date this episode of care in this facility began) (cont.)

Examples

1. Mrs. H was admitted to the facility from an acute care hospital on 09/14/2013 for rehabilitation after a hip replacement. In completing her Admission assessment, the facility entered 09/14/2013 in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 03, acute hospital in item A1800, Entered From; and entered 09/14/2013 in item A1900, Admission Date.

2. The facility received communication from an acute care hospital discharge planner stating that Mrs. H, a former resident of the facility who was discharged home return not anticipated on 11/02/2013 after a successful recovery and rehabilitation, was admitted to their hospital on 2/8/2014 and wished to return to the facility for rehabilitation after hospital discharge. Mrs. H returned to the facility on 2/15/2014. Although Mrs. H was a resident of the facility in September of 2013, she was discharged home return not anticipated; therefore, the facility rightly considered Mrs. H as a new admission. In completing her Admission assessment, the facility entered 02/15/2014 in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 03, acute hospital in item A1800, Entered From; and entered 02/15/2014 in item A1900, Admission Date.

3. Mr. K was admitted to the facility on 10/05/2013 and was discharged to the hospital, return anticipated, on 10/20/2013. He returned to the facility on 10/26/2013. Since Mr. K was a resident of the facility, was discharged return anticipated, and returned within 30 days of discharge, Mr. K was considered as continuing in his current stay. Therefore, when the facility completed his Entry Tracking Record on return from the hospital, they entered 10/26/2013 in A1600, Entry Date; coded A1700 = 2, Reentry; chose Code 03, acute hospital in item A1800; and entered 10/05/2013 in item A1900, Admission Date.

   Approximately a month after his return, Mr. K was again sent to the hospital, return anticipated on 11/05/2013. He returned to the facility on 11/22/2013. Again, since Mr. K was a resident of the facility, was discharged return anticipated, and returned within 30 days of discharge, Mr. K was considered as continuing in his current stay. Therefore, when the facility completed his Entry Tracking Record, they entered 11/22/2013 in A1600, Entry Date; coded A1700 = 2, Reentry; chose Code 03, acute hospital in item A1800; and entered 10/05/2013 in item A1900, Admission Date.

4. Ms. S was admitted to the facility on 8/26/2014 for rehabilitation after a total knee replacement. Three days after admission, Ms. S spiked a fever and her surgical site was observed to have increased drainage, was reddened, swollen and extremely painful. The facility sent Ms. S to the emergency room and completed her OBRA Discharge assessment as return anticipated. The hospital called the facility to inform them Ms. S was admitted. A week into her hospitalization, Ms. S developed a blood clot in her affected leg, further complicating her recovery. The facility was contacted to readmit Ms. S for rehabilitative services following discharge from the hospital on 10/10/2014. Even though Ms. S was a former patient in the facility's rehabilitation unit and was discharged

A1900: Admission Date (Date this episode of care in this facility began) (cont.)

return anticipated, she did not return within 30 days of discharge to the hospital. Therefore, Ms. S is considered a new admission to the facility. On her return, when the facility completed Ms. S's Admission assessment, they entered 10/10/2014 in A1600, Entry Date; coded A1700 = 1, Admission; chose Code 03, acute hospital in item A1800, Entered From; and entered 10/10/2014 in item A1900, Admission Date.

Coding Tips and Special Populations

- Both swing bed facilities and nursing homes must apply the above instructions for coding items A1600 through A1900 to determine whether a patient or resident is an admission/entry or reentry.
- In determining if a patient or resident returns to the facility within 30 days, the day of discharge from the facility is not counted in the 30 days. For example, a resident discharged return anticipated on December 1 would need to return to the facility by December 31 to meet the "within 30 days" requirement.
- If the Type of Entry for this assessment is an Admission (A1700 = 1), the Admission Date (A1900) and the Entry Date (A1600) must be the same.
- If the Type of Entry for this assessment is a Reentry (A1700 = 2), the Admission Date (A1900) will remain the same, and the Entry Date (A1600) must be later than the date in A1900.
- Item A1900 (Admission Date) is tied to items A1600 (Entry Date), A1700 (Type of Entry), and A1800 (Entered From). It is also tied to the concepts of a "stay" and an "episode." A stay is a set of contiguous days in the facility and an episode is a series of one or more stays that may be separated by brief interruptions in the resident's time in the facility. An episode continues across stays until one of three events occurs: the resident is discharged with return not anticipated, the resident is discharged with return anticipated but is out of the facility for more than 30 days, or the resident dies in the facility.
- A1900 (Admission Date) should remain the same on all assessments for a given episode even if it is interrupted by temporary discharges from the facility. If the resident is discharged and reenters within the course of an episode, that will start a new stay. The date in item A1600 (Entry Date) will change, but the date in item A1900 (Admission Date) will remain the same. If the resident returns after a discharge return not anticipated or after a gap of more than 30 days outside of the facility, a new episode would begin and a new admission would be required.
- When a resident is first admitted to a facility, item A1600 (Entry Date) should be coded with the date the person first entered the facility, and A1700 (Type of Entry) should be coded as 1, Admission. The place where the resident was admitted from should be documented in A1800 (Entered From), and the date in item A1900 (Admission Date) should match the date in A1600 (Entry Date). These items would be coded the same way for all subsequent assessments within the first stay of an episode. If the resident is briefly discharged (e.g., brief hospitalization) and then reenters the facility, a new (second) stay

A1900: Admission Date (Date this episode of care in this facility began) (cont.)

would start, but the current episode would continue. On the Entry Tracking Record and on subsequent assessments for the second stay, the date in A1600 (Entry Date) would change depending on the date of reentry, and item A1700 (Type of Entry) would be coded as 2, Reentry. Item A1800 (Entered From) would reflect where the resident was prior to this reentry, and item A1900 (Admission Date) would continue to show the original admission date (the date that began his or her first stay in the episode).

A2000: OBRA Discharge Date

A2000. Discharge Date Complete only if A0310F = 10, 11, or 12	
	Month – Day – Year

Item Rationale

- Closes the episode in the QIES ASAP system.

Coding Instructions

- Enter the date the resident was discharged (whether or not return is anticipated). This is the date the resident leaves the facility.
- For OBRA Discharge assessments, the Discharge Date (A2000) and ARD (A2300) must be the same date.
- Do not include leave of absence or hospital observational stays less than 24 hours unless admitted to the hospital.
- Obtain data from the medical, admissions or transfer records.

Coding Tips and Special Populations

- A Part A PPS Discharge assessment (NPE Item Set) is required under the SNF QRP when the resident's Medicare Part A stay ends, but the resident does not leave the facility.
- If a resident receiving services under SNF Part A PPS has a Discharge Date (A2000) that occurs **on the day of or one day after** the End Date of Most Recent Medicare Stay (A2400C), then both an OBRA Discharge assessment and a Part A PPS Discharge assessment are required; but these two assessments may be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000).

A2100: OBRA Discharge Status

A2100. Discharge Status Complete only if A0310F = 10, 11, or 12	
Enter Code ☐☐	01. **Community** (private home/apt., board/care, assisted living, group home) 02. **Another nursing home or swing bed** 03. **Acute hospital** 04. **Psychiatric hospital** 05. **Inpatient rehabilitation facility** 06. **ID/DD facility** 07. **Hospice** 08. **Deceased** 09. **Long Term Care Hospital** (LTCH) 99. **Other**

Item Rationale

- Demographic and outcome information.

Steps for Assessment

1. Review the medical record including the discharge plan and discharge orders for documentation of discharge location.

Coding Instructions

Select the 2-digit code that corresponds to the resident's discharge status.

- **Code 01, community (private home/apt., board/care, assisted living, group home):** if discharge location is a private home, apartment, board and care, assisted living facility, or group home.
- **Code 02, another nursing home or swing bed:** if discharge location is an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds.
- **Code 03, acute hospital:** if discharge location is an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons.
- **Code 04, psychiatric hospital:** if discharge location is an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill residents.
- **Code 05, inpatient rehabilitation facility:** if discharge location is an institution that is engaged in providing, under the supervision of physicians, rehabilitation services for the rehabilitation of injured, disabled or sick persons. Includes IRFs that are units within acute care hospitals.
- **Code 06, ID/DD facility:** if discharge location is an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who have intellectual or developmental disabilities.
- **Code 07, hospice:** if discharge location is a program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and

A2100: OBRA Discharge Status (cont.)

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. Includes community-based (e.g., home) or inpatient hospice programs.

- **Code 08, deceased:** if resident is deceased.
- **Code 09, long term care hospital (LTCH):** if discharge location is an institution that is certified under Medicare as a short-term, acute-care hospital which has been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under §1886(d)(1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.
- **Code 99, other:** if discharge location is none of the above.

A2200: Previous Assessment Reference Date for Significant Correction

A2200. Previous Assessment Reference Date for Significant Correction Complete only if A0310A = 05 or 06	
	☐☐ – ☐☐ – ☐☐☐☐ Month Day Year

Item Rationale

- To identify the ARD of a previous comprehensive (A0310 = 01, 03, or 04) or Quarterly assessment (A0310A = 02) in which a significant error is discovered.

Coding Instructions

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

A2300: Assessment Reference Date

A2300. Assessment Reference Date	
	Observation end date: ☐☐ – ☐☐ – ☐☐☐☐ Month Day Year

A2300: Assessment Reference Date (cont.)

Item Rationale

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

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

Steps for Assessment

1. Interdisciplinary team members should select the ARD based on the reason for the assessment and compliance with all timing and scheduling requirements outlined in Chapter 2.

Coding Instructions

- Enter the appropriate date on the lines provided. Do not leave any spaces blank. If the month or day contains only a single digit, enter a "0" in the first space. Use four digits for the year. For example, October 2, 2010, should be entered as: 10-02-2010.
- For detailed information on the timing of the assessments, see Chapter 2 on assessment schedules.
- For discharge assessments, the discharge date item (A2000) and the ARD item (A2300) must contain the same date.

Coding Tips and Special Populations

- When the resident dies or is discharged prior to the end of the look-back period for a required assessment, the ARD must be adjusted to equal the discharge date.
- The look-back period may not be extended simply because a resident was out of the nursing home during part of the look-back period (e.g., a home visit, therapeutic leave, or hospital observation stay less than 24 hours when resident is not admitted). For example, if the ARD is set at day 13 and there is a 2-day temporary leave during the look-back period, the 2 leave days are still considered part of the look-back period.
- When collecting assessment information, data from the time period of the leave of absence is captured as long as the particular MDS item permits. For example, if the family takes the resident to the physician during the leave, the visit would be counted in Item O0600, **Physician Examination** (if criteria are otherwise met).

DEFINITION

ASSESSMENT REFERENCE DATE (ARD)

The specific end-point for the look-back periods in the MDS assessment process. Almost all MDS items refer to the resident's status over a designated time period referring back in time from the Assessment Reference Date (ARD). Most frequently, this look-back period, also called the observation or assessment period, is a 7-day period ending on the ARD. Look-back periods may cover the 7 days ending on this date, 14 days ending on this date, etc.

A2300: Assessment Reference Date (cont.)

This requirement applies to all assessments, regardless of whether they are being completed for clinical or payment purposes.

A2400: Medicare Stay

A2400. Medicare Stay
Complete only if A0310G1= 0

Enter Code ☐

A. Has the resident had a Medicare-covered stay since the most recent entry?
0. **No** → Skip to B0100, Comatose
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Item Rationale

- Identifies when a resident is receiving services under the scheduled PPS.
- Identifies when a resident's Medicare Part A stay begins and ends.
- The end date is used to determine if the resident's stay qualifies for the short stay assessment.

Coding Instructions for A2400A, Has the Resident Had a Medicare-covered Stay since the Most Recent Entry?

- **Code 0, no:** if the resident has not had a Medicare Part A covered stay since the most recent admission/entry or reentry. Skip to B0100, Comatose.
- **Code 1, yes:** if the resident has had a Medicare Part A covered stay since the most recent admission/entry or reentry. Continue to A2400B.

Coding Instructions for A2400B, Start of Most Recent Medicare Stay

- **Code the date of day 1** of this Medicare stay if A2400A is **coded 1, yes**.

Coding Instructions for A2400C, End Date of Most Recent Medicare Stay

- **Code the date of last day** of this Medicare stay if A2400A is **coded 1, yes**.

DEFINITIONS

MOST RECENT MEDICARE STAY
This is a Medicare Part A covered stay that has started on or after the most recent admission/entry or reentry to the nursing facility.

MEDICARE-COVERED STAY
Skilled Nursing Facility stays billable to Medicare Part A. Does not include stays billable to Medicare Advantage HMO plans.

CURRENT MEDICARE STAY
NEW ADMISSION: Day 1 of Medicare Part A stay.
READMISSION: Day 1 of Medicare Part A coverage after readmission following a discharge.

A2400: Medicare Stay (cont.)

- If the Medicare Part A stay is ongoing, there will be no end date to report. Enter dashes to indicate that the stay is ongoing.
- The end of Medicare date is coded as follows, whichever occurs first:
  - Date SNF benefit exhausts (i.e., the 100th day of the benefit); or
  - Date of last day covered as recorded on the effective date from the Notice of Medicare Non-Coverage (NOMNC); or
  - The last paid day of Medicare A when payer source changes to another payer (regardless if the resident was moved to another bed or not); or
  - Date the resident was discharged from the facility (see Item A2000, Discharge Date).

Coding Tips and Special Populations

- When a resident on Medicare Part A returns following a therapeutic leave of absence or a hospital observation stay of less than 24 hours (without hospital admission), this is a continuation of the Medicare Part A stay, not a new Medicare Part A stay.
- *When a resident on Medicare Part A has an interrupted stay (i.e., is discharged from SNF care and subsequently readmitted to the same SNF within the interruption window after the discharge), this is a continuation of the Medicare Part A stay, not a new Medicare Part A stay.*
- The End Date of the Most Recent Medicare Stay (A2400C) may be **earlier** than the actual Discharge Date (A2000) from the facility. If this occurs, the Part A PPS Discharge assessment is required. If the resident subsequently physically leaves the facility, the OBRA Discharge assessment would be required.
- If the End Date of Most Recent Medicare Stay (A2400C) **occurs on the day of or one day before** the Discharge Date (A2000), the OBRA Discharge assessment and Part A PPS Discharge assessment are both required and may be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000).
- If the End Date of Most Recent Medicare Stay (A2400C) **occurs on the same day** that the resident dies, a Death in Facility Tracking Record is completed, with the Discharge Date (A2000) equal to the date the resident died. In this case, a Part A PPS Discharge assessment is **not** required.
- For a **standalone** Part A PPS Discharge assessment, the End Date of the Most Recent Medicare Stay (A2400C) must be equal to the ARD (Item A2300).

A2400: Medicare Stay (cont.)

Examples

1. Mrs. G. began receiving services under Medicare Part A on October 14, 2016. Due to her stable condition and ability to manage her medications and dressing changes, the facility determined that she no longer qualified for Part A SNF coverage and began planning her discharge. An Advanced Beneficiary Notice (ABN) and an NOMNC with the last day of coverage as November 23, 2016 were issued. Mrs. G. was discharged home from the facility on November 24, 2016. Code the following on her combined OBRA and Part A PPS Discharge assessment:

   - A0310F = 10
   - A0310G = 1
   - A0310H = 1
   - A2000 = 11-24-2016
   - A2100 = 01
   - A2300 = 11-24-2016
   - A2400A = 1
   - A2400B = 10-14-2016
   - A2400C = 11-23-2016

   Rationale: Because Mrs. G's last day covered under Medicare was one day before her physical discharge from the facility, a combined OBRA and Part A PPS Discharge was completed.

2. Mr. N began receiving services under Medicare Part A on December 11, 201*9*. He was unexpectedly sent to the *emergency department* on December 19, *2019* at 8:30 p.m. and was not admitted to the hospital. He returned to the facility on December 20, *2019*, at 11:00 a.m. *Upon Mr. N's return, his physician's orders included significant changes in his treatment regime. The facility staff determined that an Interim Payment Assessment (IPA) was indicated as the PDPM nursing component was impacted. They completed the IPA with an ARD of December 24, 2019. Code the following on the IPA:*

   - A2400A = 1
   - A2400B = 12-11-*2019*
   - A2400C = ----------

   Rationale: Mr. N was out of the facility at midnight but returned in less than 24 hours and was not admitted to the hospital, so was considered LOA. Therefore, no Discharge assessment was required. His Medicare Part A Stay is considered ongoing; therefore, the date in A2400C is dashed.

A2400: Medicare Stay (cont.)

3. Mr. R. began receiving services under Medicare Part A on October 15, 2016. Due to complications from his recent surgery, he was unexpectedly discharged to the hospital for emergency surgery on October 20, 2016, but is expected to return within 30 days. Code the following on his OBRA Discharge assessment:

   - A0310F = 11
   - A0310G = 2
   - A0310H = 1
   - A2000 = 10-20-2016
   - A2100 = 03
   - A2300 = 10-20-2016
   - A2400A = 1
   - A2400B = 10-15-2016
   - A2400C = 10-20-2016

   Rationale: Mr. R's physical discharge to the hospital was unplanned, yet it is anticipated that he will return to the facility within 30 days. Therefore, only an OBRA Discharge was required. Even though only an OBRA Discharge was required, when the Date of the End of the Medicare Stay is on the day of or one day before the Date of Discharge, MDS specifications require that A0310H be coded as 1.

4. Mrs. K began receiving services under Medicare Part A on October 4, 2016. She was discharged from Medicare Part A services on December 17, 2016. She and her family had already decided that Mrs. K would remain in the facility for long-term care services, and she was moved into a private room (which was dually certified) on December 18, 2016. Code the following on her Part A PPS Discharge assessment:

   - A0310F = 99
   - A0310G = ^
   - A0310H = 1
   - A2000 = ^
   - A2100 = ^
   - A2300 = 12-17-2016
   - A2400A = 1
   - A2400B = 10-04-2016
   - A2400C = 12-17-2016

   Rationale: Because Mrs. K's Medicare Part A stay ended, and she remained in the facility for long-term care services, a **standalone** Part A PPS Discharge was required.

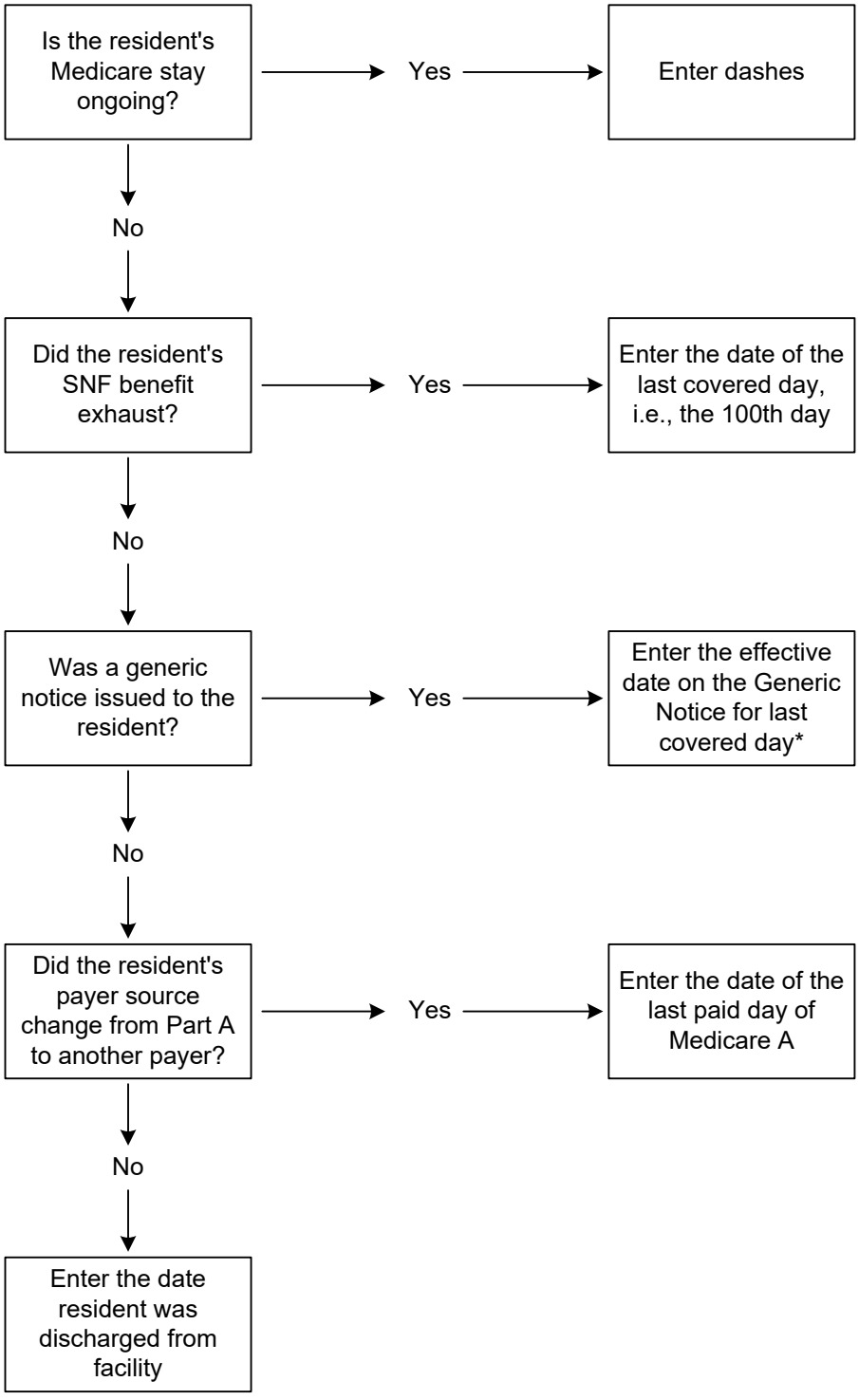
A2400: Medicare Stay (cont.)

5. Mr. W began receiving services under Medicare Part A on November 15, 2016. His Medicare Part A stay ended on November 25, 2016, and he was unexpectedly discharged to the hospital on November 26, 2016. However, he is expected to return to the facility within 30 days. Code the following on his OBRA Discharge assessment:

   - A0310F = 11
   - A0310G = 2
   - A0310H = 1
   - A2000 = 11-26-2016
   - A2100 = 03
   - A2300 = 11-26-2016
   - A2400A = 1
   - A2400B = 11-15-2016
   - A2400C = 11-25-2016

   Rationale: Mr. W's Medicare stay ended the day before discharge and he is expected to return to the facility within 30 days. Because his discharge to the hospital was unplanned, only an OBRA Discharge assessment was required. Even though only an OBRA Discharge was required, when the Date of the End of the Medicare Stay is on the day of or one day before the Date of Discharge, MDS specifications require that A0310H be coded as 1.

Medicare Stay End Date Algorithm
A2400C



*if resident leaves facility prior to last covered day as recorded on the generic notice, enter date resident left facility.

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

- **Code 1, yes:** if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words.

Coding Tips

- Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.
- If the resident needs an interpreter, every effort should be made to have an interpreter present for the BIMS. If it is not possible for a needed interpreter to participate on the day of the interview, code C0100 = 0 to indicate interview not attempted and complete C0700-C1000, **Staff Assessment of Mental Status**, instead of C0200-C0500, **Brief Interview for Mental Status**.
- Includes residents who use American Sign Language (ASL).
- If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item C0100 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items.
- Do not complete the Staff Assessment for Mental Status items (C0700-C1000) if the resident interview should have been conducted, but was not done.
- *Because a PDPM cognitive level is utilized in the speech language pathology (SLP) payment component of PDPM,* ***only*** *in the case of PPS assessments, staff may complete the Staff Assessment for Mental Status for an interviewable resident when the resident is unexpectedly discharged from a Part A stay prior to the completion of the BIMS. In this case, the assessor should enter 0, No in C0100: Should Brief Interview for Mental Status Be Conducted? and proceed to the Staff Assessment for Mental Status.*

C0500: BIMS Summary Score (cont.)

- Abrupt changes in cognitive status (as indicative of a delirium) often signal an underlying potentially life threatening illness and a change in cognition may be the only indication of an underlying problem.
- Care plans can be more individualized based upon reliable knowledge of resident function.

Steps for Assessment

After completing C0200-C0400:

1. Add up the values for all questions from C0200 through C0400.
2. Do not add up the score while you are interviewing the resident. Instead, focus your full attention on the interview.

Coding Instructions

Enter the total score as a two-digit number. The total possible BIMS score ranges from 00 to 15.

- If the resident chooses not to answer a specific question(s), that question is coded as incorrect and the item(s) counts in the total score. If, however, the resident chooses not to answer four or more items, then the interview is coded as incomplete and a staff assessment is completed.
- To be considered a completed interview, the resident had to attempt and provide relevant answers to at least four of the questions included in C0200-C0400. To be relevant, a response only has to be related to the question (logical); it does not have to be correct. See general coding tips *below* for residents who choose not to participate at all.
- **Code 99, unable to complete interview:** if (a) the resident chooses not to participate in the BIMS, (b) if four or more items were coded 0 because the resident chose not to answer or gave a nonsensical response, ***or*** (c) if any of the BIMS items is coded with a dash.
  - Note: a zero score does not mean the BIMS was incomplete. To be incomplete, a resident had to choose not to answer or give completely unrelated, nonsensical responses to four or more items.

Coding Tips

- Occasionally, a resident can communicate but chooses not to participate in the BIMS and therefore does not attempt any of the items in the section. This would be considered an incomplete interview; enter 99 for C0500, **BIMS Summary Score**, and complete the staff assessment of mental status.

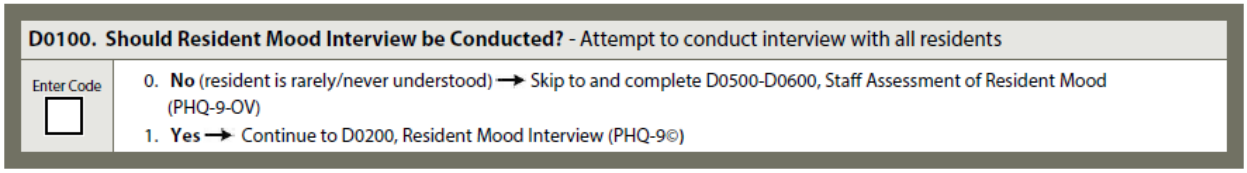
SECTION D: MOOD

Intent: The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable.

It is important to note that coding the presence of indicators in Section D does not automatically mean that the resident has a diagnosis of depression or other mood disorder. Assessors do not make or assign a diagnosis in Section D; they simply record the presence or absence of specific clinical mood indicators. Facility staff should recognize these indicators and consider them when developing the resident's individualized care plan.

- Depression can be associated with:
  - psychological and physical distress (e.g., poor adjustment to the nursing home, loss of independence, chronic illness, increased sensitivity to pain),
  - decreased participation in therapy and activities (e.g., caused by isolation),
  - decreased functional status (e.g., resistance to daily care, decreased desire to participate in activities of daily living [ADLs]), and
  - poorer outcomes (e.g., decreased appetite, decreased cognitive status).
- Findings suggesting mood distress should lead to:
  - identifying causes and contributing factors for symptoms,
  - identifying interventions (treatment, personal support, or environmental modifications) that could address symptoms, and
  - ensuring resident safety.

D0100: Should Resident Mood Interview Be Conducted?



D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
1. **Yes** → Continue to D0200, Resident Mood Interview (PHQ-9©)

Item Rationale

Health-related Quality of Life

- Most residents who are capable of communicating can answer questions about how they feel.
- Obtaining information about mood directly from the resident, sometimes called "hearing the resident's voice," is more reliable and accurate than observation alone for identifying a mood disorder.

D0100: Should Resident Mood Interview Be Conducted? (cont.)

Planning for Care

- Symptom-specific information from direct resident interviews will allow for the incorporation of the resident's voice in the individualized care plan.
- If a resident cannot communicate, then **Staff Mood Interview** (D0500 A-J) should be conducted.

Steps for Assessment

1. Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.
2. Determine whether the resident is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip to D0500, Staff Assessment of Resident Mood (PHQ-9-OV©).
3. Review Language item (A1100) to determine if the resident needs or wants an interpreter to communicate with doctors or health care staff (A1100 = 1).
   - If the resident needs or wants an interpreter, complete the interview with an interpreter.

Coding Instructions

- **Code 0, no:** if the interview should not be conducted because the resident is rarely/never understood or cannot respond verbally, in writing, or using another method, or an interpreter is needed but not available. Skip to item D0500, Staff Assessment of Resident Mood (PHQ-9-OV©).
- **Code 1, yes:** if the resident interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. Continue to item D0200, Resident Mood Interview (PHQ-9©).

Coding Tips and Special Populations

- Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.
- If the resident needs an interpreter, every effort should be made to have an interpreter present for the PHQ-9© interview. If it is not possible for a needed interpreter to be present on the day of the interview, code D0100 = 0 to indicate that an interview was not attempted and complete items D0500-D06*0*0.
- Includes residents who use American Sign Language (ASL).

D0100: Should Resident Mood Interview Be Conducted? (cont.)

- If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item D0100 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items.
- Do not complete the Staff Assessment of Resident Mood items (D0500) if the resident interview should have been conducted, but was not done.

D0200: Resident Mood Interview (PHQ-9©)

D0200. Resident Mood Interview (PHQ-9©)

Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: "*About **how often** have you been bothered by this?*"
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
   9. **No response** (leave column 2 blank)

2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*	☐	☐
B. *Feeling down, depressed, or hopeless*	☐	☐
C. *Trouble falling or staying asleep, or sleeping too much*	☐	☐
D. *Feeling tired or having little energy*	☐	☐
E. *Poor appetite or overeating*	☐	☐
F. *Feeling bad about yourself - or that you are a failure or have let yourself or your family down*	☐	☐
G. *Trouble concentrating on things, such as reading the newspaper or watching television*	☐	☐
H. *Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual*	☐	☐
I. *Thoughts that you would be better off dead, or of hurting yourself in some way*	☐	☐

Item Rationale

Health-related Quality of Life

- Depression can be associated with:
  - — psychological and physical distress,
  - — decreased participation in therapy and activities,
  - — decreased functional status, and
  - — poorer outcomes.

DEFINITION

9-ITEM PATIENT HEALTH QUESTIONNAIRE (PHQ-9©)
A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder.

D0200: Resident Mood Interview (PHQ-9©) (cont.)

- Mood disorders are common in nursing homes and are often underdiagnosed and undertreated.

Planning for Care

- Findings suggesting mood distress could lead to:
  - identifying causes and contributing factors for symptoms and
  - identifying interventions (treatment, personal support, or environmental modifications) that could address symptoms.

Steps for Assessment

Look-back period for this item is 14 days.

1. Conduct the interview preferably the day before or day of the ARD.
2. Interview any resident when D0100 = 1.
3. Conduct the interview in a private setting.
4. If an interpreter is used during resident interviews, the interpreter should not attempt to determine the intent behind what is being translated, the outcome of the interview, or the meaning or significance of the resident's responses. Interpreters are people who translate oral or written language from one language to another.
5. Sit so that the resident can see your face. Minimize glare by directing light sources away from the resident's face.
6. Be sure the resident can hear you.
   - Residents with a hearing impairment should be tested using their usual communication devices/techniques, as applicable.
   - Try an external assistive device (headphones or hearing amplifier) if you have any doubt about hearing ability.
   - Minimize background noise.
7. If you are administering the PHQ-9© in paper form, be sure that the resident can see the print. Provide large print or assistive device (e.g., page magnifier) if necessary.
8. Explain the reason for the interview before beginning.
   Suggested language: "I am going to ask you some questions about your mood and feelings over the past 2 weeks. I will also ask about some common problems that are known to go along with feeling down. Some of the questions might seem personal, but everyone is asked to answer them. This will help us provide you with better care."
9. Explain and /or show the interview response choices. A cue card with the response choices clearly written in large print might help the resident comprehend the response choices.
   Suggested language: "I am going to ask you how often you have been bothered by a particular problem over the last 2 weeks. I will give you the choices that you see on this card." (Say while pointing to cue card): "0-1 days—never or 1 day, 2-6 days—several days, 7-11 days—half or more of the days, or 12-14 days—nearly every day."
10. Interview the resident.
    Suggested language: "Over the last 2 weeks, have you been bothered by any of the following problems?"

D0200: Resident Mood Interview (PHQ-9©) (cont.)

Then, for each question in **Resident Mood Interview** (D0200):

- Read the item as it is written.
- Do not provide definitions because the meaning **must be** based on the resident's interpretation. For example, the resident defines for himself what "tired" means; the item should be scored based on the resident's interpretation.
- Each question **must be** asked in sequence to assess presence (column 1) and frequency (column 2) before proceeding to the next question.
- Enter code 9 for any response that is unrelated, incomprehensible, or incoherent or if the resident's response is not informative with respect to the item being rated; this is considered a **nonsensical** response (e.g., when asked the question about "poor appetite or overeating," the resident answers, "I always win at poker.").
- For a **yes** response, ask the resident to tell you how often he or she was bothered by the symptom over the last 14 days. Use the response choices in D0200 Column 2, **Symptom Frequency**. Start by asking the resident the number of days that he or she was bothered by the symptom and read and show cue card with frequency categories/descriptions (0-1 days—never or 1 day, 2-6 days—several days, 7-11 days—half or more of the days, or 12-14 days—nearly every day).

Coding Instructions for Column 1. Symptom Presence

- **Code 0, no:** if resident indicates symptoms listed are not present enter 0. Enter 0 in Column 2 as well.
- **Code 1, yes:** if resident indicates symptoms listed are present enter 1. Enter 0, 1, 2, or 3 in Column 2, Symptom Frequency.
- **Code 9, no response:** if the resident was unable or chose not to complete the assessment, responded nonsensically and/or the facility was unable to complete the assessment. Leave Column 2, Symptom Frequency, blank.

Coding Instructions for Column 2. Symptom Frequency

Record the resident's responses as they are stated, regardless of whether the resident or the assessor attributes the symptom to something other than mood. Further evaluation of the clinical relevance of reported symptoms should be explored by the responsible clinician.

- **Code 0, never or 1 day:** if the resident indicates that he or she has never or has only experienced the symptom on 1 day.
- **Code 1, 2-6 days (several days):** if the resident indicates that he or she has experienced the symptom for 2-6 days.
- **Code 2, 7-11 days (half or more of the days):** if the resident indicates that he or she has experienced the symptom for 7-11 days.
- **Code 3, 12-14 days (nearly every day):** if the resident indicates that he or she has experienced the symptom for 12-14 days.

D0200: Resident Mood Interview (PHQ-9©) (cont.)

Coding Tips and Special Populations

- For question D0200I, Thoughts That You Would Be Better Off Dead or of Hurting Yourself in Some Way:
  - Beginning interviewers may feel uncomfortable asking this item because they may fear upsetting the resident or may feel that the question is too personal. Others may worry that it will give the resident inappropriate ideas. However,
    - Experienced interviewers have found that most residents who are having this feeling appreciate the opportunity to express it.
    - Asking about thoughts of self-harm does not give the person the idea. It does let the provider better understand what the resident is already feeling.
    - The best interviewing approach is to ask the question openly and without hesitation.
- If the resident uses his or her own words to describe a symptom, this should be briefly explored. If you determine that the resident is reporting the intended symptom but using his or her own words, ask him to tell you how often he or she was bothered by that symptom.
- Select only one frequency response per item.
- If the resident has difficulty selecting between two frequency responses, code for the higher frequency.
- Some items (e.g., item F) contain more than one phrase. If a resident gives different frequencies for the different parts of a single item, select the highest frequency as the score for that item.
- Residents may respond to questions:
  - verbally,
  - by pointing to their answers on the cue card, OR
  - by writing out their answers.

Interviewing Tips and Techniques

- Repeat a question if you think that it has been misunderstood or misinterpreted.
- Some residents may be eager to talk with you and will stray from the topic at hand. When a person strays, you should gently guide the conversation back to the topic.
  - **Example:** Say, "That's interesting, now I need to know…"; "Let's get back to…"; "I understand, can you tell me about…."
    - Validate your understanding of what the resident is saying by asking for clarification.
  - **Example:** Say, "I think I hear you saying that…"; "Let's see if I understood you correctly."; "You said…. Is that right?"

D0200: Resident Mood Interview (PHQ-9©) (cont.)

- If the resident has difficulty selecting a frequency response, start by offering a single frequency response and follow with a sequence of more specific questions. This is known as unfolding.
  - **Example:** Say, "Would you say [name symptom] bothered you more than half the days in the past 2 weeks?"
    - If the resident says "yes," show the cue card and ask whether it bothered him or her nearly every day (12-14 days) or on half or more of the days (7-11 days).
    - If the resident says "no," show the cue card and ask whether it bothered him or her several days (2-6 days) or never or 1 day (0-1 day).
- Noncommittal responses such as "not really" should be explored. Residents may be reluctant to report symptoms and should be gently encouraged to tell you if the symptom bothered him or her, even if it was only some of the time. This is known as probing. Probe by asking neutral or nondirective questions such as:
  - "What do you mean?"
  - "Tell me what you have in mind."
  - "Tell me more about that."
  - "Please be more specific."
  - "Give me an example."
- Sometimes respondents give a long answer to interview items. To narrow the answer to the response choices available, it can be useful to summarize their longer answer and then ask them which response option best applies. This is known as echoing.
  - **Example:** Item D0200E, **Poor Appetite or Overeating**. The resident responds "the food is always cold and it just doesn't taste like it does at home. The doctor won't let me have any salt."
    - Possible interviewer response: "You're telling me the food isn't what you eat at home and you can't add salt. How often would you say that you were bothered by poor appetite or over-eating during the last 2 weeks?"
  - **Example:** Item D0200A, **Little Interest or Pleasure in Doing Things**. The resident, when asked how often he or she has been bothered by little interest or pleasure in doing things, responds, "There's nothing to do here, all you do is eat, bathe, and sleep. They don't do anything I like to do."
    - Possible interview response: "You're saying there isn't much to do here and I want to come back later to talk about some things you like to do. Thinking about how you've been feeling over the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things."
  - **Example:** Item D0200B, **Feeling Down, Depressed, or Hopeless**. The resident, when asked how often he or she has been bothered by feeling down, depressed, or hopeless, responds: "How would you feel if you were here?"
    - Possible interview response: "You asked how I would feel, but it is important that I understand **your** feelings right now. How often would you say that you have been bothered by feeling down, depressed, or hopeless during the last 2 weeks?"

D0200: Resident Mood Interview (PHQ-9©) (cont.)

- If the resident has difficulty with longer items, separate the item into shorter parts, and provide a chance to respond after each part. This method, known as disentangling, is helpful if a resident has moderate cognitive impairment but can respond to simple, direct questions.
  - **Example:** Item D0200E, Poor Appetite or Overeating.
    - You can simplify this item by asking: "In the last 2 weeks, how often have you been bothered by poor appetite?" (pause for a response) "Or overeating?"
  - **Example:** Item D0200C, Trouble Falling or Staying Asleep, or Sleeping Too Much.
    - You can break the item down as follows: "How often are you having problems falling asleep?" (pause for response) "How often are you having problems staying asleep?" (pause for response) "How often do you feel you are sleeping too much?"
  - **Example:** Item D0200H, Moving or Speaking So Slowly That Other People Could Have Noticed. Or the Opposite—Being So Fidgety or Restless That You Have Been Moving Around a Lot More than Usual.
    - You can simplify this item by asking: "How often are you having problems with moving or speaking so slowly that other people could have noticed?" (pause for response) "How often have you felt so fidgety or restless that you move around a lot more than usual?"

D0300: Total Severity Score

D0300. Total Severity Score	
Enter Score ☐☐	**Add scores for all frequency responses in Column 2,** Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).

Item Rationale

Health-related Quality of Life

- The score does not diagnose a mood disorder or depression but provides a standard score which can be communicated to the resident's physician, other clinicians and mental health specialists for appropriate follow up.
- The **Total Severity Score** is a summary of the frequency scores on the PHQ-9© that indicates the extent of potential depression symptoms and can be useful for knowing when to request additional assessment by providers or mental health specialists.

DEFINITION

TOTAL SEVERITY SCORE
A summary of the frequency scores that indicates the extent of potential depression symptoms. The score does not diagnose a mood disorder, but provides a standard of communication with clinicians and mental health specialists.

Planning for Care

- The PHQ-9© **Total Severity Score** also provides a way for health care providers and clinicians to easily identify and track symptoms and how they are changing over time.

Steps for Assessment

After completing D0200 A-I:

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

Coding Instructions

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

Coding Tips and Special Populations

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

    1-4: minimal depression
    5-9: mild depression
    10-14: moderate depression
    15-19: moderately severe depression
    20-27: severe depression

D0500: Staff Assessment of Resident Mood (PHQ-9-OV©)

D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)
Do not conduct if Resident Mood Interview (D0200-D0300) was completed

Over the last 2 weeks, did the resident have any of the following problems or behaviors?

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)

2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things	☐	☐
B. Feeling or appearing down, depressed, or hopeless	☐	☐
C. Trouble falling or staying asleep, or sleeping too much	☐	☐
D. Feeling tired or having little energy	☐	☐
E. Poor appetite or overeating	☐	☐
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down	☐	☐
G. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual	☐	☐
I. States that life isn't worth living, wishes for death, or attempts to harm self	☐	☐
J. Being short-tempered, easily annoyed	☐	☐

Item Rationale

Health-related Quality of Life

- PHQ-9© **Resident Mood Interview** is preferred as it improves the detection of a possible mood disorder. However, a small percentage of patients are unable or unwilling to complete the PHQ-9© **Resident Mood Interview**. Therefore, staff should complete the PHQ-9© *Observational Version (PHQ-9-OV©)* **Staff Assessment of Mood** in these instances so that any behaviors, signs, or symptoms of mood distress are identified.
- Persons unable to complete the PHQ-9© **Resident Mood Interview** may still have a mood disorder.
- Even if a resident was unable to complete the **Resident Mood Interview**, important insights may be gained from the responses that were obtained during the interview, as well as observations of the resident's behaviors and affect during the interview.
- The identification of symptom presence and frequency as well as staff observations are important in the detection of mood distress, as they may inform need for and type of treatment.
- It is important to note that coding the presence of indicators in Section D does not automatically mean that the resident has a diagnosis of depression or other mood disorder. Assessors do not make or assign a diagnosis in Section D; they simply record the presence or absence of specific clinical mood indicators.

D0500: Staff Assessment of Resident Mood (PHQ-9-OV©) (cont.)

- Alternate means of assessing mood must be used for residents who cannot communicate or refuse or are unable to participate in the PHQ-9© **Resident Mood Interview**. This ensures that information about their mood is not overlooked.

Planning for Care

- When the resident is not able to complete the PHQ-9©, scripted interviews with staff who know the resident well should provide critical information for understanding mood and making care planning decisions.

Steps for Assessment

Look-back period for this item is 14 days.

1. Interview staff from all shifts who know the resident best. Conduct interview in a location that protects resident privacy.
2. The same administration techniques outlined above for the PHQ-9© **Resident Mood Interview** (pages D-4–D-6) and Interviewing Tips & Techniques (pages D-6–D-8) should also be followed when staff are interviewed.
3. Encourage staff to report symptom frequency, even if the staff believes the symptom to be unrelated to depression.
4. Explore unclear responses, focusing the discussion on the specific symptom listed on the assessment rather than expanding into a lengthy clinical evaluation.
5. If frequency cannot be coded because the resident has been in the facility for less than 14 days, talk to family or significant other and review transfer records to inform the selection of a frequency code.

Examples of Staff Responses That Indicate Need for Follow-up Questioning with the Staff Member

1. **D0500A, Little Interest or Pleasure in Doing Things**
   - The resident doesn't really do much here.
   - The resident spends most of the time in his or her room.
2. **D0500B, Feeling or Appearing Down, Depressed, or Hopeless**
   - She's 95—what can you expect?
   - How would you feel if you were here?
3. **D0500C, Trouble Falling or Staying Asleep, or Sleeping Too Much**
   - Her back hurts when she lies down.
   - He urinates a lot during the night.
4. **D0500D, Feeling Tired or Having Little Energy**
   - She's 95—she's always saying she's tired.
   - He's having a bad spell with his COPD right now.

D0500: Staff Assessment of Resident Mood (PHQ-9-OV©) (cont.)

5. **D0500E, Poor Appetite or Overeating**
   - She has not wanted to eat much of anything lately.
   - He has a voracious appetite, more so than last week.
6. **D0500F, Indicating That S/he Feels Bad about Self, Is a Failure, or Has Let Self or Family Down**
   - She does get upset when there's something she can't do now because of her stroke.
   - He gets embarrassed when he can't remember something he thinks he should be able to.
7. **D0500G, Trouble Concentrating on Things, Such as Reading the Newspaper or Watching Television**
   - She says there's nothing good on TV.
   - She never watches TV.
   - He can't see to read a newspaper.
8. **D0500H, Moving or Speaking So Slowly That Other People Have Noticed. Or the Opposite— Being So Fidgety or Restless That S/he Has Been Moving Around a Lot More than Usual**
   - His arthritis slows him down.
   - He's bored and always looking for something to do.
9. **D0500I, States That Life Isn't Worth Living, Wishes for Death, or Attempts to Harm Self**
   - She says God should take her already.
   - He complains that man was not meant to live like this.
10. **D0500J, Being Short-Tempered, Easily Annoyed**
    - She's OK if you know how to approach her.
    - He can snap but usually when his pain is bad.
    - Not with me.
    - He's irritable.

Coding Instructions for Column 1. Symptom Presence

- **Code 0, no:** if symptoms listed are not present. Enter 0 in Column 2, **Symptom Frequency**.
- **Code 1, yes:** if symptoms listed are present. Enter 0, 1, 2, or 3 in Column 2, **Symptom Frequency**.

D0500: Staff Assessment of Resident Mood (PHQ-9-OV©) (cont.)

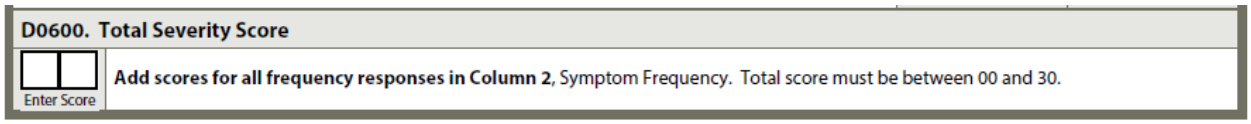
Coding Instructions for Column 2. Symptom Frequency

- **Code 0, never or 1 day:** if staff indicate that the resident has never or has experienced the symptom on only 1 day.
- **Code 1, 2-6 days (several days):** if staff indicate that the resident has experienced the symptom for 2-6 days.
- **Code 2, 7-11 days (half or more of the days):** if staff indicate that the resident has experienced the symptom for 7-11 days.
- **Code 3, 12-14 days (nearly every day):** if staff indicate that the resident has experienced the symptom for 12-14 days.

Coding Tips and Special Populations

- Ask the staff member being interviewed to select how often over the past 2 weeks the symptom occurred. Use the descriptive and/or numeric categories on the form (e.g., "nearly every day" or 3 = 12-14 days) to select a frequency response.
- If you separated a longer item into its component parts, select the **highest** frequency rating that is reported.
- If the staff member has difficulty selecting between two frequency responses, code for the **higher** frequency.
- If the resident has been in the facility for less than 14 days, also talk to the family or significant other and review transfer records to inform selection of the frequency code.

D0600: Total Severity Score



Item Rationale

Health-related Quality of Life

- Review Item Rationale for D0300, **Total Severity Score** (page D-8).
- The PHQ-9-OV© is adapted to allow the assessor to interview staff and identify a **Total Severity Score** for potential depressive symptoms.

Planning for Care

- The score can be communicated among health care providers and used to track symptoms and how they are changing over time.
- The score is useful for knowing when to request additional assessment by providers or mental health specialists for underlying depression.

D0600: Total Severity Score (cont.)

Steps for Assessment

After completing items D0500 A-J:

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

Coding Instructions

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

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

Coding Tips and Special Populations

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

    1-4: minimal depression

    5-9: mild depression

    10-14: moderate depression

    15-19: moderately severe depression

    20-30: severe depression

SECTION GG: FUNCTIONAL ABILITIES AND GOALS

Intent: This section includes items about functional abilities and goals. It includes items focused on prior function, admission performance, discharge goals, and discharge performance. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.

GG0100. Prior Functioning: Everyday Activities

GG0100. Prior Functioning: Everyday Activities. Indicate the resident's usual ability with everyday activities prior to the current illness, exacerbation, or injury
Complete only if A0310B = 01

Coding:
3. **Independent** - Resident completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
2. **Needed Some Help** - Resident needed partial assistance from another person to complete activities.
1. **Dependent** - A helper completed the activities for the resident.
8. **Unknown.**
9. **Not Applicable.**

↓ Enter Codes in Boxes	
☐	**A. Self-Care:** Code the resident's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.
☐	**B. Indoor Mobility (Ambulation):** Code the resident's need for assistance with walking from room to room (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
☐	**C. Stairs:** Code the resident's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation, or injury.
☐	**D. Functional Cognition:** Code the resident's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

Item Rationale

- Knowledge of the resident's functioning prior to the current illness, exacerbation, or injury may inform treatment goals.

Steps for Assessment

1. Ask the resident or his or her family about, or review the resident's medical records describing, the resident's prior functioning with everyday activities.

Coding Instructions

- **Code 3, Independent:** if the resident completed the activities by himself or herself, with or without an assistive device, with no assistance from a helper.
- **Code 2, Needed Some Help:** if the resident needed partial assistance from another person to complete the activities.
- **Code 1, Dependent:** if the helper completed the activities for the resident, or the assistance of two or more helpers was required for the resident to complete the activities.
- **Code 8, Unknown:** if the resident's usual ability prior to the current illness, exacerbation, or injury is unknown.
- **Code 9, Not Applicable:** if the activities were not applicable to the resident prior to the current illness, exacerbation, or injury.

GG0100. Prior Functioning: Everyday Activities (cont.)

Coding Tips

- Record the resident's usual ability to perform self-care, indoor mobility (ambulation), stairs, and functional cognition prior to the current illness, exacerbation, or injury.
- If no information about the resident's ability is available after attempts to interview the resident or his or her family and after reviewing the resident's medical record, code as 8, Unknown.

Examples for Coding Prior Functioning: Everyday Activities

1. **Self-Care:** Ms. R was admitted to an acute care facility after sustaining a right hip fracture and subsequently admitted to the SNF for rehabilitation. Prior to the hip fracture, Ms. R was independent in eating, bathing, dressing, and using the toilet. Ms. R used a raised toilet seat because of arthritis in both knee joints. Both she and her family indicated that there were no safety concerns when she performed these everyday activities in her home.

   Coding: GG0100A would be coded 3, Independent.

   Rationale: Prior to her hip fracture, the resident completed the self-care tasks of eating, bathing, dressing, and using the toilet safely without any assistance from a helper. The resident may use an assistive device, such as a raised toilet seat, and still be coded as independent.

2. **Self-Care:** Mr. T was admitted to an acute care facility after sustaining a stroke and subsequently admitted to the SNF for rehabilitation. Prior to the stroke, Mr. T was independent in eating and using the toilet; however, Mr. T required assistance for bathing and putting on and taking off his shoes and socks. The assistance needed was due to severe arthritic lumbar pain upon bending, which limited his ability to access his feet.

   Coding: GG0100A would be coded 2, Needed Some Help.

   Rationale: Mr. T needed partial assistance from a helper to complete the activities of bathing and dressing. While Mr. T did not need help for all self-care activities, he did need some help. Code 2 is used to indicate that Mr. T needed some help for self-care.

3. **Self-Care:** Mr. R was diagnosed with a progressive neurologic condition five years ago. He lives in a long-term nursing facility and was recently hospitalized for surgery and has now been admitted to the SNF for skilled services. According to Mr. R's wife, prior to the surgery, Mr. R required complete assistance with self-care activities, including eating, bathing, dressing, and using the toilet.

   Coding: GG0100A would be coded 1, Dependent.

   Rationale: Mr. R's wife has reported that Mr. R was completely dependent in self-care activities that included eating, bathing, dressing, and using the toilet. Code 1, Dependent, is appropriate based upon this information.

GG0100. Prior Functioning: Everyday Activities (cont.)

4. **Self-Care:** Mr. F was admitted with a diagnosis of stroke and a severe communication disorder and is unable to communicate with staff using alternative communication devices. Mr. F had been living alone prior to admission. The staff has not been successful in contacting either Mr. F's family or his friends. Mr. F's prior self-care abilities are unknown.

   Coding: GG0100A would be coded 8, Unknown.
   Rationale: Attempts to seek information regarding Mr. F's prior functioning were made; however, no information was available. This item is coded 8, Unknown.

5. **Indoor Mobility (Ambulation):** Mr. C was admitted to an acute care hospital after experiencing a stroke. Prior to admission, he used a cane to walk from room to room. In the morning, Mr. C' s wife would provide steadying assistance to Mr. C when he walked from room to room because of joint stiffness and severe arthritis pain. Occasionally, Mr. C required steadying assistance during the day when walking from room to room.

   Coding: GG0100B would be coded 2, Needed Some Help.
   Rationale: The resident needed some assistance (steadying assistance) from his wife to complete the activity of walking in the home.

6. **Indoor Mobility (Ambulation):** Approximately three months ago, Mr. K had a cardiac event that resulted in anoxia, and subsequently a swallowing disorder. Mr. K has been living at home with his wife and developed aspiration pneumonia. After this most recent hospitalization, he was admitted to the SNF for *a diagnosis of* aspiration pneumonia and severe deconditioning. Prior to the most recent acute care hospitalization, Mr. K needed some assistance when walking.

   Coding: GG0100B would be coded 2, Needed Some Help.
   Rationale: While the resident experienced a cardiac event three months ago, he recently had an exacerbation of a prior condition that required care in an acute care hospital and skilled nursing facility. The resident's prior functioning is based on the time immediately before his most recent condition exacerbation that required acute care.

7. **Indoor Mobility (Ambulation):** Mrs. L had a stroke one year ago that resulted in her using a wheelchair to self-mobilize, as she was unable to walk. Mrs. L subsequently had a second stroke and was transferred from an acute care unit to the SNF for skilled services.

   Coding: GG0100B would be coded 9, Not Applicable.
   Rationale: The resident did not ambulate immediately prior to the current illness, injury, or exacerbation (the second stroke).

GG0100. Prior Functioning: Everyday Activities (cont.)

8. **Stairs:** Prior to admission to the hospital for bilateral knee surgery, followed by his recent admission to the SNF for rehabilitation, Mr. V experienced severe knee pain upon ascending and particularly descending his internal and external stairs at home. Mr. V required assistance from his wife when using the stairs to steady him in the event his left knee would buckle. Mr. V's wife was interviewed about her husband's functioning prior to admission, and the therapist noted Mr. V's prior functional level information in his medical record.

   Coding: GG0100C would be coded 2, Needed Some Help.
   Rationale: Prior to admission, Mr. V required some help in order to manage internal and external stairs.

9. **Stairs:** Mrs. E lived alone prior to her hospitalization for sepsis and has early stage multiple sclerosis. She has now been admitted to a SNF for rehabilitation as a result of deconditioning. Mrs. E reports that she used a straight cane to ascend and descend her indoor stairs at home and small staircases within her community. Mrs. E reports that she did not require any human assistance with the activity of using stairs prior to her admission.

   Coding: GG0100C would be coded 3, Independent.
   Rationale: Mrs. E reported that prior to admission, she was independent in using her internal stairs and the use of small staircases in her community.

10. **Stairs:** Mr. P has expressive aphasia and difficulty communicating. SNF staff have not received any response to their phone messages to Mr. P's family members requesting a return call. Mr. P has not received any visitors since his admission. The medical record from his prior facility does not indicate Mr. P's prior functioning. There is no information to code item GG0100C, but there have been attempts at seeking this information.

    Coding: GG0100C would be coded 8, Unknown.
    Rationale: Attempts were made to seek information regarding Mr. P's prior functioning; however, no information was available.

11. **Functional Cognition:** Mr. K has mild dementia and recently sustained a fall resulting in complex multiple fractures requiring multiple surgeries. Mr. K has been admitted to the SNF for rehabilitation. Mr. K's caregiver reports that when living at home, Mr. K needed reminders to take his medications on time, manage his money, and plan tasks, especially when he was fatigued.

    Coding: GG0100D would be coded 2, Needed Some Help.
    Rationale: Mr. K required some help to recall, perform, and plan regular daily activities as a result of cognitive impairment.

GG0100. Prior Functioning: Everyday Activities (cont.)

12. **Functional Cognition:** Ms. L recently sustained a brain injury from a fall at home. Prior to her recent hospitalization, she had been living in an apartment by herself. Ms. L's cognition is currently impaired. Ms. L's cousin, who had visited her frequently prior to her recent hospitalization, indicated that Ms. L did not require any help with taking her prescribed medications, planning her daily activities, and managing money when shopping.

    Coding: GG0100D would be coded 3, Independent.

    Rationale: Ms. L's cousin, who frequently visited Ms. L prior to her sustaining a brain injury, reported that Ms. L was independent in taking her prescribed medications, planning her daily activities, and managing money when shopping, indicating her independence in using memory and problem-solving skills.

13. **Functional Cognition:** Mrs. R had a stroke, resulting in a severe communication disorder. Her family members have not returned phone calls requesting information about Mrs. R's prior functional status, and her medical records do not include information about her functional cognition prior to the stroke.

    Coding: GG0100D would be coded 8, Unknown.

    Rationale: Attempts to seek information regarding Mrs. R's prior functioning were made; however, no information was available.

GG0110. Prior Device Use

GG0110. Prior Device Use. Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury Complete only if A0310B = 01	
↓	**Check all that apply**
☐	**A. Manual wheelchair**
☐	**B. Motorized wheelchair and/or scooter**
☐	**C. Mechanical lift**
☐	**D. Walker**
☐	**E. Orthotics/Prosthetics**
☐	**Z. None of the above**

Item Rationale

- Knowledge of the resident's routine use of devices and aids immediately prior to the current illness, exacerbation, or injury may inform treatment goals.

Steps for Assessment

1. Ask the resident or his or her family or review the resident's medical records to determine the resident's use of prior devices and aids.

GG0110. Prior Device Use (cont.)

Coding Instructions

- Check all devices that apply.
- **Check Z, None of the above:** if the resident did not use any of the listed devices or aids immediately prior to the current illness, exacerbation, or injury.

Coding Tips

- For GG0110D, Prior Device Use - Walker: "Walker" refers to all types of walkers (for example, pickup walkers, hemi-walkers, rolling walkers, and platform walkers).
- GG0110C, Mechanical lift, includes sit-to-stand, stand assist, *stair lift,* and full-body-style lifts.

Example for Coding Prior Device Use

1. Mrs. M is a bilateral lower extremity amputee and has multiple diagnoses, including diabetes, obesity, and peripheral vascular disease. She is unable to walk and did not walk prior to the current episode of care, which started because of a pressure ulcer and respiratory infection. She uses a motorized wheelchair to mobilize.

   Coding: GG0110B would be checked.
   Rationale: Mrs. M used a motorized wheelchair prior to the current illness/injury.

GG0130: Self-Care (3-day assessment period)
Admission (Start of Medicare Part A Stay)

GG0130. Self-Care (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:

Safety and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
☐☐	☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	☐☐	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	☐☐	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	☐☐	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	☐☐	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

GG0130: Self-Care (3-day assessment period)
Interim Performance (Interim Payment Assessment - Optional)

GG0130. Self-Care (Assessment period is the last 3 days)

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.

Coding:

Safety and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

5. Interim Performance **Enter Codes in Boxes** ↓	
☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

GG0130: Self-Care (3-day assessment period) Discharge (End of Medicare Part A Stay)

GG0130. Self-Care (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance Enter Codes in Boxes ↓	
☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
☐☐	**B. Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.
☐☐	**C. Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
☐☐	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
☐☐	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

Item Rationale

- During a Medicare Part A SNF stay, residents may have self-care limitations on admission. In addition, residents may be at risk of further functional decline during their stay in the SNF.

GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Steps for Assessment

1. Assess the resident's self-care performance based on direct observation, *incorporating* resident self-report*s* and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the three-day assessment period. CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period. For Section GG, the admission assessment period is the first three days of the Part A stay starting with the date in A2400B, the Start of Most Recent Medicare Stay. On admission, these items are completed only when A0310B = 01 (5-Day PPS assessment). *For the Interim Payment Assessment (A0310B=08), the assessment period for Section GG is the last 3 days (i.e., the ARD and two days prior).*
2. Residents should be allowed to perform activities as independently as possible, as long as they are safe.
3. For the purposes of completing Section GG, a "helper" is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). Thus, "helper" does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration such as hospice staff, nursing/certified nursing assistant students, etc. Therefore, when helper assistance is required because a resident's performance is unsafe or of poor quality, consider only facility staff when scoring according to the amount of assistance provided.
4. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
5. The admission functional assessment, when possible, should be conducted prior to the *resident* benefitting from treatment interventions in order to *reflect the resident's* true *admission* baseline functional status. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.
6. Refer to facility, Federal, and State policies and procedures to determine which staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.

DEFINITION

USUAL PERFORMANCE

A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance.

QUALIFIED CLINICIAN

Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.

GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

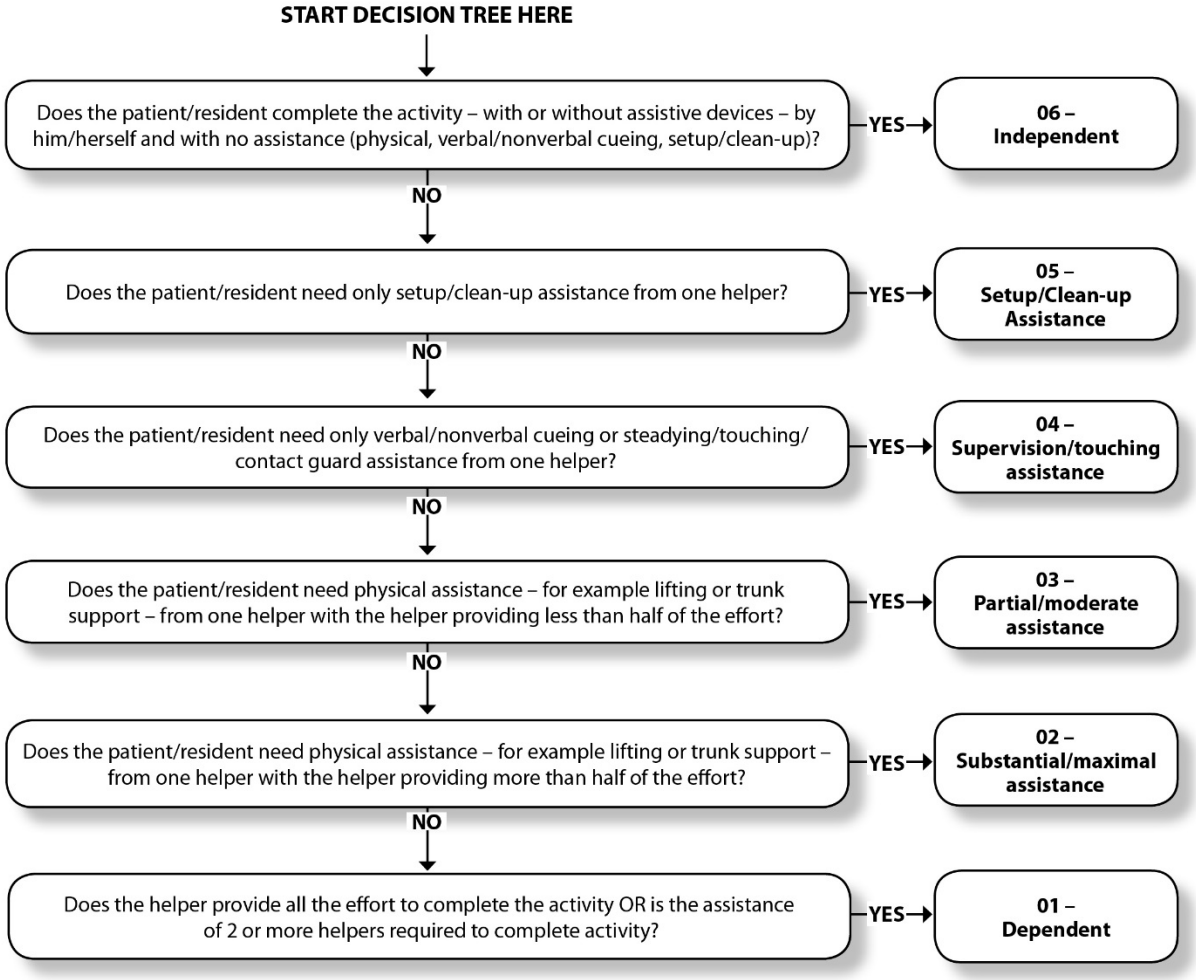
Admission*, Interim,* or Discharge Performance Coding Instructions

- When coding the resident's usual performance and discharge goal(s), use the six-point scale, or use one of the four "activity was not attempted" codes to specify the reason why an activity was not attempted.
- **Code 06, Independent:** if the resident completes the activity by him/herself with no assistance from a helper.
- **Code 05, Setup or clean-up assistance:** if the helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires assistance cutting up food or opening container, or requires setup of hygiene item(s) or assistive device(s).
- **Code 04, Supervision or touching assistance:** if the helper provides verbal cues or touching/steadying*/contact guard* assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete activity; or resident may require only incidental help such as contact guard or steadying assist during the activity.
- **Code 03, Partial/moderate assistance:** if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- **Code 02, Substantial/maximal assistance:** if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- **Code 01, Dependent:** if the helper does ALL of the effort. Resident does none of the effort to complete the activity; or the assistance of two or more helpers is required for the resident to complete the activity.
- **Code 07, Resident refused:** if the resident refused to complete the activity.
- **Code 09, Not applicable:** if the activity was not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- **Code 10, Not attempted due to environmental limitations:** if the resident did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.
- **Code 88, Not attempted due to medical condition or safety concerns:** if the activity was not attempted due to medical condition or safety concerns.

GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Decision Tree

Use this decision tree to code the resident's performance on the assessment instrument. If helper assistance is required because the resident's performance is unsafe or of poor quality, score according to the amount of assistance provided. Only use the "activity not attempted codes" if the activity did not occur; that is, the resident did not perform the activity and a helper did not perform that activity for the resident.



GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Assessment Period

- **Admission:** The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay.
  - For the 5-Day PPS assessment, code the resident's functional status based on a clinical assessment of the resident's performance that occurs soon after the resident's admission. This functional assessment must be completed within the first three days (3 calendar days) of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, and the following two days, ending at 11:59 PM on day 3. The admission function scores are to reflect the resident's admission baseline status and are to be based on an assessment. The scores should reflect the resident's status prior to any benefit from interventions. The assessment should occur, when possible, prior to the resident benefitting from treatment interventions in order to determine the resident's true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.
- ***Interim Performance (Optional):*** *The Interim Payment Assessment (IPA) is an optional assessment that may be completed by providers in order to report a change in the resident's PDPM classification. For Section GG on the IPA, providers will use the same 6-point scale and activity not attempted codes to complete the column "Interim Performance," which will capture the interim functional performance of the resident. The ARD for the IPA is determined by the provider, and the assessment period is the last 3 days (i.e., the ARD and the 2 calendar days prior). It is important to note that the IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed. The IPA does not affect the variable per diem schedule.*
- **Discharge:** The Part A PPS Discharge assessment is required to be completed when the resident's Medicare Part A Stay ends (as documented in A2400C, End of Most Recent Medicare Stay), either as a standalone assessment when the resident's Medicare Part A stay ends, but the resident remains in the facility; or may be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or one day before the resident's Discharge Date (A2000). Please see Chapter 2 and Section A of the RAI Manual for additional details regarding the Part A PPS Discharge assessment.
  - For the Discharge assessment (i.e., standalone Part A PPS or combined OBRA/Part A PPS), code the resident's discharge functional status, based on a clinical assessment of the resident's performance that occurs as close to the time of the resident's discharge from Medicare Part A as possible. This functional assessment must be completed within the last three calendar days of the resident's Medicare Part A stay, which includes the day of discharge from Medicare Part A and the two days prior to the day of discharge from Medicare Part A.

GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Coding Tips: Admission*, Interim,* or Discharge Performance

General Coding Tips

- When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity (e.g., eating, oral hygiene). For example, when assessing Eating (item GG0130A), determine the type and amount of assistance required to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
- Residents with cognitive impairments/limitations may need physical and/or verbal assistance when completing an activity. Code based on the resident's need for assistance to perform the activity safely (for example, choking risk due to rate of eating, amount of food placed into mouth, risk of falling).
- If the resident does not attempt the activity and a helper does not complete the activity for the resident during the entire assessment period, code the reason the activity was not attempted. For example, code as 07 if the resident refused to attempt the activity; code as 09 if the activity is not applicable for the resident (the activity did not occur at the time of the assessment and prior to the current illness, injury, or exacerbation); code as 10 if the resident was not able to attempt the activity due to environmental limitations; or code as 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.
- An activity can be completed independently with or without devices. If the resident uses adaptive equipment and uses the device independently when performing an activity, enter code 06, Independent.
- If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent.
- To clarify your own understanding of the resident's performance of an activity, ask probing questions to the care staff about the resident, beginning with the general and proceeding to the more specific. See examples of probing questions at the end of this section.
- A dash ("-") indicates "No information." CMS expects dash use to be a rare occurrence.
- Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident's medical record. This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with State and Federal regulations.

GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Tips for Coding the Resident's Usual Performance

- When coding the resident's usual performance, "effort" refers to the type and amount of assistance a helper provides in order for the activity to be completed. The six-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.
- Do not record the resident's best performance, and do not record the resident's worst performance, but rather record the resident's usual performance during the assessment period.
- Code based on the resident's performance. Do not record the staff's assessment of the resident's potential capability to perform the activity.
- If the resident performs the activity more than once during the assessment period and the resident's performance varies, coding in Section GG should be based on the resident's "usual performance," which is identified as the resident's usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the resident's Self-Care performance varies during the assessment period, report the resident's usual performance, not the resident's most independent performance and not the resident's most dependent performance. A provider may need to use the entire three-day assessment period to obtain the resident's usual performance.

Coding Tips for GG0130A, Eating

- *GG0130A, Eating involves bringing food and liquids to the mouth and swallowing food. The administration of tube feedings and parenteral nutrition is not considered when coding this activity. The following is guidance for some situations in which a resident receives tube feedings or parenteral nutrition*:
  - If the resident does not eat or drink by mouth and relies **solely** on nutrition and liquids through tube feedings or *total parenteral nutrition (*TPN*)* because of a **new (recent-onset) medical condition,** code GG0130A as 88, Not attempted due to medical condition or safety concerns. Assistance with tube feedings or TPN is not considered when coding Eating.
  - If the resident does not eat or drink by mouth at the time of the assessment, and the resident did not eat or drink by mouth **prior to the current** illness, injury, or exacerbation, code GG0130A as 09, Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. Assistance with tube feedings or *parenteral nutrition* is not considered when coding Eating.
  - If the resident eats and drinks by mouth, and relies **partially** on obtaining nutrition and liquids via tube feedings or *parenteral nutrition*, code Eating based on the amount of assistance the resident requires to eat and drink by mouth. Assistance with tube feedings or *parenteral nutrition* is not considered when coding Eating.

GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

- If the resident eats finger foods using his or her hands, then code Eating based upon the amount of assistance provided. If the resident eats finger foods with his or her hands independently, for example, the resident would be coded as 06, Independent.

Examples for Coding Admission*, Interim,* or Discharge Performance

Note: The following are coding examples for each Self-Care item. Some examples describe a single observation of the person completing the activity; other examples describe a summary of several observations of the resident completing an activity across different times of the day and different days.

Examples for GG0130A, Eating

1. **Eating:** Ms. S has multiple sclerosis, affecting her endurance and strength. Ms. S prefers to feed herself as much as she is capable. During all meals, after eating three-fourths of the meal by herself, Ms. S usually becomes extremely fatigued and requests assistance from the certified nursing assistant to feed her the remainder of the meal.

   Coding: GG0130A would be coded 03, Partial/moderate assistance.
   Rationale: The certified nursing assistant provides less than half the effort for the resident to complete the activity of eating for all meals.

2. **Eating:** Mr. M has upper extremity weakness and fine motor impairments. The occupational therapist places an adaptive device onto Mr. M's hand that supports the eating utensil within his hand. At the start of each meal Mr. M can bring food and liquids to his mouth. Mr. M then tires and the certified nursing assistant feeds him more than half of each meal.

   Coding: GG0130A would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provides more than half the effort for the resident to complete the activity of eating at each meal.

3. **Eating:** Mr. A eats all meals without any physical assistance or supervision from a helper. He has a gastrostomy tube (G-tube), but it is no longer used, and it will be removed later today.

   Coding: GG0130A would be coded 06, Independent.
   Rationale: The resident can independently complete the activity without any assistance from a helper for this activity. In this scenario, the presence of a G-tube does not affect the eating score.

4. **Eating:** The dietary aide opens all of Mr. S's cartons and containers on his food tray before leaving the room. There are no safety concerns regarding Mr. S's ability to eat. Mr. S eats the food himself, bringing the food to his mouth using appropriate utensils and swallowing the food safely.

   Coding: GG0130A would be coded 05, Setup or clean-up assistance.
   Rationale: The helper provided setup assistance prior to the eating activity.

GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

5. **Eating:** Mrs. H does not have any food consistency restrictions, but often needs to swallow 2 or 3 times so that the food clears her throat due to difficulty with pharyngeal peristalsis. She requires verbal cues from the certified nursing assistant to use the compensatory strategy of extra swallows to clear the food.

   Coding: GG0130A would be coded 04, Supervision or touching assistance.
   Rationale: Mrs. H swallows all types of food consistencies and requires verbal cueing (supervision) from the helper.

6. **Eating:** Mrs. V has had difficulty seeing on her left side since her stroke. During meals, the certified nursing assistant has to remind her to scan her entire meal tray to ensure she has seen all the food.

   Coding: GG0130A would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cueing assistance during meals as Mrs. V completes the activity of eating. Supervision, such as reminders, may be provided throughout the activity or intermittently.

7. **Eating:** Mrs. N is impulsive. While she eats, the certified nursing assistant provides verbal and tactile cueing so that Mrs. N does not lift her fork to her mouth until she has swallowed the food in her mouth.

   Coding: GG0130A would be coded 04, Supervision or touching assistance.
   Rationale: The resident requires supervision and touching assistance in order to eat safely.

8. **Eating:** Mr. R is unable to eat by mouth since he had a stroke one week ago. He receives nutrition through a gastrostomy tube (G-tube), which is administered by nurses.

   Coding: GG0130A would be coded 88, Not attempted due to medical condition or safety concerns.
   Rationale: The resident does not eat or drink by mouth at this time due to his recent-onset stroke. This item includes eating and drinking by mouth only. Since eating and drinking did not occur due to his recent-onset medical condition, the activity is coded as 88, Not attempted due to medical condition and safety concerns. Assistance with G-tube feedings is not considered when coding this item.

9. **Eating:** Mr. F is fed all meals by the certified nursing assistant, because Mr. F has severe arm weakness and he is unable to assist.

   Coding: GG0130A would be coded 01, Dependent.
   Rationale: The helper does all of the effort for each meal. The resident does not contribute any effort to complete the eating activity.

GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

10. **Eating:** Mr. J had a stroke that affects his left side. He is left-handed and feeds himself more than half of his meals, but tires easily. Mr. J requests assistance from the certified nursing assistant with the remainder of his meals.

    Coding: GG0130A would be coded 03, Partial/moderate assistance.
    Rationale: The certified nursing assistant provides less than half the effort for the resident to complete the activity of eating.

11. **Eating:** Mrs. M has osteoporosis, which contributed to the fracture of her right wrist and hip during a recent fall. She is right-handed. Mrs. M starts eating on her own, but she does not have the coordination in her left hand to manage the eating utensils to feed herself without great effort. Mrs. M tires easily and cannot complete eating the meal. The certified nursing assistant feeds her more than half of the meal.

    Coding: GG0130A would be coded 02, Substantial/maximal assistance.
    Rationale: The helper provides more than half the effort for the resident to complete the activity of eating.

Coding Tip for GG0130B, Oral hygiene

- If a resident does not perform oral hygiene during therapy, determine the resident's abilities based on performance on the nursing care unit.

Examples for GG0130B, Oral hygiene

1. **Oral hygiene:** In the morning and at night, Mrs. F brushes her teeth while sitting on the side of the bed. Each time, the certified nursing assistant gathers her toothbrush, toothpaste, water, and an empty cup and puts them on the bedside table for her before leaving the room. Once Mrs. F is finished brushing her teeth, which she does without any help, the certified nursing assistant returns to gather her items and dispose of the waste.

    Coding: GG0130B would be coded 05, Setup or clean-up assistance.
    Rationale: The helper provides setup and clean-up assistance. The resident brushes her teeth without any help.

2. **Oral hygiene:** Before bedtime, the nurse provides steadying assistance to Mr. S as he walks to the bathroom. The nurse applies toothpaste onto Mr. S's toothbrush. Mr. S then brushes his teeth at the sink in the bathroom without physical assistance or supervision. Once Mr. S is done brushing his teeth and washing his hands and face, the nurse returns and provides steadying assistance as the resident walks back to his bed.

    Coding: GG0130B would be coded 05, Setup or clean-up assistance.
    Rationale: The helper provides setup assistance (putting toothpaste on the toothbrush) every evening before Mr. S brushes his teeth. *Do not consider assistance provided to get to or from the bathroom to score Oral hygiene.*

GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

3. **Oral hygiene:** At night, the certified nursing assistant provides Mrs. K water and toothpaste to clean her dentures. Mrs. K cleans her upper denture plate. Mrs. K then cleans half of her lower denture plate, but states she is tired and unable to finish cleaning her lower denture plate. The certified nursing assistant finishes cleaning the lower denture plate and Mrs. K replaces the dentures in her mouth.

   Coding: GG0130B would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided less than half the effort to complete oral hygiene.

4. **Oral hygiene:** Mr. W is edentulous (without teeth) and his dentures no longer fit his gums. In the morning and evening, Mr. W begins to brush his upper gums after the helper applies toothpaste onto his toothbrush. He brushes his upper gums, but cannot finish due to fatigue. The certified nursing assistant completes the activity of oral hygiene by brushing his back upper gums and his lower gums.

   Coding: GG0130B would be coded 02, Substantial/maximal assistance.
   Rationale: The resident begins the activity. The helper completes the activity by performing more than half the effort.

5. **Oral hygiene:** Mr. G has Parkinson's disease, resulting in tremors and incoordination. The certified nursing assistant retrieves all oral hygiene items for Mr. G and applies toothpaste to his toothbrush. Mr. G requires assistance to guide the toothbrush into his mouth and to steady his elbow while he brushes his teeth. Mr. G usually starts by brushing his upper and lower front teeth and the certified nursing assistant completes the activity by brushing the rest of his teeth.

   Coding: GG0130B would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half the effort for the resident to complete the activity of oral hygiene.

6. **Oral hygiene:** Ms. T has Lewy body dementia and multiple bone fractures. She does not understand how to use oral hygiene items nor does she understand the process of completing oral hygiene. The certified nursing assistant brushes her teeth and explains each step of the activity to engage cooperation from Ms. T; however, she requires full assistance for the activity of oral hygiene.

   Coding: GG0130B would be coded 01, Dependent.
   Rationale: The helper provides all the effort for the activity to be completed.

GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

7. **Oral hygiene:** Mr. D has experienced a stroke. He can brush his teeth while sitting on the side of the bed, but when the certified nursing assistant hands him the toothbrush and toothpaste, he looks up at her puzzled what to do next. The certified nursing assistant cues Mr. D to put the toothpaste on the toothbrush and instructs him to brush his teeth. Mr. D then completes the task of brushing his teeth.

   Coding: GG0130B would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cues to assist the resident in completing the activity of brushing his teeth.

8. **Oral hygiene:** Ms. K suffered a stroke a few months ago that resulted in cognitive limitations. She brushes her teeth at the sink, but is unable to initiate the task on her own. The occupational therapist cues Ms. K to put the toothpaste onto the toothbrush, brush all areas of her teeth, and rinse her mouth after brushing. The occupational therapist remains with Ms. K providing verbal cues until she has completed the task of brushing her teeth.

   Coding: GG0130B would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cues to assist the resident in completing the activity of brushing her teeth.

9. **Oral hygiene:** Mrs. N has early stage amyotrophic lateral sclerosis. She starts brushing her teeth and completes cleaning her upper teeth and part of her lower teeth when she becomes fatigued and asks the certified nursing assistant to help her finish the rest of the brushing.

   Coding: GG0130B would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided less than half the effort to complete oral hygiene.

Coding Tips for GG0130C, Toileting hygiene

- Toileting hygiene includes managing undergarments, clothing, and incontinence products and performing perineal cleansing before and after voiding or having a bowel movement. If the resident does not usually use undergarments, then assess the resident's need for assistance to manage lower body clothing and perineal hygiene.
- Toileting hygiene takes place before and after use of the toilet, commode, bedpan, or urinal. If the resident completes a bowel toileting program in bed, code Toileting hygiene based on the resident's need for assistance in managing clothing and perineal cleansing.
- If the resident has an indwelling urinary catheter and has bowel movements, code the Toilet hygiene item based on the amount of assistance needed by the resident before and after moving his or her bowels.

GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Examples for GG0130C, Toileting hygiene

1. **Toileting hygiene:** Mrs. J uses a bedside commode. The certified nursing assistant provides steadying (touching) assistance as Mrs. J pulls down her pants and underwear before sitting down on the *commode*. When Mrs. J is finished voiding or having a bowel movement, the certified nursing assistant provides steadying assistance as Mrs. J wipes her perineal area and pulls up her pants and underwear without assistance.

   Coding: GG0130C would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides steadying (touching) assistance to the resident to complete toileting hygiene.

2. **Toileting hygiene:** Mrs. L uses the toilet to void and have bowel movements. Mrs. L is unsteady, so the certified nursing assistant walks into the bathroom with her in case she needs help. During the assessment period, a staff member has been present in the bathroom, but has not needed to provide any physical assistance with managing clothes or cleansing.

   Coding: GG0130C would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides supervision as the resident performs the toilet hygiene activity. The resident is unsteady and the staff provide supervision for safety reasons.

3. **Toileting hygiene:** Mrs. P has urinary urgency. As soon as she gets in the bathroom, she asks the certified nursing assistant to lift her gown and pull down her underwear due to her balance problems. After voiding, Mrs. P wipes herself*,* pulls her underwear back up*, and adjusts her gown*.

   Coding: GG0130C would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides more than touching assistance. The resident performs more than half the effort; the helper does less than half the effort. The resident completes two of the three toileting hygiene tasks.

4. **Toileting hygiene:** Mr. J is morbidly obese and has a diagnosis of debility. He requests the use of a bedpan when voiding or having bowel movements and requires two certified nursing assistants to pull down his pants and underwear and mobilize him onto and off the bedpan. Mr. J is unable to complete any of his perineal/perianal hygiene. Both certified nursing assistants help Mr. J pull up his underwear and pants.

   Coding: GG0130C would be coded 01, Dependent.
   Rationale: The assistance of two helpers was needed to complete the activity of toileting hygiene.

GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

5. **Toileting hygiene:** Mr. C has Parkinson's disease and significant tremors that cause intermittent difficulty for him to perform perineal hygiene after having a bowel movement in the toilet. He walks to the bathroom with close supervision and lowers his pants, but asks the certified nursing assistant to help him with perineal hygiene after moving his bowels. He then pulls up his pants without assistance.

   Coding: GG0130C would be coded 03, Partial/moderate assistance.

   Rationale: The helper provides less than half the effort. The resident performs two of the three toileting hygiene tasks by himself. Walking to the bathroom is not considered when scoring toileting hygiene.

6. **Toileting hygiene:** Ms. Q has a progressive neurological disease that affects her fine and gross motor coordination, balance, and activity tolerance. She wears a hospital gown and underwear during the day. Ms. Q uses a bedside commode as she steadies herself in standing with one hand and initiates pulling down her underwear with the other hand but needs assistance to complete this activity due to her coordination impairment. After voiding, Ms. Q wipes her perineal area without assistance while sitting on the commode. When Ms. Q has a bowel movement, a certified nursing assistant performs perineal hygiene as Ms. Q needs to steady herself with both hands to stand for this activity. Ms. Q is usually too fatigued at this point and requires full assistance to pull up her underwear.

   Coding: GG0130C would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half the effort needed for the resident to complete the activity of toileting hygiene.

Coding Tips for GG0130E, Shower/bathe self

- Shower/bathe self includes the ability to wash, rinse, and dry the face, upper and lower body, perineal area, and feet. Do not include washing, rinsing, and drying the resident's back or hair. Shower/bathe self does not include transferring in/out of a tub/shower.
- Assessment of Shower/bathe self can take place in a shower or bath or at a sink (i.e., full body sponge bath).
- If the resident bathes himself or herself and a helper sets up materials for bathing/showering, then code as 05, Setup or clean-up assistance.
- If the resident cannot bathe his or her entire body because of a medical condition, then code Shower/bathe self based on the amount of assistance needed to complete the activity.

GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Examples for GG0130E, Shower/bathe self

1. **Shower/bathe self:** Mr. J sits on a tub bench as he washes, rinses, and dries himself. A certified nursing assistant stays with him to ensure his safety, as Mr. J has had instances of losing his sitting balance. The certified nursing assistant also provides lifting assistance as Mr. J gets onto and off of the tub bench.

   Coding: GG0130E would be coded 04, Supervision or touching assistance.

   Rationale: The helper provides supervision as Mr. J washes, rinses, and dries himself. The transfer onto or off of the tub bench is not considered when coding the Shower/bathe self activity.

2. **Shower/bathe self:** Mrs. E has a severe and progressive neurological condition that has affected her endurance as well as her fine and gross motor skills. She is transferred to the shower bench with partial/moderate assistance. Mrs. E showers while sitting on a *shower* bench and washes her arms and chest using a wash mitt. A certified nursing assistant then must help wash the remaining parts of her body, as a result of Mrs. E's fatigue, to complete the activity. Mrs. E uses a *hand-held showerhead* to rinse herself but tires halfway through the task. The certified nursing assistant dries Mrs. E's entire body.

   Coding: GG0130E would be coded 02, Substantial/maximal assistance.

   Rationale: The helper assists Mrs. E with more than half of the task of showering, which includes bathing, rinsing, and drying her body. The transfer onto the shower bench is not considered in coding this activity.

3. **Shower/bathe self:** Mr. Y has limited mobility resulting from his multiple and complex medical conditions. He prefers to wash his body while sitting in front of the sink in his bathroom. A helper assists with washing, rinsing, and drying Mr. Y's arms/hands, upper legs, lower legs, buttocks, and back.

   Coding: GG0130E would be coded 02, Substantial/maximal assistance.

   Rationale: The helper completed more than half the activity. Bathing may occur at the sink. When coding this activity, do not include assistance provided with washing, rinsing, or drying the resident's back.

GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Coding Tips for GG0130F, Upper body dressing, GG0130G, Lower body dressing, and GG0130H, Putting on/taking off footwear

- For upper body dressing, lower body dressing, and putting on/taking off footwear, if the resident dresses himself or herself and a helper retrieves or puts away the resident's clothing, then code 05, Setup or clean-up assistance.
- When coding upper body dressing and lower body dressing, helper assistance with buttons and/or fasteners is considered touching assistance.
- If donning and doffing an elastic bandage, elastic stockings, or an orthosis or prosthesis occurs while the resident is dressing/undressing, then count the elastic bandage/elastic stocking/orthotic/prosthesis as a piece of clothing when determining the amount of assistance the resident needs when coding the dressing item.
- The following items are considered a piece of clothing when coding the dressing items:
  - Upper body dressing examples: thoracic-lumbar-sacrum orthosis (TLSO), abdominal binder, back brace, stump sock/shrinker, upper body support device, neck support, hand or arm prosthetic/orthotic.
  - Lower body dressing examples: knee brace, elastic bandage, stump sock/shrinker, lower-limb prosthesis.
  - Footwear examples: ankle-foot orthosis (AFO), elastic bandages, foot orthotics, orthopedic walking boots, compression stockings (considered footwear because of dressing don/doff over foot).
- Upper body dressing items used for coding include bra, undershirt, T-shirt, button-down shirt, pullover shirt, dresses, sweatshirt, sweater, nightgown (not hospital gown), and pajama top. Upper body dressing cannot be assessed based solely on donning/doffing a hospital gown.
- Lower body dressing items used for coding include underwear, incontinence brief, slacks, shorts, capri pants, pajama bottoms, and skirts.
- Footwear dressing items used for coding include socks, shoes, boots, and running shoes.

GG0130: Self-Care (3-day assessment period) Admission/*Interim*/Discharge (Start/*Interim*/End of Medicare Part A Stay) (cont.)

- For residents with bilateral lower extremity amputations with or without use of prostheses, the activity of putting on/taking off footwear may not occur. For example, the socks and shoes may be attached to the prosthesis associated with the upper or lower leg.
  - If the resident performed the activity of putting on/taking off footwear immediately prior to the current illness, exacerbation, or injury, code as 88, Not attempted due to medical condition or safety concerns.
  - If the resident did not perform the activity of putting on/taking off footwear immediately prior to the current illness, exacerbation, or injury because the resident had bilateral lower-extremity amputations and the activity of putting on/taking off footwear was not performed during the assessment period, code as 09, Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- For residents with a single lower extremity amputation with or without use of a prosthesis, the activity of putting on/taking off footwear could apply to the intact limb or both the limb with the prosthesis and the intact limb.
  - If the resident performed the activity of putting on/taking off footwear for the intact limb only, then code based upon the amount of assistance needed to complete the activity.
  - If the resident performed the activity of putting on/taking off footwear for both the intact limb and the prosthetic limb, then code based upon the amount of assistance needed to complete the activity.

Examples for GG0130F, Upper body dressing

1. **Upper body dressing:** Mrs. Y has right-side upper extremity weakness as a result of a stroke and has worked in therapy to relearn how to dress her upper body. During the day, she requires a certified nursing assistant only to place her clothing next to her bedside. Mrs. Y can now use compensatory strategies to put on her bra and top without any assistance. At night she removes her top and bra independently and puts the clothes on the nightstand, and the certified nursing assistant puts them away in her dresser**.**

   Coding: GG0130F would be coded 05, Setup or clean-up assistance.

   Rationale: Mrs. Y dresses and undresses her upper body and requires a helper only to retrieve *and put away* her clothing, that is, setting up the clothing for her use. The description refers to Mrs. Y as "independent" (when removing clothes), but she needs setup assistance, so she is not independent with regard to the entire activity of upper body dressing.

GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

2. **Upper body dressing:** Mrs. Z wears a bra and a sweatshirt most days while in the SNF. She requires assistance from a certified nursing assistant to initiate the threading of her arms into her bra. Mrs. Z completes the placement of the bra over her chest. The helper hooks the bra clasps. Mrs. Z pulls the sweatshirt over her arms, head, and trunk. When undressing, Mrs. Z removes the sweatshirt, with the helper assisting her with one sleeve. Mrs. Z slides the bra off, once it has been unclasped by the helper.

   Coding: GG0130F would be coded 03, Partial/moderate assistance.

   Rationale: The helper provides assistance with threading Mrs. Z's arms into her bra and hooking and unhooking her bra clasps and assistance with removing one sleeve of the sweatshirt. Mrs. Z performs more than half of the effort.

3. **Upper body dressing:** Mr. K sustained a spinal cord injury that has affected both movement and strength in both upper extremities. He places his left hand into one-third of his left sleeve of his shirt with much time and effort and is unable to continue with the activity. A certified nursing assistant then completes the remaining upper body dressing for Mr. K.

   Coding: GG0130F would be coded 02, Substantial/maximal assistance.

   Rationale: Mr. K can perform a small portion of the activity of upper body dressing but requires assistance by a helper for more than half of the effort of upper body dressing.

Examples for GG0130G, Lower body dressing

1. **Lower body dressing:** Mr. D is required to follow hip precautions as a result of recent hip surgery. *The occupational therapist in the acute care hospital instructed him in the use of adaptive equipment to facilitate lower body dressing.* He requires a helper to retrieve his clothing from the closet. Mr. D uses his adaptive equipment to assist in threading his legs into his pants. Because of balance issues, Mr. D needs the helper to steady him when standing to manage pulling on or pulling down his pants/undergarments. Mr. D also needs some assistance to put on and take off his socks and shoes.

   Coding: GG0130G would be coded 04, Supervision or touching assistance.

   Rationale: A helper steadies Mr. D when he is standing and performing the activity of lower body dressing, which is supervision or touching assistance. Putting on and taking off socks and shoes is not considered when coding lower body dressing.

GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

2. **Lower body dressing:** Mrs. M has severe rheumatoid arthritis and multiple fractures and sprains due to a fall. She has been issued a knee brace, to be worn during the day. Mrs. M threads her legs into her garments, and pulls up and down her clothing to and from just below her hips. Only a little assistance from a helper is needed to pull up her garments over her hips. Mrs. M requires the helper to fasten her knee brace because of grasp and fine motor weakness.

   Coding: GG0130G would be coded 03, Partial/moderate assistance.

   Rationale: A helper provides only a little assistance when Mrs. M is putting on her lower extremity garments and fastening the knee brace. The helper provides less than half of the effort. Assistance putting on and removing the knee brace she wears is considered when determining the help needed when coding lower body dressing.

3. **Lower body dressing:** Mrs. R has peripheral neuropathy in her upper and lower extremities. Each morning, Mrs. R needs assistance from a helper to place her lower limb into, or to take it out of (don/doff), her lower limb prosthesis. She needs no assistance to put on and remove her underwear or slacks.

   Coding: GG0130G would be coded 03, Partial/moderate assistance.

   Rationale: A helper performs less than half the effort of lower body dressing (with a prosthesis considered a piece of clothing). The helper lifts, holds, or supports Mrs. R's trunk or limbs, but provides less than half the effort for the task of lower body dressing.

Examples for GG0130H, Putting on/taking off footwear

1. **Putting on/taking off footwear:** Mr. M is undergoing rehabilitation for right-side upper and lower body weakness following a stroke. He has made significant progress toward his independence and will be discharged to home tomorrow. Mr. M wears an ankle-foot orthosis that he puts on his foot and ankle after he puts on his socks but before he puts on his shoes. He always places his AFO, socks, and shoes within easy reach of his bed. While sitting on the bed, he needs to bend over to put on and take off his AFO, socks, and shoes, and he occasionally loses his sitting balance, requiring staff to place their hands on him to maintain his balance while performing this task.

   Coding: GG0130H would be coded 04, Supervision or touching assistance.

   Rationale: Mr. M puts on and takes off his AFO, socks, and shoes by himself; however, because of occasional loss of balance, he needs a helper to provide touching assistance when he is bending over.

GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

2. **Putting on/taking off footwear:** Mrs. F was admitted to the SNF for a neurologic condition and experiences visual impairment and fine motor coordination and endurance issues. She requires setup for retrieving her socks and shoes, which she prefers to keep in the closet. Mrs. F often drops her shoes and socks as she attempts to put them onto her feet or as she takes them off. Often a certified nursing assistant must first thread her socks or shoes over her toes, and then Mrs. F can complete the task. Mrs. F needs the certified nursing assistant to initiate taking off her socks and unstrapping the Velcro used for fastening her shoes.

   Coding: GG0130H would be coded *02, Substantial/maximal assistance.*
   Rationale: A helper provides Mrs. F with assistance in initiating putting on and taking off her footwear because of her limitations regarding fine motor coordination when putting on/taking off footwear. The helper completes more than half of the effort with this activity.

Examples of Probing Conversations with Staff

1. **Eating:** Example of a probing conversation between a nurse and a certified nursing assistant regarding the resident's eating abilities:

   Nurse: "Please describe to me how Mr. S eats his meals. Once the food and liquid are presented to him, does he use utensils to bring food to his mouth and swallow?"

   Certified nursing assistant: "No, I have to feed him."

   Nurse: "Do you always have to physically feed him or can he sometimes do some aspect of the eating activity with encouragement or cues to feed himself?"

   Certified nursing assistant: "No, he can't do anything by himself. I scoop up each portion of the food and bring the fork or spoon to his mouth. I try to encourage him to feed himself or to help guide the spoon to his mouth but he can't hold the fork. I even tried encouraging him to eat food he could pick up with his fingers, but he will not eat unless he is completely assisted for food and liquid."

   In this example, the nurse inquired specifically how Mr. S requires assistance to eat his meals. The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, he/she may not have received enough information to make an accurate assessment of the assistance Mr. S received. Accurate coding is important for reporting on the type and amount of care provided. Be sure to consider each activity definition fully.

   Coding: GG0130A would be coded 01, Dependent.
   Rationale: The resident requires complete assistance from the certified nursing assistant to eat his meals.

GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

2. **Oral hygiene:** Example of a probing conversation between a nurse determining a resident's oral hygiene score and a certified nursing assistant regarding the resident's oral hygiene routine:

   Nurse: "Does Mrs. K help with brushing her teeth?"

   Certified nursing assistant: "She can help clean her teeth."

   Nurse: "How much help does she need to brush her teeth?"

   Certified nursing assistant: "She usually gets tired after starting to brush her upper teeth. I have to brush most of her teeth."

   In this example, the nurse inquired specifically how Mrs. K manages her oral hygiene. The nurse asked about physical assistance and how the resident performed the activity. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. K received.

   Coding: GG0130B would be coded 02, Substantial/maximal assistance.
   Rationale: The certified nursing assistant provides more than half the effort to complete Mrs. K's oral hygiene.

Discharge Goals: Coding Tips

Discharge goals are coded with each Admission (Start of SNF PPS Stay) assessment.

- For the SNF Quality Reporting Program (QRP), a minimum of one self-care or mobility discharge goal must be coded. However, facilities may choose to complete more than one self-care or mobility discharge goal. Code the resident's discharge goal(s) using the six-point scale. Use of the "activity was not attempted" codes (07, 09, 10, and 88) is permissible to code discharge goal(s). Use of a dash is permissible for any remaining self-care or mobility goals that were not coded. Of note, at least one Discharge Goal must be indicated for either Self-Care or Mobility. Using the dash in this allowed instance after the coding of at least one goal does not affect Annual Payment Update (APU) determination.
- Licensed, qualified clinicians can establish a resident's Discharge Goal(s) at the time of admission based on the resident's prior medical condition, admission assessment self-care and mobility status, discussions with the resident and family, professional judgment, the professional's standard of practice, expected treatments, the resident's motivation to improve, anticipated length of stay, and the resident's discharge plan. Goals should be established as part of the resident's care plan.
- If the admission performance of an activity was coded 88, Not attempted due to medical condition or safety concern during the admission assessment, a Discharge Goal may be entered using the 6-point scale if the resident is expected to be able to perform the activity by discharge.

GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Discharge Goal: Coding Examples

1. Discharge Goal Code Is Higher than 5-Day PPS Assessment Admission Performance Code

If the qualified clinician determines that the resident is expected to make gains in function by discharge, the code reported for Discharge Goal will be higher than the admission performance code.

2. Discharge Goal Code Is the Same as 5-Day PPS Assessment Admission Performance Code

The qualified clinician determines that a medically complex resident is not expected to progress to a higher level of functioning during the SNF Medicare Part A stay; however, the qualified clinician determines that the resident would be able to maintain her admission functional performance level. The qualified clinician discusses functional status goals with the resident and her family and they agree that maintaining functioning is a reasonable goal. In this example, the Discharge Goal is coded at the same level as the resident's admission performance code.

Oral Hygiene 5-Day PPS Assessment Admission Performance: In this example, the qualified clinician anticipates that the resident will have the same level of function for oral hygiene at admission and discharge. The resident's 5-Day PPS admission performance code is coded and the Discharge Goal is coded at the same level. Mrs. E has stated her preference for participation twice daily in her oral hygiene activity. Mrs. E has severe arthritis, Parkinson's disease, diabetic neuropathy, and renal failure. These conditions result in multiple impairments (e.g., limited endurance, weak grasp, slow movements, and tremors). The qualified clinician observes Mrs. E's 5-Day PPS admission performance and discusses her usual performance with qualified clinicians, caregivers, and family to determine the necessary interventions for skilled therapy (e.g., positioning of an adaptive toothbrush cuff, verbal cues, lifting, and supporting Mrs. E's limb). The qualified clinician codes Mrs. E's 5-Day PPS assessment admission performance as 02, Substantial/maximal assistance. The helper performs more than half the effort when lifting or holding her limb.

Oral Hygiene 5-Day PPS Assessment Discharge Goal: The qualified clinician anticipates Mrs. E's discharge performance will remain 02, Substantial/maximal assistance. Due to Mrs. E's progressive and degenerative condition, the qualified clinician and resident feel that, while Mrs. E is not expected to make gains in oral hygiene performance, maintaining her function at this same level is desirable and achievable as a Discharge Goal.

GG0130: Self-Care (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

3. Discharge Goal Code Is *Lower* than 5-Day PPS Assessment Admission Performance Code

The qualified clinician determines that a resident with a progressive neurologic condition is expected to rapidly decline and that skilled therapy services may slow the decline of function. In this scenario, the Discharge Goal code is lower than the resident's 5-Day PPS assessment admission performance code.

Toileting Hygiene: Mrs. T's participation in skilled therapy is expected to slow down the pace of her anticipated functional deterioration. The resident's Discharge Goal code will be lower than the 5-Day PPS Admission Performance code.

Toileting Hygiene 5-Day PPS Assessment Admission Performance: Mrs. T has a progressive neurological illness that affects her strength, coordination, and endurance. Mrs. T prefers to use a bedside commode rather than incontinence undergarments for as long as possible. The certified nursing assistant currently supports Mrs. T while she is standing so that Mrs. T can release her hand from the grab bar (next to her bedside commode) and pull down her underwear before sitting onto the bedside commode. When Mrs. T has finished voiding, she wipes her perineal area. Mrs. T then requires the helper to support her trunk while Mrs. T pulls up her underwear. The qualified clinician codes the 5-Day PPS assessment admission performance as 03, Partial/moderate assistance. The certified nursing assistant provides less than half the effort for Mrs. T's toileting hygiene.

Toileting Hygiene Discharge Goal: By discharge, it is expected that Mrs. T will need assistance with toileting hygiene and that the helper will perform more than half the effort. The qualified clinician codes her Discharge Goal as 02, Substantial/maximal assistance.

GG0170: Mobility (3-day assessment period)
Admission (Start of Medicare Part A Stay)

GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	☐☐	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	☐☐	**G. Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
☐☐	☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

GG0170: Mobility (3-day assessment period) Admission (Start of Medicare Part A Stay) (cont.)

GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B) - Continued
Complete only if A0310B = 01

Code the resident's usual performance at the start of the SNF PPS stay (admission) for each activity using the 6-point scale. If activity was not attempted at the start of the SNF PPS stay (admission), code the reason. Code the resident's end of SNF PPS stay (discharge) goal(s) using the 6-point scale. Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal(s).

Coding:

Safety and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

1. Admission Performance	2. Discharge Goal	
↓ Enter Codes in Boxes ↓		
☐☐	☐☐	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	☐☐	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	☐☐	**O. 12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	☐☐	**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
		☐ **Q1. Does the resident use a wheelchair and/or scooter?** 0. **No** → Skip to GG0130, Self Care (Discharge) 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
		☐ **RR1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**
☐☐	☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
		☐ **SS1. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

GG0170: Mobility (3-day assessment period)
Interim Performance (Interim Payment Assessment - Optional)

GG0170. Mobility (Assessment period is the last 3 days)

Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.

Coding:

Safety and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

5. Interim Performance Enter Codes in Boxes ↓	
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If interim performance is coded 07, 09, 10, or 88 → Skip to H0100C, Appliances
☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

GG0170: Mobility (3-day assessment period)
Discharge (End of Medicare Part A Stay)

GG0170. Mobility (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.

Coding:

Safety and **Quality of Performance -** If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance Enter Codes in Boxes ↓	
☐☐	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
☐☐	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	**G. Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
☐☐	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
☐☐	**J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

GG0170: Mobility (3-day assessment period) Discharge (End of Medicare Part A Stay) (cont.)

GG0170. Mobility (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C) - Continued
Complete only if A0310G is not = 2 **and** A0310H = 1 **and** A2400C minus A2400B is greater than 2 **and** A2100 is not = 03

Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.

Coding:

Safety and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided.

Activities may be completed with or without assistive devices.

06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.

If activity was not attempted, code reason:

07. **Resident refused**
09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical condition or safety concerns**

3. Discharge Performance Enter Codes in Boxes ↓	
☐☐	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	**N. 4 steps:** The ability to go up and down four steps with or without a rail. If discharge performance is coded 07, 09, 10, or 88 → Skip to GG0170P, Picking up object
☐☐	**O. 12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	☐ **Q3. Does the resident use a wheelchair and/or scooter?** 0. **No** → Skip to H0100, Appliances 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	☐ **RR3. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**
☐☐	**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	☐ **SS3. Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Item Rationale

- During a Medicare Part A SNF stay, residents may have mobility limitations on admission. In addition, residents may be at risk of further functional decline during their stay in the SNF.

Steps for Assessment

1. Assess the resident's mobility performance based on direct observation, *incorporating resident* self-reports *and reports from* qualified clinicians, care staff, or family *documented in the resident's medical record* during the three-day assessment period. CMS anticipates that a multidisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period. For Section GG, the assessment period is the first three days of the Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay. On admission, these items are completed only when A0310B = 01 (5-Day PPS assessment). *For the Interim Payment Assessment (A0310B=08), the assessment period for Section GG is the last 3 days (i.e., the ARD and two days prior).*
2. Residents should be allowed to perform activities as independently as possible, as long as they are safe.
3. For the purposes of completing Section GG, a "helper" is defined as facility staff who are direct employees and facility-contracted employees (e.g., rehabilitation staff, nursing agency staff). Thus, does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration, such as hospice staff, nursing/certified nursing assistant students, etc. Therefore, when helper assistance is required because a resident's performance is unsafe or of poor quality, only consider facility staff when scoring according to amount of assistance provided.
4. Activities may be completed with or without assistive device(s). Use of assistive device(s) to complete an activity should not affect coding of the activity.
5. The admission functional assessment, when possible, should be conducted prior to the *resident* benefitting from treatment interventions in order to *reflect the resident's* true *admission* baseline functional status. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.
6. Refer to facility, Federal, and State policies and procedures to determine which SNF staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.

DEFINITION

USUAL PERFORMANCE
A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Admission*, Interim,* or Discharge Performance Coding Instructions

- When coding the resident's usual performance and the resident's discharge goal(s), use the six-point scale, or one of the four "activity was not attempted" codes (07, 09, 10, and 88), to specify the reason why an activity was not attempted.
- **Code 06, Independent:** if the resident completes the activity by him/herself with no assistance from a helper.
- **Code 05, Setup or clean-up assistance:** if the helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires placement of a bed rail to facilitate rolling, or requires setup of a leg lifter or other assistive devices.
- **Code 04, Supervision or touching assistance:** if the helper provides verbal cues or touching/steadying*/contact guard* assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete the activity; or resident may require only incidental help such as contact guard or steadying assistance during the activity.
- **Code 03, Partial/moderate assistance:** if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. For example, the resident requires assistance such as partial weight-bearing assistance, but HELPER does LESS THAN HALF the effort.
- **Code 02, Substantial/maximal assistance:** if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- **Code 01, Dependent:** if the helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity.
- **Code 07, Resident refused:** if the resident refused to complete the activity.
- **Code 09, Not applicable:** if the activity was not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- **Code 10, Not attempted due to environmental limitations:** if the resident did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.
- **Code 88, Not attempted due to medical condition or safety concerns:** if the activity was not attempted due to medical condition or safety concerns.
- *For additional information on coding the resident's performance on the assessment instrument, refer to the Decision Tree on page GG-12.*

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Admission*, Interim,* or Discharge Performance Coding Tips

- **Admission:** The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay.
  - For the 5-Day PPS assessment, code the resident's functional status based on a clinical assessment of the resident's performance that occurs soon after the resident's admission. This functional assessment must be completed within the first three days (three calendar days) of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, and the following two days, ending at 11:59 PM on day 3. The admission function scores are to reflect the resident's admission baseline status and are to be based on an assessment. The scores should reflect the resident's status prior to any benefit from interventions. The assessment should occur prior to the resident benefitting from treatment interventions in order to determine the resident's true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.
- ***Interim Performance (Optional):*** *The Interim Payment Assessment (IPA) is an optional assessment that may be completed by providers in order to report a change in the resident's PDPM classification. For Section GG on the IPA, providers will use the same 6-point scale and activity not attempted codes to complete the column "Interim Performance," which will capture the interim functional performance of the resident. The ARD for the IPA is determined by the provider, and the assessment period is the last 3 days (i.e., the ARD and the 2 calendar days prior). It is important to note that the IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed. The IPA does not affect the variable per diem schedule.*
- **Discharge:** The Part A PPS Discharge assessment is required to be completed when the resident's Medicare Part A stay ends as documented in A2400C, End of Most Recent Medicare Stay, either as a standalone assessment when the resident's Medicare Part A stay ends, but the resident remains in the facility; or may be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or one day before, the resident's Discharge Date (A2000). Please see Chapter 2 and Section A of the RAI Manual for additional details regarding the Part A PPS Discharge assessment.
  - For the Discharge assessment, (i.e., standalone Part A PPS or combined OBRA/Part A PPS), code the resident's discharge functional status, based on a clinical assessment of the resident's performance that occurs as close to the time of the resident's discharge from Medicare Part A as possible. This functional assessment must be completed within the last three calendar days of the resident's Medicare Part A stay, which includes the day of discharge from Medicare Part A and the two days prior to the day of discharge from Medicare Part A.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Admission*, Interim,* and Discharge Performance Coding Tips

General Coding Tips

- When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity. For example, when assessing GG0170J, Walk 50 feet with two turns, determine the type and amount of assistance required as the resident walks 50 feet *and negotiates two turns*.
- If the resident does not attempt the activity and a helper does not complete the activity for the resident during the entire assessment period, code the reason the activity was not attempted. For example, code as 07, if the resident refused to attempt the activity; code as 09, if the activity is not applicable for the resident (the activity did not occur at the time of the assessment, and prior to the current illness, exacerbation, or injury); code as 10, if the resident was not able to attempt the activity due to environmental limitations; or code as 88, if the resident was not able to attempt the activity due to a medical condition or safety concerns.
- An activity can be completed independently with or without devices. If the resident has adaptive equipment, retrieves the equipment without assistance, and performs the activity independently using the device, enter code 06, Independent.
- If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent.
- To clarify your own understanding and observations about a resident's performance of an activity, ask probing questions, beginning with the general and proceeding to the more specific. See examples of using probes when talking with staff at the end of this section.
- A dash ("-") indicates "No information." CMS expects dash use to be a rare occurrence.
- Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident's medical record. This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with local, State, and Federal regulations.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Tips for Coding the Resident's Usual Performance

- When coding the resident's usual performance, "effort" refers to the type and amount of assistance a helper provides in order for the activity to be completed. The six-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.
- Do not record the resident's best performance, and do not record the resident's worst performance, but rather record the resident's usual performance during the assessment period.
- Code based on the resident's performance. Do not record the staff's assessment of the resident's potential capability to perform the activity.
- If the resident performs the activity more than once during the assessment period and the resident's performance varies, coding in Section GG is based on the resident's "usual performance," which is identified as the resident's usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. A provider may need to use the entire three-day assessment period to obtain the resident's usual performance.

Examples and Coding Tips for Admission*, Interim,* or Discharge Performance

Note: The following are coding examples and coding tips for mobility items. Some examples describe a single observation of the person completing the activity; other examples describe a summary of several observations of the resident completing an activity across different times of the day and different days.

Examples for GG0170A, Roll left and right

1. **Roll left and right:** Mrs. R has a history of skin breakdown. A nurse instructs her to turn onto her right side, providing step-by-step instructions to use the bedrail, bend her left leg, and then roll onto her right side. Mrs. R attempts to roll with the use of the bedrail, but indicates she cannot perform the task. The nurse then rolls her onto her right side. Next, Mrs. R is instructed to return to lying on her back, which she successfully completes. Mrs. R then requires physical assistance from the nurse to roll onto her left side and to return to lying on her back to complete the activity.

   Coding: GG0170A would be coded 02, Substantial/maximal assistance.
   Rationale: The nurse provides more than half of the effort needed for the resident to complete the activity of rolling left and right. This is because the nurse provides physical assistance to move Mrs. R's body weight to turn onto her right side. The nurse provides the same assistance when Mrs. R turns to her left side and when she returns to her back. Mrs. R is able to return to lying on her back from her right side by herself.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

2. **Roll left and right:** A physical therapist helps Mr. K turn onto his right side by instructing him to bend his left leg and roll onto his right side. He then instructs him on how to position his limbs to return to lying on his back and then to repeat a similar process for rolling onto his left side and then return to lying on his back. Mr. K completes the activity without physical assistance from the physical therapist.

   Coding: GG0170A would be coded 04, Supervision or touching assistance.
   Rationale: The physical therapist provides verbal cues (i.e., instructions) to Mr. K as he rolls from his back to his right side and returns to lying on his back, and then again as he performs the same activities with respect to his left side. The physical therapist does not provide any physical assistance.

3. **Roll left and right:** Mr. Z had a stroke that resulted in paralysis on his right side and is recovering from cardiac surgery. He requires the assistance of two certified nursing assistants when rolling onto his right side and returning to lying on his back and also when rolling onto his left side and returning to lying on his back.

   Coding: GG0170A would be coded 01, Dependent.
   Rationale: Two certified nursing assistants are needed to help Mr. Z roll onto his left and right side and back while in bed.

4. **Roll left and right:** Mr. M fell and sustained left shoulder contusions and a fractured left hip and underwent an open reduction internal fixation of the left hip. A physician's order allows him to roll onto his left hip as tolerated. A certified nursing assistant assists Mr. M in rolling onto his right side by instructing him to bend his left leg while rolling to his right side. Mr. M needs physical assistance from the certified nursing assistant to initiate his rolling right because of his left arm weakness when grasping the right bedrail to assist in rolling. Mr. M returns to lying on his back without assistance and uses his right arm to grasp the left bedrail to slowly roll onto his left hip and then return to lying on his back.

   Coding: GG0170A would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half the effort needed for the resident to complete the activity of rolling left and right.

Examples for GG0170B, Sit to lying

1. **Sit to lying:** Mrs. H requires assistance from a nurse to transfer from sitting at the edge of the bed to lying flat on the bed because of paralysis on her right side. The helper lifts and positions Mrs. H's right leg. Mrs. H uses her arms to position her upper body and lowers herself to a lying position flat on her back.

   Coding: GG0170B would be coded 03, Partial/moderate assistance.
   Rationale: A helper lifts Mrs. H's right leg and helps her position it as she moves from a seated to a lying position; the helper performs less than half of the effort.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

2. **Sit to lying:** Mrs. F requires assistance from a certified nursing assistant to get from a sitting position to lying flat on the bed because of postsurgical open reduction internal fixation healing fractures of her right hip and left and right wrists. The certified nursing assistant cradles and supports her trunk and right leg to transition Mrs. F from sitting at the side of the bed to lying flat on the bed. Mrs. F assists herself a small amount by bending her elbows and left leg while pushing her elbows and left foot into the mattress only to straighten her trunk while transitioning into a lying position.

   Coding: GG0170B would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half the effort for the resident to complete the activity of sit to lying.

3. **Sit to lying:** Mrs. H requires assistance from two certified nursing assistants to transfer from sitting at the edge of the bed to lying flat on the bed due to paralysis on her right side, obesity, and cognitive limitations. One of the certified nursing assistants explains to Mrs. H each step of the sitting to lying activity. Mrs. H is then fully assisted to get from sitting to a lying position on the bed. Mrs. H makes no attempt to assist when asked to perform the incremental steps of the activity.

   Coding: GG0170B would be coded 01, Dependent.
   Rationale: The assistance of two certified nursing assistants was needed to complete the activity of sit to lying. If two or more helpers are required to assist the resident to complete an activity, code as 01, Dependent.

4. **Sit to lying:** Mr. F had a stroke about 2 weeks ago and is unable to sequence the necessary movements to complete an activity (apraxia). He can maneuver himself when transitioning from sitting on the side of the bed to lying flat on the bed if the certified nursing assistant provides verbal instructions as to the steps needed to complete this task.

   Coding: GG0170B would be coded 04, Supervision or touching assistance.
   Rationale: A helper provides verbal cues in order for the resident to complete the activity of sit to lying flat on the bed.

5. **Sit to lying:** Mrs. G suffered a traumatic brain injury three months prior to admission. She requires the certified nursing assistant to steady her movements from sitting on the side of the bed to lying flat on the bed. Mrs. G requires steadying (touching) assistance throughout the completion of this activity.

   Coding: GG0170B would be coded 04, Supervision or touching assistance.
   Rationale: A helper provides steadying assistance in order for the resident to complete the activity of sit to lying flat on her bed.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

6. **Sit to lying:** Mrs. E suffered a pelvic fracture during a motor vehicle accident. Mrs. E requires the certified nursing assistant to lift and position her left leg when she transfers from sitting at the edge of the bed to lying flat on the bed due to severe pain in her left pelvic area. Mrs. E uses her arms to position and lower her upper body to lying flat on the bed.

   Coding: GG0170B would be coded 03, Partial/moderate assistance.
   Rationale: A helper lifts Mrs. E's left leg and helps her position it as Mrs. E transitions from a seated to a lying position; the helper does less than half of the effort.

7. **Sit to lying:** Mr. A suffered multiple vertebral fractures due to a fall off a ladder. He requires assistance from a therapist to get from a sitting position to lying flat on the bed because of significant pain in his lower back. The therapist supports his trunk and lifts both legs to assist Mr. A from sitting at the side of the bed to lying flat on the bed. Mr. A assists himself a small amount by raising one leg onto the bed and then bending both knees while transitioning into a lying position.

   Coding: GG0170B would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half the effort for the resident to complete the activity of sit to lying.

Coding Tips for GG0170C, Lying to sitting on side of bed

- The activity includes resident transitions from lying on his or her back to sitting on the side of the bed with his or her feet flat on the floor and sitting upright on the bed without back support. The residents' ability to perform each of the tasks within this activity and how much support the residents require to complete the tasks within this activity is assessed.
- For item GG0170C, Lying to sitting on side of bed, clinical judgment should be used to determine what is considered a "lying" position for a particular resident.
- If the resident's feet do not reach the floor upon lying to sitting, the qualified clinician will determine if a bed height adjustment is required to accommodate foot placement on the floor.
- Back support refers to an object or person providing support for the resident's back.
- If the qualified clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, then code the activities GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, as 88, Not attempted due to medical condition or safety concern.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Examples for GG0170C, Lying to sitting on side of bed

1. **Lying to sitting on side of bed:** Mr. B pushes up from the bed to get himself from a lying to a seated position. The certified nursing assistant provides steadying (touching) assistance as Mr. B scoots himself to the edge of the bed and lowers his feet onto the floor.

   Coding: GG0170C would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance as the resident moves from a lying to sitting position.

2. **Lying to sitting on side of bed:** Mr. B pushes up on the bed to attempt to get himself from a lying to a seated position as the occupational therapist provides much of the lifting assistance necessary for him to sit upright. The occupational therapist provides additional lifting assistance as Mr. B scoots himself to the edge of the bed and lowers his feet to the floor.

   Coding: GG0170C would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provides lifting assistance (more than half the effort) as the resident moves from a lying to sitting position.

3. **Lying to sitting on side of bed:** Ms. P is being treated for sepsis and has multiple infected wounds on her lower extremities. Full assistance from the certified nursing assistant is needed to move Ms. P from a lying position to sitting on the side of her bed because she usually has pain in her lower extremities upon movement.

   Coding: GG0170C would be coded 01, Dependent.
   Rationale: The helper fully completed the activity of lying to sitting on the side of bed for the resident.

4. **Lying to sitting on side of bed:** Ms. H is recovering from a spinal fusion. She rolls to her right side and pushes herself up from the bed to get from a lying to a seated position. The therapist provides verbal cues as Ms. H safely uses her hands and arms to support her trunk and avoid twisting as she raises herself from the bed. Ms. H then maneuvers to the edge of the bed, finally lowering her feet to the floor to complete the activity.

   Coding: GG0170C would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cues as the resident moves from a lying to sitting position and does not lift the resident during the activity.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

5. **Lying to sitting on side of bed:** Mrs. P is recovering from Guillain-Barre Syndrome with residual lower body weakness. The certified nursing assistant steadies Mrs. P's trunk as she gets to a fully upright sitting position on the bed and lifts each leg toward the edge of the bed. Mrs. P then scoots toward the edge of the bed and places both feet flat on the floor. Mrs. P completes most of the effort to get from lying to sitting on the side of the bed.

   Coding: GG0170C would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided lifting assistance and less than half the effort for the resident to complete the activity of lying to sitting on side of bed.

Coding Tip for GG0170D, Sit to stand

- If a sit-to-stand (stand assist) lift is used and two helpers are needed to assist with the sit-to-stand lift, then code as 01, Dependent.

Examples for GG0170D, Sit to stand

1. **Sit to stand:** Mr. M has osteoarthritis and is recovering from sepsis. Mr. M transitions from a sitting to a standing position with the steadying (touching) assistance of the nurse's hand on Mr. M's trunk.

   Coding: GG0170D would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance only.

2. **Sit to stand:** Mrs. L has multiple healing fractures and multiple sclerosis, requiring two certified nursing assistants to assist her to stand up from sitting in a chair.

   Coding: GG0170D would be coded 01, Dependent.
   Rationale: Mrs. L requires the assistance of two helpers to complete the activity.

3. **Sit to stand:** Mr. B has complete tetraplegia and is currently unable to stand when getting out of bed. He transfers from his bed into a wheelchair with assistance. The activity of sit to stand is not attempted due to his medical condition.

   Coding: GG0170D would be coded 88, Not attempted due to medical condition or safety concerns.
   Rationale: The activity is not attempted due to the resident's diagnosis of complete tetraplegia.

4. **Sit to stand:** Ms. Z has amyotrophic lateral sclerosis with moderate weakness in her lower and upper extremities. Ms. Z has prominent foot drop in her left foot, requiring the use of an ankle foot orthosis (AFO) for standing and walking. The certified nursing assistant applies Ms. Z's AFO and places the platform walker in front of her; Ms. Z uses the walker to steady herself once standing. The certified nursing assistant provides lifting assistance to get Ms. Z

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

to a standing position and must also provide assistance to steady Ms. Z's balance to complete the activity.

Coding: GG0170D would be coded 02, Substantial/maximal assistance.
Rationale: The helper provided lifting assistance and more than half of the effort for the resident to complete the activity of sit to stand.

5. **Sit to stand:** Ms. R has severe rheumatoid arthritis and uses forearm crutches to ambulate. The certified nursing assistant brings Ms. R her crutches and helps her to stand at the side of the bed. The certified nursing assistant provides some lifting assistance to get Ms. R to a standing position but provides less than half the effort to complete the activity.

   Coding: GG0170D would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided lifting assistance and less than half the effort for the resident to complete the activity of sit to stand.

Coding Tips for GG0170E, Chair/bed-to-chair transfer

- Item GG0170E, Chair/bed-to-chair transfer, begins with the resident sitting in a chair or wheelchair or sitting upright at the edge of the bed and returning to sitting in a chair or wheelchair or sitting upright at the edge of the bed. The activities of GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, are two separate activities that are not assessed as part of GG0170E.
- If a mechanical lift is used to assist in transferring a resident for a chair/bed-to-chair transfer and two helpers are needed to assist with the mechanical lift transfer, then code as 01, Dependent, even if the resident assists with any part of the chair/bed-to-chair transfer.

Examples for GG0170E, Chair/bed-to-chair transfer

1. **Chair/bed-to-chair transfer:** Mr. L had a stroke and currently is not able to walk. He uses a wheelchair for mobility. When Mr. L gets out of bed, the certified nursing assistant moves the wheelchair into the correct position and locks the brakes so that Mr. L can transfer into the wheelchair safely. Mr. L had been observed several other times to determine any safety concerns, and it was documented that he transfers safely without the need for supervision. Mr. L transfers into the wheelchair by himself (no helper) after the certified nursing assistant leaves the room.

   Coding: GG0170E would be coded 05, Setup or clean-up assistance.
   Rationale: Mr. L is not able to walk, so he transfers from his bed to a wheelchair when getting out of bed. The helper provides setup assistance only. Mr. L transfers safely and does not need supervision or physical assistance during the transfer.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

2. **Chair/bed-to-chair transfer:** Mr. C is sitting on the side of the bed. He stands and pivots into the chair as the nurse provides contact guard (touching) assistance. The nurse reports that one time Mr. C only required verbal cues for safety, but usually Mr. C requires touching assistance.

   Coding: GG0170E would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance during the transfers.

3. **Chair/bed-to-chair transfer:** Mr. F's medical conditions include morbid obesity, diabetes mellitus, and sepsis, and he recently underwent bilateral above-the-knee amputations. Mr. F requires full assistance with transfers from the bed to the wheelchair using a lift device. Two certified nursing assistants are required for safety when using the device to transfer Mr. F from the bed to a wheelchair. Mr. F is unable to assist in the transfer from his bed to the wheelchair.

   Coding: GG0170E would be coded 01, Dependent.
   Rationale: The two helpers completed all the effort for the activity of chair/bed-to-chair transfer. If two or more helpers are required to assist the resident to complete an activity, code as 01, Dependent.

4. **Chair/bed-to-chair transfer:** Ms. P has metastatic bone cancer, severely affecting her ability to use her lower and upper extremities during daily activities. Ms. P is motivated to assist with her transfers from the side of her bed to the wheelchair. Ms. P pushes herself up from the bed to begin the transfer while the therapist provides limited trunk support with weight-bearing assistance. Once standing, Ms. P shuffles her feet, turns, and slowly sits down into the wheelchair with the therapist providing trunk support with weight-bearing assistance.

   Coding: GG0170E would be coded 03, Partial/moderate assistance.
   Rationale: The helper provided less than half of the effort for the resident to complete the activity of chair/bed-to-chair transfer.

5. **Chair/bed-to-chair transfer:** Mr. U had his left lower leg amputated due to gangrene associated with his diabetes mellitus and he has reduced sensation and strength in his right leg. He has not yet received his below-the-knee prosthesis. Mr. U uses a transfer board for chair/bed-to-chair transfers. The therapist places the transfer board under his buttock. Mr. U then attempts to scoot from the bed onto the transfer board. Mr. U has reduced sensation in his hands and limited upper body strength, but assists with the transfer. The physical therapist assists him in side scooting by lifting his *buttocks/*trunk in a rocking motion across the transfer board and into the wheelchair.

   Coding: GG0170E would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half of the effort for the resident to complete the activity of chair/bed-to-chair transfer.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Examples for GG0170F, Toilet transfer

1. **Toilet transfer:** The certified nursing assistant moves the wheelchair footrests up so that Mrs. T can transfer from the wheelchair onto the toilet by herself safely. The certified nursing assistant is not present during the transfer, because supervision is not required. Once Mrs. T completes the transfer from the toilet back to the wheelchair, she flips the footrests back down herself.

   Coding: GG0170F would be coded 05, Setup or clean-up assistance.

   Rationale: The helper provides setup assistance (moving the footrest out of the way) before Mrs. T can transfer safely onto the toilet.

2. **Toilet transfer:** Mrs. Q transfers onto and off the elevated toilet seat with the certified nursing assistant supervising due to her unsteadiness.

   Coding: GG0170F would be coded 04, Supervision or touching assistance.

   Rationale: The helper provides supervision as the resident transfers onto and off the toilet. The resident may use an assistive device.

3. **Toilet transfer:** Mrs. Y is anxious about getting up to use the bathroom. She asks the certified nursing assistant to stay with her in the bathroom as she gets on and off the toilet. The certified nursing assistant stays with her, as requested, and provides verbal encouragement and instructions (cues) to Mrs. Y.

   Coding: GG0170F would be coded 04, Supervision or touching assistance.

   Rationale: The helper provides supervision/verbal cues as Mrs. Y transfers onto and off the toilet.

4. **Toilet transfer:** The certified nursing assistant provides steadying (touching) assistance as Mrs. Z lowers her underwear and then transfers onto the toilet. After voiding, Mrs. Z cleanses herself. She then stands up as the helper steadies her and Mrs. Z pulls up her underwear as the helper steadies her to ensure Mrs. Z does not lose her balance.

   Coding: GG0170F would be coded 04, Supervision or touching assistance.

   Rationale: The helper provides steadying assistance as the resident transfers onto and off the toilet. Assistance with managing clothing and cleansing is coded under item GG0130C, Toileting hygiene and is not considered when rating the Toilet transfer item.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

5. **Toilet transfer:** The therapist supports Mrs. M's trunk with a gait belt by providing weight-bearing as Mrs. M pivots and lowers herself onto the toilet.

   Coding: GG0170F would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half the effort to complete the activity. The helper provided weight-bearing assistance as the resident transferred on and off the toilet.

6. **Toilet transfer:** Ms. W has peripheral vascular disease and sepsis, resulting in lower extremity pain and severe weakness. Ms. W uses a bedside commode when having a bowel movement. The certified nursing assistant raises the bed to a height that facilitates the transfer activity. Ms. W initiates lifting her buttocks from the bed and in addition requires some of her weight to be lifted by the certified nursing assistant to stand upright. Ms. W then reaches and grabs onto the armrest of the bedside commode to steady herself. The certified nursing assistant provides weight-bearing assistance as she slowly rotates and lowers Ms. W onto the bedside commode.

   Coding: GG0170F would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half of the effort for the resident to complete the activity of toilet transfer.

7. **Toilet transfer:** Mr. H has paraplegia incomplete, pneumonia, and a chronic respiratory condition. Mr. H prefers to use the bedside commode when moving his bowels. Due to his severe weakness, history of falls, and dependent transfer status, two certified nursing assistants assist during the toilet transfer.

   Coding: GG0170F would be coded 01, Dependent.
   Rationale: The activity required the assistance of two or more helpers for the resident to complete the activity.

8. **Toilet transfer:** Mrs. S is on bedrest due to a medical complication. She uses a bedpan for bladder and bowel management.

   Coding: GG0170F would be coded 88, Not attempted due to medical condition or safety concerns.
   Rationale: The resident does not transfer onto or off a toilet due to being on bedrest because of a medical condition.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Coding Tips for GG0170G, Car transfer

- *For item GG0170G, Car transfer, use of an indoor car can be used to simulate outdoor car transfers. These half or full cars would need to have similar physical features of a real car for the purpose of simulating a car transfer, that is, a car seat within a car cabin.*
- *The Car transfer item does not include transfers into the driver's seat, opening/closing the car door, fastening/unfastening the seat belt. The Car transfer item includes the resident's ability to transfer in and out of the passenger seat of a car or car simulator.*
- *In the event of inclement weather or if an indoor car simulator or outdoor car is not available during the entire 3-day assessment period, then use code 10, Not attempted due to environmental limitations.*
- *If at the time of the assessment the resident is unable to attempt car transfers, and could not perform the car transfers prior to the current illness, exacerbation or injury, code 09, Not applicable.*

Examples for GG0170G, Car transfer

1. **Car transfer:** Mrs. W uses a wheelchair and ambulates for only short distances. She requires lifting assistance from a physical therapist to get from a seated position in the wheelchair to a standing position. The therapist provides trunk support when Mrs. W takes several steps during the transfer turn. Mrs. W lowers herself into the car seat with steadying assistance from the therapist. She lifts her legs into the car with support from the therapist.

   Coding: GG0170G would be coded 02, Substantial/maximal assistance.
   Rationale: Although Mrs. W also contributes effort to complete the activity, the helper contributed more than half the effort needed to transfer Mrs. W into the car by providing lifting assistance and trunk support.

2. **Car transfer:** During her rehabilitation stay Mrs. N works with an occupational therapist on transfers in and out of the passenger side of a car. On the day before discharge, when performing car transfers, Mrs. N requires verbal reminders for safety and light touching assistance. The therapist instructs her on strategic hand placement while Mrs. N transitions to sitting in the car's passenger seat. The therapist opens and closes the door.

   Coding: GG0170G would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance as the resident transfers into the passenger seat of the car. Assistance with opening and closing the car door is not included in the definition of this item and is not considered when coding this item.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Coding Tips for GG0170I–G0170L Walking Items

- Walking activities do not need to occur during one session. Allowing a resident to rest between activities or completing activities at different times during the day or on different days may facilitate completion of the activities.
- When coding GG0170 walking items, **do not** consider the resident's mobility performance when using parallel bars. Parallel bars are not a portable assistive device. If safe, assess and code walking using a portable walking device.
- The turns included in item GG0170J, Walk 50 feet with two turns, are 90-degree turns. The turns may be in the same direction (two 90-degree turns to the right or two 90-degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right). The 90-degree turn should occur at the person's ability level and can include use of an assistive device (for example, cane).

Examples for GG0170I, Walk 10 feet

1. **Walk 10 feet:** Mrs. C has resolving sepsis and has not walked in three weeks because of her medical condition. A physical therapist determines that it is unsafe for Mrs. C to use a walker, and the resident only walks using the parallel bars. On day 3 of the Admission assessment period, Mrs. C walks 10 feet using the parallel bars while the therapist provides substantial weight-bearing support throughout the activity.

   Coding: GG0170I would be coded 88, Not attempted due to medical condition or safety concerns.
   Rationale: When assessing a resident for GG0170 walking items, do not consider walking in parallel bars, as parallel bars are not a portable assistive device. If the resident is unable to walk without the use of parallel bars because of his or her medical condition or safety concerns, use code 88, Activity not attempted due to medical condition or safety concerns.

2. **Walk 10 feet:** Mr. L had bilateral amputations three years ago, and prior to the current admission he used a wheelchair and did not walk. Currently Mr. L does not use prosthetic devices and uses only a wheelchair for mobility. Mr. L's care plan includes fitting and use of bilateral lower extremity prostheses.

   Coding: GG0170I would be coded 09, Not applicable, not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
   Rationale: When assessing a resident for GG0170I, Walk 10 feet, consider the resident's status prior to the current episode of care and current three-day assessment status. Use code 09, Not applicable, because Mr. L did not walk prior to the current episode of care and did not walk during the three-day assessment period. Mr. L's care plan includes fitting and use of bilateral prostheses and walking as a goal. A discharge goal for any admission performance item skipped may be entered if a discharge goal is determined as part of the resident's care plan.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

3. **Walk 10 feet:** Mrs. C has Parkinson's disease and walks with a walker. A physical therapist must advance the walker for Mrs. C with each step. The physical therapist assists Mrs. C by physically initiating the stepping movement forward, advancing Mrs. C's foot, during the activity of walking 10 feet.

   Coding: GG0170I would be coded 02, Substantial/maximal assistance.
   Rationale: A helper provides more than half the effort as the resident completes the activity.

4. **Walk 10 feet:** Mr. O has bilateral upper extremity tremors, lower extremity weakness, and Parkinson's disease. A *physical therapist* assistant guides and steadies the shaking, rolling walker forward while cueing Mr. O to take larger steps. Mr. O requires steadying at the beginning of the walk and progressively requires some of his weight to be supported for the last two feet of the 10-foot walk.

   Coding: GG0170I would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half the effort required for the resident to complete the activity, Walk 10 feet. While the helper guided and steadied the walker during the walk, Mr. O supported his own body weight with his arms and legs and propelled his legs forward for 8 of the 10 feet. The helper supported part of Mr. O's weight only for 2 of the 10 feet; thus Mr. O contributed more than half the effort.

5. **Walk 10 feet:** Mrs. U has an above-the-knee amputation and severe rheumatoid arthritis. Once a nurse has donned her stump sock and prosthesis, Mrs. U is assisted to stand and uses her rolling walker while walking. The nurse places his hand on Mrs. U's back to steady her toward the last half of her 10-foot walk.

   Coding: GG0170I would be coded 04, Supervision or touching assistance.
   Rationale: A helper provides touching assistance in order for the resident to complete the activity of Walk 10 feet. Assistance in donning the stump stock, prosthesis, and getting from a sitting to standing position is not coded as part of the Walk 10 feet item.

Examples for GG0170J, Walk 50 feet with two turns

1. **Walk 50 feet with two turns:** A therapist provides steadying assistance as Mrs. W gets up from a sitting position to a standing position. After the therapist places Mrs. W's walker within reach, Mrs. W walks 60 feet down the hall with two turns without any assistance from the therapist. No supervision is required while she walks.

   Coding: GG0170J would be coded 05, Setup or clean-up assistance.
   Rationale: Mrs. W walks more than 50 feet and makes two turns once the helper places the walker within reach. Assistance with getting from a sitting to a standing position is coded separately under the item GG0170D, Sit to stand (04, Supervision or touching assistance).

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

2. **Walk 50 feet with two turns:** Mrs. P walks 70 feet with a quad cane, completing two turns during the walk. The therapist provides steadying assistance only when Mrs. P turns.

   Coding: GG0170J would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance as the resident walks more than 50 feet and makes two turns. The resident may use an assistive device.

3. **Walk 50 feet with two turns:** Mrs. L is unable to bear her full weight on her left leg. As she walks 60 feet down the hall with her crutches and makes two turns, the certified nursing assistant supports her trunk providing weight-bearing assistance.

   Coding: GG0170J would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides trunk support as the resident walks more than 50 feet and makes two turns.

4. **Walk 50 feet with two turns:** Mr. T walks 50 feet with the therapist providing trunk support. *He also requires a second helper, the rehabilitation aide, who provides supervision and follows closely behind with a wheelchair for safety.* Mr. T walks the 50 feet with two turns *with the assistance of two helpers*.

   Coding: GG0170J would be coded 01, Dependent.
   Rationale: Mr. T requires two helpers to complete the activity.

5. **Walk 50 feet with two turns:** Mrs. U has an above-the-knee amputation, severe rheumatoid arthritis, and uses a prosthesis. Mrs. U is assisted to stand and, after walking 10 feet, requires progressively more help as she nears the 50-foot mark. Mrs. U is unsteady and typically loses her balance when turning, requiring significant support to remain upright. The therapist provides significant trunk support for about 30 to 35 feet.

   Coding: GG0170J would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provided more than half of the effort for the resident to complete the activity of walk 50 feet with two turns.

Examples for GG0170K, Walk 150 feet

1. **Walk 150 feet:** Mrs. D walks down the hall using her walker and the certified nursing assistant usually needs to provide touching assistance to Mrs. D, who intermittently loses her balance while she uses the walker.

   Coding: GG0170K would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides touching assistance intermittently throughout the activity.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

2. **Walk 150 feet:** Mr. R has endurance limitations due to heart failure and has only walked about 30 feet during the 3-day assessment period. He has not walked 150 feet or more during the assessment period, including with the physical therapist who has been working with Mr. R. The therapist speculates that Mr. R could walk this distance in the future with additional assistance.

   Coding: GG0170K would be coded 88, Activity not attempted due to medical condition or safety concerns, and the resident's ability to walk a shorter distance would be coded in item GG0170I. The resident did not complete the activity, and a helper cannot complete the activity for the resident.
   Rationale: The activity was not attempted.

3. **Walk 150 feet:** Mrs. T has an unsteady gait due to balance impairment. Mrs. T walks the length of the hallway using her quad cane in her right hand. The physical therapist supports her trunk, helping her to maintain her balance while ambulating. The therapist provides less than half of the effort to walk the 160-foot distance.

   Coding: GG0170K would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half of the effort for the resident to complete the activity of walking at least 150 feet.

4. **Walk 150 feet:** Mr. W, who has Parkinson's disease, walks the length of the hallway using his rolling walker. The physical therapist provides trunk support and advances Mr. W's right leg in longer strides with each step. The therapist occasionally prevents Mr. W from falling as he loses his balance during the activity.

   Coding: GG0170K would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provides more than half the effort for the resident to complete the activity of walk 150 feet.

Example for GG0170L, Walking 10 feet on uneven surfaces

1. **Walking 10 feet on uneven surfaces:** Mrs. N has severe joint degenerative disease and is recovering from sepsis. Upon discharge Mrs. N will need to be able to walk on the uneven and sloping surfaces of her driveway. During her SNF stay, a physical therapist takes Mrs. N outside to walk on uneven surfaces. Mrs. N requires the therapist's weight-bearing assistance less than half the time during walking in order to prevent Mrs. N from falling as she navigates walking 10 feet over uneven surfaces.

   Coding: GG0170L would be coded 03, Partial/moderate assistance.
   Rationale: Mrs. N requires a helper to provide weight-bearing assistance several times to prevent her from falling as she walks 10 feet on uneven surfaces. The helper contributes less than half the effort required for Mrs. N to walk 10 feet on uneven surfaces.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Example for GG0170M, 1 step (curb)

1. **1 step (curb):** Mrs. Z has had a stroke; she must be able to step up and down one step to enter and exit her home. A physical therapist provides standby assistance as she uses her quad cane to support her balance in stepping up one step. The physical therapist provides steadying assistance as Mrs. Z uses her cane for balance and steps down one step.

   Coding: GG0170M would be coded 04, Supervision or touching assistance.
   Rationale: A helper provides touching assistance as Mrs. Z completes the activity of stepping up and down one step.

Example for GG0170N, 4 steps

1. **4 steps:** Mr. J has lower body weakness, and a physical therapist provides steadying assistance when he ascends 4 steps. While descending 4 steps, the physical therapist provides trunk support (more than touching assistance) as Mr. J holds the stair railing.

   Coding: GG0170N would be coded 03, Partial/moderate assistance.
   Rationale: A helper provides touching assistance as Mr. J ascends 4 steps. The helper provides trunk support (more than touching assistance) when he descends the 4 steps.

Example for GG0170O, 12 steps

1. **12 steps:** Ms. Y is recovering from a stroke resulting in motor issues and poor endurance. Ms. Y's home has 12 stairs, with a railing, and she needs to use these stairs to enter and exit her home. Her physical therapist uses a gait belt around her trunk and supports less than half of the effort as Ms. Y ascends and then descends 12 stairs.

   Coding: GG0170O would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half the required effort in providing the necessary support for Ms. Y as she ascends and descends 12 stairs.

Examples for GG0170P, Picking up object

1. **Picking up object:** Mr. P has a neurologic condition that has resulted in balance problems. He wants to be as independent as possible. Mr. P lives with his wife and will soon be discharged from the SNF. He tends to drop objects and has been practicing bending or stooping from a standing position to pick up small objects, such as a spoon, from the floor. An occupational therapist needs to remind Mr. P of safety strategies when he bends to pick up objects from the floor, and she needs to steady him to prevent him from falling.

   Coding: GG0170P would be coded 04, Supervision or touching assistance.
   Rationale: A helper is needed to provide verbal cues and touching or steadying assistance when Mr. P picks up an object because of his coordination issues.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

2. **Picking up object:** Ms. C has recently undergone a hip replacement. When she drops items she uses a long-handled reacher that she had been using at home prior to admission. She is ready for discharge and can now ambulate with a walker without assistance. When she drops objects from her walker basket she requires a certified nursing assistant to locate her long-handled reacher and bring it to her in order for her to use it. She does not need assistance to pick up the object after the helper brings her the reacher.

   Coding: GG0170P would be coded 05, Setup or clean-up assistance.

   Rationale: The helper provides set-up assistance so that Ms. C can use her long-handled reacher.

Coding Tips for GG0170R and GG0170S, Wheelchair Items

- The intent of the wheelchair mobility items is to assess the ability of residents who are learning how to self-mobilize using a wheelchair or who used a wheelchair prior to admission. Use clinical judgment to determine whether a resident's use of a wheelchair is for self-mobilization as a result of the resident's medical condition or safety.
- Do not code wheelchair mobility if the resident uses a wheelchair only when transported between locations within the facility or for staff convenience (e.g., because the resident walks slowly). Only code wheelchair mobility based on an assessment of the resident's ability to mobilize in the wheelchair.
- If the resident walks and is not learning how to mobilize in a wheelchair, and only uses a wheelchair for transport between locations within the facility *or for staff convenience (e.g., because the resident walks slowly)*, code the wheelchair gateway items at admission and/or discharge—GG0170Q1 and/or GG0170Q3, Does the resident use a wheelchair/scooter?—as 0, No, and skip all remaining wheelchair questions.
- Admission assessment for wheelchair items should be coded for residents who used a wheelchair prior to admission.
  - The responses for gateway admission and discharge wheelchair items (GG0170Q1 and GG0170Q3) do not have to be the same on the Admission and Discharge assessments.
- If a wheelchair is used for transport purposes only, then GG0170Q1 and/or GG0170Q3, Does the resident use a wheelchair or scooter? is coded as 0, No; then follow the skip pattern to continue coding the assessment.
  - Example of using a wheelchair for transport convenience: A resident is transported in a wheelchair by staff between her room and the therapy gym or by family to the facility cafeteria, but the resident is not expected to use a wheelchair after discharge.
- The turns included in item GG0170R (wheeling 50 feet with two turns) are 90-degree turns. The turns may be in the same direction (two 90-degree turns to the right or two 90-degree turns to the left) or may be in different directions (one 90-degree turn to the left and one 90-degree turn to the right). The 90-degree turn should occur at the person's ability level.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Example for GG0170Q1, Does the resident use a wheelchair/scooter?

1. **Does the resident use a wheelchair/scooter?** On admission, Mr. T wheels himself using a manual wheelchair, but with difficulty due to his severe osteoarthritis and COPD.

   Coding: GG0170Q1 would be coded 1, Yes. The admission performance codes for wheelchair items GG0170R and GG0170S are coded; in addition, the type of wheelchair Mr. T uses for GG0170RR1 is indicated as code 1, Manual. If wheelchair goal(s) are clinically indicated, then wheelchair goals can be coded.

   Rationale: The resident currently uses a wheelchair. Coding the resident's performance and the type of wheelchair (manual) is indicated. Wheeling goal(s) if clinically indicated may be coded.

Examples for GG0170R, Wheel 50 feet with two turns, and GG0170RR, Indicate the type of wheelchair/scooter used

1. **Wheel 50 feet with two turns:** Mrs. M is unable to bear any weight on her right leg due to a recent fracture. The certified nursing assistant provides steadying assistance when transferring Mrs. M from the bed into the wheelchair. Once in her wheelchair, Mrs. M propels herself about 60 feet down the hall using her left leg and makes two turns without any physical assistance or supervision.

   Coding: GG0170R would be coded 06, Independent.

   Rationale: The resident wheels herself more than 50 feet. Assistance provided with the transfer is not considered when scoring Wheel 50 feet with two turns. There is a separate item for scoring bed-to-chair transfers.

2. **Indicate the type of wheelchair/scooter used:** In the above example Mrs. M used a manual wheelchair during the 3-day assessment period.

   Coding: GG0170RR would be coded 1, Manual.

   Rationale: Mrs. M used a manual wheelchair during the 3-day assessment period.

3. **Wheel 50 feet with two turns:** Mr. R is very motivated to use his motorized wheelchair with an adaptive throttle for speed and steering. Mr. R has amyotrophic lateral sclerosis, and moving his upper and lower extremities is very difficult. The *physical therapist* assistant is required to walk next to Mr. R for frequent readjustments of his hand position to better control the steering and speed throttle. Mr. R often drives too close to corners, becoming stuck near doorways upon turning, preventing him from continuing to mobilize/wheel himself. The *physical therapist* assistant backs up Mr. R's wheelchair for him so that he may continue mobilizing/wheeling himself.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Coding: GG0170R would be coded 03, Partial/moderate assistance.
Rationale: The helper provided less than half of the effort for the resident to complete the activity, Wheel 50 feet with two turns.

4. **Indicate the type of wheelchair/scooter used:** In the above example Mr. R used a motorized wheelchair during the 3-day assessment period.

   Coding: GG0170RR would be coded 2, Motorized.
   Rationale: Mr. R used a motorized wheelchair during the 3-day assessment period.

5. **Wheel 50 feet with two turns:** Mr. V had a spinal tumor resulting in paralysis of his lower extremities. The *physical therapist* assistant provides verbal instruction for Mr. V to navigate his manual wheelchair in his room and into the hallway while making two turns.

   Coding: GG0170R would be coded 04, Supervision or touching assistance.
   Rationale: The helper provided verbal cues for the resident to complete the activity, Wheel 50 feet with two turns.

6. **Indicate the type of wheelchair/scooter used:** In the above example Mr. V used a manual wheelchair during the 3-day assessment period.

   Coding: GG0170RR would be coded 1, Manual.
   Rationale: Mr. V used a manual wheelchair during the 3-day assessment period.

7. **Wheel 50 feet with two turns:** Once seated in the manual wheelchair, Ms. R wheels about 10 feet in the corridor, then asks the certified nursing assistant to push the wheelchair an additional 40 feet turning into her room and then turning into her bathroom.

   Coding: GG0170R would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provides more than half the effort to assist the resident to complete the activity.

8. **Indicate the type of wheelchair/scooter used:** In the above example Ms. R used a manual wheelchair during the 3-day assessment period.

   Coding: GG0170RR would be coded 1, Manual.
   Rationale: Ms. R used a manual wheelchair during the 3-day assessment period.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Examples for GG0170S, Wheel 150 feet and GG0170SS, Indicate the type of wheelchair/scooter used

1. **Wheel 150 feet:** Mr. G always uses a motorized scooter to mobilize himself down the hallway and the certified nursing assistant provides cues due to safety issues (to avoid running into the walls).

   Coding: GG0170S would be coded 04, Supervision or touching assistance.
   Rationale: The helper provides verbal cues to complete the activity.

2. **Indicate the type of wheelchair/scooter used:** In the example above, Mr. G uses a motorized scooter.

   Coding: GG0170SS would be coded 2, Motorized.
   Rationale: Mr. G used a motorized scooter during the 3-day assessment period.

3. **Wheel 150 feet:** Mr. N uses a below-the-knee prosthetic limb. Mr. N has peripheral neuropathy and limited vision due to complications of diabetes. Mr. N's prior preference was to ambulate within the home and use a manual wheelchair when mobilizing himself within the community. Mr. N is assessed for the activity of 150 feet wheelchair mobility. Mr. N's usual performance indicates a helper is needed to provide verbal cues for safety due to vision deficits.

   Coding: GG0170S would be coded 04, Supervision or touching assistance.
   Rationale: Mr. N requires the helper to provide verbal cues for his safety when using a wheelchair for 150 feet.

4. **Indicate the type of wheelchair/scooter used:** In the above example Mr. N used a manual wheelchair during the 3-day assessment period.

   Coding: GG0170SS would be coded 1, Manual.
   Rationale: Mr. N used a manual wheelchair during the 3-day assessment period.

5. **Wheel 150 feet:** Mr. L has multiple sclerosis, resulting in extreme muscle weakness and minimal vision impairment. Mr. L uses a motorized wheelchair with an adaptive joystick to control both the speed and steering of the motorized wheelchair. He occasionally needs reminders to slow down around the turns and requires assistance from the nurse for backing up the scooter when barriers are present.

   Coding: GG0170S would be coded 03, Partial/moderate assistance.
   Rationale: The helper provides less than half of the effort to complete the activity of wheel 150 feet.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

6. **Indicate the type of wheelchair/scooter used:** Mr. L used a motorized wheelchair during the 3-day assessment period.

   Coding: GG0170SS would be coded 2, Motorized.
   Rationale: Mr. L used a motorized wheelchair during the 3-day assessment period.

7. **Wheel 150 feet:** Mr. M has had a mild stroke, resulting in muscle weakness in his right upper and lower extremities. Mr. M uses a manual wheelchair. He usually can self-propel himself about 60 to 70 feet but needs assistance from a helper to complete the distance of 150 feet.

   Coding: GG0170S would be coded 02, Substantial/Maximal assistance.
   Rationale: The helper provides more than half of the effort to complete the activity of wheel 150 feet.

8. **Indicate the type of wheelchair/scooter used:** In the above example, Mr. M used a manual wheelchair during the 3-day assessment period.

   Coding: GG0170SS would be coded 1, Manual.
   Rationale: Mr. M used a manual wheelchair during the 3-day assessment period.

9. **Wheel 150 feet:** Mr. A has a cardiac condition with medical precautions that do not allow him to *propel his own* wheelchair. Mr. A is completely dependent on a helper to wheel him 150 feet using a manual wheelchair.

   Coding: GG0170S would be coded 01, Dependent.
   Rationale: The helper provides all the effort and the resident does none of the effort to complete the activity of wheel 150 feet.

10. **Indicate the type of wheelchair/scooter used:** In the above example, Mr. A is wheeled using a manual wheelchair during the 3-day assessment period.

    Coding: GG0170SS would be coded 1, Manual.
    Rationale: Mr. A is assisted using a manual wheelchair during the 3-day assessment period.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

Examples of Probing Conversations with Staff

1. **Sit to lying:** Example of a probing conversation between a nurse determining a resident's score for sit to lying and a certified nursing assistant regarding the resident's bed mobility:

   Nurse: "Please describe how Mrs. H moves herself from sitting on the side of the bed to lying flat on the bed. When she is sitting on the side of the bed, how does she move to lying on her back?"

   Certified nursing assistant: "She can lie down with some help."

   Nurse: "Please describe how much help she needs and exactly how you help her."

   Certified nursing assistant: "I have to lift and position her right leg, but once I do that, she can use her arms to position her upper body."

   In this example, the nurse inquired specifically about how Mrs. H moves from a sitting position to a lying position. The nurse asked about physical assistance.

   Coding: GG0170B would be coded 03, Partial/moderate assistance.

   Rationale: The certified nursing assistant lifts Mrs. H's right leg and helps her position it as she moves from a sitting position to a lying position. The helper does less than half the effort.

2. **Lying to sitting on side of bed:** Example of a probing conversation between a nurse determining a resident's score for lying to sitting on side of bed and a certified nursing assistant regarding the resident's bed mobility:

   Nurse: "Please describe how Mrs. L moves herself in bed. When she is in bed, how does she move from lying on her back to sitting up on the side of the bed?"

   Certified nursing assistant: "She can sit up by herself."

   Nurse: "She sits up without any instructions or physical help?"

   Certified nursing assistant: "No, I have to remind her to check on the position of her arm that has limited movement and sensation as she moves in the bed, but once I remind her to check her arm, she can do it herself."

   In this example, the nurse inquired specifically about how Mrs. L moves from a lying position to a sitting position. The nurse asked about instructions and physical assistance.

   Coding: GG0170C would be coded 04, Supervision or touching assistance.

   Rationale: The certified nursing assistant provides verbal instructions as the resident moves from a lying to sitting position.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

3. **Sit to stand:** Example of a probing conversation between a nurse determining a resident's sit to stand score and a certified nursing assistant regarding the resident's sit to stand ability:

   Nurse: "Please describe how Mrs. L usually moves from sitting on the side of the bed or chair to a standing position. Once she is sitting, how does she get to a standing position?"

   Certified nursing assistant: "She needs help to get to sitting up and then standing."

   Nurse: "I'd like to know how much help she needs for safely rising up from sitting in a chair or sitting on the bed to get to a standing position."

   Certified nursing assistant: "She needs two people to assist her to stand up from sitting on the side of the bed or when she is sitting in a chair."

   In this example, the nurse inquired specifically about how Mrs. L moves from a sitting position to a standing position and clarified that this did not include any other positioning to be included in the answer. The nurse specifically asked about physical assistance.

   Coding: GG0170D would be coded 01, Dependent.
   Rationale: Mrs. L requires the assistance of two helpers to complete the activity.

4. **Chair/bed-to-chair transfer:** Example of a probing conversation between a nurse determining a resident's score for chair/bed-to-chair transfer and a certified nursing assistant regarding the resident's chair/bed-to-chair transfer ability:

   Nurse: "Please describe how Mr. C moves into the chair from the bed. When he is sitting at the side of the bed, how much help does he need to move from the bed to the chair?"

   Certified nursing assistant: "He needs me to help him move from the bed to the chair."

   Nurse: "Does he help with these transfers when you give him any instructions, setup, or physical help?"

   Certified nursing assistant: "Yes, he will follow some of my instructions to get ready to transfer, such as moving his feet from being spread out to placing them under his knees. I have to place the chair close to the bed and then I lift him because he is very weak. I then tell him to reach for the armrest of the chair. Mr. C follows these directions and that helps a little in transferring him from the bed to the chair. He does help with the transfer."

   In this example, the nurse inquired specifically about how Mr. C moves from sitting on the side of the bed to sitting in a chair. The nurse asked about instructions, physical assistance, and cueing instructions. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. C received.

   Coding: GG0170E would be coded 02, Substantial/maximal assistance.
   Rationale: The helper provides more than half of the effort to complete the activity of Chair/bed-to-chair transfer.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

5. **Toilet transfer:** Example of a probing conversation between a nurse determining the resident's score and a certified nursing assistant regarding a resident's toilet transfer assessment:

   Nurse: "I understand that Mrs. M usually uses a wheelchair to get to her toilet. Please describe how Mrs. M moves from her wheelchair to the toilet. How does she move from sitting in a wheelchair to sitting on the toilet?"

   Certified nursing assistant: "It is hard for her, but she does it with my help."

   Nurse: "Can you describe the amount of help in more detail?"

   Certified nursing assistant: "I have to give her a bit of a lift using a gait belt to get her to stand and then remind her to reach for the toilet grab bar while she pivots to the toilet. Sometimes, I have to remind her to take a step while she pivots to or from the toilet, but she does most of the effort herself."

   In this example, the nurse inquired specifically about how Mrs. M moves from sitting in a wheelchair to sitting on the toilet. The nurse specifically asked about instructions and physical assistance. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. M received.

   Coding: GG0170F would be coded 03, Partial/moderate assistance.
   Rationale: The certified nursing assistant provides less than half the effort to complete this activity.

6. **Walk 50 feet with two turns:** Example of a probing conversation between a nurse determining a resident's score for walking 50 feet with two turns and a certified nursing assistant regarding the resident's walking ability:

   Nurse: "How much help does Mr. T need to walk 50 feet and make two turns once he is standing?"

   Certified nursing assistant: "He needs help to do that."

   Nurse: "How much help does he need?"

   Certified nursing assistant: "He walks about 50 feet with one of us holding onto the gait belt and another person following closely with a wheelchair in case he needs to sit down."

   In this example, the nurse inquired specifically about how Mr. T walks 50 feet and makes two turns. The nurse asked about physical assistance. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. T received.

   Coding: GG0170J would be coded 01, Dependent.
   Rationale: Mr. T requires two helpers to complete this activity.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

7. **Walk 150 feet:** Example of a probing conversation between a nurse determining a resident's score for walking 150 feet and a certified nursing assistant regarding the resident's walking ability:

   Nurse: "Please describe how Mrs. D walks 150 feet in the corridor once she is standing."

   Certified nursing assistant: "She uses a walker and some help."

   Nurse: "She uses a walker and how much instructions or physical help does she need?"

   Certified nursing assistant: "I have to support her by holding onto the gait belt that is around her waist so that she doesn't fall. She does push the walker forward most of the time."

   Nurse: "Do you help with more than or less than half the effort?"

   Certified nursing assistant: "I have to hold onto her belt firmly when she walks because she frequently loses her balance when taking steps. Her balance gets worse the further she walks, but she is very motivated to keep walking. I would say I help her with more than half the effort."

   In this example, the nurse inquired specifically about how Mrs. D walks 150 feet. The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mrs. D received.

   Coding: GG0170K would be coded 02, Substantial/maximal assistance**.**
   Rationale: The certified nursing assistant provides trunk support that is more than half the effort as Mrs. D walks 150 feet.

8. **Wheel 50 feet with two turns:** Example of a probing conversation between a nurse determining a resident's score for wheel 50 feet with two turns and a certified nursing assistant regarding the resident's mobility:

   Nurse: "I understand that Ms. R uses a manual wheelchair. Describe to me how Ms. R wheels herself 50 feet and makes two turns once she is seated in the wheelchair."

   Certified nursing assistant: "She wheels herself."

   Nurse: "She wheels herself without any instructions or physical help?"

   Certified nursing assistant: "Well yes, she needs help to get around turns, so I have to help her and set her on a straight path, but once I do, she wheels herself."

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

In this example, the nurse inquired specifically about how Ms. R wheels 50 feet with two turns. The nurse asked about instructions and physical assistance. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Ms. R received.

Coding: GG0170R would be coded 03, Partial/Moderate assistance.

Rationale: The certified nursing assistant must physically push the wheelchair at some points of the activity; however, the helper does less than half of the activity for the resident.

9. **Wheel 150 feet:** Example of a probing conversation between a nurse determining a resident's score for wheel 150 feet and a certified nursing assistant regarding the resident's mobility:

   Nurse: "I understand that Mr. G usually uses an electric scooter for longer distances. Once he is seated in the scooter, does he need any help to mobilize himself at least 150 feet?"

   Certified nursing assistant: "He drives the scooter himself … he's very slow."

   Nurse: "He uses the scooter himself without any instructions or physical help?"

   Certified nursing assistant: "That is correct."

   In this example, the nurse inquired specifically about how Mr. G uses an electric scooter to mobilize himself 150 feet. If this nurse had not asked probing questions, he/she would not have received enough information to make an accurate assessment of the actual assistance Mr. G received.

   Coding: GG0170S would be coded 06, Independent.

   Rationale: The resident navigates in the corridor for at least 150 feet without assistance.

Discharge Goals: Coding Tips

Discharge goals are coded with each Admission (Start of SNF PPS Stay) assessment.

- For the SNF QRP, a minimum of one self-care or mobility goal must be coded. However, facilities may choose to complete more than one self-care or mobility discharge goal. Code the resident's discharge goal(s) using the six-point scale. Use of "activity not attempted" codes (07, 09, 10, and 88) is permissible to code discharge goal(s). The use of a dash is permissible for any remaining self-care or mobility goals that were not coded. Using the dash in this allowed instance after the coding of at least one goal does not affect APU determination.

GG0170: Mobility (3-day assessment period) Admission/*Interim/* Discharge (Start/*Interim/*End of Medicare Part A Stay) (cont.)

- Licensed qualified clinicians can establish a resident's discharge goal(s) at the time of admission based on the resident's prior medical condition, Admission assessment self-care and mobility status, discussions with the resident and family, professional judgment, the profession's practice standards, expected treatments, resident motivation to improve, anticipated length of stay, and the resident's discharge plan. Goals should be established as part of the resident's care plan.
- If the performance of an activity was coded 88, Not attempted due to medical condition or safety concerns, during the Admission assessment, a discharge goal may be coded using the six-point scale if the resident is expected to be able to perform the activity by discharge.

SECTION I: ACTIVE DIAGNOSES

Intent: The items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status.

I0020: Indicate the resident's primary medical condition category

I0020. Indicate the resident's primary medical condition category
Complete only if A0310B = 01 or 08

Enter Code ☐☐

Indicate the resident's primary medical condition category that best describes the primary reason for admission

01. **Stroke**
02. **Non-Traumatic Brain Dysfunction**
03. **Traumatic Brain Dysfunction**
04. **Non-Traumatic Spinal Cord Dysfunction**
05. **Traumatic Spinal Cord Dysfunction**
06. **Progressive Neurological Conditions**
07. **Other Neurological Conditions**
08. **Amputation**
09. **Hip and Knee Replacement**
10. **Fractures and Other Multiple Trauma**
11. **Other Orthopedic Conditions**
12. **Debility, Cardiorespiratory Conditions**
13. **Medically Complex Conditions**

I0020B. ICD Code

☐☐☐☐☐☐☐☐

Item Rationale

Health-related Quality of Life

- Disease processes can have a significant adverse effect on residents' functional improvement.

Planning for Care

- *Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay*.

Steps for Assessment

1. *Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay*. Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.

I0020: Indicate the resident's primary medical condition category (cont.)

Coding Instructions

Complete only if A0310B = 01 or 08

- *Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay; then proceed to I0020B and enter the International Classification of Diseases (ICD) code for that condition, including the decimal.*
- *While certain conditions described below represent acute diagnoses, SNFs should not use acute diagnosis codes in I0020B. Sequelae and other such codes should be used instead.*
- Include the primary medical condition coded in this item in Section I: Active Diagnoses in the last 7 days.
  - **Code 01, Stroke,** if the resident's primary medical condition category is due to stroke. Examples include ischemic stroke, subarachnoid hemorrhage, cerebral vascular accident (CVA), and other cerebrovascular disease.
  - **Code 02, Non-Traumatic Brain Dysfunction,** if the resident's primary medical condition category is non-traumatic brain dysfunction. Examples include Alzheimer's disease, dementia with or without behavioral disturbance, malignant neoplasm of brain, and anoxic brain damage.
  - **Code 03, Traumatic Brain Dysfunction,** if the resident's primary medical condition category is traumatic brain dysfunction. Examples include traumatic brain injury, severe concussion, and cerebral laceration and contusion.
  - **Code 04, Non-Traumatic Spinal Cord Dysfunction,** if the resident's primary medical condition category is non-traumatic spinal cord injury. Examples include spondylosis with myelopathy, transverse myelitis, spinal cord lesion due to spinal stenosis, and spinal cord lesion due to dissection of aorta.
  - **Code 05, Traumatic Spinal Cord Dysfunction,** if the resident's primary medical condition category is due to traumatic spinal cord dysfunction. Examples include paraplegia and quadriplegia following trauma.
  - **Code 06, Progressive Neurological Conditions,** if the resident's primary medical condition category is a progressive neurological condition. Examples include multiple sclerosis and Parkinson's disease.
  - **Code 07, Other Neurological Conditions,** if the resident's primary medical condition category is other neurological condition. Examples include cerebral palsy, polyneuropathy, and myasthenia gravis.
  - **Code 08, Amputation,** if the resident's primary medical condition category is an amputation. An example is acquired absence of limb.
  - **Code 09, Hip and Knee Replacement,** if the resident's primary medical condition category is due to a hip or knee replacement. An example is total knee replacement. If hip replacement is secondary to hip fracture, code as fracture.

I0020: Indicate the resident's primary medical condition category (cont.)

- **Code 10, Fractures and Other Multiple Trauma,** if the resident's primary medical condition category is fractures and other multiple trauma. Examples include hip fracture, pelvic fracture, and fracture of tibia and fibula.
- **Code 11, Other Orthopedic Conditions,** if the resident's primary medical condition category is other orthopedic condition. An example is unspecified disorders of joint.
- **Code 12, Debility, Cardiorespiratory Conditions,** if the resident's primary medical condition category is debility or a cardiorespiratory condition. Examples include chronic obstructive pulmonary disease (COPD), asthma, and other malaise and fatigue.
- **Code 13, Medically Complex Conditions,** if the resident's primary medical condition category is a medically complex condition. Examples include diabetes, pneumonia, chronic kidney disease, open wounds, pressure ulcer/injury, infection, and disorders of fluid, electrolyte, and acid-base balance.

Examples of Primary Medical Condition

1. Ms. K is a 67-year-old female with a history of Alzheimer's dementia and diabetes who is admitted after a stroke. The diagnosis of stroke, as well as the history of Alzheimer's dementia and diabetes, is documented in Ms. K's history and physical by the admitting physician.

   Coding: I0020 would be coded **01, Stroke.** *I0020B would be coded as I69.051 (Hemiplegia and hemiparesis following non-traumatic subarachnoid hemorrhage).*

   Rationale: The physician's history and physical documents the diagnosis stroke as the reason for Ms. K's admission. *The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.*

2. Mrs. E is an 82-year-old female who was hospitalized for a hip fracture with subsequent total hip replacement and is admitted for rehabilitation. The admitting physician documents Mrs. E's primary medical condition as total hip replacement (THR) in her medical record. The hip fracture resulting in the total hip replacement is also documented in the medical record in the discharge summary from the acute care hospital.

   Coding: I0020 would be coded **10, Fractures and Other Multiple Trauma.** *I0020B would be coded as S72.062D (Displaced articular fracture of the head of the left femur).*

   Rationale: Medical record documentation demonstrates that Mrs. E had a total hip replacement due to a hip fracture and required rehabilitation. Because she was admitted for rehabilitation as a result of the hip fracture and total hip replacement, Mrs. E's primary medical condition category is **10, Fractures and Other Multiple Trauma.** *The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.*

I0020: Indicate the resident's primary medical condition category (cont.)

3. *Mrs. H is a 78-year-old female with a history of hypertension and a hip replacement 2 years ago. She was admitted to an extended hospitalization for idiopathic pancreatitis. She had a central line placed during the hospitalization so she could receive TPN (total parenteral nutrition). She also received regular blood glucose monitoring and treatment with insulin when she became hyperglycemic. During her SNF stay, she is being transitioned from being NPO (nothing by mouth) and receiving her nutrition parenterally to being able to tolerate oral nutrition. The hospital discharge diagnoses of idiopathic pancreatitis, hypertension, and malnutrition were incorporated into Mrs. H's SNF medical record.*

   Coding: *I0020 would be coded* ***13, Medically Complex Conditions.*** *I0020B would be coded as K85.00 (Idiopathic acute pancreatitis without necrosis or infection).*

   Rationale: *Mrs. H had hospital care for pancreatitis immediately prior to her SNF stay. Her principal diagnosis of pancreatitis was included in the summary from the hospital. The surgical placement of her central line does not change her care to a surgical category because it is not considered to be a major surgery. The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.*

I: Active Diagnoses in the Last 7 Days

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

	Cancer
☐	**I0100. Cancer** (with or without metastasis)
	Heart/Circulation
☐	**I0200. Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
☐	**I0300. Atrial Fibrillation or Other Dysrhythmias** (e.g., bradycardias and tachycardias)
☐	**I0400. Coronary Artery Disease (CAD)** (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
☐	**I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)**
☐	**I0600. Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
☐	**I0700. Hypertension**
☐	**I0800. Orthostatic Hypotension**
☐	**I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**
	Gastrointestinal
☐	**I1100. Cirrhosis**
☐	**I1200. Gastroesophageal Reflux Disease (GERD) or Ulcer** (e.g., esophageal, gastric, and peptic ulcers)
☐	**I1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease**
	Genitourinary
☐	**I1400. Benign Prostatic Hyperplasia (BPH)**
☐	**I1500. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)**
☐	**I1550. Neurogenic Bladder**
☐	**I1650. Obstructive Uropathy**
	Infections
☐	**I1700. Multidrug-Resistant Organism (MDRO)**
☐	**I2000. Pneumonia**
☐	**I2100. Septicemia**
☐	**I2200. Tuberculosis**
☐	**I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)**
☐	**I2400. Viral Hepatitis** (e.g., Hepatitis A, B, C, D, and E)
☐	**I2500. Wound Infection** (other than foot)
	Metabolic
☐	**I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
☐	**I3100. Hyponatremia**
☐	**I3200. Hyperkalemia**
☐	**I3300. Hyperlipidemia** (e.g., hypercholesterolemia)
☐	**I3400. Thyroid Disorder** (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)
	Musculoskeletal
☐	**I3700. Arthritis** (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))
☐	**I3800. Osteoporosis**
☐	**I3900. Hip Fracture** - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
☐	**I4000. Other Fracture**
	Neurological
☐	**I4200. Alzheimer's Disease**
☐	**I4300. Aphasia**
☐	**I4400. Cerebral Palsy**
☐	**I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
☐	**I4800. Non-Alzheimer's Dementia** (e.g. Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)

Neurological Diagnoses continued on next page

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

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Neurological - Continued

- ☐ **I4900. Hemiplegia or Hemiparesis**
- ☐ **I5000. Paraplegia**
- ☐ **I5100. Quadriplegia**
- ☐ **I5200. Multiple Sclerosis (MS)**
- ☐ **I5250. Huntington's Disease**
- ☐ **I5300. Parkinson's Disease**
- ☐ **I5350. Tourette's Syndrome**
- ☐ **I5400. Seizure Disorder or Epilepsy**
- ☐ **I5500. Traumatic Brain Injury (TBI)**

Nutritional

- ☐ **I5600. Malnutrition** (protein or calorie) or at risk for malnutrition

Psychiatric/Mood Disorder

- ☐ **I5700. Anxiety Disorder**
- ☐ **I5800. Depression** (other than bipolar)
- ☐ **I5900. Bipolar Disorder**
- ☐ **I5950. Psychotic Disorder** (other than schizophrenia)
- ☐ **I6000. Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
- ☐ **I6100. Post Traumatic Stress Disorder (PTSD)**

Pulmonary

- ☐ **I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
- ☐ **I6300. Respiratory Failure**

Vision

- ☐ **I6500. Cataracts, Glaucoma, or Macular Degeneration**

None of Above

- ☐ **I7900. None of the above active diagnoses** within the last 7 days

Other

I8000. Additional active diagnoses
Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

A. _____ | | | | | | | | |

B. _____ | | | | | | | | |

C. _____ | | | | | | | | |

D. _____ | | | | | | | | |

E. _____ | | | | | | | | |

F. _____ | | | | | | | | |

G. _____ | | | | | | | | |

H. _____ | | | | | | | | |

I. _____ | | | | | | | | |

J. _____ | | | | | | | | |

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

There are two look-back periods for this section:

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

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

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

   - Although open communication regarding diagnostic information between the physician and other members of the interdisciplinary team is important, it is also essential that diagnoses communicated verbally be documented in the medical record by the physician to ensure follow-up.
   - Diagnostic information, including past history obtained from family members and close contacts, must also be documented in the medical record by the physician to ensure validity and follow-up.

2. **Determine whether diagnoses are active:** Once a diagnosis is identified, it must be determined if the diagnosis is **active.** Active diagnoses are diagnoses that have a **direct relationship** to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses.

DEFINITIONS

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

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

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

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

- Item I2300 UTI, has specific coding criteria and does not use the active 7-day look-back. Please refer to Page I-*12* for specific coding instructions for Item I2300 UTI.
- Check the following information sources in the medical record for the last 7 days to identify "active" diagnoses: transfer documents, physician progress notes, recent history and physical, recent discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor's orders, consults and official diagnostic reports, and other sources as available.

Coding Instructions

Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period (except Item I2300 UTI, which does not use the active diagnosis 7-day look-back. Please refer to Item I2300 UTI, Page I-12 for specific coding instructions).

- Document active diagnoses on the MDS as follows:
  - Diagnoses are listed by major disease category: Cancer; Heart/Circulation; Gastrointestinal; Genitourinary; Infections; Metabolic; Musculoskeletal; Neurological; Nutritional; Psychiatric/Mood Disorder; Pulmonary; and Vision.
  - Examples of diseases are included for some disease categories. Diseases to be coded in these categories are not meant to be limited to only those listed in the examples. For example, **I0200, Anemia,** includes anemia of any etiology, including those listed (e.g., aplastic, iron deficiency, pernicious, sickle cell).
- Check off each active disease. Check all that apply.
- If a disease or condition is **not** specifically listed, enter the diagnosis and ICD code in item I8000, Additional active diagnosis.
- Computer specifications are written such that the ICD code should be automatically justified. The important element is to ensure that the ICD code's decimal point is in its own box and should be right justified (aligned with the right margin so that any unused boxes and on the left.)
- If an individual is receiving aftercare following a hospitalization, a Z code may be assigned. Z codes cover situations where a patient requires continued care for healing, recovery, or long-term consequences of a disease when initial treatment for that disease has already been performed. When Z codes are used, another diagnosis for the related primary medical condition should be checked in items I0100–I7900 or entered in I8000. ICD-10-CM coding guidance with links to appendices can be found here: https://www.cms.gov/Medicare/Coding/ICD10/index.html.

Cancer

- **I0100,** cancer (with or without metastasis)

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

Heart/Circulation

- **I0200,** anemia (e.g., aplastic, iron deficiency, pernicious, sickle cell)
- **I0300,** atrial fibrillation or other dysrhythmias (e.g., bradycardias, tachycardias)
- **I0400,** coronary artery disease (CAD) (e.g., angina, myocardial infarction, atherosclerotic heart disease [ASHD])
- **I0500,** deep venous thrombosis (DVT), pulmonary embolus (PE), or pulmonary thrombo-embolism (PTE)
- **I0600,** heart failure (e.g., congestive heart failure [CHF], pulmonary edema)
- **I0700,** hypertension
- **I0800,** orthostatic hypotension
- **I0900,** peripheral vascular disease or peripheral arterial disease

Gastrointestinal

- **I1100,** cirrhosis
- **I1200,** gastroesophageal reflux disease (GERD) or ulcer (e.g., esophageal, gastric, and peptic ulcers)
- **I1300,** ulcerative colitis or Crohn's disease or inflammatory bowel disease

Genitourinary

- **I1400,** benign prostatic hyperplasia (BPH)
- **I1500,** renal insufficiency, renal failure, or end-stage renal disease (ESRD)
- **I1550,** neurogenic bladder
- **I1650,** obstructive uropathy

Infections

- **I1700,** multidrug resistant organism (MDRO)
- **I2000,** pneumonia
- **I2100,** septicemia
- **I2200,** tuberculosis
- **I2300,** urinary tract infection (UTI) (last 30 days)
- **I2400,** viral hepatitis (e.g., hepatitis A, B, C, D, and E)
- **I2500,** wound infection (other than foot)

Metabolic

- **I2900,** diabetes mellitus (DM) (e.g., diabetic retinopathy, nephropathy, neuropathy)

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

- **I3100,** hyponatremia
- **I3200,** hyperkalemia
- **I3300,** hyperlipidemia (e.g., hypercholesterolemia)
- **I3400,** thyroid disorder (e.g., hypothyroidism, hyperthyroidism, Hashimoto's thyroiditis)

Musculoskeletal

- **I3700,** arthritis (e.g., degenerative joint disease [DJD], osteoarthritis, rheumatoid arthritis [RA])
- **I3800,** osteoporosis
- **I3900,** hip fracture (any hip fracture that has a relationship to current status, treatments, monitoring (e.g., subcapital fractures and fractures of the trochanter and femoral neck)
- **I4000,** other fracture

Neurological

- **I4200,** Alzheimer's disease
- **I4300,** aphasia
- **I4400,** cerebral palsy
- **I4500,** cerebrovascular accident (CVA), transient ischemic attack (TIA), or stroke
- **I4800,** dementia (e.g., Lewy-Body dementia; vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia, such as Pick's disease; and dementia related to stroke, Parkinson's disease or Creutzfeldt-Jakob diseases)
- **I4900,** hemiplegia or hemiparesis
- **I5000,** paraplegia
- **I5100,** quadriplegia
- **I5200,** multiple sclerosis (MS)
- **I5250,** Huntington's disease
- **I5300,** Parkinson's disease
- **I5350,** Tourette's syndrome
- **I5400,** seizure disorder or epilepsy
- **I5500,** traumatic brain injury (TBI)

Nutritional

- **I5600,** malnutrition (protein or calorie) or at risk for malnutrition

Psychiatric/Mood Disorder

- **I5700,** anxiety disorder

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

- **I5800,** depression (other than bipolar)
- **I5900,** bipolar *disorder*
- **I5950,** psychotic disorder (other than schizophrenia)
- **I6000,** schizophrenia (e.g., schizoaffective and schizophreniform disorders)
- **I6100,** post-traumatic stress disorder (PTSD)

Pulmonary

- **I6200,** asthma, chronic obstructive pulmonary disease (COPD), or chronic lung disease (e.g., chronic bronchitis and restrictive lung diseases, such as asbestosis)
- **I6300,** respiratory failure

Vision

- **I6500,** cataracts, glaucoma, or macular degeneration

None of Above

- **I7900,** none of the above active diagnoses within the past 7 days

Other

- **I8000,** additional active diagnoses

Coding Tips

The following indicators may assist assessors in determining whether a diagnosis should be coded as active in the MDS.

- **There may be specific documentation in the medical record by a physician, nurse practitioner, physician assistant, or clinical nurse specialist of active diagnosis.**
  - The physician may specifically indicate that a condition is active. Specific documentation may be found in progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc.
  - For example, the physician documents that the resident has inadequately controlled hypertension and will modify medications. This would be sufficient documentation of active disease and would require no additional confirmation.
- **In the absence of specific documentation that a disease is active, the following indicators may be used to confirm active disease:**
  - Recent onset or acute exacerbation of the disease or condition indicated by a positive study, test or procedure, hospitalization for acute symptoms and/or recent change in therapy in the last 7 days. Examples of a recent onset or acute exacerbation include the following: new diagnosis of pneumonia indicated by chest X-ray; hospitalization for fractured hip; or a blood transfusion for a hematocrit of 24. Sources may include radiological reports, hospital discharge summaries, doctor's orders, etc.

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

- Symptoms and abnormal signs indicating ongoing or decompensated disease in the last 7 days. For example, intermittent claudication (lower extremity pain on exertion) in conjunction with a diagnosis of peripheral vascular disease would indicate active disease. Sometimes signs and symptoms can be nonspecific and could be caused by several disease processes. Therefore, a symptom must be specifically attributed to the disease. For example, a productive cough would confirm a diagnosis of pneumonia if specifically noted as such by a physician. Sources may include radiological reports, nursing assessments and care plans, progress notes, etc.
- Listing a disease/diagnosis (e.g., arthritis) on the resident's medical record problem list is not sufficient for determining active or inactive status. To determine if arthritis, for example, is an "active" diagnosis, the reviewer would check progress notes (including the history and physical) during the 7-day look-back period for notation of treatment of symptoms of arthritis, doctor's orders for medications for arthritis, and documentation of physical or other therapy for functional limitations caused by arthritis.
- Ongoing therapy with medications or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor potentially severe side effects in the last 7 days. A medication indicates active disease if that medication is prescribed to manage an ongoing condition that requires monitoring or is prescribed to decrease active symptoms associated with a condition. This includes medications used to limit disease progression and complications. If a medication is prescribed for a condition that requires regular staff monitoring of the drug's effect on that condition (therapeutic efficacy), then the prescription of the medication would indicate active disease.

- **It is expected that nurses monitor all medications for adverse effects as part of usual nursing practice.** For coding purposes, this monitoring relates to management of pharmacotherapy and not to management or monitoring of the underlying disease.
- **Item I2300 Urinary tract infection (UTI):**
  - The UTI has a look-back period of 30 days for active disease instead of 7 days.
  - **Code only if both of the following are met in the last 30 days:**
    1. It was determined that the resident had a UTI using evidence-based criteria such as McGeer, NHSN, or Loeb in the last 30 days,

       AND
    2. A physician documented UTI diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days.

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

— In accordance with requirements at §483.80(a) Infection Prevention and Control Program, the facility must establish routine, ongoing and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections. The facility's surveillance system must include a data collection tool and the use of nationally recognized surveillance criteria. Facilities are expected to use the same nationally recognized criteria chosen for use in their Infection Prevention and Control Program to determine the presence of a UTI in a resident.

— Example: if a facility chooses to use the Surveillance Definitions of Infections (updated McGeer criteria) as part of the facility's Infection Prevention and Control Program, then the facility should also use the same criteria to determine whether or not a resident has a UTI.

— If the diagnosis of UTI was made prior to the resident's admission, entry, or reentry into the facility, it is **not** necessary to obtain or evaluate the evidence-based criteria used to make the diagnosis in the prior setting. A documented physician diagnosis of UTI prior to admission is acceptable. This information may be included in the hospital transfer summary or other paperwork.

— When the resident is transferred, but not admitted, to a hospital (e.g., emergency room visit, observation stay) the facility must use evidence-based criteria to evaluate the resident and determine if the criteria for UTI are met AND verify that there is a physician-documented UTI diagnosis when completing I2300 Urinary Tract Infection (UTI).

— **Resources for evidence-based UTI criteria:**

- Loeb criteria: https://www.researchgate.net/publication/12098745_Development_of_Minimum_Criteria_for_the_Initiation_of_Antibiotics_in_Residents_of_Long-Term-Care_Facilities_Results_of_a_Consensus_Conference
- Surveillance Definitions of Infections in LTC (updated McGeer criteria): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538836/
- National Healthcare Safety Network (NHSN): https://www.cdc.gov/nhsn/ltc/uti/index.html

In response to questions regarding the resident with colonized MRSA, we consulted with the Centers for Disease Control (CDC) who provided the following information:

A physician often prescribes empiric antimicrobial therapy for a suspected infection **after a culture is obtained, but prior to receiving the culture results**. The confirmed diagnosis of UTI will depend on the culture results and other clinical assessment to determine appropriateness and continuation of antimicrobial therapy. This should not be any different, even if the resident is known to be colonized with an antibiotic resistant organism. An appropriate culture will help to ensure the diagnosis of infection is correct, and the appropriate antimicrobial is prescribed to treat the infection. The CDC does not

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

recommend routine antimicrobial treatment for the purposes of attempting to eradicate colonization of MRSA or any other antimicrobial resistant organism.

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

- Item I5100 Quadriplegia:
  - Quadriplegia primarily refers to the paralysis of all four limbs, arms and legs, caused by spinal cord injury.
  - Coding I5100 Quadriplegia is limited to spinal cord injuries and must be a primary diagnosis and not the result of another condition.
  - Functional quadriplegia refers to complete immobility due to severe physical disability or frailty. Conditions such as cerebral palsy, stroke, contractures, brain disease, advanced dementia, etc. can also cause functional paralysis that may extend to all limbs hence, the diagnosis functional quadriplegia. For individuals with these types of severe physical disabilities, where there is minimal ability for purposeful movement, their primary physician-documented diagnosis should be coded on the MDS and not the resulting paralysis or paresis from that condition. For example, an individual with cerebral palsy with spastic quadriplegia should be coded in I4400 Cerebral Palsy, and not in I5100, Quadriplegia.

Examples of Active Disease

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

   Coding: Hypertension item (I0700), would be **checked**.
   Rationale: This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy.

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

   Coding: Atrial fibrillation item (I0300), would be **checked**.
   Rationale: This would be considered an active diagnosis because of the need for ongoing monitoring to ensure treatment efficacy as well as to monitor for side effects related to the medication.

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

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

   Coding: Arthritis item (I3700), would be **checked**.
   Rationale: Arthritis would be considered an active diagnosis because of the need for medical therapy. Given that the resident has a history of a healed peptic ulcer without current symptoms, the proton-pump inhibitor prescribed is preventive and therefore PUD would not be coded as an active disease.

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

   Coding: Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke item (I4500), would be **checked**.
   Rationale: The physician note within the last 30 days indicates stroke, and the resident is receiving medication and therapies to manage continued symptoms from stroke.

Examples of Inactive Diagnoses (do not code)

1. The admission history states that the resident had pneumonia 2 months prior to this admission. The resident has recovered completely, with no residual effects and no continued treatment during the 7-day look back period.

   Coding: Pneumonia item (I2000), would **not be checked.**
   Rationale: The pneumonia diagnosis would not be considered active because of the resident's complete recovery and the discontinuation of any treatment during the look-back period.

2. The problem list includes a diagnosis of coronary artery disease (CAD). The resident had an angioplasty 3 years ago, is not symptomatic, and is not taking any medication for CAD.

   Coding: CAD item (I0400), would **not be checked.**
   Rationale: The resident has had no symptoms and no treatment during the 7-day look-back period; thus, the CAD would be considered inactive.

3. Mr. J fell and fractured his hip 2 years ago. At the time of the injury, the fracture was surgically repaired. Following the surgery, the resident received several weeks of physical therapy in an attempt to restore him to his previous ambulation status, which had been independent without any devices. Although he received therapy services at that time, he now requires assistance to stand from the chair and uses a walker. He also needs help with lower body dressing because of difficulties standing and leaning over.

   Coding: Hip Fracture item (I3900), would **not be checked.**
   Rationale: Although the resident has mobility and self-care limitations in ambulation and ADLs due to the hip fracture, he has not received therapy services during the 7-day look-back period; thus, Hip Fracture would be considered inactive.

SECTION J: HEALTH CONDITIONS

Intent: The intent of the items in this section is to document a number of health conditions that impact the resident's functional status and quality of life. The items include an assessment of pain which uses an interview with the resident or staff if the resident is unable to participate. The pain items assess the presence of pain, pain frequency, effect on function, intensity, management and control. Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, falls*, prior surgery, and surgery requiring active SNF care*.

J0100: Pain Management (5-Day Look Back)

J0100. Pain Management - Complete for all residents, regardless of current pain level	
At any time in the last **5** days, has the resident:	
Enter Code ☐	**A. Received scheduled pain medication regimen?** 0. **No** 1. **Yes**
Enter Code ☐	**B. Received PRN pain medications OR was offered and declined?** 0. **No** 1. **Yes**
Enter Code ☐	**C. Received non-medication intervention for pain?** 0. **No** 1. **Yes**

Item Rationale

Health-related Quality of Life

- Pain can cause suffering and is associated with inactivity, social withdrawal, depression, and functional decline.
- Pain can interfere with participation in rehabilitation.
- Effective pain management interventions can help to avoid these adverse outcomes.

Planning for Care

- Goals for pain management for most residents should be to achieve a consistent level of comfort while maintaining as much function as possible.
- Identification of pain management interventions facilitates review of the effectiveness of pain management and revision of the plan if goals are not met.
- Residents may have more than one source of pain and will need a comprehensive, individualized management regimen.
- Most residents with moderate to severe pain will require regularly dosed pain medication, and some will require additional PRN (as-needed) pain medications for breakthrough pain.
- Some residents with intermittent or mild pain may have orders for PRN dosing only.

DEFINITION

PAIN MEDICATION REGIMEN

Pharmacological agent(s) prescribed to relieve or prevent the recurrence of pain. Include all medications used for pain management by any route and any frequency during the look-back period. Include oral, transcutaneous, subcutaneous, intramuscular, rectal, intravenous injections or intraspinal delivery. This item does not include medications that primarily target treatment of the underlying condition, such as chemotherapy or steroids, although such treatments may lead to pain reduction.

J0200: Should Pain Assessment Interview Be Conducted? (cont.)

2. Determine whether or not the resident is rarely/never understood verbally, in writing, or using another method. If the resident is rarely/never understood, skip to item J0800, Indicators of Pain or Possible Pain.
3. Review Language item (A1100) to determine whether or not the resident needs or wants an interpreter.
   - If the resident needs or wants an interpreter, complete the interview with an interpreter.

Coding Instructions

*Attempt to complete the interview if the resident is at least sometimes understood and an **interpreter is present** or not required.*

- **Code 0, no:** if the resident is rarely/never understood or an interpreter is required but not available. Skip to **Indicators of Pain or Possible Pain** item (J0800).
- **Code 1, yes:** if the resident is at least sometimes understood and an interpreter is present or not required. Continue to **Pain Presence** item (J0300).

Coding Tips and Special Populations

- Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.
- If the resident interview should have been conducted, but was not done within the look-back period of the ARD (except when an interpreter is needed/requested and unavailable), item J0200 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items J0300–J0600. Item J0700, Should the Staff Assessment for Pain be Conducted, is coded 0, No.
- Do not complete the Staff Assessment for Pain items (J0800–J0850) if the resident interview should have been conducted, but was not done.
- If it is not possible for an interpreter to be present during the look-back period, code J0200 = 0 to indicate interview not attempted and complete **Staff Assessment of Pain** item (J0800), instead of the **Pain Interview** items (J0300-J0600).

J1700: Fall History on Admission (cont.)

2. On admission interview a resident denies a history of falling. However, her daughter says that she found her mother on the floor near her toilet twice about 3-4 months ago.

   Coding: J1700B would be **coded 1, yes**.

   Rationale: If the individual is found on the floor, a fall is assumed to have occurred.

3. On admission interview, Mr. M. and his family deny any history of falling. However, nursing notes in the transferring hospital record document that Mr. M. repeatedly tried to get out of bed unassisted at night to go to the bathroom and was found on a mat placed at his bedside to prevent injury the week prior to nursing home transfer.

   Coding: J1700A would be **coded 1, yes**.

   Rationale: Medical records from an outside facility document that Mr. M. was found on a mat on the floor. This is defined as a fall.

4. Medical records note that Miss K. had hip surgery 5 months prior to admission to the nursing home. Miss K.'s daughter says the surgery was needed to fix a broken hip due to a fall.

   Coding: Both J1700B and J1700C would be **coded 1, yes**.

   Rationale: Miss K. had a fall related fracture 1-6 months prior to nursing home entry.

5. Mr. O.'s hospital transfer record includes a history of osteoporosis and vertebral compression fractures. The record does not mention falls, and Mr. O. denies any history of falling.

   Coding: J1700C would be **coded 0, no**.

   Rationale: The fractures were not related to a fall.

6. Ms. P. has a history of a "Colles' fracture" of her left wrist about 3 weeks before nursing home admission. Her son recalls that the fracture occurred when Ms. P. tripped on a rug and fell forward on her outstretched hands.

   Coding: Both J1700A and J1700C would be **coded 1, yes.**

   Rationale: Ms. P. had a fall-related fracture less than 1 month prior to entry.

J1800: Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent	
Enter Code ☐	Has the resident **had any falls since admission/entry or reentry or the prior assessment** (OBRA or Scheduled PPS), whichever is more recent? 0. **No** → Skip to J2000, Prior Surgery 1. **Yes** → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

Item Rationale

Health-related Quality of Life

- Falls are a leading cause of morbidity and mortality among nursing home residents.
- Falls result in serious injury, especially hip fractures.
- Fear of falling can limit an individual's activity and negatively impact quality of life.

DEFINITION

PRIOR ASSESSMENT
Most recent MDS assessment that reported on falls.

J1800: Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent (cont.)

Planning for Care

- Identification of residents who are at high risk of falling is a top priority for care planning. A previous fall is the most important predictor of risk for future falls.
- Falls may be an indicator of functional decline and development of other serious conditions such as delirium, adverse drug reactions, dehydration, and infections.
- External risk factors include medication side effects, use of appliances and restraints, and environmental conditions.
- A fall should stimulate evaluation of the resident's need for rehabilitation, ambulation aids, modification of the physical environment, or additional monitoring (e.g., toileting, to avoid incontinence).

Steps for Assessment

1. If this is the first assessment/entry or reentry (A0310E = 1), review the medical record for the time period from the admission date to the ARD.
2. If this is not the first assessment/entry or reentry (A0310E = 0), the review period is from the day after the ARD of the last MDS assessment to the ARD of the current assessment.
3. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment.
4. Review nursing home incident reports, fall logs and the medical record (physician, nursing, therapy, and nursing assistant notes).
5. Ask the resident and family about falls during the look-back period. Resident and family reports of falls should be captured here whether or not these incidents are documented in the medical record.

Coding Instructions

- **Code 0, no:** if the resident has not had any fall since the last assessment. Skip to **Swallowing Disorder** item (K0100*) if the assessment being completed is an OBRA assessment. If the assessment being completed is a Scheduled PPS assessment, skip to **Prior Surgery** item (J2000*).
- **Code 1, yes:** if the resident has fallen since the last assessment. Continue to **Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)** item (J1900), whichever is more recent.

Example

1. An incident report describes an event in which Mr. S. was walking down the hall and appeared to slip on a wet spot on the floor. He lost his balance and bumped into the wall, but was able to grab onto the hand rail and steady himself.

   Coding: J1800 would be **coded 1, yes**.
   Rationale: An intercepted fall is considered a fall.

J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent (cont.)

- **Code 2, two or more:** if the resident had two or more injurious falls (except major) since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

Coding Instructions for J1900C, Major Injury

- **Code 0, none:** if the resident had no major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 1, one:** if the resident had one major injurious fall since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).
- **Code 2, two or more:** if the resident had two or more major injurious falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

Coding Tip

- If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to *the Quality Improvement and Evaluation System (*QIES*) Assessment Submission and Processing (*ASAP*) system*, the assessment must be modified to update the level of injury that occurred with that fall.

Examples

1. A nursing note states that Mrs. K. slipped out of her wheelchair onto the floor while at the dining room table. Before being assisted back into her chair, a *range of motion* assessment was completed that indicated no injury. *A skin assessment conducted shortly after the fall also revealed no injury.*

   Coding: J1900A would be **coded 1, one**.

   Rationale: Slipping to the floor is a fall. No injury was noted.

2. Nurse's notes describe a situation in which Ms. Z. went out with her family for dinner. When they returned, her son stated that while at the restaurant, she fell in the bathroom. No injury was noted when she returned from dinner.

   Coding: J1900A would be **coded 1, one**.

   Rationale: Falls during the nursing home stay, even if on outings, are captured here.

3. A nurse's note describes a resident who, while being treated for pneumonia, climbed over his bedrails and fell to the floor. He had a cut over his left eye and some swelling on his arm. He was sent to the emergency room, where X-rays revealed no injury and neurological checks revealed no changes in mental status.

   Coding: J1900B would be **coded 1, one**.

   Rationale: Lacerations and swelling without fracture are classified as injury (except major).

J1900: Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent (cont.)

4. A resident fell, lacerated his head, and head CT scan indicated a subdural hematoma.

   Coding: J1900C would be **coded 1, one**.
   Rationale: Subdural hematoma is a major injury. The injury occurred as a result of a fall.

5. Mr. R. fell on his right hip in the facility on the ARD of his Quarterly MDS and complained of mild right hip pain. The initial x-ray of the hip did not show any injury. The nurse completed Mr. R's Quarterly assessment and coded the assessment to reflect this information. The assessment was submitted to QIES ASAP. Three days later, Mr. R. complained of increasing pain and had difficulty ambulating, so a follow-up x-ray was done. The follow-up x-ray showed a hairline fracture of the right hip. This injury is noted by the physician to be attributed to the recent fall that occurred during the look-back period of the Quarterly assessment.

   Original Coding: J1900B, Injury (except major) *is* **coded 1, one** *and J1900C, Major Injury is* ***coded 0, none***.
   Rationale: Mr. R. had a fall-related injury that caused him to complain of pain.
   Modification of Quarterly assessment: J1900B, Injury (except major) is **coded 0, none** and J1900C, Major Injury, is **coded 1, one**.
   Rationale: The extent of the injury did not present itself right after the fall; however, it was directly related to the fall that occurred during the look-back period of the Quarterly assessment. Since the assessment had been submitted to QIES ASAP and the level of injury documented on the submitted Quarterly was now found to be different based on a repeat x-ray of the resident's hip, the Quarterly assessment needed to be modified to accurately reflect the injury sustained during that fall.

J2000: Prior Surgery

J2000. Prior Surgery - Complete only if A0310B = 01	
Enter Code ☐	Did the resident have major surgery during the **100 days prior to admission**? 0. **No** 1. **Yes** 8. **Unknown**

Item Rationale

Health-related Quality of Life

- A recent history of major surgery during the 100 days prior to admission can affect a resident's recovery.

J2000: Prior Surgery (cont.)

Planning for Care

- This item identifies whether the resident has had major surgery during the 100 days prior to *the start of the Medicare Part A stay*. A recent history of major surgery can affect a resident's recovery.

Steps for Assessment

1. Ask the resident and his or her family or significant other about any surgical procedures in the 100 days prior to admission.
2. Review the resident's medical record to determine whether the resident had major surgery during the 100 days prior to admission.

   Medical record sources include medical records received from facilities where the resident received health care during the previous 100 days, the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.

Coding Instructions

- **Code 0, No:** if the resident did not have major surgery during the 100 days prior to admission.
- **Code 1, Yes:** if the resident had major surgery during the 100 days prior to admission.
- **Code 8, Unknown:** if it is unknown or cannot be determined whether the resident had major surgery during the 100 days prior to admission.

Coding Tips

- Generally, major surgery for item J2000 refers to a procedure that meets the following criteria:
  1. the resident was an inpatient in an acute care hospital for at least one day in the 100 days prior to admission to the skilled nursing facility (SNF), **and**
  2. the surgery carried some degree of risk to the resident's life or the potential for severe disability.

Examples

1. Mrs. T reports that she required surgical removal of a skin tag from her neck a month and a half ago. She had the procedure as an outpatient. Mrs. T reports no other surgeries in the last 100 days.

   Coding: J2000 would be coded **0, No.**

   Rationale: Mrs. T's skin tag removal surgery did not require an acute care inpatient stay; therefore, the skin tag removal does not meet the required criteria to be coded as major surgery. Mrs. T did not have any other surgeries in the last 100 days.

J2000: Prior Surgery (cont.)

2. Mr. A's wife informs his nurse that six months ago he was admitted to the hospital for five days following a bowel resection (partial colectomy) for diverticulitis. Mr. A's wife reports Mr. A has had no other surgeries since the time of his bowel resection.

   Coding: J2000 would be coded **0, No.**

   Rationale: Bowel resection is a major surgery that has some degree of risk for death or severe disability, and Mr. A required a five-day hospitalization. However, the bowel resection did not occur in the last 100 days; it happened six months ago, and Mr. A has not undergone any surgery since that time.

3. Mrs. G. was admitted to the facility for wound care related to dehiscence of a surgical wound subsequent to a complicated cholecystectomy. The attending physician also noted diagnoses of anxiety, diabetes, and morbid obesity in her medical record. She was transferred to the facility immediately following a four-day acute care hospital stay.

   Coding: J2000 would be coded **1, Yes.**

   Rationale: In the last 100 days, Mrs. G underwent a complicated cholecystectomy, which required a four-day hospitalization. She additionally had comorbid diagnoses of diabetes, morbid obesity, and anxiety contributing some additional degree of risk for death or severe disability.

J2100: Recent Surgery Requiring Active SNF Care

J2100. Recent Surgery Requiring Active SNF Care - Complete only if A0310B = 01 or 08	
Enter Code ☐	Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay? 0. **No** 1. **Yes** 8. **Unknown**

Item Rationale

Health-related Quality of Life

- *A recent history of major surgery during the inpatient stay that preceded the resident's Part A admission can affect a resident's recovery.*

Planning for Care

- *This item identifies whether the resident had major surgery during the inpatient stay that immediately preceded the resident's Part A admission. A recent history of major surgery can affect a resident's recovery.*

J2100: Recent Surgery Requiring Active SNF Care (cont.)

Steps for Assessment

1. Ask the resident and his or her family or significant other about any surgical procedures that occurred during the inpatient hospital stay that immediately preceded the resident's Part A admission.
2. Review the resident's medical record to determine whether the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.

   Medical record sources include medical records received from facilities where the resident received health care during the inpatient hospital stay that immediately preceded the resident's Part A admission, the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.

Coding Instructions

- ***Code 0, No:*** *if the resident did not have major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.*
- ***Code 1, Yes:*** *if the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.*
- ***Code 8, Unknown:*** *if it is unknown or cannot be determined whether the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.*

Coding Tips

- *Generally, major surgery for item J2100 refers to a procedure that meets the following criteria:*
  1. *the resident was an inpatient in an acute care hospital for at least one day in the 30 days prior to admission to the skilled nursing facility (SNF),* ***and***
  2. *the surgery carried some degree of risk to the resident's life or the potential for severe disability.*

J2300 – J5000: Recent Surgeries Requiring Active SNF Care

Surgical Procedures - Complete only if J2100 = 1	
↓ **Check all that apply**	
	Major Joint Replacement
☐	**J2300. Knee Replacement** - partial or total
☐	**J2310. Hip Replacement** - partial or total
☐	**J2320. Ankle Replacement** - partial or total
☐	**J2330. Shoulder Replacement** - partial or total
	Spinal Surgery
☐	**J2400. Involving the spinal cord or major spinal nerves**
☐	**J2410. Involving fusion of spinal bones**
☐	**J2420. Involving lamina, discs, or facets**
☐	**J2499. Other major spinal surgery**
	Other Orthopedic Surgery
☐	**J2500. Repair fractures of the shoulder** (including clavicle and scapula) **or arm** (but not hand)
☐	**J2510. Repair fractures of the pelvis, hip, leg, knee, or ankle** (not foot)
☐	**J2520. Repair but not replace joints**
☐	**J2530. Repair other bones** (such as hand, foot, jaw)
☐	**J2599. Other major orthopedic surgery**
	Neurological Surgery
☐	**J2600. Involving the brain, surrounding tissue or blood vessels** (excludes skull and skin but includes cranial nerves)
☐	**J2610. Involving the peripheral or autonomic nervous system** - open or percutaneous
☐	**J2620. Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices**
☐	**J2699. Other major neurological surgery**
	Cardiopulmonary Surgery
☐	**J2700. Involving the heart or major blood vessels** - open or percutaneous procedures
☐	**J2710. Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords** - open or endoscopic
☐	**J2799. Other major cardiopulmonary surgery**
	Genitourinary Surgery
☐	**J2800. Involving male or female organs** (such as prostate, testes, ovaries, uterus, vagina, external genitalia)
☐	**J2810. Involving the kidneys, ureters, adrenal glands, or bladder** - open or laparoscopic (includes creation or removal of nephrostomies or urostomies)
☐	**J2899. Other major genitourinary surgery**
	Other Major Surgery
☐	**J2900. Involving tendons, ligaments, or muscles**
☐	**J2910. Involving the gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, or spleen** - open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hernia repair)
☐	**J2920. Involving the endocrine organs** (such as thyroid, parathyroid), **neck, lymph nodes, or thymus** - open
☐	**J2930. Involving the breast**
☐	**J2940. Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant**
☐	**J5000. Other major surgery not listed above**

Item Rationale

Health-related Quality of Life

- *A recent history of major surgery during the inpatient stay that preceded the resident's Part A admission can affect a resident's recovery.*

Planning for Care

- *This item identifies whether the resident had major surgery during the inpatient stay that immediately preceded the resident's Part A admission. A recent history of major surgery can affect a resident's recovery.*

J2300 – J5000: Recent Surgeries Requiring Active SNF Care (cont.)

Steps for Assessment

1. ***Identify recent surgeries:*** *The surgeries in this section must have been documented by a physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days and must have occurred during the inpatient stay that immediately preceded the resident's Part A admission.*
   - *Medical record sources for recent surgeries include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available.*
   - *Although open communication regarding resident information between the physician and other members of the interdisciplinary team is important, it is also essential that resident information communicated verbally be documented in the medical record by the physician to ensure follow-up.*
   - *Surgery information, including past history obtained from family members and close contacts, must also be documented in the medical record by the physician to ensure validity and follow-up.*
2. ***Determine whether the surgeries require active care during the SNF stay:*** *Once a recent surgery is identified, it must be determined if the surgery requires **active** care during the SNF stay. Surgeries requiring active care during the SNF stay are surgeries that have a **direct relationship** to the resident's primary SNF diagnosis, as coded in I0020B.*
   - *Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered surgeries that do not require active care during the SNF stay.*
   - *Check the following information sources in the medical record for the last 30 days to identify "active" surgeries: transfer documents, physician progress notes, recent history and physical, recent discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor's orders, consults and official diagnostic reports, and other sources as available.*

Coding Instructions

Code surgeries that are documented to have occurred in the last 30 days, and during the inpatient stay that immediately preceded the resident's Part A admission, that have a direct relationship to the resident's primary SNF diagnosis, as coded in I0020B.

- *Check off each surgery requiring active SNF care as defined above, as follows:*
  - *Surgeries are listed by major surgical category: Major Joint Replacement, Spinal Surgery, Orthopedic Surgery, Neurologic Surgery, Cardiopulmonary Surgery, Genitourinary Surgery, Other Major Surgery.*

J2300 – J5000: Recent Surgeries Requiring Active SNF Care (cont.)

— *Examples of surgeries are included for each surgical category. For example,* ***J2810, Genitourinary surgery - the kidneys, ureter, adrenals, and bladder—open, laparoscopic,*** *includes open or laparoscopic surgeries on the kidneys, ureter, adrenals, and bladder, but not other components of the genitourinary system.*

- *Check all that apply.*

Major Joint Replacement

- ***J2300,*** *Knee Replacement - partial or total*
- ***J2310,*** *Hip Replacement - partial or total*
- ***J2320,*** *Ankle Replacement - partial or total*
- ***J2330,*** *Shoulder Replacement - partial or total*

Spinal Surgery

- ***J2400,*** *Spinal surgery - spinal cord or major spinal nerves*
- ***J2410,*** *Spinal surgery - fusion of spinal bones*
- ***J2420,*** *Spinal surgery - lamina, discs, or facets*
- ***J2499,*** *Spinal surgery - other*

Orthopedic Surgery

- ***J2500,*** *Ortho surgery - repair fractures of shoulder or arm*
- ***J2510,*** *Ortho surgery - repair fractures of pelvis, hip, leg, knee, or ankle*
- ***J2520,*** *Ortho surgery - repair but not replace joints*
- ***J2530,*** *Ortho surgery - repair other bones*
- ***J2599,*** *Ortho surgery - other*

Neurologic Surgery

- ***J2600,*** *Neuro surgery - brain, surrounding tissue or blood vessels*
- ***J2610,*** *Neuro surgery - peripheral and autonomic nervous system - open and percutaneous*
- ***J2620,*** *Neuro surgery - insertion or removal of spinal and brain neurostimulators, electrodes, catheters, and CSF drainage devices*
- ***J2699,*** *Neuro surgery - other*

J2300 – J5000: Recent Surgeries Requiring Active SNF Care (cont.)

Cardiopulmonary Surgery

- ***J2700,*** *Cardiopulmonary surgery - heart or major blood vessels - open and percutaneous procedures*
- ***J2710,*** *Cardiopulmonary surgery - respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords - open and endoscopic*
- ***J2799,*** *Cardiopulmonary surgery - other*

Genitourinary Surgery

- ***J2800,*** *Genitourinary surgery - male or female organs*
- ***J2810,*** *Genitourinary surgery - the kidneys, ureter, adrenals, and bladder - open, laparoscopic*
- ***J2899,*** *Genitourinary surgery - other*

Other Major Surgery

- ***J2900,*** *Major surgery - tendons, ligament, or muscles*
- ***J2910,*** *Major surgery - the GI tract and abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, spleen - open or laparoscopic*
- ***J2920,*** *Major surgery - endocrine organs (such as thyroid, parathyroid), neck, lymph nodes, and thymus - open*
- ***J2930,*** *Major surgery - the breast*
- ***J2940,*** *Major surgery - repair of deep ulcers, internal brachytherapy, bone marrow, or stem cell harvest or transplant*
- ***J5000,*** *Major surgery - not listed above*

Coding Tips

The following information may assist assessors in determining whether a surgery should be coded as requiring active care during the SNF stay.

- ***There may be specific documentation in the medical record by a physician, nurse practitioner, physician assistant, or clinical nurse specialist.***
  - *The physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) may specifically indicate that the SNF stay is for treatment related to the surgical intervention. Specific documentation may be found in progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc.*

J2300 – J5000: Recent Surgeries Requiring Active SNF Care (cont.)

- ***In the rare circumstance of the absence of specific documentation that a surgery requires active SNF care, the following indicators may be used to confirm that the surgery requires active SNF care:***

  The inherent complexity of the services prescribed for a resident is such that they can be performed safely and/or effectively only by or under the general supervision of skilled nursing. For example:

  — *The management of a surgical wound that requires skilled care (e.g., managing potential infection or drainage).*

  — *Daily skilled therapy to restore functional loss after surgical procedures.*

  — *Administration of medication and monitoring that requires skilled nursing.*

Examples of surgeries requiring active SNF care and related to the primary SNF diagnosis

1. *Mrs. V was hospitalized for gram-negative pneumonia. Since this was her second episode of pneumonia in the past six months, a diagnostic bronchoscopy was performed while in the hospital. She also has Parkinson's disease and rheumatoid arthritis. She was discharged to a SNF for continued antibiotic treatment for her pneumonia and requires daily skilled care.*

   ***Coding: I0020** is coded as 13, Medically Complex Conditions, and the **I0020B** SNF ICD-10 code is J15.6, Pneumonia due to other aerobic Gram-negative bacteria. There is no documentation that the resident had major surgery; therefore, **J2100** is coded 0, No.*

   ***Rationale:** Mrs. V did not receive any major surgery during the prior inpatient stay, and she was admitted to the SNF for continued care due to pneumonia.*

2. *Mrs. O, a diabetic, was hospitalized for sepsis from an infection due to Methicillin susceptible Staphylococcus aureus that developed after outpatient bunion surgery. A central line was placed to administer antibiotics. She was discharged to a SNF for continued antibiotic treatment and monitoring.*

   ***Coding: I0020** is coded as 13, Medically Complex Conditions. The **I0020B** SNF ICD-10 code is A41.01 (Sepsis due to Methicillin susceptible Staphylococcus aureus). There is no documentation that the resident had major surgery; therefore, **J2100** is coded 0, No.*

   ***Rationale:** Neither the placement of a central line nor the outpatient bunion surgery is considered to be a major surgery, but the resident was admitted to the SNF for continued antibiotic treatment and monitoring.*

J2300 – J5000: Recent Surgeries Requiring Active SNF Care (cont.)

3. *Mrs. H was hospitalized for severe back pain from a compression fracture of a lumbar vertebral body, which was caused by her age-related osteoporosis. She was treated with a kyphoplasty that relieved her pain. She was transferred to a SNF after discharge because of her mild dementia and need to regulate her anticoagulant treatment for atrial fibrillation.*

   Coding: *I0020 is coded 10, Fractures and Other Multiple Trauma. The* ***I0020B*** *SNF ICD-10 code is M80.08XD (Age-related osteoporosis with current pathological fracture, vertebra(e), subsequent encounter for fracture with routine healing). There was no documentation that the resident had major surgery; therefore,* ***J2100*** *is coded 0, No.*

   Rationale: *Mrs. H was treated with a kyphoplasty during the inpatient stay prior to SNF admission. Although kyphoplasty is a minor surgery and does not require SNF care in and of itself, the resident has other conditions requiring skilled care that are unrelated to the kyphoplasty surgery.*

4. *Mrs. J had a craniotomy to drain a subdural hematoma after suffering a fall at home. She has COPD and uses oxygen at night. In addition, she has moderate congestive heart failure, is moderately overweight, and has hypothyroidism. After a six-day hospital stay, she was discharged to a SNF for continuing care. The hospital discharge summary indicated that the patient had a loss of consciousness of 45 minutes.*

   Coding: *I0020 is coded 07, Other Neurological Conditions. The* ***I0020B*** *SNF ICD-10 code is S06.5X2D (Traumatic subdural hemorrhage with loss of consciousness of 31 minutes to 59 minutes, subsequent encounter).* ***J2100*** *would be coded 1, Yes.* ***J2600****, Neuro surgery - brain, surrounding tissue or blood vessels, would be checked.*

   Rationale: *The craniotomy surgery during the inpatient stay immediately preceding the SNF stay requires continued skilled care and skilled monitoring for wound care, as well as therapies to address any deficits that led to her fall or any functional deficits resulting from her fall.*

5. *Mr. D was admitted to an acute care hospital for cytoreductive surgery for metastatic renal cell carcinoma. He was admitted to the SNF for further treatment of the metastatic renal cell carcinoma and post-surgical care.*

   Coding: *I0020 is coded as 13, Medically Complex Conditions. The* ***I0020B*** *SNF ICD-10 code is C79.01 (Secondary malignant neoplasm of the right kidney and renal pelvis).* ***J2100*** *would be coded 1, Yes.* ***J2810****, Genitourinary surgery – the kidneys, ureter, adrenals, and bladder – open, laparoscopic, would be checked.*

   Rationale: *Mr. D was treated with a surgical procedure, genitourinary surgery of the kidney, and admitted to the SNF for further treatment of the metastatic kidney cancer and post-surgical care.*

J2300 – J5000: Recent Surgeries Requiring Active SNF Care (cont.)

6. *Mr. G was admitted to an acute care hospital for severe abdominal pain. He was found to have diverticulitis of the small intestine with perforation and abscess without bleeding. He had surgery to repair the perforation. He was admitted to the SNF for continued antibiotics and post-surgical care.*

   Coding: ***I0020*** *is coded 13, Medically Complex Conditions. The* ***I0020B*** *SNF ICD-10 code is K57.00 (Diverticulitis of small intestine with perforation and abscess without bleeding), and* ***J2100*** *would be coded 1, Yes.* ***J2910****, Major surgery – the GI tract and abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, spleen – open or laparoscopic, would be checked.*

   Rationale: *Mr. G was treated with a surgical procedure, repair of the small intestine perforation, which is a major surgical procedure. He was admitted to the SNF for continued antibiotics and post-surgical care.*

7. *Mr. W underwent surgical repair for a left fractured hip (i.e., subtrochanteric fracture) during an inpatient hospitalization. He was admitted to the SNF for post-surgical care.*

   Coding: ***I0020*** *is coded as Code 10, Fractures and Other Multiple Trauma. The* ***I0020B*** *SNF ICD-10 code is S72.22XD (Displaced subtrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing) and* ***J2100*** *is coded as 1, Yes.* ***J2510****, Ortho surgery – repair fractures of pelvis, hip, leg, knee, or ankle, would be checked.*

   Rationale: *This is major surgery requiring skilled nursing care to provide wound care and to monitor for early signs of infection or blood clots, for which Mr. W was admitted to the SNF.*

K0200: Height and Weight (cont.)

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

K0300: Weight Loss

K0300. Weight Loss	
Enter Code ☐	**Loss of 5% or more in the last month or loss of 10% or more in last 6 months** 0. **No** or unknown 1. **Yes, on** physician-prescribed weight-loss regimen 2. **Yes, not on** physician-prescribed weight-loss regimen

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

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

DEFINITIONS

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

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

K0300: Weight Loss (cont.)

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

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

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

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

K0310: Weight Gain

K0310. Weight Gain	
Enter Code ☐	**Gain of 5% or more in the last month or gain of 10% or more in last 6 months** 0. **No** or unknown 1. **Yes, on** physician-prescribed weight-gain regimen 2. **Yes, not on** physician-prescribed weight-gain regimen

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

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

DEFINITIONS

5% WEIGHT GAIN IN 30 DAYS

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

10% WEIGHT GAIN IN 180 DAYS

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

K0310: Weight Gain (cont.)

- If the resident is gaining a significant amount of weight, the facility should not wait for the 30- or 180-day timeframe to address the problem. Weight changes of 5% in 1 month, 7.5% in 3 months, or 10% in 6 months should prompt a thorough assessment of the resident's nutritional status.
- To code K0310 as **1, yes**, the expressed goal of the weight gain diet must be documented.

K0510: Nutritional Approaches

K0510. Nutritional Approaches Check all of the following nutritional approaches that were performed during the last **7 days** **1. While NOT a Resident** Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank **2. While a Resident** Performed ***while a resident*** of this facility and within the ***last 7 days***	**1. While NOT a Resident**	**2. While a Resident**
	↓ Check all that apply ↓	
A. Parenteral/IV feeding	☐	☐
B. Feeding tube - nasogastric or abdominal (PEG)	☐	☐
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)		☐
D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)		☐
Z. None of the above	☐	☐

Item Rationale

Health-related Quality of Life

- Nutritional approaches that vary from the normal (e.g., mechanically altered food) or that rely on alternative methods (e.g., parenteral/IV or feeding tubes) can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating.
- The resident's clinical condition may potentially benefit from the various nutritional approaches included here. It is important to work with the resident and family members to establish nutritional support goals that balance the resident's preferences and overall clinical goals.

Planning for Care

- Alternative nutritional approaches should be monitored to validate effectiveness.
- Care planning should include periodic reevaluation of the appropriateness of the approach.

DEFINITIONS

PARENTERAL/IV FEEDING
Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous).

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

K0510: Nutritional Approaches (cont.)

Steps for Assessment

- Review the medical record to determine if any of the listed nutritional approaches were performed during the 7-day look-back period.

Coding Instructions for Column 1

- Check all nutritional approaches performed **prior** to admission/entry or reentry to the facility and within the 7-day look-back period. Leave Column 1 blank if the resident was admitted/entered or reentered the facility more than 7 days ago.
- *When completing the Interim Payment Assessment (IPA), the completion of items K0510A, K0510B, and K0510Z will still be required.*

Coding Instructions for Column 2

Check all nutritional approaches performed **after** admission/entry or reentry to the facility and within the 7-day look-back period.

Check all that apply. If none apply, check K0510Z, None of the above

- **K0510A,** parenteral/IV feeding
- **K0510B,** feeding tube – nasogastric or abdominal (PEG)
- **K0510C,** mechanically altered diet – require change in texture of food or liquids (e.g., pureed food, thickened liquids)
- **K0510D,** therapeutic diet (e.g., low salt, diabetic, low cholesterol)
- **K0510Z,** none of the above

DEFINITIONS

MECHANICALLY ALTERED DIET
A diet specifically prepared to alter the texture or consistency of food to facilitate oral intake. Examples include soft solids, puréed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet.

THERAPEUTIC DIET
A therapeutic diet is a diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status, to eliminate, decrease, or increase certain substances in the diet (e.g. sodium, potassium) (ADA, 2011).

Coding Tips for K0510A

K0510A includes any and all nutrition and hydration received by the nursing home resident in the last 7 days either at the nursing home, at the hospital as an outpatient or an inpatient, provided they were administered for nutrition or hydration.

- Parenteral/IV feeding—The following fluids may be included **when there is supporting documentation that reflects the need for additional fluid intake specifically addressing a nutrition or hydration need. This supporting documentation should be noted in the resident's medical record according to State and/or internal facility policy:**

K0510: Nutritional Approaches (cont.)

Examples

1. Mrs. H is receiving an antibiotic in 100 cc of normal saline via IV. She has a urinary tract infection (UTI), fever, abnormal lab results (e.g., new pyuria, microscopic hematuria, urine culture with growth >100,000 colony forming units of a urinary pathogen), and documented inadequate fluid intake (i.e., output of fluids far exceeds fluid intake) with signs and symptoms of dehydration. She is placed on the nursing home's hydration plan to ensure adequate hydration. Documentation shows IV fluids are being administered as part of the already identified need for additional hydration.

   Coding: K0510A would **be checked.** The IV medication would be coded at **IV Medications** item (O0100H).
   Rationale: The resident received 100 cc of IV fluid **and** there is supporting documentation that reflected an identified need for additional fluid intake for hydration.

2. Mr. J is receiving an antibiotic in 100 cc of normal saline via IV. He has a UTI, no fever, and documented adequate fluid intake. He is placed on the nursing home's hydration plan to ensure adequate hydration.

   Coding: K0510A would **NOT be checked.** The IV medication would be coded at **IV Medications** item (O0100H).
   Rationale: Although the resident received the additional fluid, there is no documentation to support a need for additional fluid intake.

K0710: Percent Intake by Artificial Route

Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B.

K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B		
2. While a Resident Performed ***while a resident*** of this facility and within the ***last 7 days*** **3. During Entire 7 Days** Performed during the entire ***last 7 days***	**2. While a Resident**	**3. During Entire 7 Days**
	Enter Codes ↓	↓
A. Proportion of total calories the resident received through parenteral or tube feeding 1. **25% or less** 2. **26-50%** 3. **51% or more**	☐	☐
B. Average fluid intake per day by IV or tube feeding 1. **500 cc/day or less** 2. **501 cc/day or more**	☐	☐

K0710: Percent Intake by Artificial Route (cont.)

Item Rationale

Health-related Quality of Life

- Nutritional approaches that vary from the normal, such as parenteral/IV or feeding tubes, can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating.

Planning for Care

- The proportion of calories received through artificial routes should be monitored with periodic reassessment to ensure adequate nutrition and hydration.
- Periodic reassessment is necessary to facilitate transition to increased oral intake as indicated by the resident's condition.

K0710A, Proportion of Total Calories the Resident Received through Parental or Tube Feeding

Steps for Assessment

1. Review intake records to determine actual intake through parenteral or tube feeding routes.
2. Calculate proportion of total calories received through these routes.
   - If the resident took no food or fluids by mouth or took just sips of fluid, stop here and **code 3, 51% or more.**
   - If the resident had more substantial oral intake than this, consult with the dietician.

Coding Instructions

- Select the best response:
  1. 25% or less
  2. 26% to 50%
  3. 51% or more

K0710: Percent Intake by Artificial Route (cont.)

Examples

1. **Calculation for Average Daily Fluid Intake**

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

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

   Coding: K0710B columns 2 and 3 would be coded **2, 501cc/day or more**.

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

2. Mr. K. has been able to take some fluids orally; however, due to his progressing multiple sclerosis, his dysphagia is not allowing him to remain hydrated enough. Therefore, he received the following fluid amounts over the last 7 days via supplemental tube feedings while in the hospital and after he was admitted to the nursing home.

While in the Hospital		While in the Nursing Home	
Mon.	400 cc	Fri.	510 cc
Tues.	520 cc	Sat.	520 cc
Wed.	500 cc	Sun.	490 cc
Thurs.	480 cc		
Total	1,900 cc	Total	1,520 cc

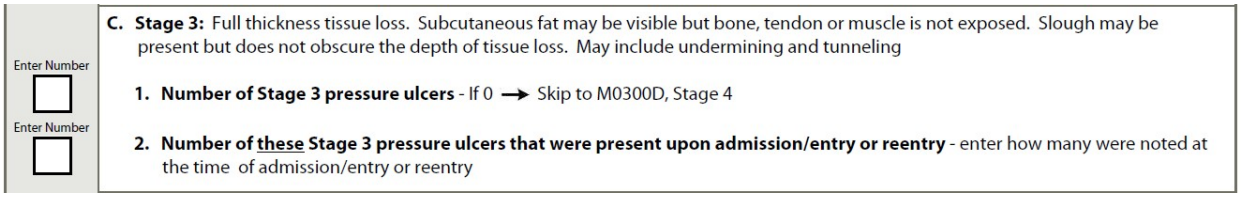
K0710: Percent Intake by Artificial Route (cont.)

Coding: K0710B2 would be coded 2, 501 cc/day or more, and K0710B3 would be coded 1, 500 cc/day or less.

Rationale: The total fluid intake within the last 7 days while Mr. K. was a resident of the nursing home was 1,520 cc (510 cc + 520 cc + 490 cc = 1,520 cc). Average fluid intake while a resident totaled 507 cc (1,520 cc divided by 3 days). 507 cc is greater than 500 cc, therefore **code 2, 501 cc/day or more is correct for K0710B2, While a Resident**.

The total fluid intake during the entire 7 days (includes fluid intake while Mr. K. was in the hospital AND while Mr. K. was a resident of the nursing home) was 3,420 cc (1,900 cc + 1,520 cc). Average fluid intake during the entire 7 days was 489 cc (3,420 cc divided by 7 days). 489 cc is less than 500 cc, therefore **code 1, 500 cc/day or less is correct for K0710B3, During Entire 7 Days**.

M0300C: Stage 3 Pressure Ulcers



Item Rationale

Health-related Quality of Life

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

Planning for Care

- Pressure ulcers at more advanced stages typically require more aggressive interventions, including more frequent repositioning, attention to nutritional status, and care that may be more time or staff intensive.
- An existing pressure ulcer may put residents at risk for further complications or skin injury.
- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the resident's overall clinical condition should be reassessed.
- Tissue characteristics of pressure ulcers should be considered when determining treatment options and choices.
- Changes in tissue characteristics over time are indicative of wound healing or degeneration.

DEFINITION

STAGE 3 PRESSURE ULCER

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling (see definition of undermining and tunneling on page M-19).

Steps for Assessment

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

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

Coding Instructions

*Pressure ulcers coded in M0210 through M0300 should **not** be coded here.*

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

Coding Tips

Arterial Ulcers

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

Venous Ulcers

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

Example

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

   Coding: Code **M1030 as 3.**

   Rationale: Ischemic changes point to the ulcer being vascular.

M1200: Skin and Ulcer/Injury Treatments (cont.)

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

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

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

Scenarios for Pressure Ulcer Coding

Example M0100-M1200

1. Mrs. P was admitted to the nursing home on 10/23/2019 for a Medicare stay. In completing the PPS 5-day assessment *(ARD of 10/28/2019)*, it was noted that the resident had a head-to-toe skin assessment and her skin was intact, but upon assessment using the Braden scale, was found to be at risk for skin breakdown. The resident was noted to have a Stage 2 pressure ulcer that was identified on her coccyx on 11/1/2019. This Stage 2 pressure ulcer was noted to have pink tissue with some epithelialization present in the wound bed. Dimensions of the ulcer were length 01.1 cm, width 00.5 cm, and no measurable depth. Mrs. P does not have any arterial or venous ulcers, wounds, or skin problems. She is receiving ulcer care with application of a dressing applied to the coccygeal ulcer. Mrs. P. also has pressure reducing devices on both her bed and chair and has been placed on a 1½ hour turning and repositioning schedule per tissue tolerance. *In order to stay closer to her family, Mrs. P was discharged to another nursing home on 11/5/2019. This was a planned discharge (A0310G = 2), and her OBRA Discharge assessment was coded at A0310F as 10, Discharge assessment – return not anticipated.*

   5-Day PPS:

   Coding:

   - **M0100B** (Formal assessment instrument), Check box.
   - **M0100C** (Clinical assessment), Check box.
   - **M0150** (Risk of Pressure Ulcers/Injuries), Code 1.
   - **M0210** (One or more unhealed pressure ulcers/injuries), Code 0 and skip to M1030 (Number of Venous and Arterial Ulcers).
   - **M1030** (Number of Venous and Arterial Ulcers), Code 0.
   - **M1040** (Other ulcers, wounds and skin problems), Check Z (None of the above).
   - **M1200** (Skin and Ulcer Treatments), Check Z (None of the above were provided).

Scenarios for Pressure Ulcer Coding (cont.)

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

***Discharge Assessment*:**

Coding:

- **M0100A** (Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device), Check box.
- **M0210** (*U*nhealed *P*ressure *U*lcers/*I*njuries), Code 1.
- **M0300B1** (Number of Stage 2 pressure ulcers), Code 1.
- **M0300B2** (Number of these Stage 2 pressure ulcers present on admission/entry or reentry), Code 0.
- **M0300C1** (Number of Stage 3 pressure ulcers), Code 0 and skip to M0300D (Stage 4).
- **M0300D1** (Number of Stage 4 pressure ulcers), Code 0 and skip to M0300E (Unstageable – Non-removable dressing/device).
- **M0300E1** (Unstageable – Non-removable dressing/device), Code 0 and skip to M0300F (Unstageable – Slough and/or eschar).
- **M0300F1** (Unstageable – Slough and/or eschar), Code 0 and skip to M0300G (Unstageable – Deep tissue injury).
- **M0300G1** (Unstageable – Deep tissue injury), Code 0 and skip to M1030 (Number of Venous and Arterial Ulcers).

Rationale: The resident *has a pressure ulcer.* On the 5-day PPS assessment, the resident's skin was noted to be intact; however, on the *Discharge* assessment, it was noted that the resident had a new Stage 2 pressure ulcer. Since the resident has had both a 5-day *PPS* and *Discharge assessment* completed, the *Discharge assessment* would be coded 0 at A0310E. This is because the Discharge assessment is **not** the first assessment since the most recent admission/entry or reentry.

SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

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

O0100: Special Treatments, Procedures, and Programs

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

O0100. Special Treatments, Procedures, and Programs
Check all of the following treatments, procedures, and programs that were performed during the last **14 days**

1. **While NOT a Resident** Performed ***while NOT a resident*** of this facility and within the ***last 14 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank 2. **While a Resident** Performed ***while a resident*** of this facility and within the ***last 14 days***	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
Cancer Treatments		
A. Chemotherapy	☐	☐
B. Radiation	☐	☐
Respiratory Treatments		
C. Oxygen therapy	☐	☐
D. Suctioning	☐	☐
E. Tracheostomy care	☐	☐
F. Invasive Mechanical Ventilator (ventilator or respirator)	☐	☐
G. Non-Invasive Mechanical Ventilator (BiPAP/CPAP)	☐	☐
Other		
H. IV medications	☐	☐
I. Transfusions	☐	☐
J. Dialysis	☐	☐
K. Hospice care	☐	☐
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	☐	☐
None of the Above		
Z. None of the above	☐	☐

Item Rationale

Health-related Quality of Life

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

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

- **O0100K, Hospice care**

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

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

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

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

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

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

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

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

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

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

Finally, when coding for isolation, the facility should review the resident's status and determine if the criteria for a Significant Change of Status Assessment (SCSA) is met based on the effect the infection has on the resident's function and plan of care. The definition and criteria of "significant change of status" is found in Chapter 2, *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.

- **O0100Z, None of the above**

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

O0250: Influenza Vaccine

O0250. Influenza Vaccine - Refer to current version of RAI manual for current influenza vaccination season and reporting period

Enter Code ☐

A. Did the **resident receive the influenza vaccine *in this facility*** 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.

O0400: Therapies (cont.)

O0400. Therapies - Continued

C. Physical Therapy

Enter Number of Minutes ☐☐☐☐

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

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** in the last 7 days

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** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date

Enter Number of Minutes ☐☐☐☐

3A. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** in the last 7 days

Enter Number of Days ☐

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

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

D. Respiratory Therapy

Enter Number of Minutes ☐☐☐☐

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days

If zero, → skip to O0400E, Psychological Therapy

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

E. Psychological Therapy (by any licensed mental health professional)

Enter Number of Minutes ☐☐☐☐

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days

If zero, → skip to O0400F, Recreational Therapy

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

F. Recreational Therapy (includes recreational and music therapy)

Enter Number of Minutes ☐☐☐☐

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days

If zero, → skip to O0420, Distinct Calendar Days of Therapy

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

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, psychological, and recreational therapy can help residents to attain or maintain their highest level of well-being and improve their quality of life.

O0400: Therapies (cont.)

Planning for Care

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

Steps for Assessment

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

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

- **Individual minutes**—Enter the total number of minutes of therapy that were provided on an individual basis in the last 7 days. **Enter 0** if none were provided. Individual services are provided by one therapist or assistant to one resident at a time.
- **Concurrent minutes**—Enter the total number of minutes of therapy that were provided on a concurrent basis in the last 7 days. **Enter 0** if none were provided. Concurrent therapy is defined as the treatment of 2 residents at the same time, when the residents are not performing the same or similar activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant for Medicare Part A. When a Part A resident receives therapy that meets this definition, it is defined as concurrent therapy for the Part A resident regardless of the payer source for the second resident. For Part B, residents may not be treated concurrently: a therapist may treat one resident at a time, and the minutes during the day when the resident is treated individually are added, even if the therapist provides that treatment intermittently (first to one resident and then to another). For all other payers, follow Medicare Part A instructions.
- **Group minutes**—Enter the total number of minutes of therapy that were provided in a group in the last 7 days. **Enter 0** if none were provided. Group therapy is defined for Part A as the treatment of *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 Medicare Part B, treatment of two patients (or more), regardless of payer source, at the same time is documented as group treatment. For all other payers, follow Medicare Part A instructions.

O0400: Therapies (cont.)

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

Coding Instructions for Respiratory, Psychological, and Recreational Therapies

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

Coding Tips and Special Populations

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

O0400: Therapies (cont.)

- In situations where the ongoing performance of a safe and effective maintenance program does not require any skilled services, once the qualified therapist has designed the maintenance program and discharged the resident from a rehabilitation (i.e., skilled) therapy program, the services performed by the therapist and the assistant are **not** to be reported in item O0400A, B, or C **Therapies**. The services may be reported on the MDS assessment in item O0500 **Restorative Nursing Care**, provided the requirements for restorative nursing program are met.
- Services provided by therapy aides are **not** skilled services (see therapy aide section below).
- When a resident refuses to participate in therapy, it is important for care planning purposes to identify why the resident is refusing therapy. However, the time spent investigating the refusal or trying to persuade the resident to participate in treatment is not a skilled service and shall not be included in the therapy minutes.

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

O0400: Therapies (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 a look back 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** he/she is able to immediately intervene/assist the student as needed.

Example:

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

Concurrent Therapy

Medicare Part A

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

O0400: Therapies (cont.)

- An Occupational Therapist provides therapy to Mr. K. for 60 minutes. An occupational therapy graduate student who is supervised by the occupational therapist, is treating Mr. R. at the same time for the same 60 minutes but Mr. K. and Mr. R. are not doing the same or similar activities. Both Mr. K. and Mr. R's stays are covered under the Medicare Part A benefit. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
  - Mr. K. received concurrent therapy for 60 minutes.
  - Mr. R. received concurrent therapy for 60 minutes.

Group Therapy

Medicare Part A

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

Medicare Part B

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

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

O0400: Therapies (cont.)

Therapy Modalities

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

Dates of Therapy

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

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

For example, Mr. N. was admitted to the nursing home following a fall that resulted in a hip fracture in November *2019*. Occupational and Physical therapy started December 3, *2019*. His physical therapy ended January 27, *2020* and occupational therapy ended January 29, *2020*. Later on during his stay at the nursing home, due to the progressive nature of his Parkinson's disease, he was referred to SLP and OT February 10, *2020* (he remained in the facility the entire time). The speech-language pathologist evaluated him on that day and the occupational therapist evaluated him the next day. The ARD for Mr. N.'s MDS assessment is February 28, *2020*. Coding values for his MDS are:

- O0400A5 (SLP start date) is *02102020*,
- O0400A6 (SLP end date) is dash filled,
- O0400B5 (OT start date) is *02112020*,
- O0400B6 (OT end date) is dash filled,
- O0400C5 (PT start date) is *12032019*, and
- O0400C6 (PT end date) is *01272020*.

O0400: Therapies (cont.)

General Coding Example:

Following a stroke, Mrs. F. was admitted to the skilled nursing facility in stable condition for rehabilitation therapy on 10/06/*19* under Part A skilled nursing facility coverage. She had slurred speech, difficulty swallowing, severe weakness in both her right upper and lower extremities, and a Stage *3* pressure ulcer on her left lateral malleolus. She was referred to SLP, OT, and PT with the long-term goal of returning home with her daughter and son-in-law. Her initial SLP evaluation was performed on 10/06/*19*, the PT initial evaluation on 10/07/*19*, and the OT initial evaluation on 10/09/*19*. She was also referred to recreational therapy and respiratory therapy. The interdisciplinary team determined that 10/*13*/1*9* was an appropriate ARD for her *5-Day assessment*. During the look-back period she received the following:

Speech-language pathology services that were provided over the 7-day look-back period:

- Individual dysphagia treatments; Monday-Friday for 30 minute sessions each day.
- Cognitive training; Monday and Thursday for 35 minute concurrent therapy sessions and Tuesday, Wednesday and Friday 25 minute group sessions.
- Individual speech techniques; Tuesday and Thursday for 20-minute sessions each day.
  Coding:
  O0400A1 would be **coded 190;** O0400A2 would be **coded 70;** O0400A3 would be **coded 75;** O0400A4 would be **coded 5;** O0400A5 would be **coded *10062019*;** and O0400A6 would be **coded with dashes**.
  Rationale:
  Individual minutes totaled 190 over the 7-day look-back period [(30 × 5) + (20 × 2) = 190]; concurrent minutes totaled 70 over the 7-day look-back period (35 × 2 = 70); and group minutes totaled 75 over the 7-day look-back period (25 × 3 = 75). Therapy was provided 5 out of the 7 days of the look-back period. Date speech-language pathology services began was 10-06-201*9*, and dashes were used as the therapy end date value because the therapy was ongoing.

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

- Individual sitting balance activities; Monday and Wednesday for 30-minute co-treatment sessions with PT each day (OT and PT each code the session as 30 minutes for each discipline).
- Individual wheelchair seating and positioning; Monday, Wednesday, and Friday for the following times: 23 minutes, 18 minutes, and 12 minutes.
- Balance/coordination activities; Tuesday-Friday for 20 minutes each day in group sessions.
  Coding:
  O0400B1 would be **coded 113,** O0400B2 would be **coded 0,** O0400B3 would be **coded 80**, O0400B3A would be **coded 60**, O0400B4 would be **coded 5**, O0400B5 would be **coded 1009201*9***, and O0400B6 would be **coded with dashes**.

O0400: Therapies (cont.)

Rationale:
Individual minutes (including 60 co-treatment minutes) totaled 113 over the 7-day look-back period [(30 × 2) + 23 + 18 + 12 = 113]; concurrent minutes totaled 0 over the 7-day look-back period (0 × 0 = 0); and group minutes totaled 80 over the 7-day look-back period (20 × 4 = 80). Therapy was provided 5 out of the 7 days of the look-back period. Date occupational therapy services began was 10-09-201*9* and dashes were used as the therapy end date value because the therapy was ongoing.

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

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

Coding:
O0400C1 would be **coded 287,** O0400C2 would be **coded 100,** O0400C3 would be **coded 0**, O0400C3A would be **coded 60**, O0400C4 would be **coded 5**, O0400C5 would be **coded 1007201*9***, and O0400C6 would be **coded with dashes**.

Rationale:
Individual minutes (including 60 co-treatment minutes) totaled 287 over the 7-day look-back period [(30 × 2) + (35 × 5) + (22 - 5) + 7 + (27 - 6) + 7 = 287]; concurrent minutes totaled 100 over the 7-day look-back period (20 × 5 = 100); and group minutes totaled 0 over the 7-day look-back period (0 × 0 = 0). Therapy was provided 5 out of the 7 days of the look-back period. Date physical therapy services began was 10-07-201*9*, and dashes were used as the therapy end date value because the therapy was ongoing.

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

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

Coding:
O0400D1 would be **coded 50,** O0400D2 would be **coded 0**.

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

O0400: Therapies (cont.)

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

- Psychological therapy services were not provided at all over the 7-day look-back period.
  Coding:
  O0400E1 would be **coded 0,** O0400E2 would be **left blank**.
  Rationale:
  There were no minutes or days of psychological therapy services provided over the 7-day look-back period.

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

- Recreational therapy services; Tuesday, Wednesday, and Friday for 30-minute sessions each day.
  Coding:
  O0400F1 would be **coded 90,** O0400F2 would be **coded 3**.
  Rationale:
  Total minutes were 90 over the 7-day look-back period (30 × 3 = 90). Sessions provided were longer than 15 minutes each day, therefore each day recreational therapy was performed can be counted.

O0400: Therapies (cont.)

O0400. Therapies

A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes: 190

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes: 70

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes: 75

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400A5, Therapy start date

Enter Number of Minutes: 0

3A. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** in the last 7 days

Enter Number of Days: 5

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

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

10 – 06 – 2019
Month Day Year

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

- - – - - – - - - -
Month Day Year

B. Occupational Therapy

Enter Number of Minutes: 113

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes: 0

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes: 80

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B5, Therapy start date

Enter Number of Minutes: 60

3A. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** in the last 7 days

Enter Number of Days: 5

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

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

10 – 09 – 2019
Month Day Year

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

- - – - - – - - - -
Month Day Year

O0400 continued on next page

O0400: Therapies (cont.)

O0400. Therapies - Continued

C. Physical Therapy

Enter Number of Minutes: 287

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes: 100

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes: 0

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C5, Therapy start date

Enter Number of Minutes: 60

3A. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** in the last 7 days

Enter Number of Days: 5

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

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

Month: 10 – Day: 07 – Year: 2019

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

Month: -- – Day: -- – Year: ----

D. Respiratory Therapy

Enter Number of Minutes: 50

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days

If zero, → skip to O0400E, Psychological Therapy

Enter Number of Days: 0

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

E. Psychological Therapy (by any licensed mental health professional)

Enter Number of Minutes: 0

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days

If zero, → skip to O0400F, Recreational Therapy

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

F. Recreational Therapy (includes recreational and music therapy)

Enter Number of Minutes: 90

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days

If zero, → skip to O0420, Distinct Calendar Days of Therapy

Enter Number of Days: 3

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

O0420: Distinct Calendar Days of Therapy

O0420. Distinct Calendar Days of Therapy	
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 in the past 7 days.

Item Rationale

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

Coding Instructions:

Enter the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days. If a resident receives more than one therapy discipline on a given calendar day, this may only count for one calendar day for purposes of coding Item O0420. Consider the following examples:

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

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)

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.*

O0425: Part A Therapies (cont.)

- *Rehabilitation (i.e., via Speech-Language Pathology Services and Occupational and Physical Therapies) and respiratory, psychological, and recreational therapy can help residents to attain or maintain their highest level of well-being and improve their quality of life.*

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 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.*
- ***For definitions of the types of therapies listed in this section, please refer to the Glossary in Appendix A.***

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, recreation therapy notes, mental health professional progress notes), and consult with each of the qualified care providers to collect the information required for this item.*

   NOTE: The look back 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.*

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 O0400 above.)*

O0425: Part A Therapies (cont.)

- ***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 O0400 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 O0400 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 O0400 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.*
- ***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.*

O0425: Part A Therapies (cont.)

- ***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 O0400 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 O0400 above.

Concurrent Therapy

For a detailed definition and example of concurrent therapy, please refer to the discussion of item O0400 above.

O0425: Part A Therapies (cont.)

Group Therapy

For a detailed definition and example of group therapy, please refer to the discussion of item O0400 above.

Therapy Modalities

For a detailed definition and explanation of therapy modalities, please refer to the discussion of item O0400 above.

General Coding Example:

Following a bilateral knee replacement, Mrs. 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, she exhibited some short-term memory difficulties specifically affecting orientation. She was non-weight bearing, had reduced range of motion, and had difficulty with ADLs. She was referred to SLP, OT, and PT with the long-term goal of returning home with her husband. Her initial SLP evaluation was performed on 10/06/19, and the OT and PT initial evaluations were done on 10/07/19. She was also referred to recreational therapy. She was in the SNF for 14 days and was discharged home on 10/19/2019. Mrs. G received the following rehabilitation services during her 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 × 6 days); concurrent minutes totaled 0 over the stay (0 × 0 = 0); and group minutes totaled 0 over the stay (0 × 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 × 12) + 53 = 413]; concurrent minutes totaled 0 over the stay (0 × 0 = 0); and group minutes totaled 200 over the stay (20 × 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 stay [(45 × 13) + (7 + 22 + 18) = 632]; concurrent minutes totaled 200 over the stay (20 × 10 = 200); and group minutes totaled 180 over the stay (30 × 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: Mrs. T was admitted to the SNF on Sunday 10/06/18 and discharged on Saturday 10/26/18. She received 60 minutes of physical therapy every Monday, Wednesday, and Friday during the SNF stay. Mrs. T also received 45 minutes of occupational therapy every Monday, Tuesday, and Friday during the stay. Given the therapy services received by Mrs. 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).*

O0450: Resumption of Therapy

O0450. Resumption of Therapy	
Enter Code ☐	A. Has a previous rehabilitation therapy regimen (speech, occupational, and/or physical therapy) ended, as reported on this End of Therapy OMRA, and has this regimen now resumed at exactly the same level for each discipline? 0. No 1. Yes

CMS does not require completion of this item; however, some States continue to require its completion. It is important to know your State's requirements for completing this item.

Item Rationale

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

Coding Instructions:

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

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

NOTE: If the EOT OMRA has not been accepted in the *Quality Improvement and Evaluation System (*QIES*) Assessment Submission and Processing (*ASAP*)* system when therapy resumes, code the EOT-R item (O0450A) on the assessment and submit the record. If the EOT OMRA without the EOT-R item ha*s* been accepted into the QIES ASAP system, then submit a modification request for that EOT OMRA with the only changes being the completion of the Resumption of Therapy item (O0450A) and check X0900*Z and* indicate that the reason for modification is the addition of the Resumption of Therapy *item*.

O0500: Restorative Nursing Programs

O0500. Restorative Nursing Programs	
Record the **number of days** each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)	
Number of Days	Technique
☐	A. Range of motion (passive)
☐	B. Range of motion (active)
☐	C. Splint or brace assistance
Number of Days	Training and Skill Practice In:
☐	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 he or she is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when restorative needs arise during the course of a longer-term stay, or in conjunction with formalized rehabilitation therapy. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy.

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:
   - Measureable objective and interventions must be documented in the care plan and in the medical record. If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this reassessment should be documented in the resident's medical record.
   - Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record. When not contraindicated by state practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established.
   - Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity.
   - A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a restorative nursing program. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents. Restorative nursing does not require a physician's order. Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In situations where such services do not actually require the involvement of a qualified therapist, the services may not be coded as therapy in item O0400, Therapies *or O0425, Part A Therapies*, because the specific interventions are considered restorative nursing services (see item O0400, Therapies *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 O0400A *or O0425A*, **Occupational Therapy** item O0400B *or O0425B*, and **Physical Therapy** *item* O0400C *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 himself or herself in bed. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- **O0500E, Transfer**

  Code activities provided to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- **O0500F, Walking**

  Code activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

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

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

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

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

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

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

O0500: Restorative Nursing Programs (cont.)

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

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

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

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

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

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

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

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

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

O0500: Restorative Nursing Programs (cont.)

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

   Coding: Eating and/or Swallowing item (O0500H), would be **coded 0.**
   Rationale: Because restorative nursing skill and practice training for eating and/or swallowing were not provided over the last 7 days.

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

   Coding: Communication item (O0500J), would be **coded 0**.
   Rationale: Because the resident has mastered the skill of communication, restorative nursing skill and practice training for communication was no longer needed or provided over the last 7 days.

O0600: Physician Examinations

O0600. Physician Examinations	
Enter Days ☐☐	Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) examine the resident?**

CMS does not require completion of this item; however, some States continue to require its completion. It is important to know your State's requirements for completing this item.

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

O0600: Physician Examinations (cont.)

Steps for Assessment

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

Coding Instructions

- Record the **number of days** that physician progress notes reflect that a physician examined the resident (or since admission if less than 14 days ago).
- If the State does not require the completion of this item, use the standard "no information" code (a dash, "**-**").

Coding Tips and Special Populations

- Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law.
- Examination (partial or full) can occur in the facility or in the physician's office. Included in this item are telehealth visits as long as the requirements are met for physician/practitioner type as defined above and whether it qualifies as a telehealth billable visit. For eligibility requirements and additional information about Medicare telehealth services refer to:
  - Chapter 15 of the ***Medicare Benefit Policy Manual*** (Pub. 100-2) and Chapter 12 of the ***Medicare Claims Processing Manual*** (Pub. 100-4) may be accessed at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.
- Do not include physician examinations that occurred prior to admission or readmission to the facility (e.g., during the resident's acute care stay).
- Do not include physician examinations that occurred during an emergency room visit or hospital observation stay.
- If a resident is evaluated by a physician off-site (e.g., while undergoing dialysis or radiation therapy), it can be coded as a physician examination as long as documentation of the physician's evaluation is included in the medical record. The physician's evaluation can include partial or complete examination of the resident, monitoring the resident for response to the treatment, or adjusting the treatment as a result of the examination.
- Psychological therapy visits by a licensed psychologist (PhD) should be recorded in O0400E, Psychological Therapy, and should not be included as a physician visit in this section.
- Does not include visits made by Medicine Men.

O0700: Physician Orders

O0700. Physician Orders	
Enter Days ☐☐	Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) change the resident's orders?**

CMS does not require completion of this item; however, some States continue to require its completion. It is important to know your State's requirements for completing this item.

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

1. **Review the physician order sheets in the medical record.**
2. **Determine the number of days during the 14-day look-back period that a physician or other authorized practitioner allowable by State law changed the resident's orders.**

Coding Instructions

- Enter the **number of days** during 14-day look-back period (or since admission, if less than 14 days ago) in which a physician changed the resident's orders.
- If the State does not require the completion of this item, use the standard "no information" code (a dash, "**-**").

Coding Tips and Special Populations

- Includes orders written by medical doctors, doctors of osteopathy, podiatrists, dentists, and physician assistants, nurse practitioners, clinical nurse specialists, qualified dietitians, clinically qualified nutrition professionals or qualified therapists, working in collaboration with the physician as allowable by state law.
- Includes written, telephone, fax, or consultation orders for new or altered treatment. Does **not** include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. Orders written on the day of admission as a result for an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.
- The prohibition against counting standard admission or readmission orders applies regardless of whether or not the orders are given at one time or are received at different times on the date of admission or readmission.

O0700: Physician Orders (cont.)

- Do not count orders prior to the date of admission or re-entry.
- A sliding scale dosage schedule that is written to cover different dosages depending on lab values, does **not** count as an order change simply because a different dose is administered based on the sliding scale guidelines.
- When a PRN (as needed) order was already on file, the potential need for the service had already been identified. Notification of the physician that the PRN order was activated does **not** constitute a new or changed order and may **not** be counted when coding this item.
- A Medicare Certification/Recertification is a renewal of an existing order and should **not** be included when coding this item.
- If a resident has multiple physicians (e.g., surgeon, cardiologist, internal medicine), and they all visit and write orders on the same day, the MDS must be coded as 1 day during which a physician visited, and 1 day in which orders were changed.
- Orders requesting a consultation by another physician may be counted. However, the order must be reasonable (e.g., for a new or altered treatment).
- An order written on the last day of the MDS observation period for a consultation planned 3-6 months in the future should be carefully reviewed.
- Orders written to increase the resident's RUG classification and facility payment are **not** acceptable.
- Orders for transfer of care to another physician may **not** be counted.
- Do **not** count orders written by a pharmacist.

V0100: Items From the Most Recent Prior OBRA or PPS Assessment

V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment
Complete only if A0310E = 0 and if the following is true for the **prior assessment**: A0310A = 01- 06 or A0310B = 01

Enter Code

A. Prior Assessment Federal OBRA Reason for Assessment (A0310A value from prior assessment)
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. None of the above

Enter Code

B. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment)
01. **5-day** scheduled assessment
08. **IPA** - Interim Payment Assessment
99. None of the above

C. Prior Assessment Reference Date (A2300 value from prior assessment)
Month – Day – Year

Enter Score

D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 value from prior assessment)

Enter Score

E. Prior Assessment Resident Mood Interview (PHQ-9©) Total Severity Score (D0300 value from prior assessment)

Enter Score

F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score (D0600 value from prior assessment)

Item Rationale

The items in V0100 are used to determine whether to trigger several of the CAAs that compare a resident's current status with their prior status. The values of these items are derived from a prior OBRA or scheduled PPS assessment that was performed since the most recent admission of any kind (i.e., since the most recent entry or reentry), if one is available. Items V0100A, B, C, D, E and F are skipped on the first assessment (OBRA or PPS) following the most recent admission of any kind (i.e., when A0310E = 1, Yes). Complete these items only if a prior assessment has been completed since the most recent admission of any kind to the facility (i.e., when A0310E = 0, No) and if the prior assessment is an OBRA or a scheduled PPS assessment. If such an assessment is available, the values of V0100A, B, C, D, E, and F should be copied from the corresponding items on that prior assessment.

Coding Instructions for V0100A, Prior Assessment Federal OBRA Reason for Assessment (A0310A Value from Prior Assessment)

- Record in V0100A the value for A0310A (Federal OBRA Reason for Assessment) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). One of the available values (01 through 06 or 99) must be selected.

V0100: Items From the Most Recent Prior OBRA or PPS Assessment (cont.)

Coding Instructions for V0100B, Prior Assessment PPS Reason for Assessment (A0310B Value from Prior Assessment)

- Record in V0100B the value for A0310B (PPS Assessment) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). One of the available values (01 or 0*8* or 99) must be selected.

  Note: The values for V0100A and V0100B cannot both be 99, indicating that the prior assessment is neither an OBRA nor a PPS assessment. If the value of V0100A is 99 (None of the above), then the value for V0100B must be 01 or 0*8*, indicating a PPS assessment. If the value of V0100B is 99 (None of the above), then the value for V0100A must be 01 through 06, indicating an OBRA assessment.

Coding Instructions for V0100C, Prior Assessment Reference Date (A2300 Value from Prior Assessment)

- Record in V0100C the value of A2300 (Assessment Reference Date) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details).

Coding Instructions for V0100D, Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 Value from Prior Assessment)

- Record in V0100D, the value for C0500 Mental Status (BIMS) Summary Score from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). This item will be compared with the corresponding item on the current assessment to evaluate resident improvement or decline in the Delirium care area.

Coding Instructions for V0100E, Prior Assessment Resident Mood Interview (PHQ-9©) Total Severity Score (D0300 Value from Prior Assessment)

- Record in V0100E the value of D0300 (Resident Mood Interview [PHQ-9©] Total Severity Score) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). This item will be compared with the corresponding item on the current assessment to evaluate resident decline in the Mood State care area.

Coding Instructions for V0100F, Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV©) Total Severity Score (D0600 Value from Prior Assessment)

- Record in V0100F the value for item D0600 (Staff Assessment of Resident Mood [PHQ-9-OV©] Total Severity Score) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). This item will be compared with the corresponding item on the current assessment to evaluate resident decline in the Mood State care area.

SECTION X: CORRECTION REQUEST

Intent: The purpose of Section X is to identify an MDS record to be modified or inactivated. The following items identify the existing assessment record that is in error. Section X is only completed if Item A0050, Type of Record, is coded a 2 (Modify existing record) or a 3 (Inactivate existing record). In Section X, the facility must reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system.

A modification request is used to correct a QIES ASAP record containing incorrect MDS item values due to:

- transcription errors,
- data entry errors,
- software product errors,
- item coding errors, and/or
- other error requiring modification

The modification request record contains correct values for all MDS items (not just the values previously in error), including the Section X items. The corrected record will replace the prior erroneous record in the QIES ASAP system.

In some cases, an incorrect MDS record requires a completely new assessment of the resident in addition to a modification request for that incorrect record. Please refer to Chapter 5 of this manual, Submission and Correction of the MDS Assessments, to determine if a new assessment is required in addition to a modification request.

An inactivation request is used to move an existing record in the QIES ASAP system from the active file to an archive (history file) so that it will not be used for reporting purposes. Inactivations should be used when the event did not occur (e.g., a discharge was submitted when the resident was not discharged). The inactivation request only includes Item A0050 and the Section X items. All other MDS sections are skipped.

The modification and inactivation processes are automated and neither completely removes the prior erroneous record from the QIES ASAP system. The erroneous record is archived in a history file. In certain cases, it is necessary to delete a record and not retain any information about the record in the QIES ASAP system. This requires a request from the facility to the facility's state agency to manually delete all traces of a record from the QIES ASAP system. The policy and procedures for a Manual Correction/Deletion Request are provided in Chapter 5 of this Manual.

A Manual Deletion Request is required **only** in the following three cases:

1. **Item A0410 Submission Requirement is incorrect.** Submission of MDS assessment records to the QIES ASAP system constitutes a release of private information and must conform to privacy laws. Only records required by the State and/or the Federal governments may be stored in the QIES ASAP system. If a record has been submitted with the incorrect Submission Requirement value in Item A0410, then that record must be manually deleted and, in some cases, a new record with a corrected A0410 value submitted. Item A0410 cannot be corrected by modification or inactivation. See Chapter 5 of this Manual for details.

2. **Inappropriate submission of a test record as a production record.** Removal of a test record from the QIES ASAP system requires manual deletion. Otherwise information for a "bogus" resident will be retained in the database and this resident will appear on some reports to the facility.
3. **Record was submitted for the wrong facility.** If a record was submitted to the QIES ASAP system for an incorrect facility, the record must be removed manually and then a new record for the correct facility must be submitted to the **QIES ASAP system. Manual deletion of the record for the wrong facility** is necessary to ensure that the resident is not associated with that facility and does not appear on reports to that facility.

X0150: Type of Provider (A0200 on existing record to be modified/inactivated)

This item contains the type of provider identified from the prior erroneous record to be modified/inactivated.

X0150. Type of Provider (A0200 on existing record to be modified/inactivated)	
Enter Code ☐	**Type of provider** 1. **Nursing home (SNF/NF)** 2. **Swing Bed**

Coding Instructions for X0150, Type of Provider

Enter the type of provider code 1 "Nursing Home (SNF/NF)" or code 2 "Swing Bed" exactly as submitted for item A0200 "Type of Provider" on the prior erroneous record to be modified/inactivated.

- **Code 1, Nursing home (SNF/NF):** if the facility is a Nursing home (SNF/NF).
- **Code 2, Swing Bed:** if the facility is a Swing Bed facility.

X0200: Name of Resident (A0500 on existing record to be modified/inactivated)

These items contain the resident's name from the prior erroneous record to be modified/inactivated.

X0200. Name of Resident (A0500 on existing record to be modified/inactivated)	
	A. **First name:** ☐☐☐☐☐☐☐☐☐☐☐☐ C. **Last name:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Coding Instructions for X0200A, First Name

- Enter the first name of the resident exactly as submitted for item A0500A "Legal Name of Resident—First Name" on the prior erroneous record to be modified/inactivated. Start entry with the leftmost box.
- Note that the first name in X0200A does not have to match the current value of A0500A on a modification request. The entries may be different if the modification is correcting the first name.

X0200: Name of Resident (A0500 on existing record to be modified/inactivated) (cont.)

Coding Instructions for X0200C, Last Name

- Enter the last name of the resident exactly as submitted for item A0500C "Legal Name of Resident— Last Name" on the prior erroneous record to be modified/inactivated. Start entry with the leftmost box. The last name in X0200C cannot be blank.
- Note that the last name in X0200C does not have to match the current value of A0500C on a modification request. The entries may be different if the modification is correcting the last name.

X0300: Gender (A0800 on existing record to be modified/inactivated)

X0300. Gender (A0800 on existing record to be modified/inactivated)

Enter Code ☐

1. **Male**
2. **Female**

Coding Instructions for X0300, Gender

- Enter the gender code 1 "Male," 2 "Female," or – (dash value indicating unable to determine) exactly as submitted for item A0800 "Gender" on the prior erroneous record to be modified/inactivated.
- Although a dash (indicating unable to determine) is no longer an acceptable value in A0800, a dash must be used in X0300 on a modification or inactivation request to locate a record if a dash was previously entered in A0800 on the original record.
- Note that the gender in X0300 does not have to match the current value of A0800 on a modification request. The entries may be different if the modification is correcting the gender.

X0400: Birth Date (A0900 on existing record to be modified/inactivated)

X0400. Birth Date (A0900 on existing record to be modified/inactivated)

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

Coding Instructions for X0400, Birth Date

- Fill in the boxes with the birth date exactly as submitted for item A0900 "Birth Date" on the prior erroneous record to be modified/inactivated. If the month or day contains only a single digit, fill in the first box with a 0 For example, January 2, 1918, should be entered as:

0	1		0	2		1	9	1	8

  If the birth date in MDS item A0900 on the prior record was a partial date, with day of the month unknown and the day of the month boxes were left blank, then the day of the month boxes must be blank in X0400. If the birth date in MDS item A0900 on the prior record was a partial date with both month and day of the month unknown and the month and day of the month boxes were left blank, then the month and day of the month boxes must be blank in X0400.
- Note that the birth date in X0400 does not have to match the current value of A0900 on a modification request. The entries may be different if the modification is correcting the birth date.

X0500: Social Security Number (A0600A on existing record to be modified/inactivated)

X0500. **Social Security Number** (A0600A on existing record to be modified/inactivated)	
	☐☐☐ - ☐☐ - ☐☐☐☐

Coding Instructions for X0500, Social Security Number

- Fill in the boxes with the Social Security number exactly as submitted for item A0600 "Social Security and Medicare numbers" on the prior erroneous record to be modified/inactivated. If the Social Security number was unknown or unavailable and left blank on the prior record, leave X0500 blank.
- Note that the Social Security number in X0500 does not have to match the current value of A0600 on a modification request. The entries may be different if the modification is correcting the Social Security number.

X0570: Optional State Assessment (A0300A/B on existing record to be modified/inactivated)

X0570. **Optional State Assessment** (A0300A/B on existing record to be modified/inactivated)	
Enter Code ☐	**A. Is this assessment for state payment purposes only?** 0. **No** 1. **Yes**
Enter Code ☐	**B. Assessment type** 1. **Start of therapy** assessment 2. **End of therapy** assessment 3. **Both Start and End of therapy** assessment 4. **Change of therapy** assessment 5. **Other payment** assessment

Item Rationale

- *This item contains the reasons for assessment from the prior erroneous Optional State Assessment record to be modified/inactivated.*

Coding Instructions for X0570A, Is this assessment for state payment purposes only?

- *Fill in the box with the state payment purpose code exactly as submitted for item A0300A "**Is this assessment for state payment purposes only?**" on the prior erroneous record to be modified/inactivated.*
- *Note that the state payment purpose code in X0570A must match the current value of A0300A on the modification request.*

Coding Instructions for X0570B, Assessment Type

- *Fill in the box with the assessment type code exactly as submitted for item A0300B "**Assessment Type**" on the prior erroneous record to be modified/inactivated.*
- *Note that the assessment type code in X0570B must match the current value of A0300B on the modification request.*

X0600: Type of Assessment/Tracking (A0310 on existing record to be modified/inactivated)

These items contain the reasons for assessment/tracking from the prior erroneous record to be modified/inactivated.

X0600. Type of Assessment (A0310 on existing record to be modified/inactivated)	
Enter Code ☐☐	**A. Federal OBRA Reason for Assessment** 01. **Admission** assessment (required by day 14) 02. **Quarterly** review assessment 03. **Annual** assessment 04. **Significant change in status** assessment 05. **Significant correction** to **prior comprehensive** assessment 06. **Significant correction** to **prior quarterly** assessment 99. **None of the above**
Enter Code ☐☐	**B. PPS Assessment** **PPS Scheduled Assessment for a Medicare Part A Stay** 01. **5-day** scheduled assessment **PPS Unscheduled Assessment for a Medicare Part A Stay** 08. **IPA** - Interim Payment Assessment **Not PPS Assessment** 99. **None of the above**
Enter Code ☐☐	**F. Entry/discharge reporting** 01. **Entry** tracking record 10. **Discharge** assessment-**return not anticipated** 11. **Discharge** assessment-**return anticipated** 12. **Death in facility** tracking record 99. **None of the above**
Enter Code ☐	**H. Is this a SNF Part A PPS Discharge Assessment?** 0. **No** 1. **Yes**

Coding Instructions for X0600A, Federal OBRA Reason for Assessment

- Fill in the boxes with the Federal OBRA reason for assessment/tracking code exactly as submitted for item A0310A "Federal OBRA Reason for Assessment" on the prior erroneous record to be modified/inactivated.
- Note that the Federal OBRA reason for assessment/tracking code in X0600A must match the current value of A0310A on a modification request.
- If item A0310A was incorrect on an assessment that was previously submitted and accepted by the QIES ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).

Coding Instructions for X0600B, PPS Assessment

- Fill in the boxes with the PPS assessment type code exactly as submitted for item A0310B "PPS Assessment" on the prior erroneous record to be modified/inactivated.
- Note that the PPS assessment code in X0600B must match the current value of A0310B on a modification request.
- If item A0310B was incorrect on an assessment that was previously submitted and accepted by the QIES ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).

X0600: Type of Assessment/Tracking (A0310 on existing record to be modified/inactivated) (cont.)

Coding Instructions for X0600F, Entry/Discharge Reporting

- Enter the number corresponding to the entry/discharge code exactly as submitted for item A0310F "Entry/discharge reporting" on the prior erroneous record to be modified/inactivated.

  01. Entry tracking record
  10. Discharge assessment-return not anticipated
  11. Discharge assessment-return anticipated
  12. Death in facility tracking record
  99. None of the above

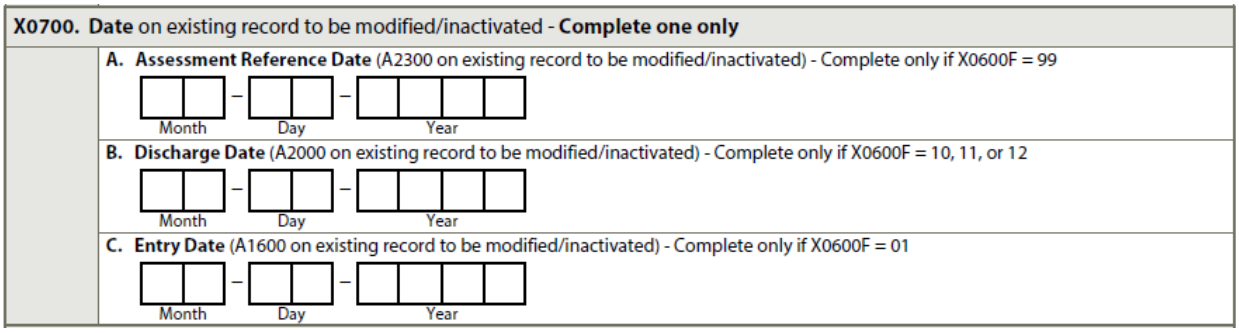
- Note that the Entry/discharge code in X0600F must match the current value of A0310F on a modification request.
- If item A0310F was incorrect on an assessment that was previously submitted and accepted by the QIES ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).

Coding Instructions for X0600H, Is this a Part A PPS Discharge Assessment?

- Enter the code exactly as submitted for item A0310H, "Is this a Part A PPS Discharge Assessment?" on the prior erroneous record to be modified/inactivated.
- **Code 0, no:** if this is not a Part A PPS Discharge assessment.
- **Code 1, yes:** if this is a Part A PPS Discharge assessment.
- Note that the code in X0600H must match the current value of A0310H on a modification request.
- If item A0310H was incorrect on an assessment that was previously submitted and accepted by the QIES ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).

X0700: Date on Existing Record to Be Modified/Inactivated – Complete one only

The item that is completed in this section is the event date for the prior erroneous record to be modified/inactivated. The event date is the assessment reference date for an assessment record, the discharge date for a discharge record, or the entry date for an entry record. In the QIES ASAP system, this date is often referred to as the "target date." Enter only one (1) date in X0700.



Coding Instructions for X0700A, Assessment Reference Date—(A2300 on existing record to be modified/inactivated) – Complete Only if X0600F = 99

- If the prior erroneous record to be modified/inactivated is an OBRA assessment or a PPS assessment, where X0600F = 99, enter the assessment reference date here exactly as submitted in item A2300 "Assessment Reference Date" on the prior record.
- Note that the assessment reference date in X0700A must match the current value of A2300 on a modification request.

Coding Instructions for X0700B, Discharge Date—(A2000 on existing record to be modified/inactivated) – Complete Only If X0600F = 10, 11, or 12

- If the prior erroneous record to be modified/inactivated is a discharge record (indicated by X0600F = 10, 11, or 12), enter the discharge date here exactly as submitted for item A2000 "Discharge Date" on the prior record. If the prior erroneous record was a discharge combined with an OBRA or PPS assessment, then that prior record will contain both a completed assessment reference date (A2300) and discharge date (A2000) and these two dates will be identical. If such a record is being modified or inactivated, enter the prior discharge date in X0700B and leave the prior assessment reference date in X0700A blank.
- Note that the discharge date in X0700B must match the current value of A2000 on a modification request.

X0700: Date on Existing Record to Be Modified/Inactivated (cont.)

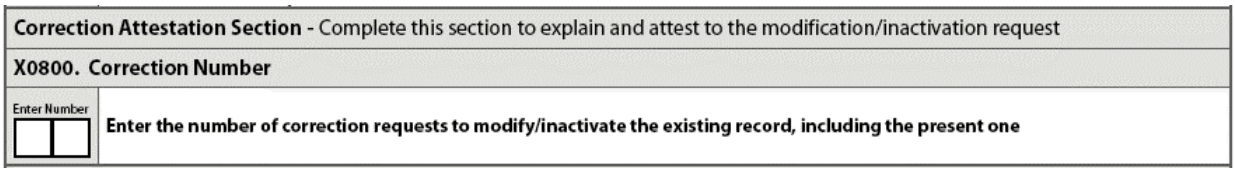
Coding Instructions for X0700C, Entry Date—(A1600 on existing record to be modified/inactivated) – Complete Only If X0600F = 01

- If the prior erroneous record to be modified/inactivated is an entry record (indicated by X0600F = 01), enter the entry date here exactly as submitted for item A1600 "Entry Date [date of admission/reentry into the facility]" on the prior record.
- Note that the entry date in X0700C must match the current value of A1600 on a modification request.

X0800: Correction Attestation Section

The items in this section indicate the number of times a record accepted into the QIES ASAP system has been corrected, the reason for the current modification/inactivation request, the person attesting to the modification/inactivation request, and the date of the attestation.

This item may be populated automatically by the nursing home's data entry software; however, if it is not, the nursing home should enter this information.



Coding Instructions for X0800, Correction Number

- Enter the total number of correction requests to modify/inactivate the record in the QIES ASAP system that is in error. Include the present modification/inactivation request in this number.
- For the first correction request (modification/inactivation) for an MDS record, code a value of 01 (zero-one); for the second correction request, code a value of 02 (zero-two); etc. With each succeeding request, X0800 is incremented by one. For values between one and nine, a leading zero should be used in the first box. For example, enter "01" into the two boxes for X0800.
- This item identifies the total number of correction requests following the original assessment or tracking record, including the present request. Note that Item X0800 is used to track successive correction requests in the QIES ASAP system.

X0900: Reasons for Modification

The items in this section indicate the possible reasons for the modification request of the record in the QIES ASAP system. Check all that apply. These items should only be completed when A0050 = 2, indicating a modification request. If A0050 = 3, indicating an inactivation request, these items should be skipped.

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (A0050 = 2)	
↓ Check all that apply	
☐	**A. Transcription error**
☐	**B. Data entry error**
☐	**C. Software product error**
☐	**D. Item coding error**
☐	**Z. Other error requiring modification** If "Other" checked, please specify: _____

Coding Instructions for X0900A, Transcription Error

- Check the box if any errors in the prior record accepted into the QIES ASAP system were caused by data transcription errors.
- A transcription error includes any error made recording MDS assessment or tracking form information from other sources. An example is transposing the digits for the resident's weight (e.g., recording "191" rather than the correct weight of "119" that appears in the medical record).

Coding Instructions for X0900B, Data Entry Error

- Check the box if any errors in the prior record accepted into the QIES ASAP system were caused by data entry errors.
- A data entry error includes any error made while encoding MDS assessment or tracking form information into the facility's computer system. An example is an error where the response to the individual minutes of physical therapy O0400C1 is incorrectly encoded as "3000" minutes rather than the correct number of "0030" minutes.

Coding Instructions for X0900C, Software Product Error

- Check the box if any errors in the prior record accepted into the QIES ASAP system were caused by software product errors.
- A software product error includes any error created by the encoding software, such as storing an item in the wrong format (e.g., storing weight as "020" instead of "200").

Coding Instructions for X0900D, Item Coding Error

- Check the box if any errors in the prior record accepted into the QIES ASAP system were caused by item coding errors.

X0900: Reasons for Modification (cont.)

- An item coding error includes any error made coding an MDS item (for exceptions when certain items may not be modified see Chapter 5), such as choosing an incorrect code for the Activities of Daily Living (ADL) bed mobility self-performance item G0110A1 (e.g., choosing a code of "4" for a resident who requires limited assistance and should be coded as "2"). Item coding errors may result when an assessor makes an incorrect judgment or misunderstands the RAI coding instructions.

Coding Instructions for X0900Z, Other Error Requiring Modification

- Check the box if any errors in the prior record accepted into the QIES ASAP system were caused by other types of errors not included in Items X0900A through X0900*D*.
- Such an error includes any other type of error that causes a record accepted into the QIES ASAP system to require modification under the Correction Policy. An example would be when a record is prematurely submitted prior to final completion of editing and review. Facility staff should describe the "other error" in the space provided with the item.

X1050: Reasons for Inactivation

The items in this section indicate the possible reasons for the inactivation request. Check all that apply. These items should only be completed when A0050 = 3, indicating an inactivation request. If A0050 = 2, indicating a modification request, these items should be skipped.

X1050. Reasons for Inactivation - Complete only if Type of Record is to inactivate a record in error (A0050 = 3)	
↓ **Check all that apply**	
☐	**A. Event did not occur**
☐	**Z. Other error requiring inactivation** If "Other" checked, please specify: _____

Coding Instructions for X1050A, Event Did Not Occur

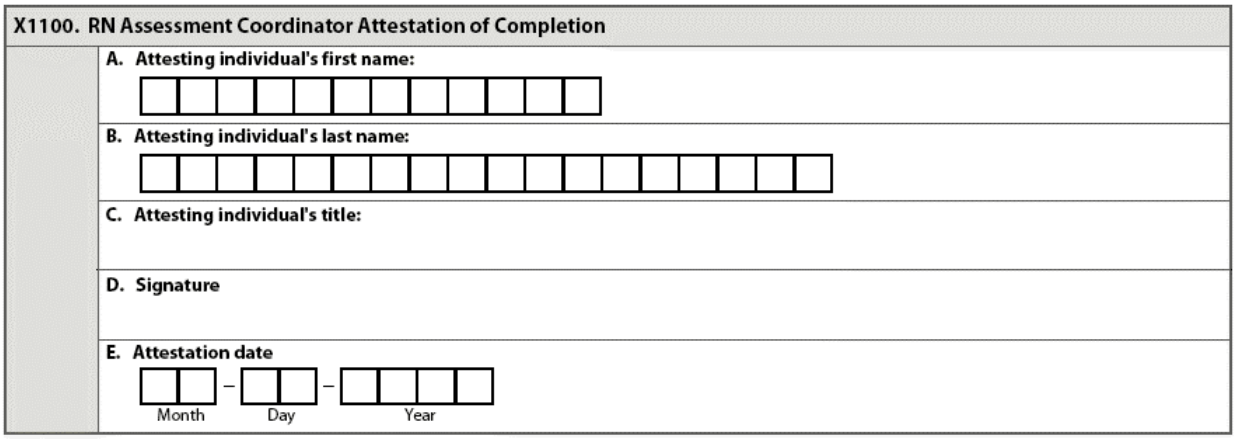
- Check the box if the record accepted into the QIES ASAP system does not represent an event that actually occurred.
- An example would be a Discharge assessment submitted for a resident, but there was no actual discharge. There was **no event**.

Coding Instructions for X1050Z, Other Reason Requiring Inactivation

- Check the box if any errors in the record accepted into the QIES ASAP system were caused by other types of errors not included in Item X1050A.
- Facility staff should describe the "other error" in the space provided with the item.

X1100: RN Assessment Coordinator Attestation of Completion

The items in this section identify the RN coordinator attesting to the correction request and the date of the attestation.



Coding Instructions for X1100A, Attesting Individual's First Name

- Enter the first name of the facility staff member attesting to the completion of the corrected information. Start entry with the leftmost box.

Coding Instructions for X1100B, Attesting Individual's Last Name

- Enter the last name of the facility staff member attesting to the completion of the corrected information. Start entry with the leftmost box.

Coding Instructions for X1100C, Attesting Individual's Title

- Enter the title of the facility staff member attesting to the completion of the corrected information on the line provided.

Coding Instructions for X1100D, Signature

- The attesting individual must sign the correction request here, certifying the completion of the corrected information. The entire correction request should be completed and signed within 14 days of detecting an error in a record accepted into the QIES ASAP system. The correction request, including the signature of the attesting facility staff, must be kept with the modified or inactivated MDS record and retained in the resident's medical record or electronic medical record.

Coding Instructions for X1100E, Attestation Date

- Enter the date the attesting facility staff member attested to the completion of the corrected information.
- Do not leave any boxes blank. For a one-digit month or day, place a zero in the first box. For example, January 2, 2011, should be entered as:

0	1		0	2		2	0	1	1

X1100: RN Assessment Coordinator Attestation of Completion (cont.)

Coding Tip for X1100, RN Assessment Coordinator Attestation of Completion

- If an inactivation is being completed, Z0400 must also be completed.

SECTION Z: ASSESSMENT ADMINISTRATION

Intent: The intent of the items in this section is to provide billing information and signatures of persons completing the assessment.

Z0100: Medicare Part A Billing

Z0100. Medicare Part A Billing	
	A. Medicare Part A HIPPS code: ☐☐☐☐☐☐☐
	B. Version code: ☐☐☐☐☐☐☐☐☐☐

Item Rationale

- Used to capture the *Patient Driven Payment Model (PDPM) case mix version code* followed by Health Insurance Prospective Payment System (HIPPS) modifier based on type of assessment.

DEFINITION

MEDICARE-COVERED STAY
Skilled Nursing Facility stays billable to Medicare Part A. Does not include stays billable to Medicare Advantage HMO plans.

Coding Instructions for Z0100A, Medicare Part A HIPPS Code

- Typically, the software data entry product will calculate this value.
- The HIPPS code is a Skilled Nursing Facility (SNF) Part A *five-position* billing code*; the first four positions represent the PDPM case mix version code and the fifth is an assessment type indicator*. For information on HIPPS, access: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/index.html.
- If the value for Z0100A is not automatically calculated by the software data entry product, enter the HIPPS code in the spaces provided (see Chapter 6 of this manual, Medicare Skilled Nursing Home Prospective Payment System, for a step-by-step worksheet for manually determining the *PDPM case mix version* code and a table that defines the assessment type indicator).
- Note that the *version code* included in this HIPPS code takes into account all MDS items used in the *PDPM* logic and is the "normal" group since the classification considers the rehabilitation therapy received.
- This HIPPS code is usually used for Medicare SNF Part A billing by the provider.
- Left-justify the 5-character HIPPS code. The extra two spaces are supplied for future use, if necessary.

DEFINITION

HIPPS CODE
Health Insurance Prospective Payment System code is comprised of the *PDPM case mix code, which is calculated from the assessment data. The first four positions of the HIPPS code contain the PDPM classification codes for each PDPM component to be billed for Medicare reimbursement,* followed by an indicator of the type of assessment that was completed.

Z0100: Medicare Part A Billing (cont.)

Coding Instructions for Z0100B, Version Code

- Typically, the software data entry product will calculate this value.
- If the value for Z0100B is not automatically calculated by the software data entry product, enter the *PDPM* version code in the spaces provided.

Z0200: State Medicaid Billing (if required by the state)

Z0200. State Medicaid Billing (if required by the state)	
	A. Case Mix group: ☐☐☐☐☐☐☐☐☐☐ B. Version code: ☐☐☐☐☐☐☐☐☐☐
Enter Code ☐	C. Is this a Short Stay assessment? 0. No 1. Yes

Item Rationale

- Used to capture the payment code in states that employ the MDS for Medicaid case-mix reimbursement.

Coding Instructions for Z0200A, Case Mix Group

- If the state has selected a standard *payment* model, this item will usually be populated automatically by the software data entry product. Otherwise, enter the case-mix code calculated based on the MDS assessment.

Coding Instructions for Z0200B, Version Code

- If the state has selected a standard *payment* model, this item will usually be populated automatically by the software data entry product. Otherwise, enter the case mix version code in the spaces provided. This is the version code appropriate to the code in Item Z0200A.

Coding Instructions for Z0200C, Is this a Short Stay assessment?

- ***Code 0, no:*** *if this is not a Short Stay assessment.*
- ***Code 1, yes:*** *if this is a Medicare Short Stay assessment.*

Coding Tip

- *The standard RUG-IV grouper automatically determines whether or not this is a Short Stay assessment. MDS software typically makes this determination automatically.*

Z0250: Alternate State Medicaid Billing (if required by state)

Z0250. Alternate State Medicaid Billing (if required by the state)	
	A. Case Mix group: ☐☐☐☐☐☐☐☐☐☐ B. Version code: ☐☐☐☐☐☐☐☐☐☐

Item Rationale

- Used to capture an alternate payment group in states that employ the MDS for Medicaid case-mix reimbursement. States may want to capture a second payment group for Medicaid purposes to allow evaluation of the fiscal impact of changing to a new payment model or to allow blended payment between two models during a transition period.

Coding Instructions for Z0250A, Case Mix Group

- If the state has selected a standard *payment* model, this item will usually be populated automatically by the software data entry product. Otherwise, enter the case-mix code calculated based on the MDS assessment.

Coding Instructions for Z0250B, Version Code

- If the state has selected a standard *payment* model, this item will usually be populated automatically by the software data entry product. Otherwise, enter the case mix version code in the spaces provided. This is the version code appropriate to the code in Item Z0250A.

Z0300: Insurance Billing

Z0300. Insurance Billing	
	A. Billing code: ☐☐☐☐☐☐☐☐☐☐ B. Billing version: ☐☐☐☐☐☐☐☐☐☐

Item Rationale

- Allows providers and vendors to capture case-mix codes required by other payers (e.g. private insurance or the Department of Veterans Affairs).

Coding Instructions for Z0300A, *B*illing Code

- If the other payer has selected a standard *payment* model, this item may be populated automatically by the software data entry product. Otherwise, enter the billing code in the space provided. This code is for use by other payment systems such as private insurance or the Department of Veterans Affairs.

Z0300: Insurance Billing (cont.)

Coding Instructions for Z0300B, Billing Version

- If the other payer has selected a standard *payment* model, this item may be populated automatically by the software data entry product. Otherwise, enter an appropriate billing version in the spaces provided. This is the billing version appropriate to the billing code in Item Z0300A.

Z0400: Signatures of Persons Completing the Assessment or Entry/Death Reporting

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Item Rationale

- To obtain the signature of all persons who completed any part of the MDS. Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. Each person completing a section or portion of a section of the MDS is required to sign the Attestation Statement.

Z0400: Signatures of Persons Completing the Assessment (cont.)

- The importance of accurately completing and submitting the MDS cannot be over-emphasized. The MDS is the basis for:
  - the development of an individualized care plan;
  - the Medicare Prospective Payment System
  - Medicaid reimbursement programs
  - quality monitoring activities, such as the quality measure reports
  - the data-driven survey and certification process
  - the quality measures used for public reporting
  - research and policy development.

Coding Instructions

- All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed.
- If a staff member cannot sign Z0400 on the same day that he or she completed a section or portion of a section, when the staff member signs, use the date the item originally was completed.
- Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident's status. Penalties may be applied for submitting false information.

Coding Tips and Special Populations

- Two or more staff members can complete items within the same section of the MDS. When filling in the information for Z0400, any staff member who has completed a sub-set of items within a section should identify which item(s) he/she completed within that section.
- Nursing homes may use electronic signatures for medical record documentation, including the MDS, when permitted to do so by state and local law and when authorized by the nursing home's policy. Nursing homes must have written policies in place that meet any and all state and federal privacy and security requirements to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.
- Although the use of electronic signatures for the MDS does not require that the entire record be maintained electronically, most facilities have the option to maintain a resident's record by computer rather than hard copy.
- Whenever copies of the MDS are printed and dates are automatically encoded, be sure to note that it is a "copy" document and not the original.

Z0400: Signatures of Persons Completing the Assessment (cont.)

- If an individual who completed a portion of the MDS is not available to sign it (e.g., in situations in which a staff member is no longer employed by the facility and left MDS sections completed but not signed for), there are portions of the MDS that may be verified with the medical record and/or resident/staff/family interview as appropriate. For these sections, the person signing the attestation must review the information to assure accuracy and sign for those portions on the date the review was conducted. For sections requiring resident interviews, the person signing the attestation for completion of that section should interview the resident to ensure the accuracy of information and sign on the date this verification occurred.

Z0500: Signature of RN Assessment Coordinator Verifying Assessment Completion

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion	
A. Signature:	B. Date RN Assessment Coordinator signed assessment as complete: ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)

Item Rationale

- Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete.

Steps for Assessment

1. Verify that all items on this assessment are complete.
2. Verify that Item Z0400 (Signature of Persons Completing the Assessment) contains attestation for all MDS sections.

Coding Instructions

- For Z0500B, use the actual date that the MDS was completed, reviewed, and signed as complete by the RN assessment coordinator. This date *must* be *equal to the latest date at Z0400 or* later than the date(s) at Z0400, which documents when portions of the assessment information were completed by assessment team members.
- If for some reason the MDS cannot be signed by the RN assessment coordinator on the date it is completed, the RN assessment coordinator should use the actual date that it is signed.

Coding Tips

- The RN assessment coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals.

Z0500: Signature of RN Assessment Coordinator Verifying Assessment Completion (cont.)

- Nursing homes may use electronic signatures for medical record documentation, including the MDS, when permitted to do so by state and local law and when authorized by the nursing home's policy. Nursing homes must have written policies in place that meet any and all state and federal privacy and security requirements to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.
- Although the use of electronic signatures for the MDS does not require that the entire record be maintained electronically, most facilities have the option to maintain a resident's record by computer rather than hard copy.
- Whenever copies of the MDS are printed and dates are automatically encoded, be sure to note that it is a "copy" document and not the original.

Table 1. Care Area Assessments in the Resident Assessment Instrument, Version 3.0

1. Delirium	2. Cognitive Loss/Dementia
3. Visual Function	4. Communication
5. Activity of Daily Living (ADL) Functional / Rehabilitation Potential	6. Urinary Incontinence and Indwelling Catheter
7. Psychosocial Well-Being	8. Mood State
9. Behavioral Symptoms	10. Activities
11. Falls	12. Nutritional Status
13. Feeding Tubes	14. Dehydration/Fluid Maintenance
15. Dental Care	16. Pressure Ulcer*/Injury*
17. Psychotropic Medication Use	18. Physical Restraints
19. Pain	20. Return to Community Referral

The CAA process does not mandate any specific tool for completing the further assessment of the triggered areas, nor does it provide any specific guidance on how to understand or interpret the triggered areas. Instead, facilities are instructed to identify and use tools that are current and grounded in current clinical standards of practice, such as evidence-based or expert-endorsed research, clinical practice guidelines, and resources. When applying these evidence-based resources to practice, the use of sound clinical problem solving and decision making (often called "critical thinking") skills is imperative.

By statute, the RAI must be completed within 14 days of admission. As an integral part of the RAI, CAAs must be completed and documented within the same time frame. While a workup cannot always be completed within 14 days, it is expected that nursing homes will assess resident needs, plan care and implement interventions in a timely manner.

CAAs are not required for Medicare PPS assessments. They are required only for OBRA comprehensive assessments (Admission, Annual, Significant Change in Status, or Significant Correction of a Prior Comprehensive). However, when a Medicare PPS assessment is combined with an OBRA comprehensive assessment, the CAAs must be completed in order to meet the requirements of the OBRA comprehensive assessment.

4.4 What Does the CAA Process Involve?

Facilities use the findings from the comprehensive assessment to develop an individualized care plan to meet each resident's needs (42 CFR 483.20(d)). The CAA process discussed in this manual refers to identifying and clarifying areas of concern that are triggered based on how specific MDS items are coded on the MDS. The process focuses on evaluating these triggered care areas using the CAAs, but does not provide exact detail on how to select pertinent interventions for care planning. Interventions must be individualized and based on applying

effective problem solving and decision making approaches to all of the information available for each resident.

Care Area Triggers (CATs) identify conditions that may require further evaluation because they may have an impact on specific issues and/or conditions, or the risk of issues and/or conditions for the resident. Each triggered item must be assessed further through the use of the CAA process to facilitate care plan decision making, but it may or may not represent a condition that should or will be addressed in the care plan. The significance and causes of any given trigger may vary for different residents or in different situations for the same resident. Different CATs may have common causes, or various items associated with several CATs may be connected.

CATs provide a "flag" for the IDT members, indicating that the triggered care area needs to be assessed more completely prior to making care planning decisions. Further assessment of a triggered care area may identify causes, risk factors, and complications associated with the care area condition. The plan of care then addresses these factors with the goal of promoting the resident's highest practicable level of functioning: (1) improvement where possible or (2) maintenance and prevention of avoidable declines.

A risk factor increases the chances of having a negative outcome or complication. For example, impaired bed mobility may increase the risk of getting a pressure ulcer*/injury*. In this example, impaired bed mobility is the risk factor, unrelieved pressure is the effect of the compromised bed mobility, and the potential pressure ulcer is the complication.

A care area issue/condition (e.g., falls) may result from a single underlying cause (e.g., administration of a new medication that causes dizziness) or from a combination of multiple factors (e.g., new medication, resident forgot walker, bed too high or too low, etc.). There can also be a single cause of multiple triggers and impairments. For example, hypothyroidism is an example of a common, potentially reversible medical condition that can have diverse physical, functional, and psychosocial complications. Thus, if a resident has hypothyroidism, it is possible that the MDS might trigger any or several of the following CAAs depending on whether or not the hypothyroidism is controlled, there is an acute exacerbation, etc.: Delirium (#1), Cognitive Loss/Dementia (#2), Visual Function (#3), Communication (#4), ADL Functional/Rehabilitation (#5), Urinary Incontinence (#6), Psychosocial Well-Being (#7), Mood State (#8), Behavior Symptoms (#9), Activities (#10), Falls (#11), Nutritional Status (#12), Dehydration (#14), Psychotropic Medication Use (#17), and Pain (#19). Even if the MDS does not trigger a particular care area, the facility can use the CAA process and resources at any time to further assess the resident.

Recognizing the connection among these symptoms and treating the underlying cause(s) to the extent possible, can help address complications and improve the resident's outcome. Conversely, failing to recognize the links and instead trying to address the triggers or MDS findings in isolation may have little if any benefit for the resident with hypothyroidism or other complex or mixed causes of impaired behavior, cognition, and mood.

For example, it is necessary to assess a resident's orientation and recall in order to complete portions of the MDS that relate to cognitive patterns (Section C) and to obtain a resident's weight and identify his or her food intake in order to complete MDS items related to nutritional status (Section K). A positive finding in Section C may trigger one or several CAAs, including Delirium (#1), Cognitive Loss/Dementia (#2), and ADL Functional/Rehabilitation Potential (#5).

directly on these conclusions. The focus of the care plan should be to address the underlying cause(s) of the resident's fall(s), as well as the factors that place him or her at risk for falling.

12. Nutritional Status

Undernutrition is not a response to normal aging, but it can arise from many diverse causes, often acting together. It may cause or reflect acute or chronic illness, and it represents a risk factor for subsequent decline.

The Nutritional Status CAA process reflects the need for an in-depth analysis of residents with impaired nutrition and those who are at nutritional risk. This CAA triggers when a resident has or is at risk for a nutrition issue/condition. Some residents who are triggered for follow-up will already be significantly underweight and thus undernourished, while other residents will be at risk of undernutrition. This CAA may also trigger based on loss of appetite with little or no accompanying weight loss and despite the absence of obvious, outward signs of impaired nutrition.

Nutritional Status CAT Logic Table

Triggering Conditions (any of the following):

1. Dehydration is selected as a problem health condition as indicated by:

   J1550C = 1

2. Body mass index (BMI) is too low or too high as indicated by:

   BMI < 18.5000 OR BMI > 24.9000

3. Any weight loss as indicated by a value of 1 or 2 as follows:

   K0300 = 1 OR K0300 = 2

4. Any planned or unplanned weight gain as indicated by a value of 1 or 2 as follows:

   K0310 = 1 OR K0310 = 2

5. Parenteral/IV feeding while NOT a resident or while a resident is used as nutritional approach as indicated by:

   K0510A1 = 1 OR K0510A2 = 1

6. Mechanically altered diet while a resident is used as nutritional approach as indicated by:

   K0510C2 = 1

7. Therapeutic diet while a resident is used as nutritional approach as indicated by:

   K0510D2 = 1

8. Resident has one or more unhealed pressure ulcer(s) at Stage 2 or higher, or one or more likely pressure ulcers that are unstageable at this time as indicated by:

   ((M0300B1 > 0 AND M0300B1 <= 9) OR

   (M0300C1 > 0 AND M0300C1 <= 9) OR

(M0300D1 > 0 AND M0300D1 <= 9) OR
(M0300E1 > 0 AND M0300E1 <= 9) OR
(M0300F1 > 0 AND M0300F1 <= 9) OR
(M0300G1 > 0 AND M0300G1 <= 9))

13. Feeding Tubes

This CAA focuses on the long-term (greater than 1 month) use of feeding tubes. It is important to balance the benefits and risks of feeding tubes in individual residents in deciding whether to make such an intervention a part of the plan of care. In some acute and longer term situations, feeding tubes may provide adequate nutrition that cannot be obtained by other means. In other circumstances, feeding tubes may not enhance survival or improve quality of life, e.g., in individuals with advanced dementia. Also, feeding tubes can be associated with diverse complications that may further impair quality of life or adversely impact survival. For example, tube feedings will not prevent aspiration of gastric contents or oral secretions and feeding tubes may irritate or perforate the stomach or intestines.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. This CAA is triggered when the resident has a need for a feeding tube for nutrition.

Feeding Tubes CAT Logic Table

Triggering Conditions (any of the following):

1. Feeding tube while NOT a resident or while a resident is used as nutritional approach as indicated by:

K0510B1 = 1 OR K0510B2 = 1

The information gleaned from the assessment should be used to identify and address the resident's status and underlying issues/conditions that necessitated the use of a feeding tube. In addition, the CAA information should be used to identify any related risk factors. The next step is to develop an individualized care plan based directly on these conclusions. The focus of the care plan should be to address the underlying cause(s), including any reversible issues and conditions that led to using a feeding tube.

16. Pressure Ulcer/*Injury*

A pressure ulcer can be defined as a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction. Pressure ulcers can have serious consequences for the elderly and are costly and time consuming to treat. They are a common preventable and treatable condition among elderly people with restricted mobility.

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

Pressure Ulcer/*Injury* CAT Logic Table

Triggering Conditions (any of the following):

1. ADL assistance for bed mobility was needed, or activity did not occur, or activity only occurred once or twice as indicated by:

   (G0110A1 >= 1 AND G0110A1 <= 4) OR

   (G0110A1 = 7 OR G0110A1 = 8)

2. Frequent urinary incontinence as indicated by:

   H0300 = 2 OR H0300 = 3

3. Frequent bowel incontinence as indicated by:

   H0400 = 2 OR H0400 = 3

4. Weight loss in the absence of physician-prescribed regimen as indicated by:

   K0300 = 2

5. Resident at risk for developing pressure ulcers as indicated by:

   M0150 = 1

6. Resident has one or more unhealed pressure ulcer(s) at Stage 2 or higher, or one or more likely pressure ulcers that are unstageable at this time as indicated by:

   ((M0300B1 > 0 AND M0300B1 <= 9) OR

   (M0300C1 > 0 AND M0300C1 <= 9) OR

   (M0300D1 > 0 AND M0300D1 <= 9) OR

   (M0300E1 > 0 AND M0300E1 <= 9) OR

   (M0300F1 > 0 AND M0300F1 <= 9) OR

   (M0300G1 > 0 AND M0300G1 <= 9))

7. Resident has one or more unhealed pressure ulcer(s) at Stage 1 as indicated by:

   M0300A > 0 AND M0300A <= 9

8. Trunk restraint used in bed has value of 1 or 2 as indicated by:

P0100B = 1 OR P0100B = 2

9. Trunk restraint used in chair or out of bed has value of 1 or 2 as indicated by:

P0100E = 1 OR P0100E = 2

The information gleaned from the assessment should be used to draw conclusions about the status of a resident's pressure ulcers(s) and to identify any related causes and/or contributing risk factors. The next step is to develop an individualized care plan based directly on these conclusions. If a pressure ulcer is not present, the goal is to prevent them by identifying the resident's risks and implementing preventive measures. If a pressure ulcer is present, the goal is to heal or close it.

17. Psychotropic Medication Use

Any medication, prescription or non-prescription, can have benefits and risks, depending on various factors (e.g., active medical conditions, coexisting medication regimen). However, psychotropic medications, prescribed primarily to affect cognition, mood, or behavior, are among the most frequently prescribed agents for elderly nursing home residents. While these medications can often be beneficial, they can also cause significant complications such as postural hypotension, extrapyramidal symptoms (e.g., akathisia, dystonia, tardive dyskinesia), and acute confusion (delirium).

When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA.

The information gleaned from the assessment should be used to draw conclusions about the appropriateness of the resident's medication, in consultation with the physician and the consultant pharmacist, and to identify any adverse consequences, as well as any related possible causes and/or contributing risk factors. The next step is to develop an individualized care plan based directly on these conclusions. Important goals of therapy include maximizing the resident's functional potential and well-being, while minimizing the hazards associated with medication side effects.

CHAPTER 5: SUBMISSION AND CORRECTION OF THE MDS ASSESSMENTS

Nursing homes are required to submit Omnibus Budget Reconciliation Act (OBRA) required Minimum Data Set (MDS) records for all residents in Medicare- or Medicaid-certified beds regardless of the pay source. Skilled nursing facilities (SNFs) and hospitals with a swing bed agreement (swing beds) are required to transmit additional MDS assessments for all Medicare beneficiaries in a Part A stay reimbursable under the SNF Prospective Payment System (PPS).

5.1 Transmitting MDS Data

All Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Required MDS records are those assessments and tracking records that are mandated under OBRA and SNF PPS. *Providers will submit the Optional State Assessment (OSA) records to the QIES ASAP system just as they submit all other MDS assessments. The OSA is not a Federally required assessment. Each State will determine if the OSA is required and when this assessment must be completed.* Assessments that are completed for purposes other than OBRA and SNF PPS reasons are not to be submitted, e.g., private insurance, including but not limited to Medicare Advantage Plans. After completion of the required assessment and/or tracking records, each provider must create electronic transmission files that meet the requirements detailed in the current MDS 3.0 Data Submission Specifications available on the CMS MDS 3.0 website at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html.

The provider indicates the certification or licensure of the unit on which the resident resides in item A0410, Unit Certification or Licensure Designation. In addition to reflecting certification or licensure of the unit, this item indicates the submission authority for a record.

- Value = 1 Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State.
- Value = 2 Unit is neither Medicare nor Medicaid certified but MDS data is required by the State.
- Value = 3 Unit is Medicare and/or Medicaid certified.

See Chapter 3 for details concerning the coding of item A0410, Unit Certification or Licensure Designation. Note: CMS certified Swing Bed unit assessments are always Value 3, Unit is Medicare and/or Medicaid certified.

Providers must establish communication with the QIES ASAP system in order to submit a file. This is accomplished by using specialized communications software and hardware and the CMS wide area network. Details about these processes are available on the QIES Technical Support Office *(QTSO)* website at: *https://qtso.cms.gov/*.

Once communication is established with the QIES ASAP system, the provider can access the Welcome to the CMS QIES Systems for Providers page in the MDS system. This site allows providers to submit MDS assessment data and access various information sources such as Bulletins and Questions and Answers. The *Minimum Data Set (MDS) 3.0 Provider User's Guide* provides more detailed information about the MDS system. It is available on the Welcome to the CMS QIES Systems for Providers page and on the QTSO MDS 3.0 website at https://qtso.cms.gov/providers/nursing-home-mdsswing-bed-providers/reference-manuals.

When the transmission file is received by the QIES ASAP system, the system performs a series of validation edits to evaluate whether or not the data submitted meet the required standards. MDS records are edited to verify that clinical responses are within valid ranges and are consistent, dates are reasonable, and records are in the proper order with regard to records that were previously accepted by the QIES ASAP system for the same resident. The provider is notified of the results of this evaluation by error and warning messages on a Final Validation Report. All error and warning messages are detailed and explained in Section 5 of the *Minimum Data Set (MDS) 3.0 Provider User's Guide*.

5.2 Timeliness Criteria

In accordance with the requirements at 42 CFR §483.20(f)(1), (f)(2), and (f)(3), long-term care facilities participating in the Medicare and Medicaid programs must meet the following conditions:

- **Completion Timing:**
  - For all non-Admission OBRA and PPS assessments, the MDS Completion Date (Z0500B) must be no later than 14 days after the Assessment Reference Date (ARD) (A2300).
  - For the Admission assessment, the MDS Completion Date (Z0500B) must be no later than 13 days after the Entry Date (A1600).
  - For the Admission assessment, the Care Area Assessment (CAA) Completion Date (V0200B2) must be no later more than 13 days after the Entry Date (A1600). For the Annual assessment, the CAA Completion Date (V0200B2) must be no later than 14 days after the ARD (A2300).
  - For the other comprehensive MDS assessments, Significant Change in Status Assessment and Significant Correction to Prior Comprehensive Assessment, the CAA Completion Date (V0200B2) must be no later than 14 days from the ARD (A2300) and no later than 14 days from the determination date of the significant change in status or the significant error, respectively.
  - For Entry and Death in Facility tracking records, the MDS Completion Date (Z0500B) must be no later than 7 days from the Event Date (A1600 for an entry record; A2000 for a Death in Facility tracking record).
- **State Requirements:** Many states have established additional MDS requirements for Medicaid payment and/or quality monitoring purposes. For information on state requirements, contact your State RAI Coordinator. (See Appendix B for a list of State RAI Coordinators.)

- **Encoding Data:** Within 7 days after completing a resident's MDS assessment or tracking record, the provider must encode the MDS data (i.e., enter the information into the facility MDS software). The encoding requirements are as follows:
  - For a comprehensive assessment (Admission, Annual, Significant Change in Status, and Significant Correction to Prior Comprehensive), encoding must occur within 7 days after the Care Plan Completion Date (V0200C2 + 7 days).
  - For a Quarterly, Significant Correction to Prior Quarterly, Discharge, or PPS assessment, encoding must occur within 7 days after the MDS Completion Date (Z0500B + 7 days).
  - For a tracking record, encoding should occur within 7 days of the Event Date (A1600 + 7 days for Entry records and A2000 + 7 days for Death in Facility records).
- **Submission Format:** For submission, the MDS data must be in record and file formats that conform to standard record layouts and data dictionaries, and pass standardized edits defined by CMS and the State. Each MDS record must be a separate file in a required XML format. The submission file is a compressed ZIP file that may contain multiple XML files. See the MDS 3.0 Data Submission Specifications on the CMS MDS 3.0 website for details concerning file and record formats, XML structure, and ZIP files.
- **Transmitting Data:** Submission files are transmitted to the QIES ASAP system using the CMS wide area network. Providers must transmit all sections of the MDS 3.0 required for their State-specific instrument, including the Care Area Assessment (CAA) Summary (Section V) and all tracking or correction information. Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirements. Care plans are not required to be transmitted.
  - **Assessment Transmission:** Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B + 14 days).
  - **Tracking Information Transmission:** For Entry and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date (A1600 + 14 days for Entry records and A2000 + 14 days for Death in Facility records).

Submission Time Frame for MDS Records

Type of Assessment/Tracking	Primary Reason (A0310A)	Secondary Reason (A0310B)	Entry/Discharge Reporting (A0310F)	Final Completion or Event Date	Submit By
Admission Assessment	01	All values	10, 11, 99	V0200C2	V0200C2 + 14
Annual Assessment	03	All values	10, 11, 99	V0200C2	V0200C2 + 14
Sign. Change in Status Assessment	04	All values	10, 11, 99	V0200C2	V0200C2 + 14
Sign. Correction to Prior Comprehensive Assessment	05	All values	10, 11, 99	V0200C2	V0200C2 + 14

(continued)

Submission Time Frame for MDS Records (continued)

Type of Assessment/Tracking	Primary Reason (A0310A)	Secondary Reason (A0310B)	Entry/Discharge Reporting (A0310F)	Final Completion or Event Date	Submit By
Quarterly Review Assessment	02	All values	10, 11, 99	Z0500B	Z0500B +14
Sign. Correction Prior Quarterly Assessment	06	All values	10, 11, 99	Z0500B	Z0500B + 14
PPS Assessment	99	01 *or 08*	10, 11, 99	Z0500B	Z0500B + 14
Discharge Assessment	All values	All values	10 or 11	Z0500B	Z0500B + 14
Death in Facility Tracking	99	99	12	A2000	A2000 + 14
Entry Tracking	99	99	*0*1	A1600	A1600 + 14
Correction Request (Modification or Inactivation)	N/A	N/A	N/A	X1100E	X1100E + 14

Table Legend:

Item	Description
V0200C2	Care Plan Completion Date: Date of the signature of the person completing the care planning decision on the CAA Summary sheet (Section V), indicating which Care Areas are addressed in the care plan. This is the date of care plan completion.
Z0500B	MDS Assessment Completion Date: Date of the RN assessment coordinator's signature, indicating that the MDS assessment is complete.
A2000	Date of discharge or death
A1600	Date of entry
X1100E	Date of the RN coordinator's signature on the Correction Request (Section X) certifying completion of the correction request information and the corrected assessment or tracking information.

- **Assessment Schedule:** An OBRA assessment (comprehensive or Quarterly) is due every quarter unless the resident is no longer in the facility. There must be no more than 92 days between OBRA assessments. An OBRA comprehensive assessment is due every year unless the resident is no longer in the facility. There must be no more than 366 days between comprehensive assessments. PPS assessments follow their own schedule. See Chapter 2 for details.

5.3 Validation Edits

The QIES ASAP system has validation edits designed to monitor the timeliness and accuracy of MDS record submissions. If transmitted MDS records do not meet the edit requirements, the system will provide error and warning messages on the provider's Final Validation Report.

Initial Submission Feedback. For each file submitted, the submitter will receive confirmation that the file was received for processing and editing by the QIES ASAP system. This

confirmation information includes the file submission identification number (ID), the date and time the file was received for processing as well as the file name.

Validation and Editing Process. Each time a user accesses the QIES ASAP system and transmits an MDS file, the QIES ASAP system performs three types of validation:

1. **Fatal File Errors.** If the file structure is unacceptable (e.g., it is not a ZIP file), the records in the ZIP file cannot be extracted, or the file cannot be read, then the file will be rejected. The Submitter Final Validation Report will list the Fatal File Errors. Files that are rejected must be corrected and resubmitted.

2. **Fatal Record Errors.** If the file structure is acceptable, then each MDS record in the file is validated individually for Fatal Record Errors. These errors include, but are not limited to:

   - Out of range responses (e.g., the valid codes for the item are 1, 2, 3, and 4 and the submitted value is a 6).
   - Inconsistent relationships between items. One example is a skip pattern violation. The resident is coded as comatose (B0100 = 1) but the Brief Interview for Mental Status is conducted (C0100 = 1). Another example is an inconsistent date pattern, such as the resident's Birth Date (Item A0900) is later than the Entry Date (Item A1600).

   Fatal Record Errors result in rejection of individual records by the QIES ASAP system. The provider is informed of Fatal Record Errors on the Final Validation Report. Rejected records must be corrected and resubmitted*, unless the Fatal Error is due to submission of a duplicate assessment*.

3. **Non-Fatal Errors (Warnings).** The record is also validated for Non-Fatal Errors. Non-Fatal Errors include, but are not limited to, missing or questionable data of a non-critical nature or item consistency errors of a non-critical nature. Examples are timing errors. Timing errors for a Quarterly assessment include (a) the submission date is more than 14 days after the MDS assessment completion date (Z0500B) or (b) the assessment completion is more than 14 days after the ARD (A2300). Another example is a record sequencing error, where an Entry record (A0310F = 01) is submitted after a Quarterly assessment record (A0310A = 02) with no intervening Discharge assessment (A0310F = 10 or 11). Any Non-Fatal Errors are reported to the provider in the Final Validation Report as warnings. The provider must evaluate each warning to identify necessary corrective actions.

Storage to the QIES ASAP System. If there are any Fatal Record Errors, the record will be rejected and not stored in the QIES ASAP system. If there are no Fatal Record Errors, the record is loaded into the QIES ASAP system, even if the record has Non-Fatal Errors (Warnings).

Detailed information on the validation edits and the error and warning messages is available in the MDS 3.0 Data Submission Specifications on the CMS MDS 3.0 website and in Section 5 of the *Minimum Data Set (MDS) 3.0 Provider User's Guide* on the Welcome to the CMS QIES Systems for Providers page and on the QTSO MDS 3.0 website.

5.4 Additional Medicare Submission Requirements that Impact Billing Under the SNF PPS

As stated in CFR §413.343(a) and (b), providers reimbursed under the SNF PPS "are required to submit the resident assessment data described at §483.20…. in the manner necessary to administer the payment rate methodology described in §413.337." This provision includes the frequency, scope, and number of assessments required in accordance with the methodology described in CFR §413.337(c) related to the adjustment of the Federal rates for case mix. SNFs must submit assessments according to a standard schedule. This schedule must include performance of resident assessments *at* specified windows *during* the Medicare Part A stay.

HIPPS Codes: Health Insurance Prospective Payment System (HIPPS) codes are billing codes used when submitting Medicare Part A SNF payment claims to the Part A/Part B Medicare Administrative Contractor (A/B MAC). The HIPPS code consists of five positions. *Under PDPM, t*he first *position represents the Physical Therapy/Occupational Therapy (PT/OT) Payment Group, the second position represents the Speech Language Pathology (SLP) Payment Group, the third position represents the Nursing Payment Group, the fourth position represents the Non-therapy Ancillary (NTA) Payment Group, and the fifth position represents the* Assessment Indicator (AI) code indicating which type of assessment was completed. Standard "grouper" logic and software for *PDPM* and the AI code are provided by CMS on the MDS 3.0 website.

The standard grouper uses MDS 3.0 items to determine both the *PDPM* group and the AI code. It is anticipated that MDS 3.0 software used by the provider will incorporate the standard grouper to automatically calculate the *PDPM* group and AI code. Detailed logic for determining the *PDPM* group and AI code is provided in Chapter 6.

The Medicare Part A HIPPS code (Item Z0100A) is most often used on the claim. The *PDPM* version code in Item Z0100B documents which version of *PDPM* was used to determine the *PDPM payment* group*s represented* in the Medicare Part A HIPPS code.

The HIPPS code (Z0100A) *and PDPM* version code (Z0100B) must be submitted to the QIES ASAP system on all Medicare PPS assessment records (indicated by A0310B = 01 or 0*8*). *Both* of these values are validated by the QIES ASAP system. The *f*inal *v*alidation *r*eport will indicate if any of these items is in error and the correct value for an incorrect item. Note that an error in one of these items is usually a non-fatal warning and the record will still be accepted in the QIES ASAP system.

The Medicare Part A SNF claim cannot be submitted until the corresponding MDS Medicare PPS assessment has been accepted in the QIES ASAP system. The claim must include the correct HIPPS code for the assessment. If the HIPPS code on the assessment was in error, then the correct HIPPS code from the Final Validation report must be used on the claim (warning error message -3616a).

5.5 MDS Correction Policy

Once completed, edited, and accepted into the QIES ASAP system, providers may not change a previously completed MDS assessment as the resident's status changes during the course of the resident's stay—the MDS must be accurate as of the ARD. Minor changes in the resident's status should be noted in the resident's record (e.g., in progress notes), in accordance with standards of clinical practice and documentation. Such monitoring and documentation is a part of the provider's responsibility to provide necessary care and services. A significant change in the resident's status warrants a new comprehensive assessment (see Chapter 2 for details).

It is important to remember that the electronic record submitted to and accepted into the QIES ASAP system is the legal assessment. Corrections made to the electronic record after QIES ASAP acceptance or to the paper copy maintained in the medical record are not recognized as proper corrections. It is the responsibility of the provider to ensure that any corrections made to a record are submitted to the QIES ASAP system in accordance with the MDS Correction Policy.

Several processes have been put into place to assure that the MDS data are accurate both at the provider and in the QIES ASAP system:

- If an error is discovered within 7 days of the completion of an MDS and before submission to the QIES ASAP system, the response may be corrected using standard editing procedures on the hard copy (cross out, enter correct response, initial and date) and/or correction of the MDS record in the facility's database. The resident's care plan should also be reviewed for any needed changes.
- Software used by the provider to encode the MDS must run all standard edits as defined in the data specifications released by CMS.
- Enhanced record rejection standards have been implemented in the QIES ASAP system.
- If an MDS record contains responses that are out of range, e.g., a 4 is entered when only 0-3 are allowable responses for an item, or item responses are inconsistent (e.g., a skip pattern is not observed), the record is rejected. Rejected records are not stored in the QIES ASAP database.
- If an error is discovered in a record that has been accepted by the QIES ASAP system, Modification or Inactivation procedures **must** be implemented by the provider to assure that the QIES ASAP system information is corrected.
- Clinical corrections must also be undertaken as necessary to assure that the resident is accurately assessed, the care plan is accurate, and the resident is receiving the necessary care. A Significant Change in Status Assessment (SCSA), Significant Correction to Prior Quarterly (SCQA), or a Significant Correction to Prior Comprehensive (SCPA) may be needed as well as corrections to the information in the QIES ASAP system. An SCSA is required only if a change in the resident's clinical status occurred. An SCPA or SCQA is required when an uncorrected significant error is identified. See Chapter 2 for details.

The remaining sections of this chapter present the decision processes necessary to identify the proper correction steps. A flow chart is provided at the end of these sections that summarizes these decisions and correction steps.

5.6 Correcting Errors in MDS Records That Have Not Yet Been Accepted Into the QIES ASAP System

If an MDS assessment is found to have errors that incorrectly reflect the resident's status, then that assessment must be corrected. The correction process depends upon the type of error. MDS assessments that have not yet been accepted in the QIES ASAP system include records that have been submitted and rejected, or records that have not been submitted at all. These records can generally be corrected and retransmitted without any special correction procedures, since they were never accepted by the QIES ASAP system. The paper copy should be corrected according to standard procedures detailed below.

Errors Identified During the Encoding Period

Facilities have up to 7 days to encode (enter into the software) and edit an MDS assessment after the MDS has been completed. Changes may be made to the electronic record for any item during the encoding and editing period, provided the response refers to the same observation period. To make revisions to the paper copy, enter the correct response, draw a line through the previous response without obliterating it, and initial and date the corrected entry. This procedure is similar to how an entry in the medical record is corrected.

When the data are encoded into the provider's MDS system from paper, the provider is responsible for verifying that all responses in the computer file match the responses on the paper form. Any discrepancies must be corrected in the computer file during the 7-day encoding period.

In addition, the provider is responsible for running encoded MDS assessment data against CMS and State-specific edits that software vendors are responsible for building into MDS Version 3.0 computer systems. For each MDS item, the response must be within the required range and also be consistent with other item responses. During this 7-day encoding period that follows the completion of the MDS assessment, a provider may correct item responses to meet required edits. Only MDS assessments that meet all of the required edits are considered complete. For corrected items, the provider must use the same observation period as was used for the original item completion (i.e., the same ARD (A2300) and look-back period). Both the electronic and paper copies of the MDS must be corrected.

Errors Identified After the Encoding Period

Errors identified after the encoding and editing period must be corrected within 14 days after identifying the errors. If the record in error is an Entry tracking record, Death in Facility tracking record, Discharge assessment, or PPS assessment record (i.e., MDS Item A0310A = 99), then the record should be corrected and submitted to the QIES ASAP system. The correction process may be more complex if the record in error is an OBRA comprehensive or Quarterly assessment record (i.e., Item A0310A = 01 through 06).

Significant versus Minor Errors in a Nursing Home OBRA Comprehensive or Quarterly Assessment Record. OBRA comprehensive and Quarterly assessment errors are classified as significant or minor errors. Errors that inaccurately reflect the resident's clinical status and/or

result in an inappropriate plan of care are considered **significant errors**. All other errors related to the coding of MDS items are considered **minor errors**.

If the only errors in the OBRA comprehensive or Quarterly assessment are minor errors, then the only requirement is for the record to be corrected and submitted to the QIES ASAP system.

The correction process is more complicated for nursing home OBRA comprehensive or Quarterly assessments with ***any significant errors*** identified after the end of the 7-day encoding and editing period but before the records have been accepted into the QIES ASAP system. First, the nursing home must correct the original OBRA comprehensive or Quarterly assessment to reflect the resident's actual status as of the ARD for that original assessment and submit the record. Second, to insure an up-to-date view of the resident's status and an appropriate care plan, the nursing home must perform an additional new assessment, either a Significant Change in Status Assessment or Significant Correction to Prior Assessment with a current observation period and ARD. If correction of the error on the MDS revealed that the resident's status met the criteria for a Significant Change in Status Assessment, then a Significant Change in Status assessment is required. If the criteria for a Significant Change in Status Assessment are not met, then a Significant Correction to Prior Assessment is required. See Chapter 2 for details.

In summary, the nursing home must take the following actions for an OBRA comprehensive or Quarterly assessment that has ***not*** been submitted to the QIES ASAP system when it contains significant errors:

- Correct the errors in the original OBRA comprehensive or Quarterly assessment.
- Submit the corrected assessment.
- Perform a ***new*** assessment – a Significant Change in Status Assessment or a Significant Correction to Prior Assessment and update the care plan as necessary.

If the assessment was performed for Medicare purposes only (A0310A = 99 and A0310B = 01 *or* 0*8*) or for a discharge (A0310A = 99 and A0310F = 10 or 11), no Significant Change in Status Assessment or Significant Correction to Prior Assessment is required. The provider would determine if the Medicare-required or Discharge assessment should be modified or inactivated. Care Area Assessments (Section V) and updated care planning are not required with Medicare-only and Discharge assessments.

5.7 Correcting Errors in MDS Records That Have Been Accepted Into the QIES ASAP System

Facilities should correct any errors necessary to ensure that the information in the QIES ASAP system accurately reflects the resident's identification, location, overall clinical status, or payment status. A correction can be submitted for any accepted record within *2* years of the target date of the record for facilities that are still open. If a facility is terminated, then corrections must be submitted within 2 years of the facility termination date. A record may be corrected even if subsequent records have been accepted for the resident.

Errors identified in QIES ASAP system records must be corrected within 14 days after identifying the errors. Inaccuracies can occur for a variety of reasons, such as transcription errors, data entry errors, software product errors, item coding errors or other errors. The following two processes have been established to correct MDS records (assessments, Entry tracking records or Death in Facility tracking records) that have been accepted into the QIES ASAP system:

- Modification
- Inactivation

A Modification request moves the inaccurate record into history in the QIES ASAP system and replaces it with the corrected record as the active record. An Inactivation request also moves the inaccurate record into history in the QIES ASAP system, but does not replace it with a new record. Both the Modification and Inactivation processes require the MDS Correction Request items to be completed in Section X of the MDS 3.0.

The MDS Correction Request items in Section X contain the minimum amount of information necessary to enable location of the erroneous MDS record previously submitted and accepted into the QIES ASAP system. Section X items are defined in the MDS 3.0 Data Submission Specifications posted on the CMS MDS 3.0 website.

When a facility maintains the MDS electronically without the use of electronic signatures, a hard copy of the Correction Request items in Section X must be kept with the corrected paper copy of the MDS record in the clinical file to track the changes made with the modification. In addition, the facility would keep a hard copy of the Correction Request items (Section X) with an inactivated record. For details on electronic records, see Chapter 2, Section 2.4.

Modification Requests

A Modification Request should be used when an MDS record (assessment, Entry tracking record or Death in Facility tracking record) is in the QIES ASAP system, but the information in the record contains clinical or demographic errors.

The Modification Request is used to modify MDS items not specifically listed under inactivation. Some of the items include:

- Target Date
  - Entry Date (Item A1600) on an Entry tracking record (Item A0310F = 1)
  - Discharge Date (Item A2000) on a Discharge/Death in Facility record (Item A0310F = 10, 11, 12),
  - Assessment Reference Date (Item A2300) on an OBRA or PPS assessment.*
- Type of Assessment (Item A0310)**
- Clinical Items (Items B0100-V0200C)

*Note: The ARD (Item A2300) can be changed when the ARD on the assessment represents a data entry/typographical error. However, the ARD cannot be altered if it results in a change in

the look back period and alters the actual assessment timeframe. Consider the following examples:

- When entering the assessment into the facility's software, the ARD, intended to be 02/12/2013, was inadvertently entered as 02/02/2013. The interdisciplinary team (IDT) completed the assessment based on the ARD of 2/12/2013 (that is, the seven day look back was 2/06/2012 through 2/12/2013). This would be an acceptable use of the modification process to modify the ARD (A2300) to reflect 02/12/2013.
- An assessment was completed by the team and entered into the software based on the ARD of 1/10/2013 (and seven day look back of 1/04/2013 through 1/10/2013). Three weeks later, the IDT determines that the date used represents a date that is not compliant with the PPS schedule and proposes changing the ARD to 1/07/2013. This would alter the look back period and result in a new assessment (rather than correcting a typographical error); this would not be an acceptable modification and shall not occur.

**Note: The Type of Assessment items (Item A0310) can only be modified when the Item Set Code (ISC) of that assessment does not change. In other words, if the Item Subset (full list can be found in Chapter 2, Section 2.5) would change, the modification cannot be done. Consider the following example:

- An Admission assessment (ISC = NC) was completed and accepted into the *QIES* ASAP system. The provider intended to code the assessment as an Admission and a 5-day PPS assessment (ISC = NC). The modification process could be used in this case as the ISC would not change.

There are a few items for which the modification process shall not be used. These items require the following correction measures if an error is identified:

- An Inactivation of the existing record followed by submission of a new corrected record is required to correct an error of the Type of Provider (Item A0200)
- An MDS 3.0 Manual Assessment Correction/Deletion Request is required to correct:
  - Unit Certification or Licensure Designation (Item A0410),
  - State-assigned facility submission ID (FAC_ID),
  - Test record submitted as a production record.

See Section 5.8 for details on the MDS 3.0 Manual Assessment Correction/Deletion Request.

When an error is discovered (except for those items listed in the preceding paragraph and instances listed in Section 5.8) in an MDS 3.0 Entry tracking record, Death in Facility tracking record, Discharge assessment, or PPS assessment that is not an OBRA assessment (where Item A0310A = 99), the provider must take the following actions to correct the record:

1. Create a corrected record with all items included, not just the items in error.
2. Complete the required Correction Request Section X items and include with the corrected record. Item A0050 should have a value of 2, indicating a modification request.
3. Submit this modification request record.

If errors are discovered in a nursing home OBRA comprehensive or Quarterly assessment (Item A0310A = 01 through 06) in the QIES ASAP system, then the nursing home must determine if there are any significant errors. If the ***only errors are minor errors***, the nursing home must take the following actions to correct the OBRA assessment:

1. Create a corrected record with all items included, not just the items in error.
2. Complete the required Correction Request Section X items and include with the corrected record. Item A0050 should have a value of 2, indicating a modification request.
3. Submit this modification request record.

When any ***significant error*** is discovered in an OBRA comprehensive or Quarterly assessment in the QIES ASAP system, the nursing home must take the following actions to correct the OBRA assessment:

1. Create a corrected record with all items included, not just the items in error.
2. Complete the required Correction Request Section X items and include with the corrected record. Item A0050 should have a value of 2, indicating a modification request.
3. Submit this modification request record.
4. Perform a new Significant Correction to Prior Assessment or Significant Change in Status Assessment and update the care plan as necessary.

A Significant Change in Status Assessment would be required only if correction of the MDS item(s) revealed that the resident met the criteria for a Significant Change in Status Assessment.

If criteria for Significant Change in Status Assessment were not met, then a Significant Correction to Prior Assessment is required.

When errors in an OBRA comprehensive or Quarterly assessment in the QIES ASAP system have been corrected in a more current OBRA comprehensive or Quarterly assessment (Item A0310A = 01 through 06), the nursing home is not required to perform a new additional assessment (Significant Change in Status or Significant Correction to Prior assessment). In this situation, the nursing home has already updated the resident's status and care plan. However, the nursing home must use the Modification process to assure that the erroneous assessment residing in the QIES ASAP system is corrected.

The 10/01/2019 Cross-Over Rule

- *A unique situation exists that will prevent providers from correcting the target date of any assessment crossing over October 1, 2019. That is, providers may not submit a modification to change a target date on an assessment completed prior to October 1, 2019 to a target date on or after October 1, 2019, nor can they submit a modification to change a target date on an assessment completed on or after October 1, 2019 to a target date prior to October 1, 2019.*
- *The item sets that are effective October 1, 2019 have had significant changes, including the omission and addition of many items. It is the target date of the assessment that identifies the required version of the item set, and, because of the substantial changes in the item sets, they are not interchangeable. Therefore, providers may not change target dates on assessments crossing over October 1, 2019.*

- *Modification records that contain a target date crossing over October 1, 2019 will result in a FATAL error and be REJECTED from the QIES ASAP system. However, all corrections to target dates that align with policies in Section 5.7 of this chapter and do not violate this rule will be allowed.*
- *To correct the target date of the assessment that violates the cross-over rule, providers must inactivate the incorrect assessment and submit a replacement assessment.*

Examples of potential scenarios that will and will not be allowed are identified below:

Original Assessment Target Date	*Modified Assessment Target Date*	*Allowed or Not Allowed*
8/15/19	*9/30/19*	*Allowed*
10/1/19	*11/1/19*	*Allowed*
9/15/19	*10/15/19*	*Not Allowed*
10/15/19	*9/15/19*	*Not Allowed*

Inactivation Requests

An Inactivation should be used when a record has been accepted into the QIES ASAP system but the corresponding event did not occur. For example, a Discharge assessment was submitted for a resident but there was no actual discharge. An Inactivation (Item A0050 = 3) **must** be completed when any of the following items are inaccurate:

- Type of Provider (Item A0200)
- Type of Assessment (A0310) **when the Item Subset would change had the MDS been modified**
- Discharge Date (Item A2000) on a Discharge assessment record (Item A0310F = 10, 11) **when the look-back period and/or clinical assessment would change had the MDS been modified**
- Assessment Reference Date (Item A2300) on an OBRA or PPS assessment **when the look-back period and/or clinical assessment would change had the MDS been modified**

When inactivating a record, the provider is required to submit an electronic Inactivation Request record. This record is an MDS record but only the Section X items and Item A0050 are completed. This is sufficient information to locate the record in the QIES ASAP system, inactivate the record and document the reason for inactivation.

For instances when the provider determines that the Type of Provider is incorrect, the provider must inactivate the record in the QIES ASAP system, then complete and submit a new MDS 3.0 record with the correct Type of Provider, ensuring that the clinical information is accurate.

Inactivations should be rare and are appropriate only under the narrow set of circumstances that indicate a record is invalid.

In such instances a new ARD date must be established based on MDS requirements, which is the date the error is determined or later, but not earlier. The new MDS 3.0 record being submitted to replace the inactivated record must include new signatures and dates for all items based on the look-back period established by the new ARD and according to established MDS assessment completion requirements.

5.8 Special Manual Record Correction Request

A few types of errors in a record in the QIES ASAP system cannot be corrected with an automated Modification or Inactivation request. These errors are:

1. The record is a test record inadvertently submitted as production.
2. The record has the wrong unit certification or licensure designation in Item A0410.
3. The record has the wrong state code or facility ID in the control Items STATE_CD or FAC_ID.

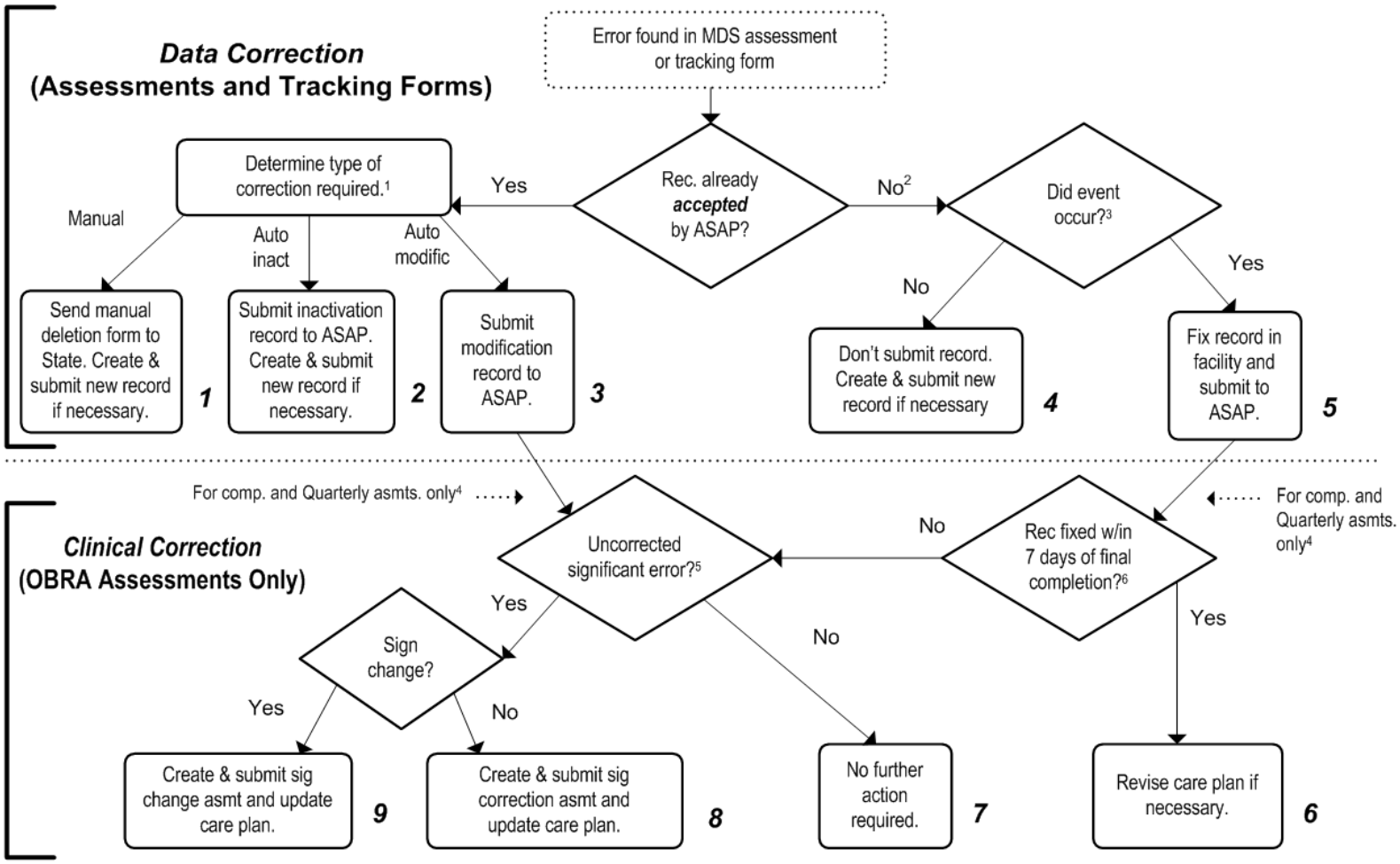
In all of these cases, the facility must contact the State Agency to have the problems fixed. The State Agency will send the facility the appropriate MDS 3.0 Manual Assessment Correction/Deletion Request form. The facility is responsible for completing the form. The facility must submit the completed form to the State Agency. Completed forms with privacy information must be sent via certified mail through the United States Postal Service (USPS). The State Agency will review the request for completion and accuracy. After approving the provider's request, the state must sign the form and send it to the QTSO Help Desk. Completed forms with privacy data must be sent via certified mail through the USPS.

When a test record is in the QIES ASAP system, the problem must be evaluated and the QIES ASAP system appropriately corrected. A normal Inactivation request will not totally fix the problem, since it will leave the test record in a history file and may also leave information about a fictitious resident. Manual deletion is necessary to completely remove the test record and associated information.

A QIES ASAP system record with an incorrect unit certification or licensure designation in Item A0410 is a very serious problem. Submission of MDS assessment records to the QIES ASAP system constitutes a release of private information and must conform to privacy laws. Item A0410 is intended to allow appropriate privacy safeguards, controlling who can access the record and whether the record can even be accepted into the QIES ASAP system. A normal Modification or Inactivation request cannot be used to correct the A0410 value, since a copy of the record in error will remain in the QIES ASAP system history file with the wrong access control. Consider a record in the QIES ASAP system with an A0410 value of 3 (Unit is Medicare and/or Medicaid certified) when actually the unit is neither Medicare nor Medicaid certified and MDS data is not required by the State (A0410 should have been 1). The record should not be in the QIES ASAP system at all and manual deletion is necessary to completely remove the record from the QIES ASAP system. Consider a record with an A0410 value of 3 indicating that the Unit is Medicare and/or Medicaid certified but actually the unit is neither Medicare nor Medicaid certified but MDS data is required by the State (A0410 should have been 2). In this case there is both federal and state access to the record, but access should be limited to the state. Manual

correction is necessary to correct A0410 and reset access control, without leaving a copy of the record with the wrong access in the QIES ASAP system history file.

If a QIES ASAP system record has the wrong state code or facility ID (control item STATE_CD, FAC_ID), then the record must be removed without leaving any trace in the QIES ASAP system. The record also should be resubmitted with the correct STATE_CD and FAC_ID value.



[1] Manual deletion request is required if test record submitted as production record, if record contains incorrect FAC_ID, or if record was submitted with an incorrect Unit Certification or Licensure Designation (A0410), for example sent in as Unit is Medicare and/or Medicaid certified (A0410 = 3) but should have been Unit is neither Medicare nor Medicaid certified but MDS data is required by the State (A0410 = 2). Otherwise, automated inactivation or modification required: (a) if event did not occur (see note #3 below), submit automated inactivation, (b) if event occurred, submit automated modification.

[2] Record has not been data entered, has not been submitted, or has been submitted and rejected by ASAP.

[3] The event occurred if the record reflects an actual entry or discharge or if an assessment was actually performed for the resident. If a record was created in error (e.g., a Discharge assessment was created for a resident who was not actually discharged), then the event did not occur.

[4] OBRA comprehensive assessments with A0310A = 01, 03, 04, 05 and Quarterly assessments with A0310A = 02, 06.

[5] The assessment contains a significant error which has not been corrected by a subsequent assessment.

[6] Final completion date is item V0200C2 for a comprehensive and Z0500B for all other assessments.

CHAPTER 6: MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM (SNF PPS)

6.1 Background

The Balanced Budget Act of 1997 included the implementation of a Prospective Payment System (PPS) for skilled nursing facilities (SNFs) and hospitals with a swing bed agreement, consolidated billing, and a number of related changes. The PPS system replaced the retrospective cost-based system for SNFs under Part A of the program (**Federal Register** Vol. 63, No. 91, May 12, 1998, Final Rule). Effective with cost reporting periods beginning on or after July 1, 2002, SNF-level services furnished in rural swing bed hospitals are paid based on the SNF PPS instead of the previous, cost-related method (**Federal Register** Vol. 66, No. 147, July 31, 2001, Final Rule). However, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 included an exemption of critical access hospital swing beds from the SNF PPS.

The SNF PPS is the culmination of substantial research efforts beginning as early as the 1970s that focus on the areas of nursing home payment and quality. In addition, it is based on a foundation of knowledge and work by a number of States that developed and implemented similar case-mix payment methodologies for their Medicaid nursing home payment systems.

The current focus in the development of the Federal payment system (i.e., PPS) for nursing home care is based on recognizing the differences among residents, particularly in the utilization of resources. Some residents require total assistance with their activities of daily living (ADLs) and have complex nursing care needs. Other residents may require less assistance with ADLs but may require rehabilitation or restorative nursing services. The recognition of these differences is the premise of a case-mix system. Reimbursement levels differ based on the resource needs of the residents. Residents with heavy care needs require more staff resources and payment levels should be higher than for those residents with less intensive care needs. In a case-mix adjusted payment system, the amount of reimbursement to the nursing home is based on the resource intensity of the resident as measured by items on the Minimum Data Set (MDS). Case-mix reimbursement has become a widely adopted method for financing nursing home care. The case-mix approach serves as the basis for the PPS for skilled nursing facilities and swing bed hospitals and is increasingly being used by States for Medicaid reimbursement for nursing homes.

6.2 Using the MDS in the Medicare Prospective Payment System

The MDS assessment data is used to calculate the resident's Patient Driven Payment Model (PDPM) classification necessary for payment. The MDS contains extensive information on the resident's nursing and therapy needs, ADL status, cognitive status, behavioral problems, and medical diagnoses. This information is used to define PDPM case-mix adjusted groups, within

which a hierarchy exists that assigns case-mix weights that capture differences in the relative resources used for treating different types of residents.

Over half of the State Medicaid programs also use the MDS for their case-mix payment systems. The Resource Utilization Group, Version IV (RUG-IV) system replaced the Resource Utilization Group, Version III (RUG-III) system for Medicare starting on October 1, 2010. Starting October 1, 2019, PDPM replaced the RUG-IV system. However, State Medicaid agencies have the option to use the RUG-III, RUG-IV, or PDPM classification systems. CMS also makes available for the States alternative RUG-IV classification systems with 66, 57, or 48 groups with varying numbers of Rehabilitation groups (similar to the RUG-III 53, 44, and 34 groups). States have the option of selecting the system (RUG-III or RUG-IV) with the number of Rehabilitation groups that better suits their Medicaid long-term care population. State Medicaid programs always have the option to develop nursing home reimbursement systems that meet their specific program goals. The decision to implement a certain classification system for Medicaid is a State decision. Please contact your State Medicaid agency if you have questions about your State Medicaid reimbursement system.

6.3 Patient Driven Payment Model (PDPM)

PDPM adjusts payment for each major element of a resident's SNF care, specifically for physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), nursing, and non-therapy ancillaries (NTA). In section 6.6 below, we provide a PDPM calculation worksheet. This calculation worksheet was developed in order to provide clinical staff with a better understanding of how PDPM works. The worksheet translates the standard software code into plain language to assist staff in understanding the logic behind the classification system.

6.4 Relationship between the Assessment and the Claim

The SNF PPS establishes a schedule of PPS assessments. The 5-Day assessment is the only required PPS assessment that is used to support PPS reimbursement. However, as described in Chapter 2, Section 2.9, an optional assessment, the Interim Payment Assessment (IPA), may be used to reclassify the resident into a new PDPM classification, and would also affect the associated payment rate. See Chapter 2 of this manual for greater detail on assessment types and requirements.

Numerous situations exist that impact the relationship between the assessment and the claim above and beyond the information provided in this chapter. It is the responsibility of the provider to ensure that claims submitted to Medicare are accurate and meet all Medicare requirements.

For example, if a resident's status does not meet the criteria for Medicare Part A SNF coverage, the provider is not to bill Medicare for any non-covered days. The assignment of a PDPM classification is not an indication that the requirements for a SNF Part A stay have been met. Once the resident no longer requires skilled services, the provider must not bill Medicare for days that are not covered. Therefore, the following information is not to be considered all-inclusive and definitive. Refer to the **Medicare Claims Processing Manual**, Chapter 6

(https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf), for detailed claims processing requirements and policies.

The SNF claim must include two data items derived from the MDS assessment:

Assessment Reference Date (ARD)

The ARD must be reported on the SNF claim. CMS has developed internal mechanisms to link the MDS assessment and the claims processing system.

Health Insurance Prospective Payment System (HIPPS) Code

Each SNF claim contains a five-position HIPPS code for the purpose of billing Part A covered days to the Medicare Administrative Contractor (MAC). The HIPPS code consists of a series of codes representing the resident's PDPM classification and the Assessment Indicator (AI) as described below. CMS provides standard software and logic for HIPPS code calculation.

PDPM Classification

The first four positions of the HIPPS code contain the PDPM classification codes for each PDPM component to be billed for Medicare reimbursement. The PDPM classification is calculated from the MDS assessment clinical data. See Section 6.6 for calculation details on each PDPM group. CMS provides standard software, development tools, and logic for PDPM calculation. CMS software, or private software developed with the CMS data specifications, is used to encode and transmit the MDS assessment data and automatically calculates the resident's PDPM classification. CMS edits and validates the PDPM classification code of transmitted MDS assessments. Skilled nursing facilities are not permitted to submit Medicare Part A claims until the assessments have been accepted into the CMS database, and they must use the PDPM classification code as validated by CMS when bills are filed, except in cases in which the facility must bill the default code (ZZZZZ). See Section 6.8 for details.

Table 1. First Character: PT/OT Component

Clinical Category	Section GG Function Score	PT/OT Case-Mix Group	HIPPS Character
Major Joint Replacement or Spinal Surgery	0-5	TA	A
Major Joint Replacement or Spinal Surgery	6-9	TB	B
Major Joint Replacement or Spinal Surgery	10-23	TC	C
Major Joint Replacement or Spinal Surgery	24	TD	D
Other Orthopedic	0-5	TE	E
Other Orthopedic	6-9	TF	F
Other Orthopedic	10-23	TG	G
Other Orthopedic	24	TH	H
Medical Management	0-5	TI	I
Medical Management	6-9	TJ	J
Medical Management	10-23	TK	K
Medical Management	24	TL	L
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	M
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	N
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	O
Non-Orthopedic Surgery and Acute Neurologic	24	TP	P

Table 2. Second Character: SLP Component

Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case-Mix Group	HIPPS Character
None	Neither	SA	A
None	Either	SB	B
None	Both	SC	C
Any one	Neither	SD	D
Any one	Either	SE	E
Any one	Both	SF	F
Any two	Neither	SG	G
Any two	Either	SH	H
Any two	Both	SI	I
All three	Neither	SJ	J
All three	Either	SK	K
All three	Both	SL	L

Table 3. Third Character: Nursing Component

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	# of Restorative Nursing Services	GG-based Function Score	PDPM Nursing Case-Mix Group	HIPPS Character
ES3	Tracheostomy & Ventilator	-	-	-	0-14	ES3	A
ES2	Tracheostomy or Ventilator	-	-	-	0-14	ES2	B
ES1	Infection	-	-	-	0-14	ES1	C
HE2/HD2	-	Serious medical conditions e.g., comatose, septicemia, respiratory therapy	Yes	-	0-5	HDE2	D
HE1/HD1	-	Serious medical conditions e.g., comatose, septicemia, respiratory therapy	No	-	0-5	HDE1	E
HC2/HB2	-	Serious medical conditions e.g., comatose, septicemia, respiratory therapy	Yes	-	6-14	HBC2	F
HC1/HB1	-	Serious medical conditions e.g., comatose, septicemia, respiratory therapy	No	-	6-14	HBC1	G
LE2/LD2	-	Serious medical conditions e.g., radiation therapy or dialysis	Yes	-	0-5	LDE2	H
LE1/LD1	-	Serious medical conditions e.g., radiation therapy or dialysis	No	-	0-5	LDE1	I
LC2/LB2	-	Serious medical conditions e.g., radiation therapy or dialysis	Yes	-	6-14	LBC2	J

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	# of Restorative Nursing Services	GG-based Function Score	PDPM Nursing Case-Mix Group	HIPPS Character
LC1/LB1	-	Serious medical conditions e.g., radiation therapy or dialysis	No	-	6-14	LBC1	K
CE2/CD2	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	Yes	-	0-5	CDE2	L
CE1/CD1	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	No	-	0-5	CDE1	M
CC2/CB2	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	Yes	-	6-14	CBC2	N
CA2	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	Yes	-	15-16	CA2	O
CC1/CB1	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	No	-	6-14	CBC1	P
CA1	-	Conditions requiring complex medical care e.g., pneumonia, surgical wounds, burns	No	-	15-16	CA1	Q
BB2/BA2	-	Behavioral or cognitive symptoms	-	2 or more	11-16	BAB2	R
BB1/BA1	-	Behavioral or cognitive symptoms	-	0-1	11-16	BAB1	S
PE2/PD2	-	Assistance with daily living and general supervision	-	2 or more	0-5	PDE2	T

RUG-IV Nursing RUG	Extensive Services	Clinical Conditions	Depression	# of Restorative Nursing Services	GG-based Function Score	PDPM Nursing Case-Mix Group	HIPPS Character
PE1/PD1	-	Assistance with daily living and general supervision	-	0-1	0-5	PDE1	U
PC2/PB2	-	Assistance with daily living and general supervision	-	2 or more	6-14	PBC2	V
PA2	-	Assistance with daily living and general supervision	-	2 or more	15-16	PA2	W
PC1/PB1	-	Assistance with daily living and general supervision	-	0-1	6-14	PBC1	X
PA1	-	Assistance with daily living and general supervision	-	0-1	15-16	PA1	Y

Table 4. Fourth Character: NTA Component

NTA Score Range	NTA Case-Mix Group	HIPPS Character
12+	NA	A
9-11	NB	B
6-8	NC	C
3-5	ND	D
1-2	NE	E
0	NF	F

The PDPM HIPPS code is recorded on the MDS 3.0 in item Z0100A (Medicare Part A HIPPS code). The HIPPS code included on the SNF claim depends on the specific type of assessment involved (as described below).

The HIPPS code in item Z0100A is validated by CMS when the assessment is submitted. If the submitted code is incorrect, the validation report will include a warning giving the correct code; the facility must enter this correct code in the HIPPS code item on the bill.

The provider must ensure that all PPS assessment requirements are met. When the provider fails to meet the PPS assessment requirements, such as when the assessment is late (as evidenced by a late ARD), the provider may be required to bill the default code. In these situations, the provider is responsible to ensure that the default code and not the PDPM classification-based HIPPS code validated by CMS in item Z0100A is billed for the applicable number of days. See Section 6.8 of this chapter for greater detail.

AI Code

The last position of the HIPPS code represents the AI, identifying the assessment type. The AI coding system indicates the different types of assessments that define different PPS payment periods and is based on the coding of item A0310B. CMS provides standard software, development tools, and logic for AI code calculation. CMS software, or private software developed with the CMS tools, automatically calculates the AI code. The AI code is validated by CMS when the assessment is submitted. If the submitted AI code is incorrect on the assessment, the validation report will include a warning and provide the correct code. The facility must enter this correct AI code in the HIPPS code item on the bill. The code consists of one digit, which is defined below. In situations when the provider is to bill the default code, the AI provided on the validation report is to be used along with the default code, ZZZZZ, on the SNF claim.

Refer to the **Medicare Claims Processing Manual**, Chapter 6, for detailed claims processing requirements and policies.

The AI code identifies the assessment used to establish the per diem payment rate for the standard PPS payment periods. These assessments are the 5-Day assessment and Interim Payment Assessment. Table 5 displays the AI code for each of the PPS assessment types and the standard payment period for each assessment type.

Table 5. Assessment Indicator Table

AI Code	Assessment Type (abbreviation)	Standard Payment Period
0	Interim Payment Assessment	See Chapter 2, Section 2.9
1	5-Day	Entire Part A Stay

6.5 SNF PPS Eligibility Criteria

Under SNF PPS, beneficiaries must meet the established eligibility requirements for a Part A SNF-level stay. These requirements are summarized in this section. Refer to the **Medicare General Information, Eligibility, and Entitlement Manual**, Chapter 1 (Pub. 100-1), and the **Medicare Benefit Policy Manual**, Chapter 8 (Pub. 100-2), for detailed SNF coverage requirements and policies.

Technical Eligibility Requirements

The beneficiary must meet the following criteria:

- Beneficiary is enrolled in Medicare Part A and has days available to use.
- There has been a three-day prior qualifying hospital stay (i.e., three midnights).
- Admission for SNF-level services is within 30 days of discharge from an acute care stay or within 30 days of discharge from a SNF level of care.

Clinical Eligibility Requirements

A beneficiary is eligible for SNF extended care if all of the following requirements are met:

- The beneficiary has a need for and receives medically necessary skilled care on a daily basis, which is provided by or under the direct supervision of skilled nursing or rehabilitation professionals.
- As a practical matter, these skilled services can only be provided in an SNF.
- The services provided must be for a condition:
  - for which the resident was treated during the qualifying hospital stay, or
  - that arose while the resident was in the SNF for treatment of a condition for which he or she was previously treated in a hospital.

Physician Certification

The attending physician or a physician on the staff of the skilled nursing facility who has knowledge of the case—or a nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS) who does not have a direct or indirect employment relationship with the facility but who is working in collaboration with the physician—must certify and then periodically recertify the need for extended care services in the skilled nursing facility.

- **Certifications** are required at the time of admission or as soon thereafter as is reasonable and practicable (42 CFR 424.20). The initial certification
  - affirms, per the required content found in 42 CFR 424.20, that the resident meets the existing SNF level of care definition, or
  - validates via written statement that the resident's assignment to one of the upper PDPM groups (defined below) is correct.

  - Those nursing groups encompassed by the Extensive Services, Special Care High, Special Care Low, and Clinically Complex nursing categories;
  - PT and OT groups TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO;
  - SLP groups SC, SE, SF, SH, SI, SJ, SK, and SL; and
  - The NTA component's uppermost (12+) comorbidity group.

- **Re-certifications** are used to document the continued need for skilled extended care services.
  - The first re-certification is required no later than the 14th day of the SNF stay.
  - Subsequent re-certifications are required at no later than 30-day intervals after the date of the first re-certification.
  - The initial certification and first re-certification may be signed at the same time.

6.6 PDPM Calculation Worksheet for SNFs

In the PDPM, there are five case-mix adjusted components: PT, OT, SLP, NTA, and Nursing. Each resident is to be classified into one and only one group for each of the five case-mix adjusted components. In other words, each resident is classified into a PT group, an OT group, an SLP group, an NTA group, and a nursing group. For each of the case-mix adjusted components, there are a number of groups to which a resident may be assigned, based on the relevant MDS 3.0 data for that component. There are 16 PT groups, 16 OT groups, 12 SLP groups, 6 NTA groups, and 25 nursing groups.

PDPM classifies residents into a separate group for each of the case-mix adjusted components, each of which has its own associated case-mix indexes and base rates. Additionally, PDPM applies variable per diem payment adjustments to three components, PT, OT, and NTA, to account for changes in resource use over a stay. The adjusted PT, OT, and NTA per diem rates are then added together with the unadjusted SLP and nursing component rates and the non-case-mix component to determine the full per diem rate for a given resident.

Calculation of PDPM Cognitive Level

The PDPM cognitive level is utilized in the SLP payment component of PDPM. One of four PDPM cognitive performance levels is assigned based on the Brief Interview for Mental Status (BIMS) or the Staff Assessment for Mental Status for the PDPM cognitive level. If neither the BIMS nor the staff assessment for the PDPM cognitive level is complete, then the PDPM cognitive level cannot be assigned and the resident will be classified as if the resident is cognitively intact.

STEP #1

Determine the resident's BIMS Summary Score on the MDS 3.0 based on the resident interview. Instructions for completing the BIMS are in Chapter 3, Section C. The BIMS involves the following items:

C0200 Repetition of three words
C0300 Temporal orientation
C0400 Recall

Item C0500 provides a BIMS Summary Score that ranges from 00 to 15. If the resident interview is not successful, then the BIMS Summary Score will equal 99.

Calculate the resident's PDPM cognitive level using the following mapping:

Table 6: Calculation of PDPM Level from BIMS

PDPM Cognitive Level	BIMS Score
Cognitively Intact	13-15
Mildly Impaired	8-12
Moderately Impaired	0-7
Severely Impaired	-

PDPM Cognitive Level: _____

If the resident's Summary Score is 99 (resident interview not successful) or the Summary Score is blank (resident interview not attempted and skipped) or the Summary Score has a dash value (not assessed), then proceed to Step #2 to use the Staff Assessment for Mental Status for the PDPM cognitive level.

STEP #2

If the resident's Summary Score is 99 or the Summary Score is blank or has a dash value, then determine the resident's cognitive status based on the Staff Assessment for Mental Status for the PDPM cognitive level using the following steps:

A) The resident classifies as severely impaired if one of the following conditions exists:

   a. Comatose (B0100 = 1) and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1 all equal 01, 09, or 88).

   b. Severely impaired cognitive skills for daily decision making (C1000 = 3).

B) If the resident is not severely impaired based on Step A, then determine the resident's Basic Impairment Count and Severe Impairment Count.

   For each of the conditions below that applies, add one to the Basic Impairment Count.

   a. In Cognitive Skills for Daily Decision Making, the resident has modified independence or is moderately impaired (C1000 = 1 or 2).

   b. In Makes Self Understood, the resident is usually understood, sometimes understood, or rarely/never understood (B0700 = 1, 2, or 3).

   c. Based on the Staff Assessment for Mental Status, the resident has a memory problem (C0700 = 1).

   Sum a., b., and c. to get the Basic Impairment Count: _____

   For each of the conditions below that applies, add one to the Severe Impairment Count.

   a. In Cognitive Skills for Daily Decision Making, the resident is moderately impaired (C1000 = 2).

   b. In Makes Self Understood, the resident is sometimes understood or rarely/never understood (B0700 = 2 or 3).

   Sum a. and b. to get the Severe Impairment Count: _____

C) The resident classifies as moderately impaired if the Severe Impairment Count is 1 or 2 and the Basic Impairment Count is 2 or 3.

D) The resident classifies as mildly impaired if the Basic Impairment Count is 1 and the Severe Impairment Count is 0, 1, or 2, or if the Basic Impairment Count is 2 or 3 and the Severe Impairment Count is 0.

E) The resident classifies as cognitively intact if both the Severe Impairment Count and Basic Impairment Count are 0.

PDPM Cognitive Level: _____

PDPM Payment Component: PT

STEP #1

Determine the resident's primary diagnosis clinical category using the ICD-10-CM code recorded in MDS item I0020B. To do so, refer to the PDPM Clinical Categories to ICD-10 Diagnosis Codes mapping (available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html), which maps a resident's primary diagnosis as recorded in MDS item I0020B to the 10 PDPM primary diagnosis clinical categories.

I0020B diagnosis: _____

Default primary diagnosis clinical category: _____

Some ICD-10-CM codes can map to a different clinical category from the default depending on a resident's prior inpatient procedure history. For these codes, a resident may be categorized into a surgical clinical category if the resident received a surgical procedure during the prior inpatient stay that relates to the primary reason for the Part A SNF stay as indicated by item J2100. If the PDPM clinical category mapping indicates that the resident's primary diagnosis code is eligible for one of the two orthopedic surgery categories (major joint replacement or spinal surgery, and orthopedic surgery (except major joint replacement or spinal surgery)), then proceed to Step 1A; if eligible for the non-orthopedic surgery category, then proceed to Step 1C. Otherwise, proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1A

Determine whether the resident received a major joint replacement or spinal surgery during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2300, J2310, J2320, J2330, J2400, J2410, or J2420 was performed during the prior inpatient stay, then the resident is categorized into the major joint replacement or spinal surgery clinical category. If none of these procedures was performed, the resident did not receive major joint replacement or spinal surgery during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Major Joint Replacement or Spinal Surgery? (Yes/No) _____

If the resident received Major Joint Replacement or Spinal Surgery, then the primary diagnosis clinical category is Major Joint Replacement or Spinal Surgery. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment. Otherwise, proceed to Step 1B.

STEP #1B

Determine whether the resident received orthopedic surgery (except major joint replacement or spinal surgery) during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2500, J2510, J2520, or J2530 was performed during the prior inpatient stay, then the resident is categorized into the Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery) clinical category. If none of these procedures was performed, the resident did not receive orthopedic surgery (except major joint replacement or spinal surgery) during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)? (Yes/No) _____

If the resident received Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery), then the primary diagnosis clinical category is Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery). Otherwise, the resident stays in the default primary diagnosis clinical category in Step 1. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1C

Determine whether the resident received a significant non-orthopedic surgical procedure during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2600, J2610, J2620, J2700, J2710, J2800, J2810, J2900, J2910, J2920, J2930, or J2940 was performed during the prior inpatient stay, then the resident is categorized into the non-orthopedic surgery clinical category. If none of these procedures was performed, the resident did not receive a significant non-orthopedic surgical procedure during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Significant Non-Orthopedic Surgical Procedure? (Yes/No) _____

If the resident received a significant Non-Orthopedic Surgical Procedure, then the primary diagnosis clinical category is Non-Orthopedic Surgery. Otherwise, the resident stays in the default primary diagnosis clinical category in Step 1. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1D

To finalize the primary diagnosis clinical category assignment, if the resident is not eligible for a different clinical category from the default, then select the default clinical category assigned to the primary diagnosis as recorded in MDS item I0020B in Step 1. If the resident is eligible for a different clinical category from the default, select the eligible surgical clinical category as determined in Steps 1A, 1B, or 1C.

Primary diagnosis clinical category: _____

STEP #2

Next, determine the resident's PT clinical category based on the mapping shown below.

Table 7: PT Clinical Category

Primary Diagnosis Clinical Category	PT Clinical Category
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Other Orthopedic
Non-Orthopedic Surgery	Non-Orthopedic Surgery
Acute Infections	Medical Management
Cardiovascular and Coagulations	Medical Management
Pulmonary	Medical Management
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic
Acute Neurologic	Acute Neurologic
Cancer	Medical Management
Medical Management	Medical Management

PT Clinical Category: _____

STEP #3

Calculate the resident's Function Score for PT payment. Use the following table to determine the Function Score for Eating Admission Performance (GG0130A1), Oral Hygiene Admission Performance (GG0130B1), Toileting Hygiene Admission Performance (GG0130C1), Sit to Lying Admission Performance (GG0170B1), Lying to Sitting on Side of Bed Admission Performance (GG0170C1), Sit to Stand Admission Performance (GG0170D1), Chair/Bed-to-Chair Transfer Admission Performance (GG0170E1), and Toilet Transfer Admission Performance (GG0170F1).

It should be noted that, in the case of an IPA, the items used for calculation of the resident's PDPM functional score are the Interim Performance items (GG0XXXX5), rather than the Admission Performance items (GG0XXXX1). For example, rather than GG0130B1, which is used on the 5-Day to assess the resident's Oral Hygiene Admission Performance, the IPA uses item GG0130B5 in order to measure the resident's Oral Hygiene Interim Performance.

Determine if the resident can walk using item GG0170I1. If the resident cannot walk 10 feet (GG0170I1 = 07, 09, 10, or 88), then the Function Score for Walk 50 Feet with Two Turns (GG0170J1) and Walk 150 Feet (GG0170K1) is 0. If the resident can walk (GG0170I1 = 06, 05, 04, 03, 02, 01), then determine the Function Score for Walk 50 Feet with Two Turns (GG0170J1) and Walk 150 Feet (GG0170K1) using the following table.

Table 8: Function Score for PT Payment

Admission or Interim Performance (Column 1 or 5) =	Function Score =
05, 06	4
04	3
03	2
02	1
01, 07, 09, 10, 88, missing	0

Enter the Function Score for each item:

Eating

Eating Function Score: _____

Oral Hygiene

Oral Hygiene Function Score: _____

Toileting Hygiene

Toileting Hygiene Function Score: _____

Bed Mobility

Sit to Lying Function Score: _____

Lying to Sitting on Side of Bed Function Score: _____

Transfer

Sit to Stand Function Score: _____

Chair/Bed-to-Chair Function Score: _____

Toilet Transfer Function Score: _____

Walking

Walk 50 Feet with Two Turns Function Score: _____

Walk 150 Feet Function Score: _____

The next step is to calculate the average function scores for the two bed mobility items, the three transfer items, and the two walking items as follows. For the Average Bed Mobility Function Score, calculate the sum of the Function Scores for Sit to Lying and Lying to Sitting on Side of Bed and divide this sum by 2. For the Average Transfer Function Score, calculate the sum of the Function Scores for Sit to Stand, Chair/Bed-to-Chair, and Toilet Transfer, and

divide this sum by 3. For the Average Walking Function Score, calculate the sum of the Function Scores for Walk 50 Feet with Two Turns and Walk 150 Feet, and divide this sum by 2. Enter the Average Bed Mobility, Average Transfer Function, and Average Walking Function Scores below.

Average Bed Mobility Function Score: _____

Average Transfer Function Score: _____

Average Walking Function Score: _____

Calculate the sum of the following Function Scores: Eating Function Score, Oral Hygiene Function Score, Toileting Hygiene Function Score, Average Bed Mobility Function Score, Average Transfer Function Score, and Average Walking Function Score. Finally, round this sum to the nearest integer. This is the **PDPM Function Score for PT Payment**. The PDPM Function Score for PT Payment ranges from 0 through 24.

PT FUNCTION SCORE: _____

STEP #4

Using the responses from Steps 2 and 3 above, determine the resident's PT group using the table below.

Table 9: PT Case-Mix Groups

Clinical Category	Section GG Function Score	PT Case-Mix Group
Major Joint Replacement or Spinal Surgery	0-5	TA
Major Joint Replacement or Spinal Surgery	6-9	TB
Major Joint Replacement or Spinal Surgery	10-23	TC
Major Joint Replacement or Spinal Surgery	24	TD
Other Orthopedic	0-5	TE
Other Orthopedic	6-9	TF
Other Orthopedic	10-23	TG
Other Orthopedic	24	TH
Medical Management	0-5	TI
Medical Management	6-9	TJ
Medical Management	10-23	TK
Medical Management	24	TL
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO
Non-Orthopedic Surgery and Acute Neurologic	24	TP

PDPM PT Classification: _____

PDPM Payment Component: OT

***Note: The steps for calculating the resident's PDPM classification for the OT component follow the same logic used for calculating the resident's PDPM classification for the PT component, described above.**

STEP #1

Determine the resident's primary diagnosis clinical category using the ICD-10-CM code recorded in MDS item I0020B. To do so, refer to the PDPM Clinical Categories to ICD-10 Diagnosis Codes mapping (available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html), which maps a resident's primary diagnosis as recorded in MDS item I0020B to the 10 PDPM primary diagnosis clinical categories.

I0020B diagnosis: _____

Default primary diagnosis clinical category: _____

Some ICD-10-CM codes can map to a different clinical category from the default depending on a resident's prior inpatient procedure history. For these codes, a resident may be categorized into a surgical clinical category if the resident received a surgical procedure during the prior inpatient stay that relates to the primary reason for the Part A SNF stay as indicated by item J2100. If the PDPM clinical category mapping indicates that the resident's primary diagnosis code is eligible for one of the two orthopedic surgery categories (major joint replacement or spinal surgery, and orthopedic surgery (except major joint replacement or spinal surgery)), then proceed to Step 1A; if eligible for the non-orthopedic surgery category, then proceed to Step 1C. Otherwise, proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1A

Determine whether the resident received a major joint replacement or spinal surgery during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2300, J2310, J2320, J2330, J2400, J2410, or J2420 was performed during the prior inpatient stay, then the resident is categorized into the major joint replacement or spinal surgery clinical category. If none of these procedures was performed, the resident did not receive major joint replacement or spinal surgery during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Major Joint Replacement or Spinal Surgery? (Yes/No) _____

If the resident received Major Joint Replacement or Spinal Surgery, then the primary diagnosis clinical category is Major Joint Replacement or Spinal Surgery. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment. Otherwise, proceed to Step 1B.

STEP #1B

Determine whether the resident received orthopedic surgery (except major joint replacement or spinal surgery) during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2500, J2510, J2520, or J2530 was performed during the prior inpatient stay, then the resident is categorized into the Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery) clinical category. If none of these procedures was performed, the resident did not receive orthopedic surgery (except major joint replacement or spinal surgery) during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)? (Yes/No) _____

If the resident received Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery), then the primary diagnosis clinical category is Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery). Otherwise, the resident stays in the default primary diagnosis clinical category in Step 1. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1C

Determine whether the resident received a significant non-orthopedic surgical procedure during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2600, J2610, J2620, J2700, J2710, J2800, J2810, J2900, J2910, J2920, J2930, or J2940 was performed during the prior inpatient stay, then the resident is categorized into the non-orthopedic surgery clinical category. If none of these procedures was performed, the resident did not receive a significant non-orthopedic surgical procedure during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Significant Non-Orthopedic Surgical Procedure? (Yes/No) _____

If the resident received a significant Non-Orthopedic Surgical Procedure, then the primary diagnosis clinical category is Non-Orthopedic Surgery. Otherwise, the resident stays in the default primary diagnosis clinical category in Step 1. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1D

To finalize the primary diagnosis clinical category assignment, if the resident is not eligible for a different clinical category from the default, then select the default clinical category assigned to the primary diagnosis as recorded in MDS item I0020B in Step 1. If the resident is eligible for a different clinical category from the default, select the eligible surgical clinical category as determined in Steps 1A, 1B, or 1C.

Primary diagnosis clinical category: _____

STEP #2

Next, determine the resident's OT clinical category based on the mapping shown below.

Table 10: OT Clinical Category

Primary Diagnosis Clinical Category	OT Clinical Category
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Other Orthopedic
Non-Orthopedic Surgery	Non-Orthopedic Surgery
Acute Infections	Medical Management
Cardiovascular and Coagulations	Medical Management
Pulmonary	Medical Management
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic
Acute Neurologic	Acute Neurologic
Cancer	Medical Management
Medical Management	Medical Management

OT Clinical Category: _____

STEP #3

Calculate the resident's Function Score for OT payment. Use the following table to determine the Function Score for Eating Admission Performance (GG0130A1), Oral Hygiene Admission Performance (GG0130B1), Toileting Hygiene Admission Performance (GG0130C1), Sit to Lying Admission Performance (GG0170B1), Lying to Sitting on Side of Bed Admission Performance (GG0170C1), Sit to Stand Admission Performance (GG0170D1), Chair/Bed-to-Chair Transfer Admission Performance (GG0170E1), and Toilet Transfer Admission Performance (GG0170F1).

It should be noted that, in the case of an IPA, the items used for calculation of the resident's PDPM functional score are the Interim Performance items (GG0XXXX5), rather than the Admission Performance items (GG0XXXX1). For example, rather than GG0130B1, which is used on the 5-Day to assess the resident's Oral Hygiene Admission Performance, the IPA uses item GG0130B5 in order to measure the resident's Oral Hygiene Interim Performance.

Determine if the resident can walk using item GG0170I1. If the resident cannot walk 10 feet (GG0170I1 = 07, 09, 10, or 88), then the Function Score for Walk 50 Feet with Two Turns (GG0170J1) and Walk 150 Feet (GG0170K1) is 0. If the resident can walk (GG0170I1 = 06, 05, 04, 03, 02, 01), then determine the Function Score for Walk 50 Feet with Two Turns (GG0170J1) and Walk 150 Feet (GG0170K1) using the following table.

Table 11: Function Score for OT Payment

Admission or Interim Performance (Column 1 or 5) =	Function Score =
05, 06	4
04	3
03	2
02	1
01, 07, 09, 10, 88, missing	0

Enter the Function Score for each item:

Eating

Eating Function Score: _____

Oral Hygiene

Oral Hygiene Function Score: _____

Toileting Hygiene

Toileting Hygiene Function Score: _____

Bed Mobility

Sit to Lying Function Score: _____

Lying to Sitting on Side of Bed Function Score: _____

Transfer

Sit to Stand Function Score: _____

Chair/Bed-to-Chair Function Score: _____

Toilet Transfer Function Score: _____

Walking

Walk 50 Feet with Two Turns Function Score: _____

Walk 150 Feet Function Score: _____

The next step is to calculate the average function scores for the two bed mobility items, the three transfer items, and the two walking items as follows. For the Average Bed Mobility Function Score, calculate the sum of the Function Scores for Sit to Lying and Lying to Sitting on Side of Bed and divide this sum by 2. For the Average Transfer Function Score, calculate the sum of the Function Scores for Sit to Stand, Chair/Bed-to-Chair, and Toilet Transfer, and

divide this sum by 3. For the Average Walking Function Score, calculate the sum of the Function Scores for Walk 50 Feet with Two Turns and Walk 150 Feet, and divide this sum by 2. Enter the Average Bed Mobility, Average Transfer Function, and Average Walking Function Scores below.

Average Bed Mobility Function Score: _____

Average Transfer Function Score: _____

Average Walking Function Score: _____

Calculate the sum of the following Function Scores: Eating Function Score, Oral Hygiene Function Score, Toileting Hygiene Function Score, Average Bed Mobility Function Score, Average Transfer Function Score, and Average Walking Function Score. Finally, round this sum to the nearest integer. This is the **PDPM Function Score for OT Payment**. The PDPM Function Score for OT Payment ranges from 0 through 24.

OT FUNCTION SCORE: _____

STEP #4

Using the responses from Steps 2 and 3 above, determine the resident's OT group using the table below.

Table 12: OT Case-Mix Groups

Clinical Category	Section GG Function Score	OT Case-Mix Group
Major Joint Replacement or Spinal Surgery	0-5	TA
Major Joint Replacement or Spinal Surgery	6-9	TB
Major Joint Replacement or Spinal Surgery	10-23	TC
Major Joint Replacement or Spinal Surgery	24	TD
Other Orthopedic	0-5	TE
Other Orthopedic	6-9	TF
Other Orthopedic	10-23	TG
Other Orthopedic	24	TH
Medical Management	0-5	TI
Medical Management	6-9	TJ
Medical Management	10-23	TK
Medical Management	24	TL
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO
Non-Orthopedic Surgery and Acute Neurologic	24	TP

PDPM OT Classification: _____

PDPM Payment Component: SLP

***Note: The primary diagnosis clinical category used for the SLP component is the same as the clinical category used for the PT and OT components.**

STEP #1

Determine the resident's primary diagnosis clinical category using the ICD-10-CM code recorded in MDS item I0020B. To do so, refer to the PDPM Clinical Categories to ICD-10 Diagnosis Codes mapping (available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html), which maps a resident's primary diagnosis as recorded in MDS item I0020B to the 10 PDPM primary diagnosis clinical categories.

I0020B diagnosis: _____

Default primary diagnosis clinical category: _____

Some ICD-10-CM codes can map to a different clinical category from the default depending on a resident's prior inpatient procedure history. For these codes, a resident may be categorized into a surgical clinical category if the resident received a surgical procedure during the prior inpatient stay that relates to the primary reason for the Part A SNF stay as indicated by item J2100. If the PDPM clinical category mapping indicates that the resident's primary diagnosis code is eligible for one of the two orthopedic surgery categories (major joint replacement or spinal surgery, and orthopedic surgery (except major joint replacement or spinal surgery)), then proceed to Step 1A; if eligible for the non-orthopedic surgery category, then proceed to Step 1C. Otherwise, proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1A

Determine whether the resident received a major joint replacement or spinal surgery during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2300, J2310, J2320, J2330, J2400, J2410, or J2420 was performed during the prior inpatient stay, then the resident is categorized into the major joint replacement or spinal surgery clinical category. If none of these procedures was performed, the resident did not receive major joint replacement or spinal surgery during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Major Joint Replacement or Spinal Surgery? (Yes/No) _____

If the resident received Major Joint Replacement or Spinal Surgery, then the primary diagnosis clinical category is Major Joint Replacement or Spinal Surgery. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment. Otherwise, proceed to Step 1B.

STEP #1B

Determine whether the resident received orthopedic surgery (except major joint replacement or spinal surgery) during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2500, J2510, J2520, or J2530 was performed during the prior inpatient stay, then the resident is categorized into the Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery) clinical category. If none of these procedures was performed, the resident did not receive orthopedic surgery (except major joint replacement or spinal surgery) during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)? (Yes/No) _____

If the resident received Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery), then the primary diagnosis clinical category is Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery). Otherwise, the resident stays in the default primary diagnosis clinical category in Step 1. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1C

Determine whether the resident received a significant non-orthopedic surgical procedure during the prior inpatient stay using item J2100. If any of the procedures indicated in items J2600, J2610, J2620, J2700, J2710, J2800, J2810, J2900, J2910, J2920, J2930, or J2940 was performed during the prior inpatient stay, then the resident is categorized into the non-orthopedic surgery clinical category. If none of these procedures was performed, the resident did not receive a significant non-orthopedic surgical procedure during the prior inpatient stay for purposes of determining the PDPM classification.

Resident Eligible for Surgical Clinical Category and Received Significant Non-Orthopedic Surgical Procedure? (Yes/No) _____

If the resident received a significant Non-Orthopedic Surgical Procedure, then the primary diagnosis clinical category is Non-Orthopedic Surgery. Otherwise, the resident stays in the default primary diagnosis clinical category in Step 1. Proceed to Step 1D to finalize the primary diagnosis clinical category assignment.

STEP #1D

To finalize the primary diagnosis clinical category assignment, if the resident is not eligible for a different clinical category from the default, then select the default clinical category assigned to the primary diagnosis as recorded in MDS item I0020B in Step 1. If the resident is eligible for a different clinical category from the default, select the eligible surgical clinical category as determined in Steps 1A, 1B, or 1C.

Primary diagnosis clinical category: _____

STEP #2

Next, determine the resident's SLP clinical category based on the mapping shown below.

Table 13: SLP Clinical Category

Primary Diagnosis Clinical Category	SLP Clinical Category
Major Joint Replacement or Spinal Surgery	Non-Neurologic
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Non-Neurologic
Non-Orthopedic Surgery	Non-Neurologic
Acute Infections	Non-Neurologic
Cardiovascular and Coagulations	Non-Neurologic
Pulmonary	Non-Neurologic
Non-Surgical Orthopedic/Musculoskeletal	Non-Neurologic
Acute Neurologic	Acute Neurologic
Cancer	Non-Neurologic
Medical Management	Non-Neurologic

SLP Clinical Category: _____

STEP #3

Determine whether the resident has one or more SLP-related comorbidities. To do so, examine the services and conditions in the table below. If any of these items is indicated as present, the resident has an SLP-related comorbidity. For conditions and services that are recorded in item I8000 of the MDS, check if the corresponding ICD-10-CM codes are coded in item I8000 using the mapping available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html.

Table 14: SLP-Related Comorbidities

MDS Item	Description
I4300	Aphasia
I4500	CVA, TIA, or Stroke
I4900	Hemiplegia or Hemiparesis
I5500	Traumatic Brain Injury
I8000	Laryngeal Cancer
I8000	Apraxia
I8000	Dysphagia
I8000	ALS
I8000	Oral Cancers
I8000	Speech and Language Deficits
O0100E2	Tracheostomy Care While a Resident
O0100F2	Ventilator or Respirator While a Resident

Presence of one or more SLP-related comorbidities? (Yes/No) _____

STEP #4

Determine whether the resident has a cognitive impairment. Calculate the resident's PDPM cognitive level, as described previously. If the PDPM cognitive level is cognitively intact, then the resident does not have a cognitive impairment. Otherwise, if the resident is assessed as mildly, moderately, or severely impaired, then the resident classifies as cognitively impaired.

Presence of Cognitive Impairment? (Yes/No) _____

STEP #5

Determine how many of the following conditions are present:

a. Based on Step 2, the resident is classified in the Acute Neurologic clinical category.

b. Based on Step 3, the resident has one or more SLP-related comorbidities.

c. Based on Step 4, the resident has a cognitive impairment.

Number of conditions present: _____

STEP #6

Determine whether the resident has a swallowing disorder using item K0100. If any of the conditions indicated in items K0100A through K0100D is present, then the resident has swallowing disorder. If none of these conditions is present, the resident does not have a swallowing disorder for purposes of this calculation.

Presence of Swallowing Disorder? (Yes/No) _____

STEP #7

Determine whether the resident has a mechanically altered diet. If K0510C2 (mechanically altered diet while a resident) is checked, then the resident has a mechanically altered diet.

Presence of Mechanically Altered Diet? (Yes/No) _____

STEP #8

Determine how many of the following conditions are present based on Steps 6 and 7:

a. The resident has neither a swallowing disorder nor a mechanically altered diet.

b. The resident has either a swallowing disorder or a mechanically altered diet.

c. The resident has both a swallowing disorder and a mechanically altered diet.

Presence of Mechanically Altered Diet or Swallowing Disorder? (Neither/Either/Both): _____

STEP #9

Determine the resident's SLP group using the responses from Steps 1-8 and the table below.

Table 15: SLP Case-Mix Groups

Presence of Acute Neurologic Condition, SLP-Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case-Mix Group
None	Neither	SA
None	Either	SB
None	Both	SC
Any one	Neither	SD
Any one	Either	SE
Any one	Both	SF
Any two	Neither	SG
Any two	Either	SH
Any two	Both	SI
All three	Neither	SJ
All three	Either	SK
All three	Both	SL

PDPM SLP Classification: _____

PDPM Payment Component: NTA

STEP #1

Determine whether resident has one or more NTA-related comorbidities.

1. Determine whether the resident has HIV/AIDS. HIV/AIDS is not reported on the MDS but is recorded on the SNF claim (ICD-10-CM code B20).

   Resident has HIV/AIDS? (Yes/No) _____

2. Determine whether the resident meets the criteria for the comorbidity: "Parenteral/IV Feeding – High Intensity" or the comorbidity: "Parenteral/IV Feeding – Low Intensity." To do so, first determine if the resident received parenteral/IV feeding during the last 7 days while a resident of the SNF using item K0510A2. If the resident did not receive parenteral/IV feeding during the last 7 days while a resident, then the resident does not meet the criteria for Parenteral/IV Feeding – High Intensity or Parenteral/IV Feeding – Low Intensity.

   If the resident did receive parenteral/IV feeding during the last 7 days while a resident, then use item K0710A to determine if the proportion of total calories the resident received through parenteral or tube feeding was 51% or more while a resident (K0710A2 = 3). If K0710A2 = 3, then the resident meets the criteria for Parenteral/IV Feeding – High Intensity. If the proportion of total calories the resident received through parenteral or tube feeding was 26-50% (K0710A2 = 2) and average fluid intake per day by IV or tube feeding was 501 cc per day or more while a resident (K0710B2 = 2), then the resident qualifies for Parenteral/IV Feeding – Low Intensity.

   Presence of Parenteral/IV Feeding – High Intensity? (Yes/No) _____

   Presence of Parenteral/IV Feeding – Low Intensity? (Yes/No) _____

3. Determine whether the resident has any additional NTA-related comorbidities. To do this, examine the conditions and services in the table below, of which all except HIV/AIDS are recorded on the MDS. HIV/AIDS is recorded on the SNF claim. For conditions and services that are recorded in item I8000 of the MDS, check if the corresponding ICD-10-CM codes are coded in item I8000 using the mapping available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html.

Table 16: NTA Comorbidity Score Calculation

Condition/Extensive Service	MDS Item	Points
HIV/AIDS	N/A (SNF claim)	8
Parenteral IV Feeding: Level High	K0510A2, K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	O0100H2	5
Special Treatments/Programs: Ventilator or Respirator Post-admit Code	O0100F2	4
Parenteral IV Feeding: Level Low	K0510A2, K0710A2, K0710B2	3
Lung Transplant Status	I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	O0100I2	2
Major Organ Transplant Status, Except Lung	I8000	2
Active Diagnoses: Multiple Sclerosis Code	I5200	2
Opportunistic Infections	I8000	2
Active Diagnoses: Asthma COPD Chronic Lung Disease Code	I6200	2
Bone/Joint/Muscle Infections/Necrosis - Except: Aseptic Necrosis of Bone	I8000	2
Chronic Myeloid Leukemia	I8000	2
Wound Infection Code	I2500	2
Active Diagnoses: Diabetes Mellitus (DM) Code	I2900	2
Endocarditis	I8000	1
Immune Disorders	I8000	1
End-Stage Liver Disease	I8000	1
Other Foot Skin Problems: Diabetic Foot Ulcer Code	M1040B	1
Narcolepsy and Cataplexy	I8000	1
Cystic Fibrosis	I8000	1
Special Treatments/Programs: Tracheostomy Care Post-admit Code	O0100E2	1
Active Diagnoses: Multi-Drug Resistant Organism (MDRO) Code	I1700	1
Special Treatments/Programs: Isolation Post-admit Code	O0100M2	1
Specified Hereditary Metabolic/Immune Disorders	I8000	1
Morbid Obesity	I8000	1
Special Treatments/Programs: Radiation Post-admit Code	O0100B2	1
Stage 4 Unhealed Pressure Ulcer Currently Present[1]	M0300D1	1
Psoriatic Arthropathy and Systemic Sclerosis	I8000	1
Chronic Pancreatitis	I8000	1

Condition/Extensive Service	MDS Item	Points
Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code	M1040A, M1040C	1
Complications of Specified Implanted Device or Graft	I8000	1
Bladder and Bowel Appliances: Intermittent Catheterization	H0100D	1
Inflammatory Bowel Disease	I1300	1
Aseptic Necrosis of Bone	I8000	1
Special Treatments/Programs: Suctioning Post-admit Code	O0100D2	1
Cardio-Respiratory Failure and Shock	I8000	1
Myelodysplastic Syndromes and Myelofibrosis	I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	I8000	1
Diabetic Retinopathy - Except: Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	I8000	1
Nutritional Approaches While a Resident: Feeding Tube	K0510B2	1
Severe Skin Burn or Condition	I8000	1
Intractable Epilepsy	I8000	1
Active Diagnoses: Malnutrition Code	I5600	1
Disorders of Immunity - Except: RxCC97: Immune Disorders	I8000	1
Cirrhosis of Liver	I8000	1
Bladder and Bowel Appliances: Ostomy	H0100C	1
Respiratory Arrest	I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	I8000	1

[1] If the number of Stage 4 Unhealed Pressure Ulcers is recorded as greater than 0, it will add one point to the NTA comorbidity score calculation. Only the presence, not the count, of Stage 4 Unhealed Pressure Ulcers affects the PDPM NTA comorbidity score calculation.

STEP #2

Calculate the resident's total NTA score using the table above. To calculate the total NTA score, sum the points corresponding to each condition or service present. If none of these conditions or services is present, the resident's score is 0.

NTA Score: _____

STEP #3

Determine the resident's NTA group using the table below.

Table 17: NTA Case-Mix Groups

NTA Score Range	NTA Case-Mix Group
12+	NA
9-11	NB
6-8	NC
3-5	ND
1-2	NE
0	NF

PDPM NTA Classification: _____

PDPM Payment Component: Nursing

STEP #1

Calculate the resident's Function Score for nursing payment. Use the following table to determine the Function Score for Eating Admission Performance (GG0130A1), Toileting Hygiene Admission Performance (GG0130C1), Sit to Lying Admission Performance (GG0170B1), Lying to Sitting on Side of Bed Admission Performance (GG0170C1), Sit to Stand Admission Performance (GG0170D1), Chair/Bed-to-Chair Transfer Admission Performance (GG0170E1), and Toilet Transfer Admission Performance (GG0170F1).

Table 18: Function Score for Nursing Payment

Admission Performance (Column 1) =	Function Score =
05, 06	4
04	3
03	2
02	1
01, 07, 09, 10, 88, missing	0

Enter the Function Score for each item:

Eating

Eating Function Score: _____

Toileting Hygiene

Toileting Hygiene Function Score: _____

Bed Mobility

Sit to Lying Function Score: _____

Lying to Sitting on Side of Bed Function Score: _____

Transfer

Sit to Stand Function Score: _____

Chair/Bed-to-Chair Function Score: _____

Toilet Transfer Function Score: _____

Next, calculate the average score for the two bed mobility items and the three transfer items as follows: Average the scores for Sit to Lying and Lying to Sitting on Side of Bed.[1] Average the scores for Sit to Stand, Chair/Bed-to-Chair and Toilet Transfer.[2] Enter the average bed mobility and transfer scores below.

Average Bed Mobility Function Score: _____

Average Transfer Function Score: _____

Calculate the sum of the following scores: Eating Function Score, Toileting Hygiene Function Score, Average Bed Mobility Score, and Average Transfer Score. Finally, round this sum to the nearest integer. This is the **PDPM Function Score for nursing payment**. The PDPM Function Score for nursing payment ranges from 0 through 16.

PDPM NURSING FUNCTION SCORE: _____

STEP #2

Determine the resident's nursing case-mix group using the hierarchical classification below. Nursing classification under PDPM employs the hierarchical classification method. Hierarchical classification is used in some payment systems, in staffing analysis, and in many research projects. In the hierarchical approach, start at the top and work down through the PDPM nursing classification model steps discussed below; the assigned classification is the first group for which the resident qualifies. In other words, start with the Extensive Services groups at the top of the PDPM nursing classification model. Then go down through the groups in hierarchical order: Extensive Services, Special Care High, Special Care Low, Clinically Complex, Behavioral Symptoms and Cognitive Performance, and Reduced Physical Function. When you find the first of the 25 individual PDPM nursing groups for which the resident qualifies, assign that group as the PDPM nursing classification.

[1] Calculate the sum of the Function Scores for Sit to Lying and Lying to Sitting on Side of Bed. Divide this sum by 2. This is the Average Bed Mobility Function Score.

[2] Calculate the sum of the Function Scores for Sit to Stand, Chair/Bed-to-Chair, and Toilet Transfer. Divide by 3. This is the Average Transfer Function Score.

CATEGORY: EXTENSIVE SERVICES

The classification groups in this category are based on various services provided. Use the following instructions to begin the calculation:

STEP #1

Determine whether the resident is coded for **one** of the following treatments or services:

O0100E2	Tracheostomy care while a resident
O0100F2	Ventilator or respirator while a resident
O0100M2	Isolation or quarantine for active infectious disease while a resident

If the resident does not receive one of these treatments or services, skip to the Special Care High Category now.

STEP #2

If at least **one** of these treatments or services is coded and the resident has a total PDPM Nursing Function Score of 14 or less, he or she classifies in the Extensive Services category. **Move to Step #3. If the resident's PDPM Nursing Function Score is 15 or 16, he or she classifies as Clinically Complex. Skip to the Clinically Complex Category, Step #2.**

STEP #3

The resident classifies in the Extensive Services category according to the following chart:

Extensive Service Conditions	PDPM Nursing Classification
Tracheostomy care* **and** ventilator/respirator*	ES3
Tracheostomy care* **or** ventilator/respirator*	ES2
Isolation or quarantine for active infectious disease* **without** tracheostomy care* **without** ventilator/respirator*	ES1

*while a resident

PDPM Nursing Classification: _____

If the resident does not classify in the Extensive Services Category, proceed to the Special Care High Category.

CATEGORY: SPECIAL CARE HIGH

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

STEP #1

Determine whether the resident is coded for **one** of the following conditions or services:

B0100, Section GG items	Comatose and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1 all equal 01, 09, or 88)
I2100	Septicemia
I2900, N0350A, B	Diabetes with **both** of the following: Insulin injections (N0350A) for all 7 days Insulin order changes on 2 or more days (N0350B)
I5100, Nursing Function Score	Quadriplegia with Nursing Function Score <= 11
I6200, J1100C	Chronic obstructive pulmonary disease **and** shortness of breath when lying flat
J1550A, others	Fever and one of the following: I2000 Pneumonia J1550B Vomiting K0300 Weight loss (1 or 2) K0510B1 or K0510B2 Feeding tube*
K0510A1 or K0510A2	Parenteral/IV feedings
O0400D2	Respiratory therapy for all 7 days

*Tube feeding classification requirements:

(1) K0710A3 is 51% or more of total calories OR

(2) K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.

If the resident does not have one of these conditions, skip to the Special Care Low Category now.

STEP #2

If at least **one** of the special care conditions above is coded and the resident has a total PDPM Nursing Function Score of 14 or less, he or she classifies as Special Care High. **Move to Step #3. If the resident's PDPM Nursing Function Score is 15 or 16, he or she classifies as Clinically Complex. Skip to the Clinically Complex Category, Step #2.**

STEP #3

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Special Care High category. Residents with signs and symptoms of depression are identified by the Patient Mood Interview (PHQ-9©) or the Staff Assessment of Patient Mood (PHQ-9-OV©). Instructions for completing the PHQ-9© are in Chapter 3, Section D. Refer to Appendix E for cases in which the PHQ-9© or PHQ-9-OV© is complete but all questions are not answered. The following items comprise the PHQ-9©:

Resident	Staff	Description
D0200A	D0500A	Little interest or pleasure in doing things
D0200B	D0500B	Feeling down, depressed, or hopeless
D0200C	D0500C	Trouble falling or staying asleep, sleeping too much
D0200D	D0500D	Feeling tired or having little energy
D0200E	D0500E	Poor appetite or overeating
D0200F	D0500F	Feeling bad about yourself - or that you are a failure or have let yourself down or your family down
D0200G	D0500G	Trouble concentrating on things, such as reading the newspaper or watching television
D0200H	D0500H	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual
D0200I	D0500I	Thoughts that you would be better off dead, or of hurting yourself in some way
-	D0500J	Being short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at item D0300 and for the staff assessment at item D0600. The resident qualifies as depressed for PDPM classification in either of the two following cases:

The D0300 Total Severity Score is greater than or equal to 10 but not 99,

or

The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

STEP #4

Select the Special Care High classification based on the PDPM Nursing Function Score and the presence or absence of depression according to this table:

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	HDE2
0-5	No	HDE1
6-14	Yes	HBC2
6-14	No	HBC1

PDPM Nursing Classification: _____

CATEGORY: SPECIAL CARE LOW

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

STEP #1

Determine whether the resident is coded for **one** of the following conditions or services:

I4400, Nursing Function Score	Cerebral palsy, with Nursing Function Score <=11
I5200, Nursing Function Score	Multiple sclerosis, with Nursing Function Score <=11
I5300, Nursing Function Score	Parkinson's disease, with Nursing Function Score <=11
I6300, O0100C2	Respiratory failure and oxygen therapy while a resident
K0510B1 or K0510B2	Feeding tube*
M0300B1	Two or more stage 2 pressure ulcers with two or more selected skin treatments**
M0300C1, D1, F1	Any stage 3 or 4 pressure ulcer with two or more selected skin treatments**
M1030	Two or more venous/arterial ulcers with two or more selected skin treatments**
M0300B1, M1030	1 stage 2 pressure ulcer and 1 venous/arterial ulcer with 2 or more selected skin treatments**
M1040A, B, C; M1200I	Foot infection, diabetic foot ulcer or other open lesion of foot with application of dressings to the feet
O0100B2	Radiation treatment while a resident
O0100J2	Dialysis treatment while a resident

*Tube feeding classification requirements:

(1) K0710A3 is 51% or more of total calories OR

(2) K0710A3 is 26% to 50% of total calories and K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.

**Selected skin treatments:
M1200A, B Pressure relieving chair and/or bed
M1200C Turning/repositioning
M1200D Nutrition or hydration intervention
M1200E Pressure ulcer care
M1200G Application of dressings (not to feet)
M1200H Application of ointments (not to feet)
#Count as one treatment even if both provided

If the resident does not have one of these conditions, skip to the Clinically Complex Category now.

STEP #2

If at least **one** of the special care conditions above is coded and the resident has a total PDPM Nursing Function Score of 14 or less, he or she classifies as Special Care Low. **Move to Step #3. If the resident's PDPM Nursing Function Score is 15 or 16, he or she classifies as Clinically Complex. Skip to the Clinically Complex Category, Step #2.**

STEP #3

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Special Care Low category. Residents with signs and symptoms of depression are identified by the Patient Mood Interview (PHQ-9©) or the Staff Assessment of Patient Mood (PHQ-9-OV©). Instructions for completing the PHQ-9© are in Chapter 3, Section D. Refer to Appendix E for cases in which the PHQ-9© or PHQ-9-OV© is complete but all questions are not answered. The following items comprise the PHQ-9©:

Resident	Staff	Description
D0200A	D0500A	Little interest or pleasure in doing things
D0200B	D0500B	Feeling down, depressed, or hopeless
D0200C	D0500C	Trouble falling or staying asleep, sleeping too much
D0200D	D0500D	Feeling tired or having little energy
D0200E	D0500E	Poor appetite or overeating
D0200F	D0500F	Feeling bad about yourself - or that you are a failure or have let yourself down or your family down
D0200G	D0500G	Trouble concentrating on things, such as reading the newspaper or watching television
D0200H	D0500H	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual
D0200I	D0500I	Thoughts that you would be better off dead, or of hurting yourself in some way
-	D0500J	Being short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at item D0300 and for the staff assessment at item D0600. The resident qualifies as depressed for PDPM classification in either of the two following cases:

The D0300 Total Severity Score is greater than or equal to 10 but not 99,

or

The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

STEP #4

Select the Special Care Low classification based on the PDPM Nursing Function Score and the presence or absence of depression according to this table:

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	LDE2
0-5	No	LDE1
6-14	Yes	LBC2
6-14	No	LBC1

PDPM Nursing Classification: _____

CATEGORY: CLINICALLY COMPLEX

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

STEP #1

Determine whether the resident is coded for **one** of the following conditions or services:

Table 19: Clinically Complex Conditions or Services

MDS Item	Condition or Service
I2000	Pneumonia
I4900, Nursing Function Score	Hemiplegia/hemiparesis with Nursing Function Score <= 11
M1040D, E	Open lesions (other than ulcers, rashes, and cuts) with any selected skin treatment* or surgical wounds
M1040F	Burns
O0100A2	Chemotherapy while a resident
O0100C2	Oxygen Therapy while a resident
O0100H2	IV Medications while a resident
O0100I2	Transfusions while a resident

*Selected Skin Treatments: M1200F Surgical wound care, M1200G Application of nonsurgical dressing (other than to feet), M1200H Application of ointments/medications (other than to feet)

If the resident does not have one of these conditions, skip to the Behavioral Symptoms and Cognitive Performance Category now.

STEP #2

Evaluate for depression. Signs and symptoms of depression are used as a third-level split for the Clinically Complex category. Residents with signs and symptoms of depression are identified by the Patient Mood Interview (PHQ-9©) or the Staff Assessment of Patient Mood (PHQ-9-OV©). Instructions for completing the PHQ-9© are in Chapter 3, section D. Refer to Appendix E for cases in which the PHQ-9© or PHQ-9-OV© is complete but all questions are not answered. The following items comprise the PHQ-9©:

Resident	Staff	Description
D0200A	D0500A	Little interest or pleasure in doing things
D0200B	D0500B	Feeling down, depressed, or hopeless
D0200C	D0500C	Trouble falling or staying asleep, sleeping too much
D0200D	D0500D	Feeling tired or having little energy
D0200E	D0500E	Poor appetite or overeating
D0200F	D0500F	Feeling bad about yourself - or that you are a failure or have let yourself down or your family down
D0200G	D0500G	Trouble concentrating on things, such as reading the newspaper or watching television
D0200H	D0500H	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual
D0200I	D0500I	Thoughts that you would be better off dead, or of hurting yourself in some way
-	D0500J	Being short-tempered, easily annoyed

These items are used to calculate a Total Severity Score for the resident interview at item D0300 and for the staff assessment at item D0600. A higher Total Severity Score is associated with more symptoms of depression. For the resident interview, a Total Severity Score of 99 indicates that the interview was not successful.

The resident qualifies as depressed for PDPM classification in either of the two following cases:

The D0300 Total Severity Score is greater than or equal to 10 but not 99,

or

The D0600 Total Severity Score is greater than or equal to 10.

Resident Qualifies as Depressed Yes _____ No _____

STEP #3

Select the Clinically Complex classification based on the PDPM Nursing Function Score and the presence or absence of depression according to this table:

Nursing Function Score	Depressed?	PDPM Nursing Classification
0-5	Yes	CDE2
0-5	No	CDE1
6-14	Yes	CBC2
15-16	Yes	CA2
6-14	No	CBC1
15-16	No	CA1

PDPM Nursing Classification: _____

CATEGORY: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

Classification in this category is based on the presence of certain behavioral symptoms or the resident's cognitive performance. Use the following instructions:

STEP #1

Determine the resident's PDPM Nursing Function Score. If the resident's PDPM Nursing Function Score is 11 or greater, go to Step #2.

If the PDPM Nursing Function Score is less than 11, skip to the Reduced Physical Function Category now.

STEP #2

If the resident interview using the Brief Interview for Mental Status (BIMS) was not conducted (indicated by a value of "0" for item C0100), skip the remainder of this step and proceed to Step #3 to check staff assessment for cognitive impairment.

Determine the resident's cognitive status based on resident interview using the BIMS. Instructions for completing the BIMS are in Chapter 3, Section C. The BIMS items involve the following:

C0200	Repetition of three words
C0300	Temporal orientation
C0400	Recall

Item C0500 provides a BIMS Summary Score for these items and indicates the resident's cognitive performance, with a score of 15 indicating the best cognitive performance and 0 indicating the worst performance. If the resident interview is not successful, then the BIMS Summary Score will equal 99.

If the resident's Summary Score is less than or equal to 9, he or she classifies in the Behavioral Symptoms and Cognitive Performance category. Skip to Step #5.

If the resident's Summary Score is greater than 9 but not 99, proceed to Step #4 to check behavioral symptoms.

If the resident's Summary Score is 99 (resident interview not successful) or the Summary Score is blank (resident interview not attempted and skipped) or the Summary Score has a dash value (not assessed), proceed to Step #3 to check staff assessment for cognitive impairment.

STEP #3

Determine the resident's cognitive status based on the staff assessment rather than on resident interview.

Check if **one** of the three following conditions exists:

1.	B0100	Coma (B0100 = 1) and completely dependent or activity did not occur at admission (GG0130A1, GG0130C1, GG0170B1, GG0170C1, GG0170D1, GG0170E1, and GG0170F1 all equal 01, 09, or 88)
2.	C1000	Severely impaired cognitive skills for daily decision making (C1000 = 3)
3.	B0700, C0700, C1000	Two or more of the following impairment indicators are present: B0700 > 0 Usually, sometimes, or rarely/never understood C0700 = 1 Short-term memory problem C1000 > 0 Impaired cognitive skills for daily decision making **and** One or more of the following severe impairment indicators are present: B0700 >= 2 Sometimes or rarely/never makes self understood C1000 >= 2 Moderately or severely impaired cognitive skills for daily decision making

If the resident meets one of the three above conditions, then he or she classifies in Behavioral Symptoms and Cognitive Performance. Skip to Step #5. If he or she does not meet any of the three conditions, proceed to Step #4.

STEP #4

Determine whether the resident presents with **one** of the following behavioral symptoms:

E0100A	Hallucinations
E0100B	Delusions
E0200A	Physical behavioral symptoms directed toward others (2 or 3)
E0200B	Verbal behavioral symptoms directed toward others (2 or 3)
E0200C	Other behavioral symptoms not directed toward others (2 or 3)
E0800	Rejection of care (2 or 3)
E0900	Wandering (2 or 3)

If the resident presents with one of the symptoms above, then he or she classifies in Behavioral Symptoms and Cognitive Performance. Proceed to Step #5. If he or she does not present with behavioral symptoms, skip to the Reduced Physical Function Category.

STEP #5

Determine Restorative Nursing Count

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

H0200C, H0500**	Urinary toileting program and/or bowel toileting program
O0500A, B**	Passive and/or active range of motion
O0500C	Splint or brace assistance
O0500D, F**	Bed mobility and/or walking training
O0500E	Transfer training
O0500G	Dressing and/or grooming training
O0500H	Eating and/or swallowing training
O0500I	Amputation/prostheses care
O0500J	Communication training

**Count as one service even if both provided

Restorative Nursing Count: _____

STEP #6

Select the final PDPM Classification by using the total PDPM Nursing Function Score and the Restorative Nursing Count.

Nursing Function Score	Restorative Nursing Count	PDPM Nursing Classification
11-16	2 or more	BAB2
11-16	0 or 1	BAB1

PDPM Nursing Classification: _____

CATEGORY: REDUCED PHYSICAL FUNCTION

STEP #1

Residents who do not meet the conditions of any of the previous categories, including those who would meet the criteria for the Behavioral Symptoms and Cognitive Performance category but have a PDPM Nursing Function Score less than 11, are placed in this category.

STEP #2

Determine Restorative Nursing Count

Count the number of the following services provided for 15 or more minutes a day for 6 or more of the last 7 days:

H0200C, H0500**	Urinary toileting program and/or bowel toileting program
O0500A, B**	Passive and/or active range of motion
O0500C	Splint or brace assistance
O0500D, F**	Bed mobility and/or walking training
O0500E	Transfer training
O0500G	Dressing and/or grooming training
O0500H	Eating and/or swallowing training
O0500I	Amputation/prostheses care
O0500J	Communication training

**Count as one service even if both provided

Restorative Nursing Count: _____

STEP #3

Select the PDPM Classification by using the PDPM Nursing Function Score and the Restorative Nursing Count.

Nursing Function Score	Restorative Nursing Count	PDPM Nursing Classification
0-5	2 or more	PDE2
0-5	0 or 1	PDE1
6-14	2 or more	PBC2
15-16	2 or more	PA2
6-14	0 or 1	PBC1
15-16	0 or 1	PA1

PDPM Nursing Classification: _____

Calculation of Variable Per Diem Payment Adjustment

PDPM incorporates variable per diem payment adjustments to account for changes in resource use over the course of a stay for three payment components: PT, OT, and NTA. To calculate the per diem rate for these components, multiply the component base rate by the case-mix index associated with the resident's case-mix group and the adjustment factor based on the day of the stay, as shown in the following equation:

Component Per Diem Payment = Component Base Rate x Resident Group CMI x Component Adjustment Factor

The adjustment factors for the PT and OT components can be found in the table below.

Table 20: PT and OT Variable Per Diem Adjustment Factors

Day in Stay	PT and OT Adjustment Factor
1-20	1.00
21-27	0.98
28-34	0.96
35-41	0.94
42-48	0.92
49-55	0.90
56-62	0.88
63-69	0.86
70-76	0.84
77-83	0.82
84-90	0.80
91-97	0.78
98-100	0.76

The adjustment factors for the NTA component can be found in the table below.

Table 21: NTA Variable Per Diem Adjustment Factors

Day in Stay	NTA Adjustment Factor
1-3	3.00
4-100	1.00

Calculation of Total Case-Mix Adjusted PDPM Per Diem Rate

The total case-mix adjusted PDPM per diem rate equals the sum of each of the five case-mix adjusted components and the non-case-mix adjusted rate component. To calculate the total case-mix adjusted per diem rate, add all component per diem rates calculated in prior steps together, along with the non-case-mix rate component, as shown in the following equation:

*Total Case-Mix Adjusted Per Diem Payment = (PT Component Per Diem Rate * PT Variable Per Diem Adjustment Factor) + (OT Component Per Diem Rate * OT Variable Per Diem Adjustment Factor) + SLP Component Per Diem Rate + (NTA Component Per Diem Rate * NTA Variable Per Diem Adjustment Factor) + Nursing Component Per Diem Rate + Non-Case-Mix Component Per Diem Rate*

6.7 SNF PPS Policies

Requirements and policies for SNF PPS are described in greater detail in Chapter 8 of the **Medicare Benefit Policy Manual** (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf). There are some situations that the SNF may encounter that may impact Medicare Part A SNF coverage for a resident, affect the PPS assessment schedule, or impact the reimbursement received by the SNF.

Delay in Requiring and Receiving Skilled Services (30-Day Transfer)

There are instances in which the resident does not require SNF level of care services when initially admitted to the SNF. When the resident requires and receives SNF level of care services within 30 days from the hospital discharge, Day 1 for the PPS assessment schedule is the day on which SNF level of care services begin. For example, if a resident is discharged from the hospital on August 1 and the SNF determines on August 30 that the resident requires skilled service for a condition that was treated during the qualifying hospital stay, then the SNF would start the PPS assessment schedule with a 5-Day PPS assessment, with August 30 as Day 1 for scheduling purposes. However, if the resident requires and receives a SNF level of care 31 or more days after the hospital discharge, the resident does not qualify for a SNF Part A stay (see Medical Appropriateness Exception below).

Medical Appropriateness Exception (Deferred Treatment)

An elapsed period of more than 30 days is permitted for starting SNF Part A services when a resident's condition makes it inappropriate to begin an active course of treatment in a SNF immediately after a qualifying hospital stay discharge. It is applicable only where, under accepted medical practice, the established pattern of treatment for a particular condition indicates that a covered level of SNF care will be required within a predeterminable time frame, and it is medically predictable at the time of hospital discharge that the resident will require SNF level of care within a predetermined time period (for more detailed information see Chapter 8 of the **Medicare Benefit Policy Manual**). For example, a resident is admitted to the SNF after a qualifying hospital stay for an open reduction and internal fixation of a hip. It is determined upon hospital discharge that the resident is not ready for weight-bearing activity but will most likely be ready in 4-6 weeks. The physician writes an order to start therapy when the resident is able to tolerate weight bearing. Once the resident is able to start therapy, the Medicare Part A stay begins, and the 5-Day assessment will be performed. Day 1 of the stay will be the first day on which the resident starts therapy services.

Interrupted Stay

An "interrupted" SNF stay is defined as one in which a resident is discharged from SNF care and subsequently readmitted to the same SNF (not a different SNF) within 3 days or less after the discharge (the "interruption window").

The interruption window is a 3-day period, starting with the calendar day of Part A discharge and including the 2 immediately following calendar days, ending at midnight. In other words, the resident must return to the same SNF by 11:59 p.m. at the end of the third calendar day. The

interruption window begins on the first non-covered day following a Part A-covered stay and ends at 11:59 p.m. on the third consecutive non-covered day following a Part A-covered stay.

If both conditions are met, the subsequent stay is considered a continuation of the previous Medicare Part A stay for the purposes of both the variable per diem schedule and the assessment schedule. The variable per diem schedule continues from the day of the previous discharge. For example, if the resident was discharged on Day 7, payment rates resume at Day 7 upon readmission. The assessment schedule also continues from the day of the previous discharge. Thus, no new 5-Day assessment is required upon the subsequent readmission, although the optional IPA may be completed at clinician's discretion.

If a resident is readmitted to the same SNF more than 3 consecutive calendar days after discharge, OR in any instance when the resident is admitted to a different SNF (regardless of the length of time between stays), then the Interrupted Stay Policy does not apply, and the subsequent stay is considered a new stay. In such cases, the variable per diem schedule resets to Day 1 payment rates, and the assessment schedule also resets to Day 1, necessitating the completion of a new 5-Day assessment.

Example 1: Mrs. A is admitted to the SNF on 11/07/19. She is admitted to a hospital on 11/20/19. She returns to the same SNF on 11/25/19. Because Mrs. A is readmitted to the same SNF more than three calendar days after discharge, this would be considered a new stay. The assessment schedule would be reset to Day 1, beginning with a new 5-Day assessment, and the variable per diem schedule would begin from Day 1.

Example 2: Mr. B is admitted to the SNF on 11/07/19. He is admitted to the hospital on 11/20/19. He is admitted to a different SNF on 11/22/19. Because Mr. B is admitted to a different SNF, this would be considered a new stay. The assessment schedule would be reset, beginning with a new 5-Day assessment, and the variable per diem schedule would begin from Day 1.

Example 3: Mrs. C is admitted to the SNF on 11/07/19. She is admitted to a hospital on 11/20/19. She returns to the same SNF on 11/22/19. Because Mrs. C is admitted to the same SNF within three days from the point of discharge, this would be considered a continuation of the previous stay. No 5-Day assessment would be required upon readmission, though the IPA would be an option. Additionally, the variable per diem would continue from Day 14 (Day of Discharge).

Resident Discharged from Part A Skilled Services and Returns to SNF Part A Skilled Level Services

In the situation in which a resident is discharged from SNF Medicare Part A services and later requires SNF Part A skilled level of care services, and it is not an instance of an interrupted stay (as described above), the resident may be eligible for Medicare Part A SNF coverage if the following criteria are met:

1. Less than 30 days have elapsed since the last day on which SNF level of care services were required and received,

2. SNF-level services required by the resident are for a condition that was treated during the qualifying hospital stay or for a condition that arose while receiving care in the SNF for a condition for which the beneficiary was previously treated in the hospital,
3. Services must be reasonable and necessary,
4. Services can only be provided on an inpatient basis,
5. Resident must require and receive the services on a daily basis, and
6. Resident has remaining days in the SNF benefit period.

For greater detail, refer to the **Medicare Benefit Policy Manual**, Chapter 8.

6.8 Non-compliance with the SNF PPS Assessment Schedule

To receive payment under the SNF PPS, the SNF must complete scheduled and unscheduled assessments as described in Chapter 2.

According to 42 CFR 413.343, an assessment that does not have an ARD within the prescribed ARD window will be paid at the default rate for the number of days the ARD is out of compliance. Frequent late assessment scheduling practices or missing assessments may result in additional review. The default rate (ZZZZZ) takes the place of the otherwise applicable Federal rate. It is equal to the sum of the rate paid for the case-mix group reflecting the lowest acuity level under each PDPM component, and would generally be lower than the Medicare rate payable if the SNF had submitted an assessment in accordance with the prescribed assessment schedule.

Late Assessment

If the SNF fails to set the ARD within the defined ARD window for a PPS assessment, and the resident is still on Part A, the SNF must complete a late assessment. The ARD can be no earlier than the day the error was identified.

The SNF will bill the default rate for the number of days that the assessment is out of compliance. This is equal to the number of days between the day following the last day of the available ARD window and the late ARD (including the late ARD). **The SNF would then bill the Health Insurance Prospective Payment System (HIPPS) code established by the late assessment for the remaining period of time that the assessment would have controlled payment.** For example, a 5-Day assessment with an ARD of Day 11 is out of compliance for 3 days and therefore would be paid at the default rate for Days 1 through 3 and the HIPPS code from the late 5-Day assessment for the remainder of the Part A stay, unless an IPA is completed. In the case of a late assessment, the variable per diem schedule still begins on Day 1 of the stay and not with the late assessment ARD and default billing will be assessed prior to billing based on the late 5-Day assessment.

Missed Assessment

If the SNF fails to set the ARD of a PPS assessment prior to the end of the last day of the ARD window, and the resident is no longer a SNF Part A resident, and as a result a PPS assessment does not exist in the QIES ASAP system for the payment period, the provider may not usually bill for days when an assessment does not exist in the QIES ASAP system. When a PPS assessment does not exist in the QIES ASAP system, there is not a HIPPS code the provider may bill. In order to bill for Medicare SNF Part A services, the provider must submit a valid PPS assessment that is accepted into the QIES ASAP system. The provider must bill the HIPPS code that is verified by the system. If the resident was already discharged from Medicare Part A when this is discovered, a PPS assessment may not be performed.

However, there are instances when the SNF may bill the default code when a PPS assessment does not exist in the QIES ASAP system. These exceptions are:

1. The stay is less than 8 days within a spell of illness,
2. The SNF is notified on an untimely basis of or is unaware of a Medicare Secondary Payer denial,
3. The SNF is notified on an untimely basis of a beneficiary's enrollment in Medicare Part A,
4. The SNF is notified on an untimely basis of the revocation of a payment ban,
5. The beneficiary requests a demand bill, or
6. The SNF is notified on an untimely basis or is unaware of a beneficiary's disenrollment from a Medicare Advantage plan.

ARD Outside the Medicare Part A SNF Benefit

A SNF may not use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for a PPS assessment. For example, the resident returns to the SNF on December 11 following a hospital stay, requires and receives SNF skilled services (and meets all other required coverage criteria), and has 3 days left in his or her SNF benefit period. The SNF must set the ARD for the PPS assessment on December 11, 12, or 13 to bill for the HIPPS code associated with the assessment.

APPENDIX A: GLOSSARY AND COMMON ACRONYMS

Glossary

Term	Abbreviation	Definition
Ability to Understand Others		Comprehension of direct person-to-person communication whether spoken, written, or in sign language or Braille. Includes the resident's ability to process and understand language.
Active Assisted Range of Motion		A type of active range of motion in which assistance is provided by an outside force, either manually or mechanically because the prime mover muscles need assistance to complete the motion. This type of range of motion may be used when muscles are weak or when joint movement causes discomfort; or for example, if the resident is able to move his or her limbs, but requires help to perform entire movement.
Active Disease Diagnosis		An illness or condition that is currently causing or contributing to a resident's complications and/or functional, cognitive, medical and psychiatric symptoms or impairments.
Active Range of Motion		Movement within the unrestricted range of motion for a segment, which is produced by active contraction of the muscles crossing that joint is completed without assistance by the resident. This type of range of motion occurs when a resident can move his or her limbs without assistance.
Activities of Daily Living	**ADLs**	Activities of daily living are those needed for self-care *and include activities such as* bathing, dressing, *grooming, oral care,* mobility *(e.g., ambulation)*, toileting, eating, transferring*, and communicating. Select self-care and mobility items from Section GG are utilized to classify a resident into the PT, OT, and nursing components for PDPM.*
Acute Change in Mental Status		Alteration in mental status (e.g., orientation, inattention, organization of thought, level of consciousness, psychomotor behavior, change in cognition) that was new or worse for this resident, usually over hours to days.
ADL Aspects		Components of ADL activities. These are listed next to each ADL in the item set. For example, the aspects of G0110H (Eating) are eating, drinking, and intake of nourishment or hydration by other means, including tube feeding, total parenteral nutrition, and IV fluids for hydration.

Term	Abbreviation	Definition
Care Area Triggers	**CAT**	A set of items and responses from the MDS that are indicators of particular issues and conditions that affect nursing facility residents.
Case Mix Index	**CMI**	Weight or numeric score assigned to each Resource Utilization Group (RUG-III, RUG IV) that reflects the relative resources predicted to provide care to a resident. The higher the case mix weight, the greater the resource requirements for the resident.
Case Mix Reimbursement System		A payment system that measures the intensity of care and services required for each resident, and translates these measures into the amount of reimbursement given to the facility for care of a resident. Payment is linked to the intensity of resource use.
Cavity		A tooth with a hole due to decay or other erosion.
CMS Certification Number	**CCN**	Replaces the term "Medicare/Medicaid Provider Number" in survey and certification, and assessment-related activities.
Centers for Medicare & Medicaid Services	**CMS**	CMS is the Federal agency that administers the Medicare, Medicaid, and Child Health Insurance Programs.
Check and Change		Involves checking the resident's dry/wet status at regular intervals and using incontinence devices and products.
Code of Federal Regulations	**CFR**	A codification of the general and permanent rules published in the Federal Register by the Executive departments and agencies of the Federal Government.
Colostomy		A surgical procedure that brings the end of the large intestine through the abdominal wall.
Comatose (Coma)		Pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; he or she may or may not open his or her eyes, does not speak, and does not move his or her extremities on command or in response to noxious stimuli (e.g., pain).
Comprehensive Assessment		Requires completion of the MDS and review of CAAs, followed by development and/or review of the comprehensive care plan.

Term	Abbreviation	Definition
Confusion Assessment Method	**CAM**	An instrument that screens for overall cognitive impairment as well as features to distinguish delirium or reversible confusion from other types of cognitive impairments.
Constipation		A condition of more than short duration where someone has fewer than three bowel movements a week or stools that are usually hard, dry, and difficult and/or painful to eliminate.
Continence		Any void that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting.
Daily Decision Making		Includes: choosing clothing; knowing when to go to scheduled meals; using environmental cues to organize and plan (e.g., clocks, calendars, posted event notices); in the absence of environmental cues, seeking information appropriately (i.e. not repetitively) from others in order to plan the day; using awareness of one's own strengths and limitations to regulate the day's events (e.g., asks for help when necessary); acknowledging need to use appropriate assistive equipment such as a walker.
Delirium		Acute onset or worsening of impaired brain function resulting in cognitive and behavioral symptoms such as worsening confusion, disordered expression of thoughts, frequent fluctuation in level of consciousness, and hallucinations.
Delusion		A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary.
Designated Local Contact Agency		Each state has designated a local contact agency responsible for contacting the individual with information about community living options. This local contact agency may be a single entry point agency, an Aging/Disabled Resource Center, an Area Agency on Aging, a Center for Independent Living, or other state contractor.
Disorganized Thinking		Having thoughts that are fragmented or not logically connected.
Dose		Total amount/strength/concentration of a medication given at one time or over a period of time. The individual dose is the amount/strength/concentration received at each administration. The amount received over a 24-hour period may be referred to as the "daily dose."

Term	Abbreviation	Definition
Down Syndrome		A common genetic disorder in which a child is born with 47 rather than 46 chromosomes, resulting in developmental delays, intellectual disability, low muscle tone, and other possible effects.
Dually Certified Facilities		Nursing facilities that participate in both the Medicare and Medicaid programs.
Duplicate Assessment Error		A fatal record error that results from a resubmission of a record previously accepted into the CMS MDS database. A duplicate record is identified as having the same target date, reason for assessment, resident, and facility. This is the only fatal record error that does not require correction and resubmission.
Entry Date		The initial date of admission/entry to the nursing home, or the date on which the resident most recently re-entered the nursing home after being discharged (whether or not the return was anticipated).
Epilepsy		A chronic neurological disorder that is characterized by recurrent unprovoked seizures, as a result of abnormal neuronal activity in the brain.
External Condom Catheter		Device attached to the shaft of the penis like a condom and connected to a drainage bag.
Facility ID	**FAC_ID**	The facility identification number is assigned to each nursing facility by the State agency. The FAC_ID must be placed in the individual MDS and tracking form records. This normally is completed as a function within the facility's MDS data entry software.
Fall		Unintentional change in position coming to rest on the ground or onto the next lower surface (e.g., onto a bed, chair, or bedside mat), but not as a result of an overwhelming external force.
Fatal File Error		An error in the MDS file format that causes the entire file to be rejected. The individual records are not validated or stored in the database. The facility must contact its software support to resolve the problem with the submission file.

Term	Abbreviation	Definition
Fatal Record Error		An error in MDS record that is severe enough to result in record rejection. A fatal record is not saved in the CMS database. The facility must correct the error that caused the rejection and resubmit a corrected original record.
Fecal Impaction		A mass of dry, hard stool that can develop in the rectum due to chronic constipation. Watery stool from higher in the bowel or irritation from the impaction may move around the mass and leak out, causing soiling, often a sign of a fecal impaction.
Federal Register		The official daily publication for rules, proposed rules, and notices of Federal agencies and organizations, as well as Executive Orders and other Presidential Documents. It is a publication of the National Archives and Records Administration, and is available by subscription and online.
Feeding Tube		Presence of any type of tube that can deliver food/nutritional substances/fluids directly into the gastrointestinal system. Examples include, but are not limited to: nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrotomy (PEG) tubes.
Fever		A fever is present when the resident's temperature (°F) is 2.4 degrees greater than the baseline temperature.
Final Validation Report	**FVR**	A report generated after the successful submission of MDS 3.0 assessment data. This report lists all of the residents for whom assessments have been submitted in a particular submission batch, and displays all errors and/or warnings that occurred during the validation process. An FVR with a submission type of "production" is a facility's documentation for successful file submission. An individual record listed on the FVR marked as "accepted" is documentation for successful record submission.
First Time in This Facility		Newly admitted resident who has not been admitted to this facility before.
Fiscal Intermediary	**FI**	In the past, an organization designated by CMS to process Medicare claims for payment that are submitted by a nursing facility. Fiscal intermediaries (FIs) are now called Medicare Administrative Contractors (MACs).
F-Tag		Numerical designations for criteria reviewed during the nursing facility survey.

Term	Abbreviation	Definition
Functional Limitation in Range of Motion		Limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living) or places the resident at risk of injury.
Grace Days		Predetermined additional days that may be added to the assessment window for Medicare scheduled assessments without incurring financial penalty. These may be used in situations such as an absence/illness or reassignment of the registered nurse (RN) assessment coordinator, or an unusually large number of assessments due at approximately the same time. Grace days may also be used to more fully capture therapy minutes or other treatments.
Gradual Dose Reduction (GDR)		Step-wise tapering of a dose to determine whether or not symptoms, conditions, or risks can be managed by a lower dose or whether or not the dose or medication can be discontinued.
Habit Training/ Scheduled Voiding		A behavior technique that calls for scheduled toileting at regular intervals on a planned basis to match the resident's voiding habits or needs.
Hallucination		A perception in a conscious and awake state, of something in the absence of external stimuli. May be auditory or visual or involve smells, tastes, or touch.
Healthcare Common Procedure Coding System	**HCPCS**	A uniform coding system that describes medical services, procedures, products, and supplies. These codes are used primarily for billing.
Health Insurance Portability and Accountability Act of 1996	**HIPAA**	Federal law that gives the Department of Health and Human Services (DHHS) the authority to mandate regulations that govern privacy, security, and electronic transactions standards for health care information.
Health Insurance Prospective Payment System	**HIPPS**	Billing codes used when submitting claims to the MACs (previously FIs) for Medicare payment. Codes comprise the *PDPM group* calculated by the assessment followed by an indicator to indicate which assessment was completed.

Term	Abbreviation	Definition
Hierarchy		The ordering of groups within the RUG Classification system is a hierarchy. The RUG hierarchy begins with groups with the highest resource use and descends to those groups with the lowest resource use. The RUG-IV Classification system has eight hierarchical levels or categories: Rehabilitation Plus Extensive Services, Rehabilitation, Extensive Services, Special Care High, Special Care Low, Clinically Complex, Behavioral Symptoms and Cognitive Performance, and Reduced Physical Function.
Hospice Services		A 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.
Ileostomy		A stoma that has been constructed by bringing the end or loop of small intestine (the ileum) out onto the surface of the skin.
Inactivation		A type of correction allowed under the MDS Correction Policy. When an invalid record has been accepted into the CMS database, a correction record is submitted with inactivation selected as the type of correction. An inactivation will remove the invalid record from the database.
Inattention		Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli.
Indwelling Catheter		A catheter that is maintained within the bladder for the purpose of continuous drainage of urine.
Intermittent Catheterization		Insertion and removal of a catheter through the urethra into the bladder for bladder drainage.
Internal Assessment ID		A sequential numeric identifier assigned to each record submitted to QIES ASAP.
International Classification of Diseases – Clinical Modification	**ICD-CM**	Official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. The ICD-CM contains a numerical list of the disease code numbers in tabular form, an alphabetical index to the disease entries, and a classification system for surgical, diagnostic, and therapeutic procedures.

Term	Abbreviation	Definition
Interrupted Stay		*Interrupted Stay is a Medicare Part A SNF stay in which a resident is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay) and subsequently resumes SNF care in the **same** SNF for a Medicare Part A-covered stay during the interruption window.*
Interruption Window		*The interruption window is a 3-day period, starting with the calendar day of discharge and including the 2 immediately following calendar days. In other words, if a resident in a Medicare Part A SNF stay is discharged from Part A, the resident must resume Part A services, or return to the **same** SNF (if physically discharged) to resume Part A services, by 11:59 p.m. at the end of the third calendar day after their Part A-covered stay ended. The interruption window begins with the first non-covered day following a Part A-covered stay and ends at 11:59 p.m. on the third consecutive non-covered day following a Part A-covered SNF stay. If these conditions are met, the subsequent stay is considered a continuation of the previous Medicare Part A-covered stay for the purposes of both the variable per diem schedule and PPS assessment completion.*
Invalid Record		As defined by the MDS Correction Policy, a record that was accepted into QIES ASAP that should not have been submitted. Invalid records are defined as: a test record submitted as production, a record for an event that did not occur, a record with the wrong resident identified or the wrong reason for assessment, or submission of an inappropriate non-required record.
Item Set Code	**ISC**	A code based upon combinations of reasons for assessment (A0310 items) that determines which items are active on a particular type of MDS assessment or tracking record.
Java-Based Resident Assessment Validation and Entry System	**jRAVEN**	Data entry software supplied by CMS for nursing facilities and hospital swing beds to use to enter MDS assessment data.
Legal Name		Resident's name as it appears on the Medicare card. If the resident is not enrolled in the Medicare program, use the resident's name as it appears on a government-issued document (i.e., driver's license, birth certificate, social security card).

Term	Abbreviation	Definition
Omnibus Budget Reconciliation Act of 1987	**OBRA '87**	Law that enacted reforms in nursing facility care and provides the statutory authority for the MDS. The goal is to ensure that residents of nursing facilities receive quality care that will help them to attain or maintain the highest practicable, physical, mental, and psychosocial well-being.
On Admission		On admission is defined as: as close to the actual time of admission as possible.
Oral Lesions		An abnormal area of tissue on the lips, gums, tongue, palate, cheek lining, or throat. This may include ulceration, plaques or patches (e.g. candidiasis), tumors or masses, and color changes (red, white, yellow, or darkened).
Pain Medication Regimen		Pharmacological agent(s) prescribed to relieve or prevent the recurrence of pain. Include all medications used for pain management by any route and any frequency during the look-back period.
Passive Range of Motion		Movement within the unrestricted range of motion for a segment, which is provided entirely by an external force. There is no voluntary muscle contraction. This type of range of motion is often used when a resident is not able to perform the movement at all; no effort is required from them.
Patient Health Questionnaire 9-Item	**PHQ-9©**	A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder.
Patient Driven Payment Model	***PDPM***	*The Patient Driven Payment Model (PDPM) is a new case-mix classification system for classifying skilled nursing facility (SNF) residents in a Medicare Part A covered stay into payment groups under the SNF Prospective Payment System. Effective beginning October 1, 2019, PDPM will replace the current case-mix classification system, the Resource Utilization Group, Version IV (RUG-IV).*
Persistent Vegetative State	**PVS**	PVS is an enduring situation in which an individual has failed to demonstrate meaningful cortical function but can sustain basic body functions supported by noncortical brain activity.

Term	Abbreviation	Definition
Recreational Therapy		Services that are provided or directly supervised by a qualified recreational therapist who holds a national certification in recreational therapy, also referred to as a Certified Therapeutic Recreation Specialist." Recreational therapy includes, but is not limited to, providing treatment services and recreation activities to individuals using a variety of techniques, including arts and crafts, animals, sports, games, dance and movement, drama, music, and community outings. Recreation therapists treat and help maintain the physical, mental, and emotional well-being of their clients by seeking to reduce depression, stress, and anxiety; recover basic motor functioning and reasoning abilities; build confidence; and socialize effectively. Recreational therapists should not be confused with recreation workers, who organize recreational activities primarily for enjoyment.
Re-entry		When a resident returns to a facility following a temporary discharge (return anticipated) and returns within 30 days of the discharge.
Registered Nurse Assessment Coordinator	**RNAC**	An individual licensed as a registered nurse by the State Board of Nursing and employed by a nursing facility, and is responsible for coordinating and certifying completion of the resident assessment instrument.
Religion		Belief in and reverence for a supernatural power or powers regarded as creator and governor of the universe. Can be expressed in practice of rituals associated with various religious faiths, attendance and participation in religious services, or in private prayer or religious study.
Resource Use		The measure of the wage-weighted minutes of care used to develop the RUG classification system.
Resource Utilization Group, Version IV	**RUG-IV**	A category-based classification system in which nursing facility residents classify into one of 66, 57, or 47 RUG-IV groups. Residents in each group utilize similar quantities and patterns of resources. Assignment of a resident to a RUG-IV group is based on certain item responses on the MDS 3.0. *Some states utilize the RUG-IV system for Medicaid payment in nursing facilities.*

Common Acronyms

Acronym	Definition
ADLs	Activities of Daily Living
ADR	Adverse Drug Reaction
AHEs	Average Hourly Earnings
ARD	Assessment Reference Date
ASAP	Assessment Submission and Processing System
BBA-97	Balanced Budget Act of 1997
BBRA	Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999
BEA	(U.S) Bureau of Economic Analysis
BIMS	Brief Interview for Mental Status
BIPA	Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000
BLS	(U.S.) Bureau of Labor Statistics
BMI	Body mass index
CAA	Care Area Assessment
CAH	Critical Access Hospital
CAM	Confusion Assessment Method
CAT	Care Area Trigger
CBSA	Core-Based Statistical Area
CFR	Code of Federal Regulations
CLIA	Clinical Laboratory Improvements Amendments (1998)
CMI	Case Mix Index
CMS	Centers for Medicare and Medicaid Services
CNN	CMS Certification Number
COTA	Certified Occupational Therapist Assistant
CPI	Consumer Price Index
CPI-U	Consumer Price Index for All Urban Consumers
CPS	Cognitive Performance Scale (MDS)
CPT	(Physicians) Current Procedural Terminology
CR	Change Request
CWF	Common Working File
DME	Durable Medical Equipment
DMERC	Durable Medical Equipment Regional Carrier
DOS	Dates of Service
ECI	Employment Cost Index
ESRD	End Stage Renal Disease

Acronym	Definition
FAC_ID	Facility ID (for MDS submission)
FI	Fiscal Intermediary
FMR	Focused Medical Review
FR	Final Rule
FVR	Final Validation Report (MDS submission)
FY	Fiscal Year
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPPS	Health Insurance PPS (Rate Codes)
ICD	International Classification of Diseases
ICD-CM	International Classification of Diseases, Clinical Modification
IFC	Interim Final Rule with Comment
IOM	Internet-Only Manual
IPA	*Interim Payment Assessment*
ISC	Item Set Code
jRAVEN	Java-Based Resident Assessment Validation and Entry System
LOA	Leave of Absence
MAC	Medicare Administrative Contractor
MDCN	Medicare Data Communications Network
MDS	Minimum Data Set
MEDPAR	Medicare Provider Analysis and Review (File)
MIM	Medicare Intermediary Manual
MRI	Magnetic Resonance Imaging
NCS	National Supplier Clearinghouse
NDC	National Drug Code
NDM	Network Data Mover
NF	Nursing Facility
NPI	National Provider Identifier
NSC	National Supplier Clearinghouse
NTA	*Non-Therapy Ancillary*
OBRA	Omnibus Budget Reconciliation Act of 1987
OMB	Office of Management and Budget
OMRA	Other Medicare-required Assessment
OSA	*Optional State Assessment*
OT	Occupational Therapy/Therapist
PCE	Personal Care Expenditures

Acronym	Definition
PDPM	*Patient Driven Payment Model*
PHQ-9©	Patient Health Questionnaire 9-Item
PHQ-9-OV©	*PHQ-9© Observational Version*
PIM	Program Integrity Manual
POS	Point of Service
PPI	Producer Price Index
PPS	Prospective Payment System
PRM	Provider Reimbursement Manual
PT	Physical Therapy/Therapist
PTA	Physical Therapist Assistant
Pub.100-1	Medicare General Information, Eligibility, and Entitlement IOM
Pub.100-2	Medicare Benefit IOM
Pub.100-4	Medicare Claims Processing IOM
Pub.100-7	Medicare State Operation IOM
Pub.100-8	Medicare Program Integrity IOM
Pub.100-12	State Medicaid IOM
PVS	Persistent Vegetative State
QI	Quality Indicator
QM	Quality Measure
QIES	Quality Improvement and Evaluation System
QIO	Quality Improvement Organization
RAI	Resident Assessment Instrument
RNAC	Registered Nurse Assessment Coordinator
RUG	Resource Utilization Group
SB-PPS	Swing Bed Prospective Payment System
SCSA	Significant Change in Status Assessment
SNF	Skilled Nursing Facility
SNF PPS	Skilled Nursing Facility Prospective Payment System
SNF QRP	*Skilled Nursing Facility Quality Reporting Program*
SLP (or ST)	Speech Language Pathology Services
SOM	State Operations Manual
SOR	Systems of Records
SSN	*Social Security Number*
STM	Staff Time Measure
SUB_REQ	Submission Requirement
TPN	*Total Parenteral Nutrition*

✓	Communication problems	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
☐	• Review Communication CAA	
☐	• Comatose (B0100)	
☐	• Difficulty making self understood (B0700)	
☐	• Difficulty understanding others (B0800)	
☐	• Aphasia (I4300)	
✓	**Dental/oral problems** (from Section L and physical assessment)	**Supporting Documentation**
☐	• See Dental Care CAA	
☐	• Broken or fractured teeth (L0200D)	
☐	• Toothache (L0200F)	
☐	• Bleeding gums (L0200E)	
☐	• Loose dentures, dentures causing sores (L0200A)	
☐	• Lip or mouth lesions (for example, cold sores, fever blisters, oral abscess) (L0200C)	
☐	• Mouth pain (L0200F)	
☐	• Dry mouth	
✓	**Other diseases and conditions** that can affect appetite or nutritional needs	**Supporting Documentation**
☐	• Anemia (I0200)	
☐	• Arthritis (I3700)	
☐	• Burns (M1040F)	
☐	• Cancer (I0100)	
☐	• Cardiovascular disease (I0300-I0900)	
☐	• Cerebrovascular accident (I4500)	
☐	• Constipation (H0600)	
☐	• Delirium (C1310)	
☐	• Depression (I5800)	
☐	• Diabetes (I2900)	
☐	• Diarrhea	
☐	• Gastrointestinal problem (I1100-I1300)	
☐	• Hospice care (O0100K)	
☐	• Liver disease (I8000)	
☐	• Pain (J0300)	
☐	• Parkinson's disease (I5300)	
☐	• Pressure ulcers*/injuries* (M0300)	

(continued)

CARE AREA GENERAL RESOURCES

The general resources contained on this page are not specific to any particular care area. Instead, they provide a general listing of known clinical practice guidelines and tools that may be used in completing the RAI CAA process.

***NOTE**: This list of resources is neither prescriptive nor all-inclusive. References to non-U.S. Department of Health and Human Services (HHS) sources or sites on the Internet are provided as a service and do not constitute or imply endorsement of these organizations or their programs by CMS or HHS. CMS is not responsible for the content of pages found at these sites. URL addresses were current as of the date of this publication.*

- Advancing Excellence in America's Nursing Homes Resources: https://www.nhqualitycampaign.org/;
- Agency for Health Care Research and Quality – Clinical Information, Evidence-Based Practice: http://www.ahrq.gov/professionals/clinicians-providers/index.html;
- Alzheimer's Association Resources: *https://www.alz.org/*;
- American Dietetic Association – Individualized Nutrition Approaches for Older Adults in Health Care Communities (PDF Version): https://www.eatrightpro.org/practice/position-and-practice-papers/position-papers/individualized-nutrition-approaches-adults-health-care-communities;
- American Geriatrics Society Clinical Practice Guidelines and Tools: http://www.americangeriatrics.org/publications-tools;
- American Medical Directors Association (AMDA) Clinical Practice Guidelines and Tools: http://www.paltc.org/product-store;
- American Pain Society: http://americanpainsociety.org/;
- American Society of Consultant Pharmacists Practice Resources: https://www.ascp.com/page/prc;
- Association for Professionals in Infection Control and Epidemiology Practice Resources: http://www.apic.org/Resources/Overview;
- Centers for Disease Control and Prevention: Infection Control in Long-Term Care Facilities Guidelines: http://www.cdc.gov/longtermcare/prevention/index.html;
- CMS Pub. 100-07 State Operations Manual Appendix PP – Guidance to Surveyors for Long Term Care Facilities (federal regulations noted throughout; resources provided in endnotes): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf;
- Emerging Solutions in Pain Tools: http://www.emergingsolutionsinpain.com/;
- Hartford Institute for Geriatric Nursing Access to Important Geriatric Tools: https://consultgeri.org/tools;
- Hartford Institute for Geriatric Nursing Evidence-Based Geriatric Content: https://consultgeri.org/;
- Improving Nursing Home Culture (CMS Special Study): http://healthcentricadvisors.org/wp-content/uploads/2015/03/INHC_Final-Report_PtI-IV_121505_mam.pdf;
  Institute for Safe Medication Practices: http://www.ismp.org/;

Centers for Medicare & Medicaid Services: Medicare General Information, Eligibility, and Entitlement Manual (Pub. 100-1). Available from http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS050111.html?DLPage=1&DLSort=0&DLSortDir=ascending

Centers for Medicare & Medicaid Services: Memorandum to State Survey Agency Directors from CMS Director, Survey and Certification Group: Clarification of Terms Used in the Definition of Physical Restraints as Applied to the Requirements for Long Term Care Facilities. Jun. 22, 2007; retrieved Oct. 16, 2009, from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter07-22.pdf

Centers for Medicare & Medicaid Services: Minimum Data Set (MDS) 3.0 Provider User's Guide. Available from *https://qtso.cms.gov/reference-and-manuals/mds-30-provider-users-guide*

Centers for Medicare & Medicaid Services: State Operations Manual, Appendix PP-Guidance to Surveyors for Long Term Care Facilities. Section 483.20(b) Utilization Guidelines for Completion of the RAI. Available from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

Folstein, M.F., Folstein, S.E., and McHugh, P.R.: "Mini-mental state." A practical method for grading the cognitive state of patients for the clinician. J. Psychiatr. Res. 12(3):189-198, Nov. 1975.

Healthcentric Advisors: The Holistic Approach to Transformational Change (HATCh™). CMS NH QIOSC Contract. Providence, RI. 2006. Available from http://healthcentricadvisors.org/wp-content/uploads/2015/03/INHC_Final-Report_PtI-IV_121505_mam.pdf.

Inouye, S.K., Van Dyck, C.H., Alessi, C.A., et al.: Clarifying confusion: the confusion assessment method. A new method for detection of delirium. Ann. Intern. Med. 113(12):941-948, 1990.

Institute of Medicine: Improving the Quality of Care in Nursing Homes. Washington, DC. National Academy Press, 1986.

National Institute of Mental Health: Suicide and the Elderly. n.d. Available from https://www.agingcare.com/Articles/Suicide-and-the-Elderly-125788.htm

National Pressure Ulcer Advisory Panel: Suspected Deep Tissue Injury [image of cross-sectioned suspected deep tissue injury]. Retrieved November 18, 2009, from http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-SuspectDTI.jpg

National Pressure Ulcer Advisory Panel: Unstageable [image of cross-sectioned unstageable pressure ulcer]. Retrieved November 18, 2009, from http://www.npuap.org/wp-content/uploads/2012/03/NPUAP-Unstage2.jpg

Newman, D.K., and Wein, A.J.: Managing and Treating Urinary Incontinence. 2nd ed. Baltimore, MD. Health Professions Press, 2009.

Physicians' Desk Reference: Physicians' Desk Reference 2008. Montvale, NJ. Thomson PDR, 2007.

Quality Improvement and Evaluation System (QIES) Technical Support Office: QIES Technical Support Office Web site. Retrieved *April 2*, 20*1*9, from *https://qtso.cms.gov/*

Saliba, D., and Buchanan, J.: Development and Validation of a Revised Nursing Home Assessment Tool: MDS 3.0 Final Report to CMS. Contract No. 500-00-0027/Task Order #2. Santa Monica, CA. Rand Corporation, April 2008. Available from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/downloads/mds30finalreport.pdf.

U.S. Department of Health and Human Services, Health Care Financing Administration: Medicare Program: Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Final Rule. Fed. Regist. 63(91):26251-26316, May 12, 1998.

U.S. Department of Health and Human Services, Health Care Financing Administration: Medicare program; Prospective payment system and consolidated billing for skilled nursing facilities—Update; final rule and notice. Fed. Regist. 64(146):41644-41683, Jul. 30, 1999.

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion: Healthy People 2020. Available from https://www.healthypeople.gov/2020/default

Track Changes
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to Title Page v1.17.1

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—	—	1	**Version 1.16~~7~~.1**
—	—	1	**October 201~~8~~9**
—	—	2	**Centers for Medicare & Medicaid Services' Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual October 201~~8~~9 For Use Effective October 1, 201~~8~~9**

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1	—	1-1	• Jennifer Pettis, MS, RN, ~~BS~~CNE, WCC
1	—	1-2	**Abt Associates** • Rosanna Bertrand, PhD • Donna Hurd, RN, MSN • Terry Moore, BSN, MPH • Teresa M. Mota, BSN, RN, CALA, WCC
1	—	1-2	**Telligen** • Gloria Batts • ~~Debra Weiland, BSN, RN~~ • Jean Eby, BS • Debra Cory, BS • ~~Kathy Langenberg, RN~~
1	—	1-3–1-4	Page length changed due to revised content.
1	—	1-3	**Hendall Inc.** • Terresita Gayden • ~~Anne Jones~~ • Galen Snowden • Terese Ketchen • Jessie Pelasara • Michael Harrup • Anh Nguyen • Sunitha Koka
1	—	1-3	**Chase Consulting Group, LLC.** • Joshua Lewis, MA, MBA • Anne Jones
1	—	1-3	**Tantus Technologies, Inc.** • Michael Barron • Toyin Bolaji

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1	—	1-3	**The MITRE Corporation** • Kathy Langenberg, RN • Siama Rizvi, BSN, RN
1	—	1-3	• ~~Thomas Dudley, MS, RN~~
1	—	1-4	• Melissa Hulbert~~, Director—Division of Advocacy and Special Issues~~ • John Kane • Jeanette Kranacs, Deputy Director~~—Division of Institutional Post-Acute Care~~Chronic Care Policy Group • ~~Sheila Lambowitz, Director (Retired)—Division of Institutional Post-Acute Care~~ • Sharon Lash, MPH, MA, RN • Alan Levitt, MD, Medical Officer—Division of Chronic and Post-Acute Care • Shari Ling, MD • Stella Mandl, BSW, BSN, PHN, RN, ~~Deputy~~ Director—Division of Chronic and Post-Acute Care • Tara McMullen, PhD, MPH • ~~Teresa M. Mota, BSN, RN, CALA, WCC~~ • Mary Pratt, MSN, RN, Deputy Director—Division of Chronic and Post-Acute Care • ~~MaryBeth Ribar, MSN, RN~~ • ~~Karen Schoeneman, Director (Retired)—Division of Nursing Homes~~ • John E. V. Sorensen • Christina Stillwell-Deaner, RN, MPH, PHP • ~~Michael Stoltz~~ • ~~Jennifer Sutcliffe, RN, BSN, RAC-CT~~ • Christine Teague, RN-BC, BS, RAC-CT • ~~Daniel Timmel~~ • ~~John Williams, Director—Division of National Systems~~ • ~~Cheryl Wiseman, MPH, MS~~ • Anne Blackfield • Casey Freeman, MSN, ANP-BC • Debra Weiland, BSN, RN

Track Changes
from Chapter 1 v1.16
to Chapter 1 v1.17.1

Chapter	Section	Page	Change
1	—	1-4	~~***Special Recognition for the development of the RAI Manual goes to Ellen Berry, PT and Stella Mandl, BSW, BSN, PHN, RN. Without their dedication, drive, and endless hours of work this manual would not have come to fruition.***~~
1	—	1-7	• **Medicare and Medicaid Payment Systems.** The MDS contains items that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status. The MDS is used as a data collection tool to classify Medicare residents into ~~RUGs (Resource Utilization Groups)~~ PDPM components. The ~~RUG~~ PDPM classification system is used in SNF PPS for skilled nursing facilities~~,~~ and non-critical access hospital swing bed programs~~,~~.~~and in many~~ States may use PDPM, a Resource Utilization Group-based system, or an alternate system ~~Medicaid case mix payment systems~~to group residents into similar resource usage categories for the purposes of Medicaid reimbursement. More detailed information on the SNF PPS is provided in Chapters 2 and 6. Please refer to the Medicare Internet-Only Manuals, including the Medicare Benefit Policy Manual, located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html for comprehensive information on SNF PPS, including, but not limited to, SNF coverage, SNF policies, and claims processing.
1	—	1-11	The goals of the MDS 3.0 revision are to introduce advances in assessment measures, increase the clinical relevance of items, improve the accuracy and validity of the tool, increase user satisfaction, and increase the resident's voice by introducing more resident interview items. Providers, consumers, and other technical experts in nursing home care requested that MDS 3.0 revisions focus on improving the tool's clinical utility, clarity, and accuracy. CMS also wanted to increase the usability of the instrument while maintaining the ability to use MDS data for quality measure reporting and Medicare SNF PPS reimbursement ~~(via resource utilization group [RUG] classification).~~ (via Patient Driven Payment Model [PDPM] classification).

Track Changes
from Chapter 1 v1.16
to Chapter 1 v1.17.1

Chapter	Section	Page	Change
1	—	1-12	The MDS is completed for all residents in Medicare- or Medicaid-certified nursing homes and residents in a PPS stay in non-critical access hospitals with Medicare swing bed agreements. The mandated assessment schedule is discussed in Chapter 2. States may also establish additional MDS requirements. For specific information on State requirements, please contact your State RAI Coordinator (see Appendix B).

Track Changes
from Chapter 2 v1.16
to Chapter 2 v1.17.1

Chapter	Section	Page	Change
2	2.1–2.14	2-1–2-56	This chapter has been extensively revised for this year's manual. Due to the scope of the revisions, individual changes have not been recorded and tracked in this Change Table. Users are encouraged to review the chapter in its entirety.

Track Changes
from Chapter 3 Intro v1.16
to Chapter 3 Intro v1.17.1

Chapter	Section	Page	Change
3	—	3-1	This chapter provides item-by-item coding instructions for all required sections and items in the ~~comprehensive~~ MDS Version 3.0 item sets. The goal of this chapter is to facilitate the accurate coding of the MDS resident assessment and to provide assessors with the rationale and resources to optimize resident care and outcomes.
3	3.3	3-4	• Use a numeric response (a number or pre-assigned value) for blank boxes (e.g., ~~D0350, **Safety Notification**~~M1030, **Number of Venous and Arterial Ulcers**).

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A	—	Standardized wording/usage of term "QIES ASAP system" throughout the section.
3	A0050	A-1	• **Code 2, Modify existing record:** if this is a **request to modify** the MDS items for a record that already has been submitted and accepted in the Quality Improvement and Evaluation System (QIES-) Assessment Submission and Processing (ASAP) system.
3	A0100	A-3	**Coding Instructions** • ~~Facilities must have a National Provider Identifier (NPI) and a CMS Certification Number (CCN).~~ • Enter the facility provider numbers: 1. National Provider Identifier (NPI). 2. CMS Certification Number (CCN) – If A0410 = 3 (federal required submission), then A0100B (facility CCN) must not be blank. 3. State Provider Number (optional). This number is assigned by the ~~Regional Office~~State survey agency and provided to the intermediary~~/carrier and the State survey agency~~. When known, enter the State Provider Number in A0100C. Completion of this is not required; however, your State may require the completion of this item.
3	A0300–A2400	A-4–A-40	Page length changed due to revised content.

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0300	A-4	

A0300: Optional State Assessment

A0300. Optional State Assessment	
Enter Code ☐	**A. Is this assessment for state payment purposes only?** 0. **No** 1. **Yes**
Enter Code ☐	**B. Assessment type** 1. **Start of therapy** assessment 2. **End of therapy** assessment 3. **Both Start and End of therapy** assessment 4. **Change of therapy** assessment 5. **Other payment** assessment

Item Rationale

- Allows for collection of data required for state payment reimbursement.

Coding Instructions for A0300, Optional State Assessment

- Enter the code identifying whether this is an optional payment assessment. This assessment is not required by CMS but may be required by your state.
- If the assessment is being completed for state-required payment purposes, complete items A0300A and A0300B.

Coding Instructions for A0300A, Is this assessment for state payment purposes only?

- Enter the value indicating whether your state requires this assessment for payment.

  0. No
  1. Yes

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0300	A-4–A-5	**Coding Tips and Special Populations** • This assessment is optional, as it is not federally required; however, it may be required by your state. • For questions regarding completion of this assessment, please contact your State agency. • This must be a standalone assessment (i.e., cannot be combined with any other type of assessment). • The responses to the items in this assessment are used to calculate the case mix group Health Insurance Prospective Payment System (HIPPS) code for state payment purposes. • If your state does not require this record for state payment purposes, enter a value of "0" (No). If your state requires this record for state payment purposes, enter a value of "1" (Yes) and proceed to item A0300B, Assessment Type. **Coding Instructions for A0300B, Assessment Type** • Enter the number corresponding to the reason for completing this state assessment. **1.** Start of therapy assessment **2.** End of therapy assessment **3.** Both Start and End of therapy assessment **4.** Change of therapy assessment **5.** Other payment assessment

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0310	A-5	Replaced screenshot. OLD **A0310. Type of Assessment** Enter Code ☐☐ **A. Federal OBRA Reason for Assessment** 01. **Admission** assessment (required by day 14) 02. **Quarterly** review assessment 03. **Annual** assessment 04. **Significant change in status** assessment 05. **Significant correction** to **prior comprehensive** assessment 06. **Significant correction** to **prior quarterly** assessment 99. **None of the above** Enter Code ☐☐ **B. PPS Assessment** **PPS Scheduled Assessments for a Medicare Part A Stay** 01. **5-day** scheduled assessment 02. **14-day** scheduled assessment 03. **30-day** scheduled assessment 04. **60-day** scheduled assessment 05. **90-day** scheduled assessment **PPS Unscheduled Assessments for a Medicare Part A Stay** 07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment) **Not PPS Assessment** 99. **None of the above** Enter Code ☐ **C. PPS Other Medicare Required Assessment - OMRA** 0. **No** 1. **Start of therapy** assessment 2. **End of therapy** assessment 3. **Both Start and End of therapy** assessment 4. **Change of therapy** assessment Enter Code ☐ **D. Is this a Swing Bed clinical change assessment?** Complete only if A0200 = 2 0. **No** 1. **Yes** Enter Code ☐ **E. Is this assessment the first assessment** (OBRA, Scheduled PPS, or Discharge) **since the most recent admission/entry or reentry?** 0. **No** 1. **Yes** Enter Code ☐☐ **F. Entry/discharge reporting** 01. **Entry** tracking record 10. **Discharge** assessment-**return not anticipated** 11. **Discharge** assessment-**return anticipated** 12. **Death in facility** tracking record 99. **None of the above** Enter Code ☐ **G. Type of discharge** - Complete only if A0310F = 10 or 11 1. **Planned** 2. **Unplanned** Enter Code ☐ **H. Is this a SNF Part A PPS Discharge Assessment?** 0. **No** 1. **Yes** NEW **A0310. Type of Assessment** Enter Code ☐☐ **A. Federal OBRA Reason for Assessment** 01. **Admission** assessment (required by day 14) 02. **Quarterly** review assessment 03. **Annual** assessment 04. **Significant change in status** assessment 05. **Significant correction** to **prior comprehensive** assessment 06. **Significant correction** to **prior quarterly** assessment 99. **None of the above** Enter Code ☐☐ **B. PPS Assessment** **PPS Scheduled Assessment for a Medicare Part A Stay** 01. **5-day** scheduled assessment **PPS Unscheduled Assessment for a Medicare Part A Stay** 08. **IPA** - Interim Payment Assessment **Not PPS Assessment** 99. **None of the above** Enter Code ☐ **E. Is this assessment the first assessment** (OBRA, Scheduled PPS, or Discharge) **since the most recent admission/entry or reentry?** 0. **No** 1. **Yes** Enter Code ☐☐ **F. Entry/discharge reporting** 01. **Entry** tracking record 10. **Discharge** assessment-**return not anticipated** 11. **Discharge** assessment-**return anticipated** 12. **Death in facility** tracking record 99. **None of the above** Enter Code ☐ **G. Type of discharge** - Complete only if A0310F = 10 or 11 1. **Planned** 2. **Unplanned** Enter Code ☐ **G1. Is this a SNF Part A Interrupted Stay?** 0. **No** 1. **Yes** Enter Code ☐ **H. Is this a SNF Part A PPS Discharge Assessment?** 0. **No** 1. **Yes**

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0310	A-6	If the assessment is being completed for both Omnibus Budget Reconciliation Act (OBRA)–required clinical reasons (A0310A) and Prospective Payment System (PPS) reasons (A0310B~~ and A0310C~~), all requirements for both types of assessments must be met. See Chapter 2 on assessment schedules for details of these requirements.
3	A0310	A-6	**Coding Tips and Special Populations** • If a nursing home resident elects the hospice benefit, the nursing home is required to complete an MDS Significant Change in Status Assessment (SCSA). The nursing home is required to complete an SCSA when the~~y~~ resident come**s** off the hospice benefit (revoke). See Chapter 2 for details on this requirement.
3	A0310	A-7	**DEFINITION** **PROSPECTIVE PAYMENT SYSTEM (PPS)** Method of reimbursement in which Medicare payment is made based on the classification system of that service~~ (e.g., resource utilization groups, RUGs, for skilled nursing facilities)~~.
3	A0310	A-7	**Coding Instructions for A0310B, PPS Assessment** • Enter the number corresponding to the PPS reason for completing this assessment. This item contains 2 digits. For codes 01–~~07~~and 08, enter "0" in the first box and place the correct number in the second box. If the assessment is not coded as 01–~~07~~or 08, enter code "99." • See Chapter 2 on assessment schedules for detailed information on the ~~scheduling and~~ timing of the assessments.

Chapter	Section	Page	Change
3	A0310	A-7	A0310: Type of Assessment (cont.) **PPS Scheduled Assessments for a Medicare Part A Stay** **01.** 5-day scheduled assessment ~~**02.** 14-day scheduled assessment~~ ~~**03.** 30-day scheduled assessment~~ ~~**04.** 60-day scheduled assessment~~ ~~**05.** 90-day scheduled assessment~~ **PPS Unscheduled Assessments for Medicare Part A Stay** ~~**07.** Unscheduled assessment used for PPS (OMRA, significant change, or significant correction assessment)~~ **08. IPA-**Interim Payment Assessment **Not PPS Assessment** **99.** None of the above
3	A0310	A-7	~~Coding Instructions for A0310C, PPS Other Medicare Required Assessment—OMRA~~ • ~~**Code 0, no:** if this assessment is not an OMRA.~~ • ~~**Code 1, Start of therapy assessment (OPTIONAL):** with an assessment reference date (ARD) that is 5 to 7 days after the first day therapy services are provided (except when the assessment is used as a Short Stay assessment, see Chapter 6). No need to combine with the 5-day assessment except for short stay. Only complete if therapy RUG (index maximized), otherwise the assessment will be rejected.~~ • ~~**Code 2, End of therapy assessment:** with an ARD that is 1 to 3 days after the last day therapy services were provided.~~ • ~~**Code 3, both the Start and End of therapy assessment:** with an ARD that is both 5 to 7 days after the first day therapy services were provided and that is 1 to 3 days after the last day therapy services were provided (except when the assessment is used as a Short Stay assessment, see Chapter 6).~~ • ~~**Code 4, Change of therapy assessment:** with an ARD that is Day 7 of the COT observation period.~~

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0310	A-7	~~**Coding Instructions for A0310D, Is This a Swing Bed Clinical Change Assessment?**~~ • ~~**Code 0, no:** if this assessment is not a Swing Bed Clinical Change assessment.~~ • ~~**Code 1, yes:** if this assessment is a swing bed clinical change assessment.~~
3	A0310	A-7	**Coding Tips and Special Populations** • A0310E = 0 for: o Entry or Death in Facility tracking records (A0310F = 01 or 12); o A standalone Part A PPS Discharge assessment (A0310A = 99, A0310B = 99, A0310F = 99, and A0310H = 1); or o ~~A standalone unscheduled PPS assessment~~An Interim Payment Assessment (A0310A = 99, A0310B = 0~~7~~8, ~~and~~ A0310F = 99, and A0310H=0). • A0310E = 1 on the first OBRA, Scheduled PPS or OBRA Discharge assessment that is completed and submitted once a facility obtains CMS certification. Note: the first submitted assessment may not be ~~the~~ an OBRA Admission assessment.
3	A0310	A-8	**DEFINITION** **Part A PPS Discharge Assessment** A discharge assessment developed to inform current and future Skilled Nursing Facility Quality Reporting Program (SNF QRP) measures and the calculation of these measures. The Part A PPS Discharge assessment is completed when a resident's Medicare Part A stay ends, but the resident remains in the facility; or may be combined with an OBRA Discharge if the Part A stay ends on the same day or the day before the resident's Discharge Date (A2000).

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0310	A-8	**Coding Instructions for A0310G, Type of Discharge (complete only if A0310F = 10 or 11)** • Enter the number corresponding to the type of discharge. • **Code 1:** if type of discharge is a planned discharge. • **Code 2:** if type of discharge is an unplanned discharge.
3	A0310	A-9	**DEFINITIONS** **Interrupted Stay** Is a Medicare Part A SNF stay in which a resident is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay) and subsequently resumes SNF care in the **same** SNF for a Medicare Part A-covered stay during the interruption window. **Interruption Window** Is a 3-day period, starting with the calendar day of Part A discharge and including the 2 immediately following calendar days. In other words, if a resident in a Medicare Part A SNF stay is discharged from Part A, the resident must resume Part A services, or return to the **same** SNF (if physically discharged) to resume Part A services, by 11:59 p.m. at the end of the third calendar day after their Part A-covered stay ended. The interruption window begins with the first non-covered day following a Part A-covered stay and ends at 11:59 p.m. on the third consecutive non-covered day following a Part A-covered SNF stay. If these conditions are met, the subsequent stay is considered a continuation of the previous Medicare Part A-covered stay for the purposes of both the variable per diem schedule and PPS assessment completion.

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0310	A-9	 **Coding Instructions for A0310G1, Is this a SNF Part A Interrupted Stay?** • **Code 0, no:** if the resident was discharged from SNF care (i.e., from a Medicare Part A-covered stay) but **did not** resume SNF care in the same SNF within the interruption window. • **Code 1, yes:** if the resident was discharged from SNF care (i.e., from a Medicare Part A-covered stay) but did resume SNF care in the same SNF within the interruption window.
3	A0310	A-9	**Coding Tips** • Item A0310G1 indicates whether or not an interrupted stay occurred. • The interrupted stay policy applies to residents who either leave the SNF, then return to the same SNF within the interruption window, or to residents who are discharged from Part A-covered services and remain in the SNF, but then resume a Part A-covered stay within the interruption window.

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0310	A-10	• The following is a list of examples of an interrupted stay when the resident leaves the SNF and then returns to the same SNF to resume Part A-covered services within the interruption window. Examples include, but are not limited to, the following: o Resident transfers to an acute care setting for evaluation or treatment due to a change in condition and returns to the same SNF within the interruption window. o Resident transfers to a psychiatric facility for evaluation or treatment and returns to the same SNF within the interruption window. o Resident transfers to an outpatient facility for a procedure or treatment and returns to the same SNF within the interruption window. o Resident transfers to an assisted living facility or a private residence with home health services and returns to the same SNF within the interruption window. o Resident leaves against medical advice and returns to the same SNF within the interruption window.

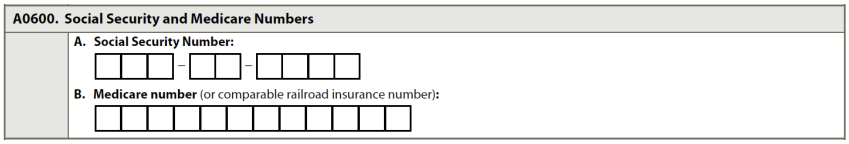
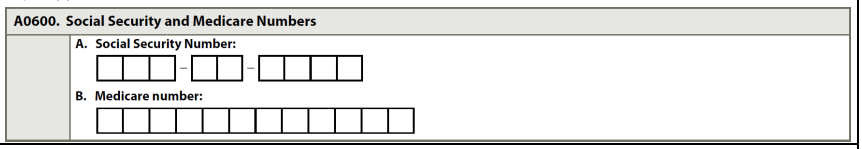
Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0310	A-10	• The following is a list of examples of an interrupted stay when the resident under a Part A-covered stay remains in the facility but the stay stops being covered under the Part A PPS benefit, and then resumes Part A-covered services in the SNF within the interruption window. Examples include, but are not limited to, the following: o Resident elects the hospice benefit, thereby declining the SNF benefit, and then revokes the hospice benefit and resumes SNF-level care within the interruption window. o Resident refuses to participate in rehabilitation and has no other daily skilled need; this ends the Part A coverage. Within the interruption window, the resident decides to engage in the planned rehabilitation regime and Part A coverage resumes. o Resident changes payer sources from Medicare Part A to an alternate payer source (i.e., hospice, private pay or private insurance) and then wishes to resume their Medicare Part A stay, at the same SNF, within the interruption window.
3	A0310	A-10	• If a resident is discharged from SNF care, remains in the SNF, and resumes a Part A-covered stay in the SNF within the interruption window, this is an interrupted stay. No discharge assessment (OBRA or Part A PPS) is required, nor is an Entry Tracking Record or 5-Day required on resumption. • If a resident leaves the SNF and returns to resume Part A-covered services in the **same** SNF within the interruption window, this is an interrupted stay. Although this situation does not end the resident's Part A PPS stay, the resident left the SNF, and therefore an OBRA Discharge assessment is required. On return to the SNF, no 5-Day would be required. An OBRA Admission **would** be required if the resident was discharged return **not** anticipated. If the resident was discharged return anticipated, no new OBRA Admission would be required.

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0310	A-11	• When an interrupted stay occurs, a 5-Day PPS assessment is not required upon reentry or resumption of SNF care in the same SNF, because an interrupted stay does not end the resident's Part A PPS stay. • If a resident is discharged from SNF care, remains in the SNF and **does not** resume Part A-covered services within the interruption window, an interrupted stay did **not** occur. In this situation, a Part A PPS Discharge is required. If the resident qualifies and there is a resumption of Part A services within the 30-day window allowed by Medicare, a 5-Day would be required as this would be considered a **new** Part A stay. The OBRA schedule would continue from the resident's original date of admission (item A1900). • If a resident leaves the SNF and **does not** return to resume Part A-covered services in the **same** SNF within the interruption window, an interrupted stay did **not** occur. In this situation, both the Part A PPS and OBRA Discharge assessments are required (and may be combined). If the resident returns to the same SNF, this would be considered a **new** Part A stay. An Entry Tracking record and 5-Day would be required on return. An OBRA Admission **would** be required if the resident was discharged return **not** anticipated. If the resident was discharged return anticipated, no new OBRA Admission would be required. • The OBRA assessment schedule is unaffected by the interrupted stay policy. Please refer to Chapter 2 for guidance on OBRA assessment scheduling requirements.
3	A0410	A-12	• Nursing homes ~~and swing bed facilities~~ must be certain they are submitting MDS assessments to the QIES ASAP system for those residents who are on a Medicare and/or Medicaid certified unit. Swing bed facilities must be certain that they are submitting MDS assessments only for those residents whose stay is covered by Medicare Part A benefits. For those residents who are in licensed-only beds, nursing homes must be certain they are submitting MDS assessments either to QIES ASAP or directly to the state in accordance with state requirements.

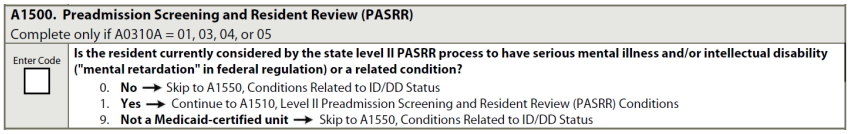
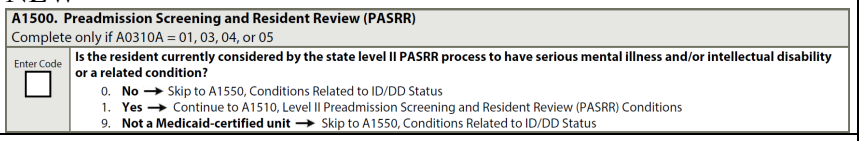
Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0410	A-13	• **Code 1, Unit is neither Medicare nor Medicaid certified and MDS data is not required by the State:** if the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, and neither CMS nor the state ~~does not~~ ha~~ves~~s authority to collect MDS information for residents on this unit, the facility may not submit MDS records to QIES ASAP. If any records are submitted under this certification designation, they will be rejected by the QIES ASAP system.
3	A0600	A-14	Replaced screenshot. OLD  NEW 
3	A0600	A-14	**DEFINITIONS** **SOCIAL SECURITY NUMBER** A tracking number assigned to an individual by the U.S. Federal government for taxation, benefits, and identification purposes. **MEDICARE NUMBER ~~(OR COMPARABLE RAILROAD INSURANCE NUMBER)~~** An identifier assigned to an individual for participation in national health insurance program. The Medicare Health Insurance identifier ~~may be~~is different from the resident's Social Security Number (SSN) and may contain both letters and numbers. ~~For example, many residents may receive Medicare benefits based on a spouse's Medicare eligibility.~~

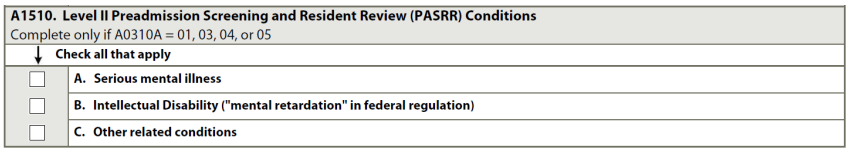
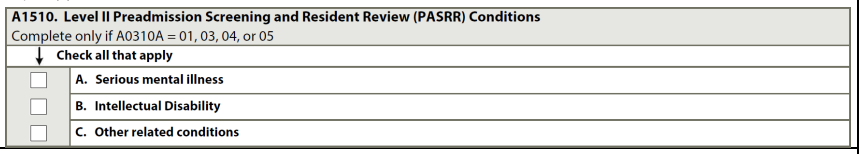
Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A0600	A-14	• Enter the Social Security Number (SSN) in A0600A, one number per space starting with the leftmost space. If no ~~social security number~~SSN is available for the resident (e.g., if the resident is a recent immigrant or a child) the item may be left blank. Note: A valid SSN should be submitted in A0600A whenever it is available so that resident matching can be performed as accurately as possible. • Enter Medicare number in A0600B exactly as it appears on the resident's documents. • ~~If the resident does not have a Medicare number, a Railroad Retirement Board (RRB) number may be substituted. These RRB numbers contain both letters and numbers. To enter the RRB number, enter the first letter of the code in the leftmost space followed by one letter/digit per space. If no Medicare number or RRB number is known or available, the item may be left blank.~~ • For PPS assessments (A0310B = 01~~, 02, 03, 04, 05, and 07~~or 08), ~~either~~ the Medicare ~~or Railroad Retirement Board (RRB)~~ number (A0600B) must be present (i.e., may not be left blank). ~~Note: A valid SSN should be submitted in A0600A whenever it is available so that resident matching can be performed as accurately as possible.~~ • A0600B ~~can only~~must be a Medicare number~~ or a Railroad Retirement Board number~~.
3	A0700	A-15	**Coding Instructions** • Record this number if the resident is a Medicaid recipient. • Enter one number or letter per box beginning in the leftmost box.
3	A0800	A-15	**Coding Tips and Special Populations** • Resident gender on the MDS ~~should~~must match what is in the Social Security system.

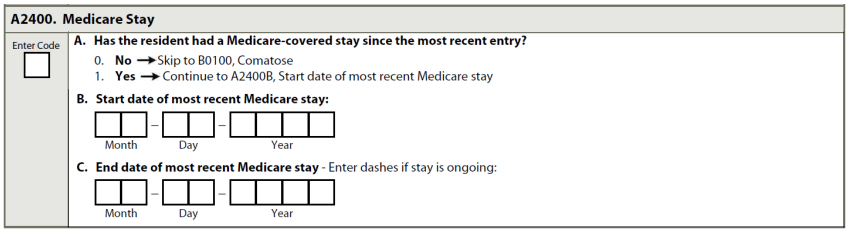
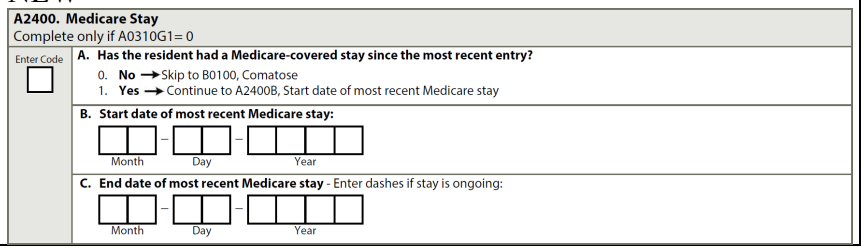
Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A1500	A-21	Replaced screenshot. OLD  **A1500. Preadmission Screening and Resident Review (PASRR)** Complete only if A0310A = 01, 03, 04, or 05 Enter Code **Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition?** 0. **No** → Skip to A1550, Conditions Related to ID/DD Status 1. **Yes** → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions 9. **Not a Medicaid-certified unit** → Skip to A1550, Conditions Related to ID/DD Status NEW  **A1500. Preadmission Screening and Resident Review (PASRR)** Complete only if A0310A = 01, 03, 04, or 05 Enter Code **Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?** 0. **No** → Skip to A1550, Conditions Related to ID/DD Status 1. **Yes** → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions 9. **Not a Medicaid-certified unit** → Skip to A1550, Conditions Related to ID/DD Status
3	A1500	A-21	• All individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), ~~("mental retardation" (MR) in federal regulation)/~~developmental disability (DD), or related conditions (please contact your local State Medicaid Agency for details regarding PASRR requirements and exemptions).
3	A1500	A-21	• A resident with MI or ID/DD must have a Resident Review (RR) conducted when there is a significant change in the resident's physical or mental condition. Therefore, when ~~a Significant Change in Status Assessment~~an SCSA is completed for a resident with MI or ID/DD, the nursing home is required to notify the State mental health authority, intellectual disability or developmental disability authority (depending on which operates in their State) in order to notify them of the resident's change in status. Section 1919(e)(7)(B)(iii) of the Social Security Act requires the notification or referral for a significant change.
3	A1500	A-22	**Steps for Assessment** 1. Complete if A0310A = 01, 03, 04 or 05 (Admission assessment, Annual assessment, ~~Significant Change in Status Assessment~~SCSA, Significant Correction to Prior Comprehensive Assessment).

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A1500	A-22	**Coding Instructions** • **Code 0, no:** and skip to A1550, Conditions Related to ID/DD Status, if any of the following apply: — PASRR Level I screening did not result in a referral for Level II screening, or — Level II screening determined that the resident does not have a serious ~~mental illness~~MI and/or ~~intellectual/developmental disability~~ID/DD or related conditions, or
3	A1510	A-23	Replaced screenshot. OLD  A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions Complete only if A0310A = 01, 03, 04, or 05 Check all that apply A. Serious mental illness B. Intellectual Disability ("mental retardation" in federal regulation) C. Other related conditions NEW  A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions Complete only if A0310A = 01, 03, 04, or 05 Check all that apply A. Serious mental illness B. Intellectual Disability C. Other related conditions
3	A1510	A-23	**Steps for Assessment** 1. Complete if A0310A = 01, 03, 04 or 05 (Admission assessment, Annual assessment, ~~Significant Change in Status Assessment~~SCSA, Significant Correction to Prior Comprehensive Assessment).
3	A1510	A-23	• **Code B, Intellectual Disability ~~("mental retardation" in federal regulation)/Developmental Disability:~~** if resident has been diagnosed with intellectual disability/developmental disability.

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A1550	A-24	**Steps for Assessment** 1. If resident is 22 years of age or older on the ~~assessment reference date~~ARD, complete only if A0310A = 01 (Admission assessment). 2. If resident is 21 years of age or younger on the ~~assessment reference date~~ARD, complete if A0310A = 01, 03, 04, or 05 (Admission assessment, Annual assessment, ~~Significant Change in Status Assessment~~SCSA, Significant Correction to Prior Comprehensive Assessment).
3	A2000	A-31	**Coding Tips and Special Populations** • A Part A PPS Discharge assessment (NPE Item Set) is required under the ~~Skilled Nursing Facility Quality Reporting Program (~~SNF QRP~~)~~ when the resident's Medicare Part A stay ends, but the resident does not leave the facility.
3	A2400	A-35	Replaced screenshot to include new instructional language. OLD  **A2400. Medicare Stay** Enter Code **A. Has the resident had a Medicare-covered stay since the most recent entry?** 0. **No** → Skip to B0100, Comatose 1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay **B. Start date of most recent Medicare stay:** Month – Day – Year **C. End date of most recent Medicare stay** - Enter dashes if stay is ongoing: Month – Day – Year NEW  **A2400. Medicare Stay** Complete only if A0310G1= 0 Enter Code **A. Has the resident had a Medicare-covered stay since the most recent entry?** 0. **No** → Skip to B0100, Comatose 1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay **B. Start date of most recent Medicare stay:** Month – Day – Year **C. End date of most recent Medicare stay** - Enter dashes if stay is ongoing: Month – Day – Year

Track Changes
from Chapter 3 Section A v1.16
to Chapter 3 Section A v1.17.1

Chapter	Section	Page	Change
3	A2400	A-36	**Coding Tips and Special Populations** • When a resident on Medicare Part A returns following a therapeutic leave of absence or a hospital observation stay of less than 24 hours (without hospital admission), this is a continuation of the Medicare Part A stay, not a new Medicare Part A stay. • When a resident on Medicare Part A has an interrupted stay (i.e., is discharged from SNF care and subsequently readmitted to the same SNF within the interruption window after the discharge), this is a continuation of the Medicare Part A stay, not a new Medicare Part A stay.
3	A2400	A-37	2. Mr. N began receiving services under Medicare Part A on December 11, 201~~6~~9. He was unexpectedly sent to the ~~ER~~ emergency department on December 19, ~~2016~~2019 at 8:30 p.m. and was not admitted to the hospital. He returned to the facility on December 20, ~~2016~~2019, at 11:00 a.m. Upon Mr. N's return, his physician's orders included significant changes in his treatment regime. The facility staff determined that an Interim Payment Assessment (IPA) was indicated as the PDPM nursing component was impacted. They completed the IPA with an ARD of December 24, 2019. Code the following on the IPA: ~~The facility completed his 14-day PPS assessment with an ARD of December 23, 2016. Code the following on his 14-day PPS assessment:~~ • A2400A = 1 • A2400B = 12-11-~~2016~~2019 • A2400C = ----------

Track Changes
from Chapter 3 Section C v1.16
to Chapter 3 Section C v1.17.1

Chapter	Section	Page	Change
3	C0100	C-2	• ~~There is one exception to completing the Staff Assessment for Mental Status items (C0700–C1000) in place of the resident interview. This exception is specific to a stand-alone, unscheduled PPS assessment only and is discussed on page 2-60. For this type of assessment only, the resident interview may be conducted up to two calendar days after the ARD.~~ • ~~When coding a stand-alone Change of Therapy OMRA (COT), a stand-alone End of Therapy OMRA (EOT), or a stand-alone Start of Therapy OMRA (SOT), the interview items may be coded using the responses provided by the resident on a previous assessment **only** if the DATE of the interview responses from the previous assessment (as documented in item Z0400) were obtained no more than 14 days prior to the DATE of completion for the interview items on the unscheduled assessment (as documented in item Z0400) for which those responses will be used.~~
3	C0100	C-2	• Because a PDPM cognitive level is utilized in the speech language pathology (SLP) payment component of PDPM, **only** in the case of PPS assessments, staff may complete the Staff Assessment for Mental Status for an interviewable resident when the resident is unexpectedly discharged from a Part A stay prior to the completion of the BIMS. In this case, the assessor should enter 0, No in C0100: Should Brief Interview for Mental Status Be Conducted? and proceed to the Staff Assessment for Mental Status.
3	C0500	C-16	• To be considered a completed interview, the resident had to attempt and provide relevant answers to at least four of the questions included in C0200-C0400. To be relevant, a response only has to be related to the question (logical); it does not have to be correct. See general coding tips ~~on page C-4~~below for residents who choose not to participate at all.

Track Changes
from Chapter 3 Section D v1.16
to Chapter 3 Section D v1.17.1

Chapter	Section	Page	Change
3	D0100	D-2	• If the resident needs an interpreter, every effort should be made to have an interpreter present for the PHQ-9© interview. If it is not possible for a needed interpreter to be present on the day of the interview, code D0100 = 0 to indicate that an interview was not attempted and complete items D0500-D06~~5~~00.
3	D0100–D0600	D-3–D-14	Page length changed due to revised content.
3	D0100	D-3	• ~~There is one exception to completing the Staff Assessment of Resident Mood items (D0500) in place of the resident interview. This exception is specific to a stand-alone, unscheduled PPS assessment only and is discussed on page 2-60. For this type of assessment only, the resident interview may be conducted up to two calendar days after the ARD.~~ • ~~When coding a stand-alone Change of Therapy OMRA (COT), a standalone End of Therapy OMRA (EOT), or a standalone Start of Therapy OMRA (SOT), the interview items may be coded using the responses provided by the resident on a previous assessment only if the DATE of the interview responses from the previous assessment (as documented in item Z0400) were obtained no more than 14 days prior to the DATE of completion for the interview items on the unscheduled assessment (as documented in item Z0400) for which those responses will be used.~~
3	D0200	D-6	**Coding Tips and Special Populations** • For question D0200I, Thoughts That You Would Be Better Off Dead or of Hurting Yourself in Some Way: — ~~The checkbox in item D0350 reminds the assessor to notify a responsible clinician (psychologist, physician, etc). Follow facility protocol for evaluating possible self-harm.~~ — Beginning interviewers may feel uncomfortable asking this item because they may fear upsetting the resident or may feel that the question is too personal. Others may worry that it will give the resident inappropriate ideas. However,

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from Chapter 3 Section D v1.16
to Chapter 3 Section D v1.17.1

Chapter	Section	Page	Change
3	D0350	D-10	~~D0350: Follow-up to D0200I~~ **D0350. Safety Notification** - Complete only if D0200I1 = 1 indicating possibility of resident self harm Enter Code ☐ **Was responsible staff or provider informed that there is a potential for resident self harm?** 0. No 1. Yes
3	D0350	D-10	~~Item Rationale~~ ~~Health-related Quality of Life~~ ~~• This item documents if appropriate clinical staff and/or mental health provider were informed that the resident expressed that he or she had thoughts of being better off dead, or hurting him or herself in some way.~~ ~~• It is well-known that untreated depression can cause significant distress and increased mortality in the geriatric population beyond the effects of other risk factors.~~ ~~• Although rates of suicide have historically been lower in nursing homes than for comparable individuals living in the community, indirect self-harm and life threatening behaviors, including poor nutrition and treatment refusal are common.~~ ~~• Recognition and treatment of depression in the nursing home can be lifesaving, reducing the risk of mortality within the nursing home and also for those discharged to the community.~~ ~~Planning for Care~~ ~~• Recognition and treatment of depression in the nursing home can be lifesaving, reducing the risk of mortality within the nursing home and also for those discharged to the community (available at https://www.agingcare.com/Articles/Suicide-and-the-Elderly-125788.htm).~~

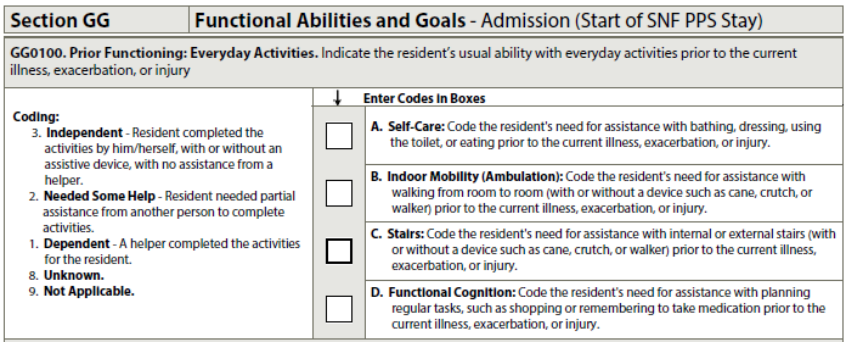
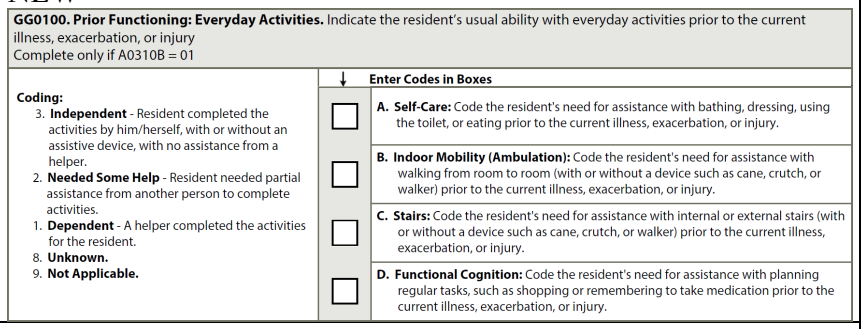
Track Changes
from Chapter 3 Section D v1.16
to Chapter 3 Section D v1.17.1

Chapter	Section	Page	Change
3	D0350	D-10	~~## Steps for Assessment~~ ~~1. Complete item D0350 **only** if item D0200I1 **Thoughts That You Would Be Better Off Dead, or of Hurting Yourself in Some Way** = 1 indicating the possibility of resident self-harm.~~ ~~## Coding Instructions~~ ~~• **Code 0, no:** if responsible staff or provider was not informed that there is a potential for resident self-harm.~~ ~~• **Code 1, yes:** if responsible staff or provider was informed that there is a potential for resident self-harm.~~
3	D0500	D-10	## Health-related Quality of Life • PHQ-9© **Resident Mood Interview** is preferred as it improves the detection of a possible mood disorder. However, a small percentage of patients are unable or unwilling to complete the PHQ-9© **Resident Mood Interview**. Therefore, staff should complete the PHQ-9-~~OV~~© Observational Version (PHQ-9-OV©) **Staff Assessment of Mood** in these instances so that any behaviors, signs, or symptoms of mood distress are identified.
3	D0600	D-13	## Health-related Quality of Life • Review Item Rationale for D0300, **Total Severity Score** (page D-8). • The ~~PHQ-9© Observational Version (~~PHQ-9-OV©~~)~~ is adapted to allow the assessor to interview staff and identify a **Total Severity Score** for potential depressive symptoms.
3	D0650	D-14	~~## D0650: Follow-up to D0500I~~ **D0650. Safety Notification** - Complete only if D0500I1 = 1 indicating possibility of resident self harm Enter Code ☐ **Was responsible staff or provider informed that there is a potential for resident self harm?** 0. No 1. Yes

Track Changes
from Chapter 3 Section D v1.16
to Chapter 3 Section D v1.17.1

Chapter	Section	Page	Change
3	D0650	D-14	~~Item Rationale~~ ~~Health-related Quality of Life~~ ~~• This item documents if appropriate clinical staff and/or mental health provider were informed that the resident expressed that they had thoughts of being better off dead, or hurting him or herself in some way.~~ ~~• It is well known that untreated depression can cause significant distress and increased mortality in the geriatric population beyond the effects of other risk factors.~~ ~~• Although rates of suicide have historically been lower in nursing homes than for comparable individuals living in the community, indirect self-harm and life-threatening behaviors, including poor nutrition and treatment refusal are common.~~ ~~Planning for Care~~ ~~• Recognition and treatment of depression in the nursing home can be lifesaving, reducing the risk of mortality within the nursing home and also for those discharged to the community (available at https://www.agingcare.com/Articles/Suicide-and-the-Elderly-125788.htm).~~
3	D0650	D-14	~~Steps for Assessment~~ ~~1. Complete item D0650 only if item D0500I, **States That Life Isn't Worth Living, Wishes for Death, or Attempts to Harm Self** = 1 indicating the possibility of resident self-harm.~~ ~~Coding Instructions~~ ~~• **Code 0, no:** if responsible staff or provider was not informed that there is a potential for resident self-harm.~~ ~~• **Code 1, yes:** if responsible staff or provider was informed that there is a potential for resident self-harm.~~

Track Changes
from Chapter 3 Section GG v1.16
to Chapter 3 Section GG v1.17.1

Chapter	Section	Page	Change
3	GG0100	GG-1	Replaced screenshot. OLD  NEW 
3	GG0100	GG-3	6. **Indoor Mobility (Ambulation):** Approximately three months ago, Mr. K had a cardiac event that resulted in anoxia, and subsequently a swallowing disorder. Mr. K has been living at home with his wife and developed aspiration pneumonia. After this most recent hospitalization, he was admitted to the SNF for a diagnosis of aspiration pneumonia and severe deconditioning. Prior to the most recent acute care hospitalization, Mr. K needed some assistance when walking.

Track Changes
from Chapter 3 Section GG v1.16
to Chapter 3 Section GG v1.17.1

<table>
<tr><th>Chapter</th><th>Section</th><th>Page</th><th>Change</th></tr>
<tr><td>3</td><td>GG0110</td><td>GG-5</td><td>Replaced screenshot.

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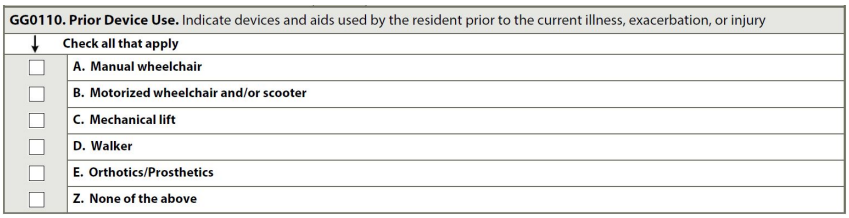
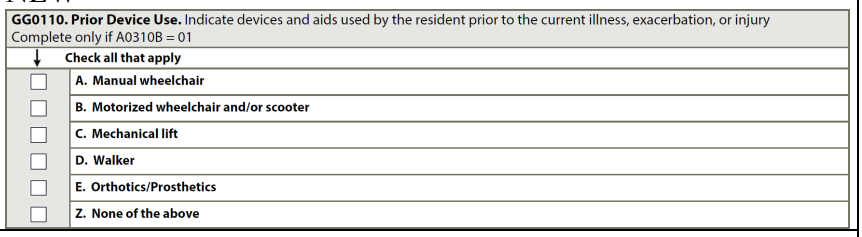
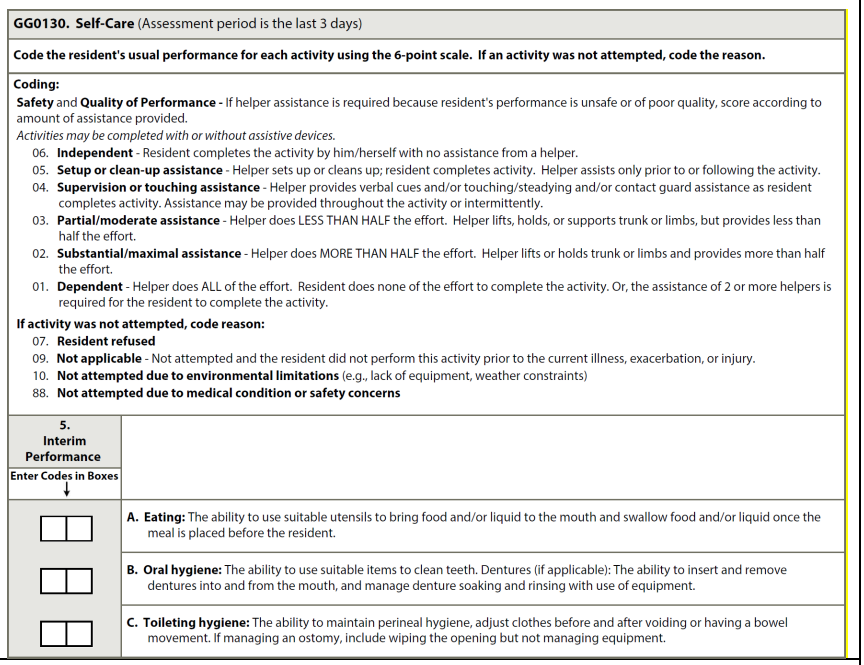
 

NEW
 
</td></tr>
<tr><td>3</td><td>GG0110</td><td>GG-6</td><td>Coding Tips

• For GG0110D, Prior Device Use - Walker: “Walker” refers to all types of walkers (for example, pickup walkers, hemi-walkers, rolling walkers, and platform walkers).

• GG0110C, Mechanical lift, includes sit-to-stand, stand assist, stair lift, and full-body-style lifts.</td></tr>
</table>

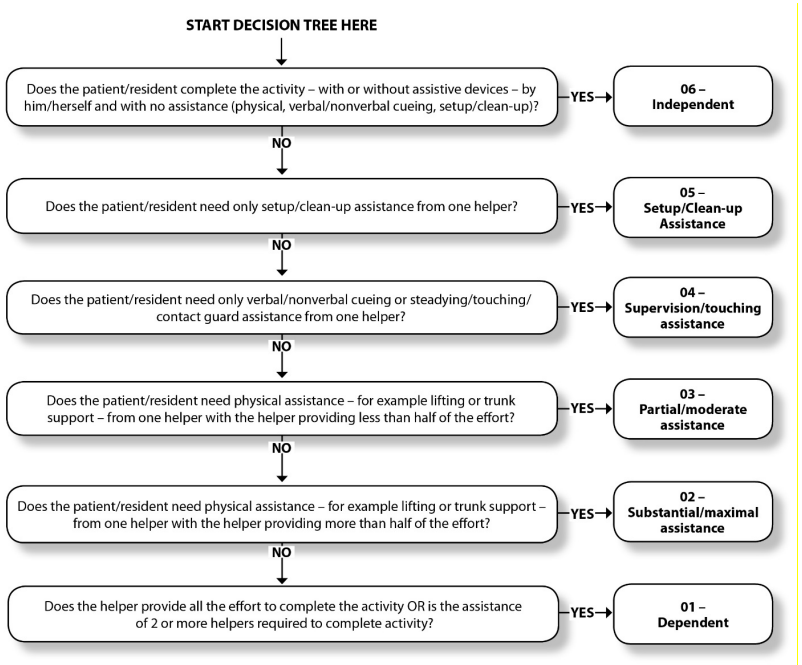
Track Changes
from Chapter 3 Section GG v1.16
to Chapter 3 Section GG v1.17.1

Chapter	Section	Page	Change
3	GG0130	GG-8	GG0130: Self-Care (3-day assessment period) Interim Performance (Interim Payment Assessment - Optional) 
3	GG0130	GG-9–GG-67	Page length changed due to revised content.
3	GG0130	GG-10–GG-31	Continued page title revised. GG0130: Self-Care (3-day assessment period) Admission/Interim/Discharge (Start/Interim/End of Medicare Part A Stay) (cont.)

Track Changes
from Chapter 3 Section GG v1.16
to Chapter 3 Section GG v1.17.1

Chapter	Section	Page	Change
3	GG0130	GG-10	**Steps for Assessment** 1. Assess the resident's self-care performance based on direct observation, ~~as well as the~~incorporating resident~~'s~~ self-reports and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the three-day assessment period. CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period. For Section GG, the admission assessment period is the first three days of the Part A stay starting with the date in A2400B, the Start of Most Recent Medicare Stay. On admission, these items are completed only when A0310B = 01 (5-Day PPS assessment). For the Interim Payment Assessment (A0310B=08), the assessment period for Section GG is the last 3 days (i.e., the ARD and two days prior).
3	GG0130	GG-10	5. The admission functional assessment, when possible, should be conducted prior to the ~~person~~resident benefitting from treatment interventions in order to ~~determine a~~reflect the resident's true admission baseline functional status ~~on admission~~. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.
3	GG0130	GG-11	**Admission, Interim, or Discharge Performance Coding Instructions**
3	GG0130	GG-11	• **Code 04, Supervision or touching assistance:** if the helper provides verbal cues or touching/steadying/contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete activity; or resident may require only incidental help such as contact guard or steadying assist during the activity.

Track Changes
from Chapter 3 Section GG v1.16
to Chapter 3 Section GG v1.17.1

Chapter	Section	Page	Change
3	GG0130	GG-12	**Decision Tree** Use this decision tree to code the resident's performance on the assessment instrument. If helper assistance is required because the resident's performance is unsafe or of poor quality, score according to the amount of assistance provided. Only use the "activity not attempted codes" if the activity did not occur; that is, the resident did not perform the activity and a helper did not perform that activity for the resident. 
3	GG0130	GG-13	• **Interim Performance (Optional):** The Interim Payment Assessment (IPA) is an optional assessment that may be completed by providers in order to report a change in the resident's PDPM classification. For Section GG on the IPA, providers will use the same 6-point scale and activity not attempted codes to complete the column "Interim Performance," which will capture the interim functional performance of the resident. The ARD for the IPA is determined by the provider, and the assessment period is the last 3 days (i.e., the ARD and the 2 calendar days prior). It is important to note that the IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed. The IPA does not affect the variable per diem schedule.

Track Changes
from Chapter 3 Section GG v1.16
to Chapter 3 Section GG v1.17.1

Chapter	Section	Page	Change
3	GG0130	GG-14	**Coding Tips: Admission, Interim, or Discharge Performance**
3	GG0130	GG-15	**Coding Tips for GG0130A, Eating** • ~~Resident receives tube feedings or total parenteral nutrition (TPN)~~GG0130A, Eating involves bringing food and liquids to the mouth and swallowing food. The administration of tube feedings and parenteral nutrition is not considered when coding this activity. The following is guidance for some situations in which a resident receives tube feedings or parenteral nutrition: o If the resident does not eat or drink by mouth and relies **solely** on nutrition and liquids through tube feedings or total parenteral nutrition (TPN) because of a **new (recent-onset) medical condition,** code GG0130A as 88, Not attempted due to medical condition or safety concerns. Assistance with tube feedings or TPN is not considered when coding Eating. o If the resident does not eat or drink by mouth at the time of the assessment, and the resident did not eat or drink by mouth **prior to the current** illness, injury, or exacerbation, code GG0130A as 09, Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. Assistance with tube feedings or ~~TPN~~ parenteral nutrition is not considered when coding Eating. o If the resident eats and drinks by mouth, and relies **partially** on obtaining nutrition and liquids via tube feedings or ~~TPN~~ parenteral nutrition, code Eating based on the amount of assistance the resident requires to eat and drink by mouth. Assistance with tube feedings or ~~TPN~~ parenteral nutrition is not considered when coding Eating.
3	GG0130	GG-16	**Examples for Coding Admission, Interim, ~~Performance~~ or Discharge Performance**

Track Changes
from Chapter 3 Section GG v1.16
to Chapter 3 Section GG v1.17.1

Chapter	Section	Page	Change
3	GG0130	GG-21	1. **Toileting hygiene:** Mrs. J uses a bedside commode. The certified nursing assistant provides steadying (touching) assistance as Mrs. J pulls down her pants and underwear before sitting down on the ~~toilet~~commode. When Mrs. J is finished voiding or having a bowel movement, the certified nursing assistant provides steadying assistance as Mrs. J wipes her perineal area and pulls up her pants and underwear without assistance.
3	GG0130	GG-21	3. **Toileting hygiene:** Mrs. P has urinary urgency. As soon as she gets in the bathroom, she asks the certified nursing assistant to lift her gown and pull down her underwear due to her balance problems. After voiding, Mrs. P wipes herself ~~and~~, pulls her underwear back up, and adjusts her gown.
3	GG0130	GG-23	2. **Shower/bathe self:** Mrs. E has a severe and progressive neurological condition that has affected her endurance as well as her fine and gross motor skills. She is transferred to the shower bench with partial/moderate assistance. Mrs. E showers while sitting on a ~~tub~~shower bench and washes her arms and chest using a wash mitt. A certified nursing assistant then must help wash the remaining parts of her body, as a result of Mrs. E's fatigue, to complete the activity. Mrs. E uses a ~~long-handled shower~~hand-held showerhead to rinse herself but tires halfway through the task. The certified nursing assistant dries Mrs. E's entire body.
3	GG0130	GG-25	**Rationale:** Mrs. Y dresses and undresses her upper body and requires a helper only to retrieve and put away her clothing, that is, setting up the clothing for her use. The description refers to Mrs. Y as "independent" (when removing clothes), but she needs setup assistance, so she is not independent with regard to the entire activity of upper body dressing.

Track Changes
from Chapter 3 Section GG v1.16
to Chapter 3 Section GG v1.17.1

Chapter	Section	Page	Change
3	GG0130	GG-26	1. **Lower body dressing:** Mr. D is required to follow hip precautions as a result of recent hip surgery. The occupational therapist in the acute care hospital instructed him in the use of adaptive equipment to facilitate lower body dressing. He requires a helper to retrieve his clothing from the closet. Mr. D uses his adaptive equipment to assist in threading his legs into his pants. Because of balance issues, Mr. D needs the helper to steady him when standing to manage pulling on or pulling down his pants/undergarments. Mr. D also needs some assistance to put on and take off his socks and shoes.
3	GG0130	GG-27	3. **Lower body dressing:** Mrs. R has peripheral neuropathy in her upper and lower extremities. Each morning, Mrs. R needs assistance from a helper to place her lower limb into, or to take it out of (don/doff), her lower limb prosthesis. She needs no assistance to put on and remove her underwear or slacks. **Coding:** GG0130G would be coded 03, Partial/moderate assistance. **Rationale:** A helper performs less than half the effort of lower body dressing (with a prosthesis considered a piece of clothing). The helper lifts, holds, or supports Mrs. R's trunk or limbs, but provides less than half the effort for the task of lower body dressing. ~~In contrast, coding level 04, Supervision or touching assistance, is used if the helper provides either verbal cues and/or only touching/steadying assistance as the resident completes the activity.~~

Track Changes
from Chapter 3 Section GG v1.16
to Chapter 3 Section GG v1.17.1

Chapter	Section	Page	Change
3	GG0130	GG-28	2. **Putting on/taking off footwear:** Mrs. F was admitted to the SNF for a neurologic condition and experiences visual impairment and fine motor coordination and endurance issues. She requires setup for retrieving her socks and shoes, which she prefers to keep in the closet. Mrs. F often drops her shoes and socks as she attempts to put them onto her feet or as she takes them off. Often a certified nursing assistant must first thread her socks or shoes over her toes, and then Mrs. F can complete the task. Mrs. F needs the certified nursing assistant to initiate taking off her socks and unstrapping the Velcro used for fastening her shoes. **Coding:** GG0130H would be coded ~~03, Partial/moderate assistance~~02, Substantial/maximal assistance.
3	GG0170	GG-34	GG0170: Mobility (3-day assessment period) Interim Performance (Interim Payment Assessment - Optional) **GG0170. Mobility** (Assessment period is the last 3 days) **Code the resident's usual performance for each activity using the 6-point scale. If an activity was not attempted, code the reason.** **Coding:** **Safety** and **Quality of Performance** - If helper assistance is required because resident's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activities may be completed with or without assistive devices.* 06. **Independent** - Resident completes the activity by him/herself with no assistance from a helper. 05. **Setup or clean-up assistance** - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. 04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. 03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. 02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01. **Dependent** - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. **If activity was not attempted, code reason:** 07. **Resident refused** 09. **Not applicable** - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury. 10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints) 88. **Not attempted due to medical condition or safety concerns** **5. Interim Performance** **Enter Codes in Boxes** ☐☐ **B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed. ☐☐ **C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support. ☐☐ **D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. ☐☐ **E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair). ☐☐ **F. Toilet transfer:** The ability to get on and off a toilet or commode. ☐☐ **I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If interim performance is coded 07, 09, 10, or 88 → Skip to H0100C, Appliances ☐☐ **J. Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns. ☐☐ **K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Track Changes
from Chapter 3 Section GG v1.16
to Chapter 3 Section GG v1.17.1

Chapter	Section	Page	Change
3	GG0170	GG-37	1. Assess the resident's mobility performance based on direct observation, ~~as well as the resident's~~incorporating resident self-~~report and the~~ reports ~~of~~and reports from qualified clinicians, ~~direct~~ care staff, or family documented in the resident's medical record during the three-day assessment period. CMS anticipates that a multidisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period. For Section GG, the assessment period is the first three days of the Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay. On admission, these items are completed only when A0310B = 01 (5-Day PPS assessment). For the Interim Payment Assessment (A0310B=08), the assessment period for Section GG is the last 3 days (i.e., the ARD and two days prior).
3	GG0170	GG-37	5. The admission functional assessment, when possible, should be conducted prior to the ~~person~~resident benefitting from treatment interventions in order to ~~determine a~~reflect the resident's true admission baseline functional status ~~on admission~~. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.
3	GG0170	GG-38	• **Code 04, Supervision or touching assistance:** if the helper provides verbal cues or touching/steadying/contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete the activity; or resident may require only incidental help such as contact guard or steadying assistance during the activity.
3	GG0170	GG-37–GG-67	Continued page title revised. GG0170: Mobility (3-day assessment period) Admission/Interim/Discharge (Start/Interim/End of Medicare Part A Stay) (cont.)

Track Changes
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to Chapter 3 Section GG v1.17.1

Chapter	Section	Page	Change
3	GG0170	GG-38	**Admission, Interim, or Discharge Performance Coding Instructions**
3	GG0170	GG-38	• For additional information on coding the resident's performance on the assessment instrument, refer to the Decision Tree on page GG-12.
3	GG0170	GG-39	**Admission, Interim, or Discharge Performance Coding Tips**
3	GG0170	GG-39	• **Interim Performance (Optional):** The Interim Payment Assessment (IPA) is an optional assessment that may be completed by providers in order to report a change in the resident's PDPM classification. For Section GG on the IPA, providers will use the same 6-point scale and activity not attempted codes to complete the column "Interim Performance," which will capture the interim functional performance of the resident. The ARD for the IPA is determined by the provider, and the assessment period is the last 3 days (i.e., the ARD and the 2 calendar days prior). It is important to note that the IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed. The IPA does not affect the variable per diem schedule.
3	GG0170	GG-40	**Admission, Interim, and Discharge Performance Coding Tips**
3	GG0170	GG-40	**General Coding Tips** • When reviewing the medical record, interviewing staff, and observing the resident, be familiar with the definition for each activity. For example, when assessing GG0170J, Walk 50 feet with two turns, determine the type and amount of assistance required as the resident walks 50 feet and negotiates two turns.
3	GG0170	GG-41	**Examples and Coding Tips for Admission, Interim, or Discharge Performance**

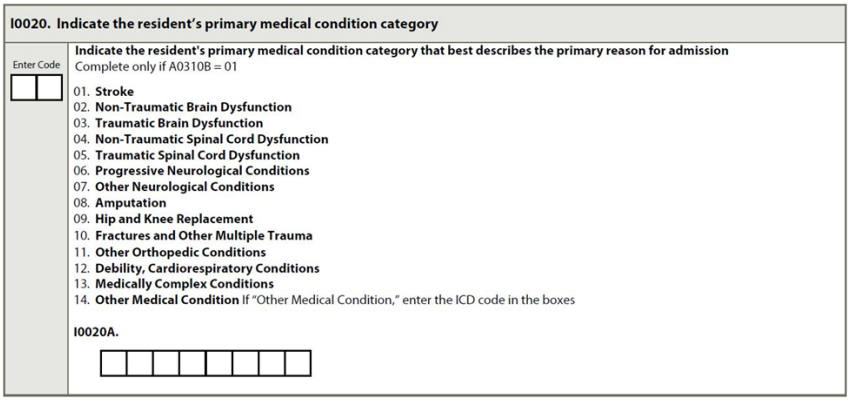
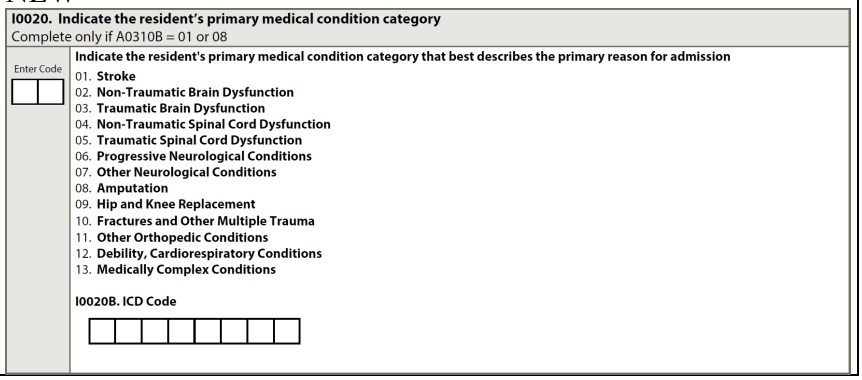
Track Changes
from Chapter 3 Section GG v1.16
to Chapter 3 Section GG v1.17.1

Chapter	Section	Page	Change
3	GG0170	GG-48	5. **Chair/bed-to-chair transfer:** Mr. U had his left lower leg amputated due to gangrene associated with his diabetes mellitus and he has reduced sensation and strength in his right leg. He has not yet received his below-the-knee prosthesis. Mr. U uses a transfer board for chair/bed-to-chair transfers. The therapist places the transfer board under his buttock. Mr. U then attempts to scoot from the bed onto the transfer board. Mr. U has reduced sensation in his hands and limited upper body strength, but assists with the transfer. The physical therapist assists him in side scooting by lifting his buttocks/trunk in a rocking motion across the transfer board and into the wheelchair.
3	GG0170	GG-51	**Coding Tips for GG0170G, Car transfer** • For item GG0170G, Car transfer, use of an indoor car can be used to simulate outdoor car transfers. These half or full cars would need to have similar physical features of a real car for the purpose of simulating a car transfer, that is, a car seat within a car cabin. • The Car transfer item does not include transfers into the driver's seat, opening/closing the car door, fastening/unfastening the seat belt. The Car transfer item includes the resident's ability to transfer in and out of the passenger seat of a car or car simulator. • In the event of inclement weather or if an indoor car simulator or outdoor car is not available during the entire 3-day assessment period, then use code 10, Not attempted due to environmental limitations. • If at the time of the assessment the resident is unable to attempt car transfers, and could not perform the car transfers prior to the current illness, exacerbation or injury, code 09, Not applicable.
3	GG0170	GG-53	4. **Walk 10 feet:** Mr. O has bilateral upper extremity tremors, lower extremity weakness, and Parkinson's disease. A ~~therapy~~physical therapist assistant guides and steadies the shaking, rolling walker forward while cueing Mr. O to take larger steps. Mr. O requires steadying at the beginning of the walk and progressively requires some of his weight to be supported for the last two feet of the 10-foot walk.

Track Changes
from Chapter 3 Section GG v1.16
to Chapter 3 Section GG v1.17.1

Chapter	Section	Page	Change
3	GG0170	GG-54	4. **Walk 50 feet with two turns:** Mr. T walks 50 feet with the therapist providing trunk support ~~and the therapy assistant providing supervision~~. He also requires a second helper, the rehabilitation aide, who provides supervision and follows closely behind with a wheelchair for safety. Mr. T walks the 50 feet with two turns with the assistance of two helpers.
3	GG0170	GG-57	• If the resident walks and is not learning how to mobilize in a wheelchair, and only uses a wheelchair for transport between locations within the facility or for staff convenience (e.g., because the resident walks slowly), code the wheelchair gateway items at admission and/or discharge—GG0170Q1 and/or GG0170Q3, Does the resident use a wheelchair/scooter?—as 0, No, and skip all remaining wheelchair questions.
3	GG0170	GG-58	3. **Wheel 50 feet with two turns:** Mr. R is very motivated to use his motorized wheelchair with an adaptive throttle for speed and steering. Mr. R has amyotrophic lateral sclerosis, and moving his upper and lower extremities is very difficult. The ~~therapy~~physical therapist assistant is required to walk next to Mr. R for frequent readjustments of his hand position to better control the steering and speed throttle. Mr. R often drives too close to corners, becoming stuck near doorways upon turning, preventing him from continuing to mobilize/wheel himself. The ~~therapy~~physical therapist assistant backs up Mr. R's wheelchair for him so that he may continue mobilizing/wheeling himself.
3	GG0170	GG-59	5. **Wheel 50 feet with two turns:** Mr. V had a spinal tumor resulting in paralysis of his lower extremities. The ~~therapy~~physical therapist assistant provides verbal instruction for Mr. V to navigate his manual wheelchair in his room and into the hallway while making two turns.
3	GG0170	GG-61	9. **Wheel 150 feet:** Mr. A has a cardiac condition with medical precautions that do not allow him to ~~participate in~~propel his own wheelchair ~~mobilization~~. Mr. A is completely dependent on a helper to wheel him 150 feet using a manual wheelchair.

Track Changes
from Chapter 3 Section I v1.16
to Chapter 3 Section I v1.17.1

Chapter	Section	Page	Change
3	I0020– I8000	I-1– I-15	Page length changed due to revised content.
3	I0020	I-1	Replaced screenshot. OLD  NEW 

Track Changes
from Chapter 3 Section I v1.16
to Chapter 3 Section I v1.17.1

Chapter	Section	Page	Change
3	I0020	I-1	**Planning for Care** • ~~This item identifies the primary medical condition category that resulted in the resident's admission to the facility and that influences the resident's functional outcomes~~Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay. **Steps for Assessment** 1. ~~Review the documentation in the medical record to identify the resident's primary medical condition associated with admission to the SNF facility~~Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay. Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.
3	I0020	I-2	***Complete only if A0310B = 01 or 8*** • ~~Enter the code that represents the primary medical condition that resulted in the resident's admission~~ Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay; then proceed to I0020B and enter the International Classification of Diseases (ICD) code for that condition, including the decimal. ~~If codes 1–13 do not apply, use code 14, "Other Medical Condition," and proceed to I0020A.~~ • While certain conditions described below represent acute diagnoses, SNFs should not use acute diagnosis codes in I0020B. Sequelae and other such codes should be used instead.
3	I0020	I-3	~~**Code 14, Other Medical Condition,** if the resident's primary medical condition category is not one of the listed categories. Enter the International Classification of Diseases (ICD) code, including the decimal, in I0200A. If item I0020 is coded 1–13, do not complete I0020A.~~

Track Changes
from Chapter 3 Section I v1.16
to Chapter 3 Section I v1.17.1

Chapter	Section	Page	Change
3	I0020	I-3	1. Ms. K is a 67-year-old female with a history of Alzheimer's dementia and diabetes who is admitted after a stroke. The diagnosis of stroke, as well as the history of Alzheimer's dementia and diabetes, is documented in Ms. K's history and physical by the admitting physician. **Coding:** I0020 would be coded **01, Stroke.** I0020B would be coded as I69.051 (Hemiplegia and hemiparesis following non-traumatic subarachnoid hemorrhage). **Rationale:** The physician's history and physical documents the diagnosis stroke as the reason for Ms. K's admission. The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.
3	I0020	I-3	2. Mrs. E is an 82-year-old female who was hospitalized for a hip fracture with subsequent total hip replacement and is admitted for rehabilitation. The admitting physician documents Mrs. E's primary medical condition as total hip replacement (THR) in her medical record. The hip fracture resulting in the total hip replacement is also documented in the medical record in the discharge summary from the acute care hospital. **Coding:** I0020 would be coded **10, Fractures and Other Multiple Trauma.** I0020B would be coded as S72.062D (Displaced articular fracture of the head of the left femur). **Rationale:** Medical record documentation demonstrates that Mrs. E had a total hip replacement due to a hip fracture and required rehabilitation. Because she was admitted for rehabilitation as a result of the hip fracture and total hip replacement, Mrs. E's primary medical condition category is **10, Fractures and Other Multiple Trauma.** The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.

Track Changes
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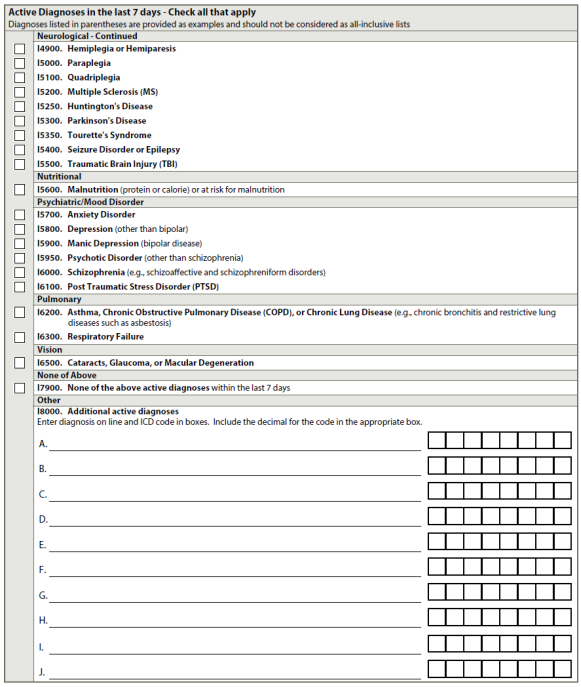
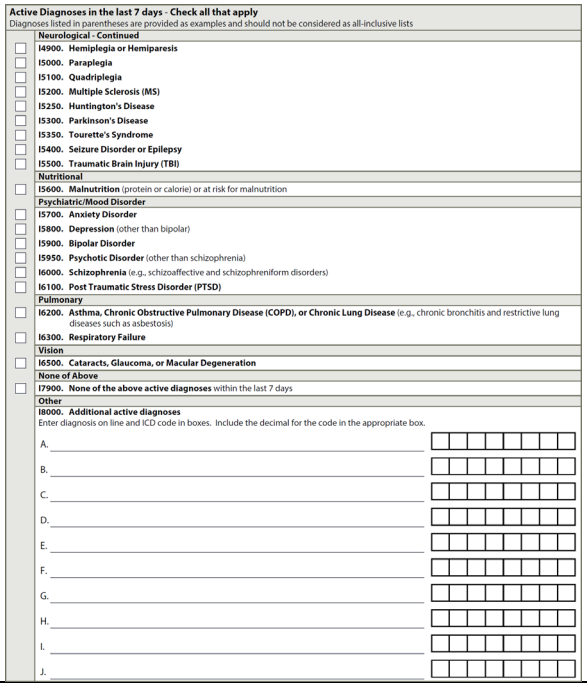
to Chapter 3 Section I v1.17.1

Chapter	Section	Page	Change
3	I0020	I-4	~~3. Mrs. H is a 93-year-old female with a history of hypertension and chronic kidney disease who is admitted to the facility, where she will complete her course of intravenous (IV) antibiotics after an acute episode of urosepsis. The discharge diagnoses of urosepsis, chronic kidney disease, and hypertension are documented in the physician's discharge summary from the acute care hospital and are incorporated into Mrs. H's medical record.~~ ~~**Coding:** I0020 would be coded **13, Medically Complex Conditions.**~~ ~~**Rationale:** The physician's discharge summary from the acute care hospital documents the need for IV antibiotics due to urosepsis as the reason for Mrs. H's admission to the facility.~~
3	I0020	I-4	3. Mrs. H is a 78-year-old female with a history of hypertension and a hip replacement 2 years ago. She was admitted to an extended hospitalization for idiopathic pancreatitis. She had a central line placed during the hospitalization so she could receive TPN (total parenteral nutrition). She also received regular blood glucose monitoring and treatment with insulin when she became hyperglycemic. During her SNF stay, she is being transitioned from being NPO (nothing by mouth) and receiving her nutrition parenterally to being able to tolerate oral nutrition. The hospital discharge diagnoses of idiopathic pancreatitis, hypertension, and malnutrition were incorporated into Mrs. H's SNF medical record. **Coding:** I0020 would be coded **13, Medically Complex Conditions.** I0020B would be coded as K85.00 (Idiopathic acute pancreatitis without necrosis or infection). **Rationale:** Mrs. H had hospital care for pancreatitis immediately prior to her SNF stay. Her principal diagnosis of pancreatitis was included in the summary from the hospital. The surgical placement of her central line does not change her care to a surgical category because it is not considered to be a major surgery. The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.

Track Changes
from Chapter 3 Section I v1.16
to Chapter 3 Section I v1.17.1

Chapter	Section	Page	Change
3	I4900–I8000	I-6	Replaced screenshot. OLD  NEW 

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Neurological - Continued
- I4900. **Hemiplegia or Hemiparesis**
- I5000. **Paraplegia**
- I5100. **Quadriplegia**
- I5200. **Multiple Sclerosis (MS)**
- I5250. **Huntington's Disease**
- I5300. **Parkinson's Disease**
- I5350. **Tourette's Syndrome**
- I5400. **Seizure Disorder or Epilepsy**
- I5500. **Traumatic Brain Injury (TBI)**

Nutritional
- I5600. **Malnutrition** (protein or calorie) or at risk for malnutrition

Psychiatric/Mood Disorder
- I5700. **Anxiety Disorder**
- I5800. **Depression** (other than bipolar)
- I5900. **Manic Depression** (bipolar disease)
- I5950. **Psychotic Disorder** (other than schizophrenia)
- I6000. **Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
- I6100. **Post Traumatic Stress Disorder (PTSD)**

Pulmonary
- I6200. **Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
- I6300. **Respiratory Failure**

Vision
- I6500. **Cataracts, Glaucoma, or Macular Degeneration**

None of Above
- I7900. **None of the above active diagnoses** within the last 7 days

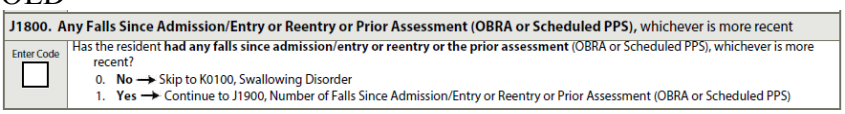
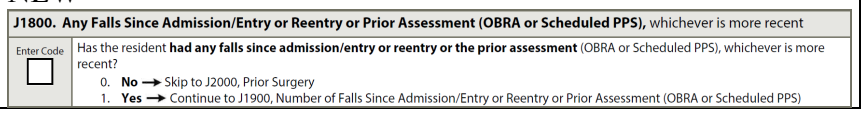
Other
I8000. **Additional active diagnoses**
Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

A. _____
B. _____
C. _____
D. _____
E. _____
F. _____
G. _____
H. _____
I. _____
J. _____

Track Changes
from Chapter 3 Section I v1.16
to Chapter 3 Section I v1.17.1

Chapter	Section	Page	Change
3	I4900–I8000	I-8	• Item I2300 UTI, has specific coding criteria and does not use the active 7-day look-back. Please refer to Page I-~~8~~12 for specific coding instructions for Item I2300 UTI. • Check the following information sources in the medical record for the last 7 days to identify "active" diagnoses: transfer documents, physician progress notes, recent history and physical, recent discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor's orders, consults and official diagnostic reports, and other sources as available. **Coding Instructions** *Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period (except Item I2300 UTI, which does not use the active diagnosis 7-day look-back. Please refer to Item I2300 UTI, Page I-~~8~~12 for specific coding instructions).*
3	I5900	I-11	• **I5900,** ~~manic depression (~~bipolar disorder~~disease)~~

Track Changes
from Chapter 3 Section J v1.16R
to Chapter 3 Section J v1.17.1

Chapter	Section	Page	Change
3	J	J-1	**Intent:** The intent of the items in this section is to document a number of health conditions that impact the resident's functional status and quality of life. The items include an assessment of pain which uses an interview with the resident or staff if the resident is unable to participate. The pain items assess the presence of pain, pain frequency, effect on function, intensity, management and control. Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, ~~and~~ falls, prior surgery, and surgery requiring active SNF care.
3	J0200	J-5	• ~~There is one exception to completing the Staff Assessment for Pain items (J0800–J0850) in place of the resident interview. This exception is specific to a stand-alone, unscheduled Prospective Payment System (PPS) assessment only and is discussed on page 2-60. For this type of assessment only, the resident interview may be conducted up to two calendar days after the ARD.~~ • ~~When coding a stand-alone Change of Therapy OMRA (COT), a stand-alone End of Therapy OMRA (EOT), or a stand-alone Start of Therapy OMRA (SOT), the interview items may be coded using the responses provided by the resident on a previous assessment **only** if the DATE of the interview responses from the previous assessment (as documented in item Z0400) was obtained no more than 14 days prior to the DATE of completion for the interview items on the unscheduled assessment (as documented in item Z0400) for which those responses will be used.~~
3	J1800	J-30	Replaced screenshot. OLD  **J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS),** whichever is more recent Enter Code ☐ Has the resident **had any falls since admission/entry or reentry or the prior assessment** (OBRA or Scheduled PPS), whichever is more recent? 0. **No** → Skip to K0100, Swallowing Disorder 1. **Yes** → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) NEW  **J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS),** whichever is more recent Enter Code ☐ Has the resident **had any falls since admission/entry or reentry or the prior assessment** (OBRA or Scheduled PPS), whichever is more recent? 0. **No** → Skip to J2000, Prior Surgery 1. **Yes** → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

Track Changes
from Chapter 3 Section J v1.16R
to Chapter 3 Section J v1.17.1

Chapter	Section	Page	Change
3	J1800	J-31	• **Code 0, no:** if the resident has not had any fall since the last assessment. Skip to **Swallowing Disorder** item (K0100) if the assessment being completed is an OBRA assessment. If the assessment being completed is a Scheduled PPS assessment, skip to **Prior Surgery** item (J2000).
3	J1900	J-34	**Coding Tip** • If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system, the assessment must be modified to update the level of injury that occurred with that fall.
3	J1900	J-34	**Examples** 1. A nursing note states that Mrs. K. slipped out of her wheelchair onto the floor while at the dining room table. Before being assisted back into her chair, a~~n~~ range of motion assessment was completed that indicated no injury. A skin assessment conducted shortly after the fall also revealed no injury.
3	J1900	J-35	5. Mr. R. fell on his right hip in the facility on the ARD of his Quarterly MDS and complained of mild right hip pain. The initial x-ray of the hip did not show any injury. The nurse completed Mr. R's Quarterly assessment and coded the assessment to reflect this information. The assessment was submitted to QIES ASAP. Three days later, Mr. R. complained of increasing pain and had difficulty ambulating, so a follow-up x-ray was done. The follow-up x-ray showed a hairline fracture of the right hip. This injury is noted by the physician to be attributed to the recent fall that occurred during the look-back period of the Quarterly assessment. **Original Coding:** J1900B, Injury (except major) ~~was~~is **coded 1, one** and J1900C, Major Injury is **coded 0, none**.

Track Changes
from Chapter 3 Section J v1.16R
to Chapter 3 Section J v1.17.1

Chapter	Section	Page	Change
3	J2000	J-36	**Planning for Care** • This item identifies whether the resident has had major surgery during the 100 days prior to ~~admission~~the start of the Medicare Part A stay. A recent history of major surgery can affect a resident's recovery.
3	J2100	J-37	**J2100: Recent Surgery Requiring Active SNF Care** **J2100. Recent Surgery Requiring Active SNF Care** - Complete only if A0310B = 01 or 08 Enter Code ☐ Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay? 0. **No** 1. **Yes** 8. **Unknown**
3	J2100	J-37	**Item Rationale** **Health-related Quality of Life** • A recent history of major surgery during the inpatient stay that preceded the resident's Part A admission can affect a resident's recovery. **Planning for Care** • This item identifies whether the resident had major surgery during the inpatient stay that immediately preceded the resident's Part A admission. A recent history of major surgery can affect a resident's recovery.

Track Changes
from Chapter 3 Section J v1.16R
to Chapter 3 Section J v1.17.1

Chapter	Section	Page	Change
3	J2100	J-38	**J2100: Recent Surgery Requiring Active SNF Care (cont.)** **Steps for Assessment** 1. Ask the resident and his or her family or significant other about any surgical procedures that occurred during the inpatient hospital stay that immediately preceded the resident's Part A admission. 2. Review the resident's medical record to determine whether the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission. Medical record sources include medical records received from facilities where the resident received health care during the inpatient hospital stay that immediately preceded the resident's Part A admission, the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.
3	J2100	J-38	**Coding Instructions** • **Code 0, No:** if the resident did not have major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission. • **Code 1, Yes:** if the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission. • **Code 8, Unknown:** if it is unknown or cannot be determined whether the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission. **Coding Tips** • Generally, major surgery for item J2100 refers to a procedure that meets the following criteria: 1. the resident was an inpatient in an acute care hospital for at least one day in the 30 days prior to admission to the skilled nursing facility (SNF), **and** 2. the surgery carried some degree of risk to the resident's life or the potential for severe disability.

Track Changes
from Chapter 3 Section J v1.16R
to Chapter 3 Section J v1.17.1

Chapter	Section	Page	Change
3	J2300–J5000	J-39	J2300 – J5000: Recent Surgeries Requiring Active SNF Care
3	J2300–J5000	J-39	**Item Rationale** **Health-related Quality of Life** • A recent history of major surgery during the inpatient stay that preceded the resident's Part A admission can affect a resident's recovery. **Planning for Care** • This item identifies whether the resident had major surgery during the inpatient stay that immediately preceded the resident's Part A admission. A recent history of major surgery can affect a resident's recovery.

Surgical Procedures - Complete only if J2100 = 1

Check all that apply

Major Joint Replacement
- ☐ **J2300. Knee Replacement** - partial or total
- ☐ **J2310. Hip Replacement** - partial or total
- ☐ **J2320. Ankle Replacement** - partial or total
- ☐ **J2330. Shoulder Replacement** - partial or total

Spinal Surgery
- ☐ **J2400. Involving the spinal cord or major spinal nerves**
- ☐ **J2410. Involving fusion of spinal bones**
- ☐ **J2420. Involving lamina, discs, or facets**
- ☐ **J2499. Other major spinal surgery**

Other Orthopedic Surgery
- ☐ **J2500. Repair fractures of the shoulder** (including clavicle and scapula) **or arm** (but not hand)
- ☐ **J2510. Repair fractures of the pelvis, hip, leg, knee, or ankle** (not foot)
- ☐ **J2520. Repair but not replace joints**
- ☐ **J2530. Repair other bones** (such as hand, foot, jaw)
- ☐ **J2599. Other major orthopedic surgery**

Neurological Surgery
- ☐ **J2600. Involving the brain, surrounding tissue or blood vessels** (excludes skull and skin but includes cranial nerves)
- ☐ **J2610. Involving the peripheral or autonomic nervous system** - open or percutaneous
- ☐ **J2620. Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices**
- ☐ **J2699. Other major neurological surgery**

Cardiopulmonary Surgery
- ☐ **J2700. Involving the heart or major blood vessels** - open or percutaneous procedures
- ☐ **J2710. Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords** - open or endoscopic
- ☐ **J2799. Other major cardiopulmonary surgery**

Genitourinary Surgery
- ☐ **J2800. Involving male or female organs** (such as prostate, testes, ovaries, uterus, vagina, external genitalia)
- ☐ **J2810. Involving the kidneys, ureters, adrenal glands, or bladder** - open or laparoscopic (includes creation or removal of nephrostomies or urostomies)
- ☐ **J2899. Other major genitourinary surgery**

Other Major Surgery
- ☐ **J2900. Involving tendons, ligaments, or muscles**
- ☐ **J2910. Involving the gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, or spleen** - open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hernia repair)
- ☐ **J2920. Involving the endocrine organs** (such as thyroid, parathyroid), **neck, lymph nodes, or thymus** - open
- ☐ **J2930. Involving the breast**
- ☐ **J2940. Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant**
- ☐ **J5000. Other major surgery not listed above**

Chapter	Section	Page	Change
3	J2300–J5000	J-40	**J2300 – J5000: Recent Surgeries Requiring Active SNF Care (cont.)** **Steps for Assessment** 1. **Identify recent surgeries:** The surgeries in this section must have been documented by a physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days and must have occurred during the inpatient stay that immediately preceded the resident's Part A admission. • Medical record sources for recent surgeries include progress notes, the most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available. • Although open communication regarding resident information between the physician and other members of the interdisciplinary team is important, it is also essential that resident information communicated verbally be documented in the medical record by the physician to ensure follow-up. • Surgery information, including past history obtained from family members and close contacts, must also be documented in the medical record by the physician to ensure validity and follow-up.

Track Changes
from Chapter 3 Section J v1.16R
to Chapter 3 Section J v1.17.1

Chapter	Section	Page	Change
3	J2300–J5000	J-40	2. **Determine whether the surgeries require active care during the SNF stay:** Once a recent surgery is identified, it must be determined if the surgery requires **active** care during the SNF stay**.** Surgeries requiring active care during the SNF stay are surgeries that have a **direct relationship** to the resident's primary SNF diagnosis, as coded in I0020B. • Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered surgeries that do not require active care during the SNF stay. • Check the following information sources in the medical record for the last 30 days to identify "active" surgeries: transfer documents, physician progress notes, recent history and physical, recent discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor's orders, consults and official diagnostic reports, and other sources as available.
3	J2300–J5000	J-40	**Coding Instructions** *Code surgeries that are documented to have occurred in the last 30 days, and during the inpatient stay that immediately preceded the resident's Part A admission, that have a direct relationship to the resident's primary SNF diagnosis, as coded in I0020B.* • Check off each surgery requiring active SNF care as defined above, as follows: — Surgeries are listed by major surgical category: Major Joint Replacement, Spinal Surgery, Orthopedic Surgery, Neurologic Surgery, Cardiopulmonary Surgery, Genitourinary Surgery, Other Major Surgery.

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Chapter	Section	Page	Change
3	J2300–J5000	J-41	**J2300 – J5000: Recent Surgeries Requiring Active SNF Care (cont.)** — Examples of surgeries are included for each surgical category. For example, **J2810, Genitourinary surgery - the kidneys, ureter, adrenals, and bladder—open, laparoscopic,** includes open or laparoscopic surgeries on the kidneys, ureter, adrenals, and bladder, but not other components of the genitourinary system. • Check all that apply.
3	J2300–J5000	J-41	**Major Joint Replacement** • **J2300,** Knee Replacement - partial or total • **J2310,** Hip Replacement - partial or total • **J2320,** Ankle Replacement - partial or total • **J2330,** Shoulder Replacement - partial or total **Spinal Surgery** • **J2400,** Spinal surgery - spinal cord or major spinal nerves • **J2410,** Spinal surgery - fusion of spinal bones • **J2420,** Spinal surgery - lamina, discs, or facets • **J2499,** Spinal surgery – other

Track Changes
from Chapter 3 Section J v1.16R
to Chapter 3 Section J v1.17.1

Chapter	Section	Page	Change
3	J2300–J5000	J-41	**Orthopedic Surgery** • **J2500,** Ortho surgery - repair fractures of shoulder or arm • **J2510,** Ortho surgery - repair fractures of pelvis, hip, leg, knee, or ankle • **J2520,** Ortho surgery - repair but not replace joints • **J2530,** Ortho surgery - repair other bones • **J2599,** Ortho surgery - other **Neurologic Surgery** • **J2600,** Neuro surgery - brain, surrounding tissue or blood vessels • **J2610,** Neuro surgery - peripheral and autonomic nervous system - open and percutaneous • **J2620,** Neuro surgery - insertion or removal of spinal and brain neurostimulators, electrodes, catheters, and CSF drainage devices • **J2699,** Neuro surgery – other

Chapter	Section	Page	Change
3	J2300–J5000	J-42	**J2300 – J5000: Recent Surgeries Requiring Active SNF Care (cont.)** **Cardiopulmonary Surgery** • **J2700,** Cardiopulmonary surgery - heart or major blood vessels - open and percutaneous procedures • **J2710,** Cardiopulmonary surgery - respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords - open and endoscopic • **J2799,** Cardiopulmonary surgery - other **Genitourinary Surgery** • **J2800,** Genitourinary surgery - male or female organs • **J2810,** Genitourinary surgery - the kidneys, ureter, adrenals, and bladder - open, laparoscopic • **J2899,** Genitourinary surgery – other
3	J2300–J5000	J-42	**Other Major Surgery** • **J2900,** Major surgery - tendons, ligament, or muscles • **J2910,** Major surgery - the GI tract and abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, spleen - open or laparoscopic • **J2920,** Major surgery - endocrine organs (such as thyroid, parathyroid), neck, lymph nodes, and thymus - open • **J2930,** Major surgery - the breast • **J2940,** Major surgery - repair of deep ulcers, internal brachytherapy, bone marrow, or stem cell harvest or transplant • **J5000,** Major surgery - not listed above

Chapter	Section	Page	Change
3	J2300–J5000	J-42	**Coding Tips** *The following information may assist assessors in determining whether a surgery should be coded as requiring active care during the SNF stay.* • **There may be specific documentation in the medical record by a physician, nurse practitioner, physician assistant, or clinical nurse specialist.** — The physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) may specifically indicate that the SNF stay is for treatment related to the surgical intervention. Specific documentation may be found in progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc.
3	J2300–J5000	J-43	J2300 – J5000: Recent Surgeries Requiring Active SNF Care (cont.) • **In the rare circumstance of the absence of specific documentation that a surgery requires active SNF care, the following indicators may be used to confirm that the surgery requires active SNF care:** The inherent complexity of the services prescribed for a resident is such that they can be performed safely and/or effectively only by or under the general supervision of skilled nursing. For example: — The management of a surgical wound that requires skilled care (e.g., managing potential infection or drainage). — Daily skilled therapy to restore functional loss after surgical procedures. — Administration of medication and monitoring that requires skilled nursing.

Track Changes
from Chapter 3 Section J v1.16R
to Chapter 3 Section J v1.17.1

Chapter	Section	Page	Change
3	J2300–J5000	J-43	**Examples of surgeries requiring active SNF care and related to the primary SNF diagnosis** 1. Mrs. V was hospitalized for gram-negative pneumonia. Since this was her second episode of pneumonia in the past six months, a diagnostic bronchoscopy was performed while in the hospital. She also has Parkinson's disease and rheumatoid arthritis. She was discharged to a SNF for continued antibiotic treatment for her pneumonia and requires daily skilled care. **Coding: I0020** is coded as 13, Medically Complex Conditions, and the **I0020B** SNF ICD-10 code is J15.6, Pneumonia due to other aerobic Gram-negative bacteria. There is no documentation that the resident had major surgery; therefore, **J2100** is coded 0, No. **Rationale:** Mrs. V did not receive any major surgery during the prior inpatient stay, and she was admitted to the SNF for continued care due to pneumonia.
3	J2300–J5000	J-43	2. Mrs. O, a diabetic, was hospitalized for sepsis from an infection due to Methicillin susceptible Staphylococcus aureus that developed after outpatient bunion surgery. A central line was placed to administer antibiotics. She was discharged to a SNF for continued antibiotic treatment and monitoring. **Coding: I0020** is coded as 13, Medically Complex Conditions. The **I0020B** SNF ICD-10 code is A41.01 (Sepsis due to Methicillin susceptible Staphylococcus aureus). There is no documentation that the resident had major surgery; therefore, **J2100** is coded 0, No. **Rationale:** Neither the placement of a central line nor the outpatient bunion surgery is considered to be a major surgery, but the resident was admitted to the SNF for continued antibiotic treatment and monitoring.

Track Changes
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to Chapter 3 Section J v1.17.1

Chapter	Section	Page	Change
3	J2300–J5000	J-44	3. Mrs. H was hospitalized for severe back pain from a compression fracture of a lumbar vertebral body, which was caused by her age-related osteoporosis. She was treated with a kyphoplasty that relieved her pain. She was transferred to a SNF after discharge because of her mild dementia and need to regulate her anticoagulant treatment for atrial fibrillation. **Coding: I0020** is coded 10, Fractures and Other Multiple Trauma. The **I0020B** SNF ICD-10 code is M80.08XD (Age-related osteoporosis with current pathological fracture, vertebra(e), subsequent encounter for fracture with routine healing). There was no documentation that the resident had major surgery; therefore, **J2100** is coded 0, No. **Rationale:** Mrs. H was treated with a kyphoplasty during the inpatient stay prior to SNF admission. Although kyphoplasty is a minor surgery and does not require SNF care in and of itself, the resident has other conditions requiring skilled care that are unrelated to the kyphoplasty surgery.
3	J2300–J5000	J-44	4. Mrs. J had a craniotomy to drain a subdural hematoma after suffering a fall at home. She has COPD and uses oxygen at night. In addition, she has moderate congestive heart failure, is moderately overweight, and has hypothyroidism. After a six-day hospital stay, she was discharged to a SNF for continuing care. The hospital discharge summary indicated that the patient had a loss of consciousness of 45 minutes. **Coding: I0020** is coded 07, Other Neurological Conditions. The **I0020B** SNF ICD-10 code is S06.5X2D (Traumatic subdural hemorrhage with loss of consciousness of 31 minutes to 59 minutes, subsequent encounter). **J2100** would be coded 1, Yes. **J2600**, Neuro surgery - brain, surrounding tissue or blood vessels, would be checked. **Rationale:** The craniotomy surgery during the inpatient stay immediately preceding the SNF stay requires continued skilled care and skilled monitoring for wound care, as well as therapies to address any deficits that led to her fall or any functional deficits resulting from her fall.

Chapter	Section	Page	Change
3	J2300–J5000	J-44	5. Mr. D was admitted to an acute care hospital for cytoreductive surgery for metastatic renal cell carcinoma. He was admitted to the SNF for further treatment of the metastatic renal cell carcinoma and post-surgical care. **Coding: I0020** is coded as 13, Medically Complex Conditions. The **I0020B** SNF ICD-10 code is C79.01 (Secondary malignant neoplasm of the right kidney and renal pelvis). **J2100** would be coded 1, Yes. **J2810**, Genitourinary surgery – the kidneys, ureter, adrenals, and bladder – open, laparoscopic, would be checked. **Rationale:** Mr. D was treated with a surgical procedure, genitourinary surgery of the kidney, and admitted to the SNF for further treatment of the metastatic kidney cancer and post-surgical care.
3	J2300–J5000	J-45	6. Mr. G was admitted to an acute care hospital for severe abdominal pain. He was found to have diverticulitis of the small intestine with perforation and abscess without bleeding. He had surgery to repair the perforation. He was admitted to the SNF for continued antibiotics and post-surgical care. **Coding: I0020** is coded 13, Medically Complex Conditions. The **I0020B** SNF ICD-10 code is K57.00 (Diverticulitis of small intestine with perforation and abscess without bleeding), and **J2100** would be coded 1, Yes. **J2910**, Major surgery – the GI tract and abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, spleen – open or laparoscopic, would be checked. **Rationale:** Mr. G was treated with a surgical procedure, repair of the small intestine perforation, which is a major surgical procedure. He was admitted to the SNF for continued antibiotics and post-surgical care.

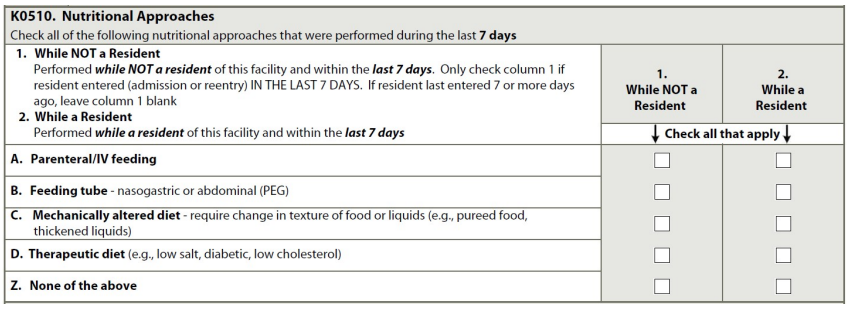
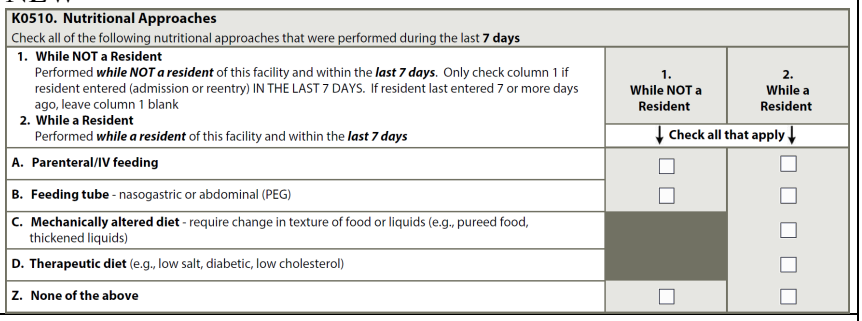
Track Changes
from Chapter 3 Section J v1.16R
to Chapter 3 Section J v1.17.1

Chapter	Section	Page	Change
3	J2300–J5000	J-45	7. Mr. W underwent surgical repair for a left fractured hip (i.e., subtrochanteric fracture) during an inpatient hospitalization. He was admitted to the SNF for post-surgical care. **Coding: I0020** is coded as Code 10, Fractures and Other Multiple Trauma. The **I0020B** SNF ICD-10 code is S72.22XD (Displaced subtrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing) and **J2100** is coded as 1, Yes. **J2510**, Ortho surgery – repair fractures of pelvis, hip, leg, knee, or ankle, would be checked. **Rationale:** This is major surgery requiring skilled nursing care to provide wound care and to monitor for early signs of infection or blood clots, for which Mr. W was admitted to the SNF.

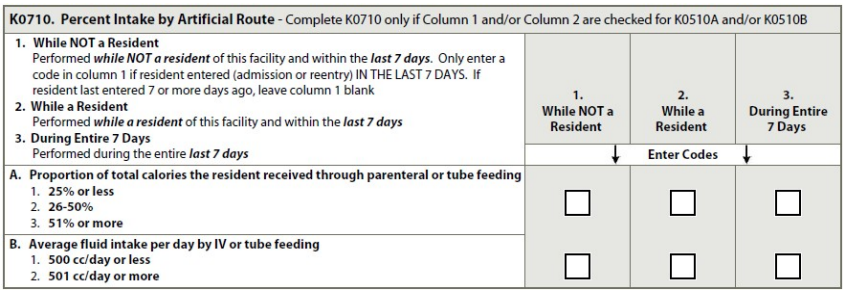
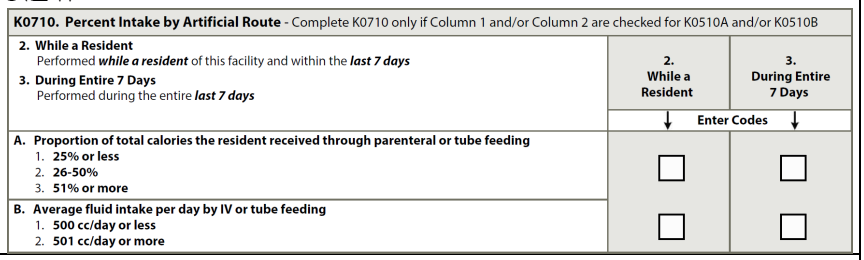
Track Changes
from Chapter 3 Section K v1.16
to Chapter 3 Section K v1.17.1

Chapter	Section	Page	Change
3	K0300	K-4	**Planning for Care** • Weight loss may be an important indicator of a change in the resident's health status or environment. • If significant weight loss is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medication (e.g., diuretics), or changed fluid volume status. • Weight ~~loss~~ should be monitored on a continuing basis; weight loss should be assessed and care planned at the time of detection and not delayed until the next MDS assessment.
3	K0310	K-8	**Planning for Care** • Weight gain may be an important indicator of a change in the resident's health status or environment. • If significant weight gain is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medication (e.g., steroidals), or changed fluid volume status. • Weight ~~gain~~ should be monitored on a continuing basis; weight gain should be assessed and care planned at the time of detection and not delayed until the next MDS assessment.

Track Changes
from Chapter 3 Section K v1.16
to Chapter 3 Section K v1.17.1

Chapter	Section	Page	Change
3	K0510	K-10	Replaced screenshot. OLD  NEW 
3	K0510	K-11	**Coding Instructions for Column 1** • ~~**CMS does not require completion of Column 1 for items K0510C and K0510D; however, some States continue to require its completion. It is important to know your State's requirements for completing these items.**~~ • Check all nutritional approaches performed **prior** to admission/entry or reentry to the facility and within the 7-day look-back period. Leave Column 1 blank if the resident was admitted/entered or reentered the facility more than 7 days ago. • ~~If the State does not require the completion of Column 1 for items K0510C and K0510D, use the standard "no information" code (a dash, " ").~~
3	K0510	K-11	• When completing the Interim Payment Assessment (IPA), the completion of items K0510A, K0510B, and K0510Z will still be required.

Track Changes
from Chapter 3 Section K v1.16
to Chapter 3 Section K v1.17.1

Chapter	Section	Page	Change
3	K0710	K-13	Replaced screenshot. OLD  NEW 
3	K0710	K-13	~~**CMS does not require completion of Column 1. While Not a Resident for items K0710A and K0710B; however, some States continue to require its completion. It is important to know your State's requirements for completing these items.**~~
3	K0710	K-14	**Coding Instructions** • Select the best response: 1. 25% or less 2. 26% to 50% 3. 51% or more • ~~If the State does not require the completion of Column 1 for this item, use the standard "no information" code (a dash, " ").~~
3	K0710	K-16	• ~~If the State does not require the completion of Column 1 for this item, use the standard "no information" code (a dash, " ").~~

Track Changes
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to Chapter 3 Section K v1.17.1

<table>
<tr><th>Chapter</th><th>Section</th><th>Page</th><th>Change</th></tr>
<tr><td>3</td><td>K0710</td><td>K-16</td><td>~~2. Calculation for Average Daily Fluid Intake~~

~~Mrs. G. received 1 liter of IV fluids in the hospital on the Tuesday prior to her admission to the nursing home on Saturday afternoon. She received no other intake via IV or tube feeding during the last 7 days.~~

<table><tr><th colspan="2">~~IV Fluid Intake~~</th></tr><tr><td>~~Sun.~~</td><td>~~0 cc~~</td></tr><tr><td>~~Mon.~~</td><td>~~0 cc~~</td></tr><tr><td>~~Tues.~~</td><td>~~1,000 cc~~</td></tr><tr><td>~~Wed.~~</td><td>~~0 cc~~</td></tr><tr><td>~~Thurs.~~</td><td>~~0 cc~~</td></tr><tr><td>~~Fri.~~</td><td>~~0 cc~~</td></tr><tr><td>~~Sat.~~</td><td>~~0 cc~~</td></tr><tr><td>~~Total~~</td><td>~~1,000 cc~~</td></tr></table>
~~**Coding:** K0710B column 1 would be coded **1, 500 cc/day or less**.~~
~~**Rationale:** The total fluid intake by supplemental tube feedings = 1000 cc~~
~~1000 cc divided by 7 days = 142.9 cc/day~~
~~142.9 cc is less than 500 cc, therefore **code 1, 500 cc/day or less** is correct.~~</td></tr>
<tr><td>3</td><td>K0710</td><td>K-16</td><td>~~3~~2. Mr. K. has been able to take some fluids orally; however, due to his progressing multiple sclerosis, his dysphagia is not allowing him to remain hydrated enough. Therefore, he received the following fluid amounts over the last 7 days via supplemental tube feedings while in the hospital and after he was admitted to the nursing home.

<table><tr><th colspan="2">While in the Hospital</th><th colspan="2">While in the Nursing Home</th></tr><tr><td>Mon.</td><td>400 cc</td><td>Fri.</td><td>510 cc</td></tr><tr><td>Tues.</td><td>520 cc</td><td>Sat.</td><td>520 cc</td></tr><tr><td>Wed.</td><td>500 cc</td><td>Sun.</td><td>490 cc</td></tr><tr><td>Thurs.</td><td>480 cc</td><td></td><td></td></tr><tr><td>Total</td><td>1,900 cc</td><td>Total</td><td>1,520 cc</td></tr></table></td></tr>
</table>

Track Changes
from Chapter 3 Section K v1.16
to Chapter 3 Section K v1.17.1

Chapter	Section	Page	Change
3	K0710	K-17	**Coding:** ~~K0710B1 would be coded 1, 500 cc/day or less.~~ K0710B2 would be coded 2, 501 cc/day or more, and K0710B3 would be coded 1, 500 cc/day or less. **Rationale:** ~~The total fluid intake within the last 7 days while Mr. K. was not a resident was 1,900 cc (400 cc + 520 cc + 500 cc + 480 cc = 1,900 cc). Average fluid intake while not a resident totaled 475 cc (1,900 cc divided by 4 days). 475 cc is less than 500 cc, therefore **code 1, 500 cc/day or less is correct for K0710B1, While NOT a Resident**.~~

Track Changes
from Chapter 3 Section M v1.16
to Chapter 3 Section M v1.17.1

Chapter	Section	Page	Change
3	M0300C	M-14	**DEFINITION** **STAGE 3 PRESSURE ULCER** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling (see definition of undermining and tunneling on page M-1~~7~~9).
3	M1030	M-27	**Coding Instructions** ~~*Check all that apply in the last 7 days.*~~ *Pressure ulcers coded in M0210 through M0300 should not be coded here.*
3	—	M-39	**Example M0100-M1200** 1. Mrs. P was admitted to the nursing home on 10/23/201~~0~~9 for a Medicare stay. In completing the PPS 5-day assessment (ARD of 10/28/2019), it was noted that the resident had a head-to-toe skin assessment and her skin was intact, but upon assessment using the Braden scale, was found to be at risk for skin breakdown. ~~On the 14-day PPS (ARD of 11/5/2010),~~ ~~t~~The resident was noted to have a Stage 2 pressure ulcer that was identified on her coccyx on 11/1/201~~0~~9. This Stage 2 pressure ulcer was noted to have pink tissue with some epithelialization present in the wound bed. Dimensions of the ulcer were length 01.1 cm, width 00.5 cm, and no measurable depth. Mrs. P does not have any arterial or venous ulcers, wounds, or skin problems. She is receiving ulcer care with application of a dressing applied to the coccygeal ulcer. Mrs. P. also has pressure reducing devices on both her bed and chair and has been placed on a 1½ hour turning and repositioning schedule per tissue tolerance. In order to stay closer to her family, Mrs. P was discharged to another nursing home on 11/5/2019. This was a planned discharge (A0310G = 2), and her OBRA Discharge assessment was coded at A0310F as 10, Discharge assessment – return not anticipated. **5-Day PPS ~~#1~~:**

Track Changes
from Chapter 3 Section M v1.16
to Chapter 3 Section M v1.17.1

Chapter	Section	Page	Change
3	—	M-40	Deleted following screenshots:

M1030. Number of Venous and Arterial Ulcers

Enter Number	
0	**Enter the total number of venous and arterial ulcers present**

M1040. Other Ulcers, Wounds and Skin Problems

↓ **Check all that apply**

	Foot Problems
☐	**A. Infection of the foot** (e.g., cellulitis, purulent drainage)
☐	**B. Diabetic foot ulcer(s)**
☐	**C. Other open lesion(s) on the foot**
	Other Problems
☐	**D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
☐	**E. Surgical wound(s)**
☐	**F. Burn(s)** (second or third degree)
☐	**G. Skin tear(s)**
☐	**H. Moisture Associated Skin Damage (MASD)** (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
	None of the Above
☒	**Z. None of the above** were present

M1200. Skin and Ulcer/Injury Treatments

↓ **Check all that apply**

☐	**A. Pressure reducing device for chair**
☐	**B. Pressure reducing device for bed**
☐	**C. Turning/repositioning program**
☐	**D. Nutrition or hydration intervention** to manage skin problems
☐	**E. Pressure ulcer/injury care**
☐	**F. Surgical wound care**
☐	**G. Application of nonsurgical dressings** (with or without topical medications) other than to feet
☐	**H. Applications of ointments/medications** other than to feet
☐	**I. Application of dressings to feet** (with or without topical medications)
☒	**Z. None of the above** were provided

Track Changes
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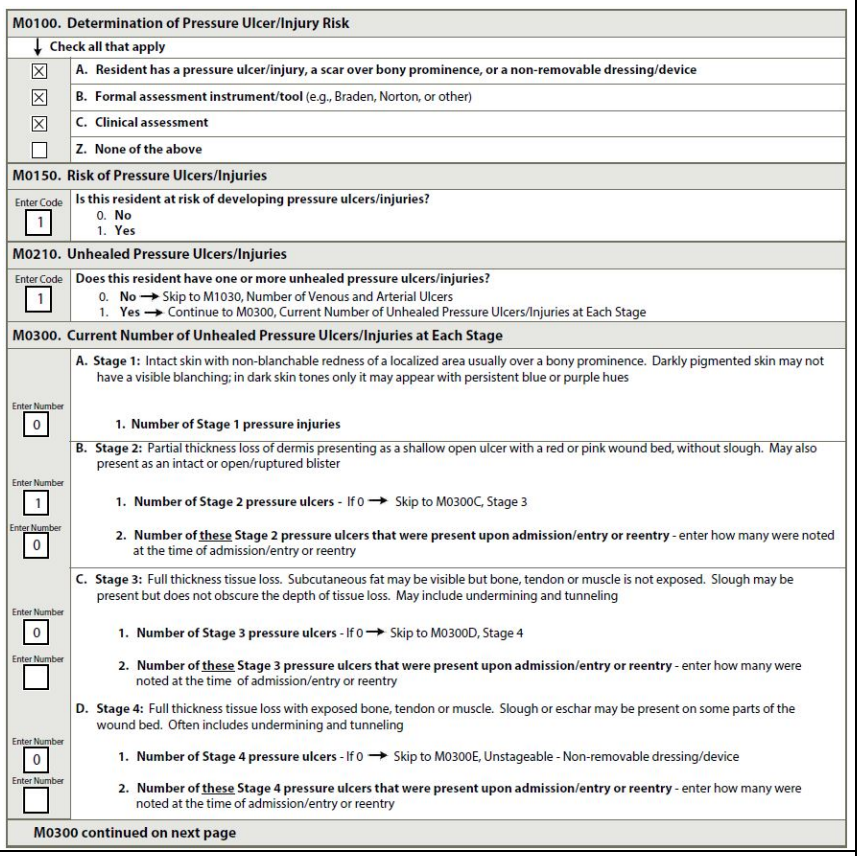
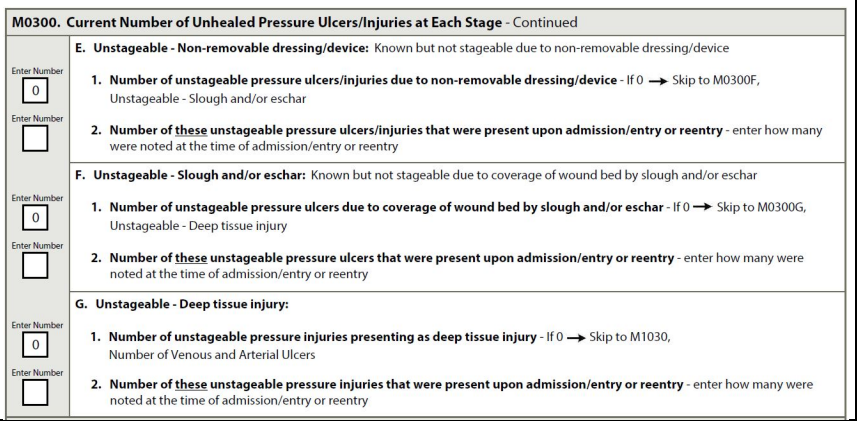
to Chapter 3 Section M v1.17.1

Chapter	Section	Page	Change
3	—	M-40	**~~14-Day PPS~~Discharge Assessment:** **Coding:** • **M0100A** (Resident has a pressure ulcer/injury, a scar over bony prominence, or a non- removable dressing/device), Check box. • ~~**M0100B** (Formal assessment instrument), Check box.~~ • ~~**M0100C** (Clinical assessment), Check box.~~ • ~~**M0150** (Risk of Pressure Ulcers/Injuries), Code 1.~~ • **M0210** (~~One or more u~~Unhealed ~~p~~Pressure ~~u~~Ulcers/~~i~~Injuries), Code 1. • ~~**M0300A** (Number of Stage 1 pressure ulcers), Code 0.~~ • **M0300B1** (Number of Stage 2 pressure ulcers), Code 1. • **M0300B2** (Number of these Stage 2 pressure ulcers present on admission/entry or reentry), Code 0. • **M0300C1** (Number of Stage 3 pressure ulcers), Code 0 and skip to M0300D (Stage 4). • **M0300D1** (Number of Stage 4 pressure ulcers), Code 0 and skip to M0300E (Unstageable – Non-removable dressing/device). • **M0300E1** (Unstageable – Non-removable dressing/device), Code 0 and skip to M0300F (Unstageable – Slough and/or eschar). • **M0300F1** (Unstageable – Slough and/or eschar), Code 0 and skip to M0300G (Unstageable – Deep tissue injury). • **M0300G1** (Unstageable – Deep tissue injury), Code 0 and skip to M1030 (Number of Venous and Arterial Ulcers). • ~~**M1030** (Number of Venous and Arterial Ulcers), Code 0.~~ • ~~**M1040** (Other Ulcers, Wounds and Skin Problems), Check Z (None of the above).~~ • ~~**M1200A** (Pressure reducing device for chair), **M1200B** (Pressure reducing device for bed), **M1200C** (Turning/repositioning program), and **M1200E** (Pressure ulcer/injury care) are all checked.~~

Chapter	Section	Page	Change
3	—	M-40	**Rationale:** The resident ~~had a formal assessment using the Braden scale and also had a head-to-toe skin assessment completed. Pressure ulcer risk was identified via formal assessment.~~has a pressure ulcer. On the 5-day PPS assessment, the resident's skin was noted to be intact; however, on the ~~14-day PPS~~Discharge assessment, it was noted that the resident had a new Stage 2 pressure ulcer. Since the resident has had both a 5-day PPS and ~~14-day PPS~~Discharge assessment completed, the ~~14-day PPS~~Discharge assessment would be coded 0 at A0310E. This is because the ~~14-day PPS~~Discharge assessment is **not** the first assessment since the most recent admission/entry or reentry. ~~There were no other skin problems noted. However, the resident, since she is at an even higher risk of breakdown since the development of a new ulcer, had preventative measures put in place, with pressure reducing devices for her chair and bed. She was also placed on a turning and repositioning program based on tissue tolerance. Therefore, items M1200A, M1200B, and M1200C were all checked. She also now requires ulcer care and application of a dressing to the coccygeal ulcer, so M1200E is also checked. M1200G (Application of nonsurgical dressings [with or without topical medications]) would **not** be coded here because **any** intervention for treating pressure ulcers is coded in M1200E (Pressure ulcer/injury care).~~

Track Changes
from Chapter 3 Section M v1.16
to Chapter 3 Section M v1.17.1

Chapter	Section	Page	Change
3	—	M-40	Deleted following screenshot: 
3	—	M-40	Deleted following screenshot: 

M0100. Determination of Pressure Ulcer/Injury Risk

Check all that apply

- ☒ A. Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device
- ☒ B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)
- ☒ C. Clinical assessment
- ☐ Z. None of the above

M0150. Risk of Pressure Ulcers/Injuries

Enter Code [1] — Is this resident at risk of developing pressure ulcers/injuries?
0. No
1. Yes

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code [1] — Does this resident have one or more unhealed pressure ulcers/injuries?
0. No → Skip to M1030, Number of Venous and Arterial Ulcers
1. Yes → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

A. **Stage 1:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

Enter Number [0] — 1. **Number of Stage 1 pressure injuries**

B. **Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

Enter Number [1] — 1. **Number of Stage 2 pressure ulcers** - If 0 → Skip to M0300C, Stage 3

Enter Number [0] — 2. **Number of <u>these</u> Stage 2 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

C. **Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling

Enter Number [0] — 1. **Number of Stage 3 pressure ulcers** - If 0 → Skip to M0300D, Stage 4

Enter Number [ ] — 2. **Number of <u>these</u> Stage 3 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

D. **Stage 4:** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling

Enter Number [0] — 1. **Number of Stage 4 pressure ulcers** - If 0 → Skip to M0300E, Unstageable - Non-removable dressing/device

Enter Number [ ] — 2. **Number of <u>these</u> Stage 4 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

M0300 continued on next page

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued

E. **Unstageable - Non-removable dressing/device:** Known but not stageable due to non-removable dressing/device

Enter Number [0] — 1. **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable - Slough and/or eschar

Enter Number [ ] — 2. **Number of <u>these</u> unstageable pressure ulcers/injuries that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

F. **Unstageable - Slough and/or eschar:** Known but not stageable due to coverage of wound bed by slough and/or eschar

Enter Number [0] — 1. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** - If 0 → Skip to M0300G, Unstageable - Deep tissue injury

Enter Number [ ] — 2. **Number of <u>these</u> unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

G. **Unstageable - Deep tissue injury:**

Enter Number [0] — 1. **Number of unstageable pressure injuries presenting as deep tissue injury** - If 0 → Skip to M1030, Number of Venous and Arterial Ulcers

Enter Number [ ] — 2. **Number of <u>these</u> unstageable pressure injuries that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

Track Changes
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to Chapter 3 Section M v1.17.1

Chapter	Section	Page	Change
3	—	M-40	Deleted following screenshots:

M1030. Number of Venous and Arterial Ulcers

Enter Number	
0	Enter the total number of venous and arterial ulcers present

M1040. Other Ulcers, Wounds and Skin Problems

↓ Check all that apply

	Foot Problems
☐	**A. Infection of the foot** (e.g., cellulitis, purulent drainage)
☐	**B. Diabetic foot ulcer(s)**
☐	**C. Other open lesion(s) on the foot**
	Other Problems
☐	**D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
☐	**E. Surgical wound(s)**
☐	**F. Burn(s)** (second or third degree)
☐	**G. Skin tear(s)**
☐	**H. Moisture Associated Skin Damage (MASD)** (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
	None of the Above
☒	**Z. None of the above** were present

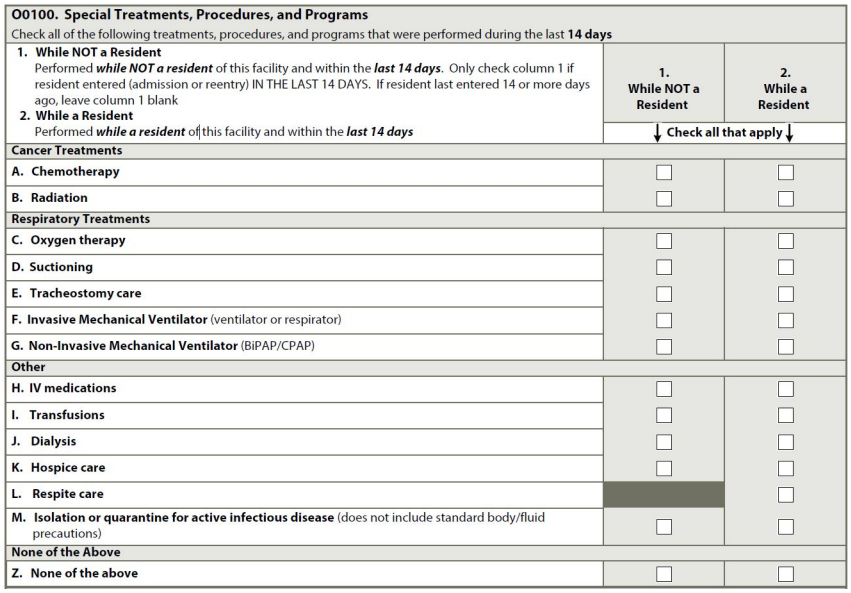
M1200. Skin and Ulcer/Injury Treatments

↓ Check all that apply

☒	**A. Pressure reducing device for chair**
☒	**B. Pressure reducing device for bed**
☒	**C. Turning/repositioning program**
☐	**D. Nutrition or hydration intervention** to manage skin problems
☒	**E. Pressure ulcer/injury care**
☐	**F. Surgical wound care**
☐	**G. Application of nonsurgical dressings** (with or without topical medications) other than to feet
☐	**H. Applications of ointments/medications** other than to feet
☐	**I. Application of dressings to feet** (with or without topical medications)
☐	**Z. None of the above** were provided

Track Changes
from Chapter 3 Section O v1.16
to Chapter 3 Section O v1.17.1

<table>
<tr><th>Chapter</th><th>Section</th><th>Page</th><th>Change</th></tr>
<tr><td>3</td><td>O0100</td><td>O-1</td><td>Replaced screenshot.

OLD
 
<table>
<tr><td colspan="3">O0100. Special Treatments, Procedures, and Programs
Check all of the following treatments, procedures, and programs that were performed during the last 14 days</td></tr>
<tr><td>1. While NOT a Resident
Performed while NOT a resident of this facility and within the last 14 days. Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank
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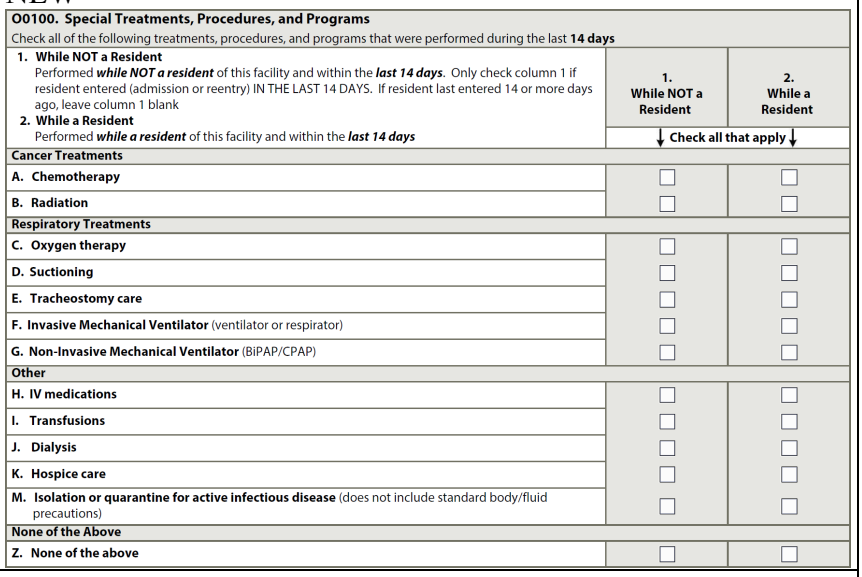
<tr><td></td><td colspan="2">↓ Check all that apply ↓</td></tr>
<tr><td>Cancer Treatments</td><td></td><td></td></tr>
<tr><td>A. Chemotherapy</td><td>☐</td><td>☐</td></tr>
<tr><td>B. Radiation</td><td>☐</td><td>☐</td></tr>
<tr><td>Respiratory Treatments</td><td></td><td></td></tr>
<tr><td>C. Oxygen therapy</td><td>☐</td><td>☐</td></tr>
<tr><td>D. Suctioning</td><td>☐</td><td>☐</td></tr>
<tr><td>E. Tracheostomy care</td><td>☐</td><td>☐</td></tr>
<tr><td>F. Invasive Mechanical Ventilator (ventilator or respirator)</td><td>☐</td><td>☐</td></tr>
<tr><td>G. Non-Invasive Mechanical Ventilator (BiPAP/CPAP)</td><td>☐</td><td>☐</td></tr>
<tr><td>Other</td><td></td><td></td></tr>
<tr><td>H. IV medications</td><td>☐</td><td>☐</td></tr>
<tr><td>I. Transfusions</td><td>☐</td><td>☐</td></tr>
<tr><td>J. Dialysis</td><td>☐</td><td>☐</td></tr>
<tr><td>K. Hospice care</td><td>☐</td><td>☐</td></tr>
<tr><td>L. Respite care</td><td></td><td>☐</td></tr>
<tr><td>M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)</td><td>☐</td><td>☐</td></tr>
<tr><td>None of the Above</td><td></td><td></td></tr>
<tr><td>Z. None of the above</td><td>☐</td><td>☐</td></tr>
</table>

NEW
 
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</table></td></tr>
<tr><td>3</td><td>O0100</td><td>O-5</td><td>• ~~O0100L, Respite care~~

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

Track Changes
from Chapter 3 Section O v1.16
to Chapter 3 Section O v1.17.1

Chapter	Section	Page	Change
3	O0100	O-6	Finally, when coding for isolation, the facility should review the resident's status and determine if the criteria for a Significant Change of Status Assessment (SCSA) is met based on the effect the infection has on the resident's function and plan of care. The definition and criteria of "significant change of status" is found in Chapter 2, ~~page 20~~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.
3	O0400	O-15	**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.
3	O0400	O-16	**Group minutes**—Enter the total number of minutes of therapy that were provided in a group in the last 7 days. **Enter 0** if none were provided. Group therapy is defined for Part A as the treatment of ~~4~~ 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 Medicare Part B, treatment of two patients (or more), regardless of payer source, at the same time is documented as group treatment. For all other payers, follow Medicare Part A instructions.
3	O0400	O-17	• **Therapy Start Date**—Record the date the most recent therapy regimen (since the most recent entry/reentry) started. This is the date the initial therapy evaluation is conducted regardless if treatment was rendered or not or the date of resumption ~~(O0450B) on the resident's EOT OMRA~~, in cases where the resident discontinued and then resumed therapy.

Track Changes
from Chapter 3 Section O v1.16
to Chapter 3 Section O v1.17.1

Chapter	Section	Page	Change
3	O0400	O-21	**Co-treatment** **For Part A:** • When two clinicians (therapists or therapy assistants), each from a different discipline, treat one resident at the same time with different treatments, both disciplines may code the treatment session in full. All policies regarding mode, modalities and student supervision must be followed as well as all other federal, state, practice and facility policies. For example, if two therapists (from different disciplines) were conducting a group treatment session, the group must be comprised of ~~four~~ 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.
3	O0400	O-23	**Modes of Therapy** A resident may receive therapy via different modes during the same day or even treatment session. When developing the plan of care, the therapist and assistant must determine which mode(s) of therapy and the amount of time the resident receives for each mode and code the MDS appropriately. The therapist and assistant should document the reason a specific mode of therapy was chosen as well as anticipated goals for that mode of therapy. For any therapy that does not meet one of the therapy mode definitions below, those minutes may not be counted on the MDS. ~~(Please also see the section on group therapy for limited exceptions related to group size.)~~ The therapy mode definitions must always be followed and apply regardless of when the therapy is provided in relationship to all assessment windows (i.e., applies whether or not the resident is in a look back period for an MDS assessment).
3	O0400	O-23	~~NOTE: The minutes being coded on the MDS are unadjusted minutes, meaning, the minutes are coded in the MDS as the full time spent in therapy; however, the software grouper will allocate the minutes appropriately. In the case of concurrent therapy, the minutes will be divided by 2.~~

Track Changes
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Chapter	Section	Page	Change
3	O0400	O-25	**Group Therapy** **Medicare Part A** The treatment of 4 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.
3	O0400	O-25	• ~~NOTE: The minutes being coded on the MDS are unadjusted minutes, meaning, the minutes are coded in the MDS as the full time spent in therapy; however, the software grouper will allocate the minutes appropriately. In the case of group therapy, the minutes will be divided by 4.~~
3	O0400	O-27	For example, Mr. N. was admitted to the nursing home following a fall that resulted in a hip fracture in November ~~2011~~2019. Occupational and Physical therapy started December 3, ~~2011~~2019. His physical therapy ended January 27, ~~2012~~2020 and occupational therapy ended January 29, ~~2012~~2020. Later on during his stay at the nursing home, due to the progressive nature of his Parkinson's disease, he was referred to SLP and OT February 10, ~~2012~~2020 (he remained in the facility the entire time). The speech-language pathologist evaluated him on that day and the occupational therapist evaluated him the next day. The ARD for Mr. N.'s MDS assessment is February 28, ~~2012~~2020. Coding values for his MDS are: • O0400A5 (SLP start date) is ~~02102012~~02102020, • O0400A6 (SLP end date) is dash filled, • O0400B5 (OT start date) is ~~02112012~~02112020, • O0400B6 (OT end date) is dash filled, • O0400C5 (PT start date) is ~~12032011~~12032019, and • O0400C6 (PT end date) is ~~01272012~~01272020.
3	O0400–O0700	O-28–O-52	Page length changed due to revised content.

Track Changes
from Chapter 3 Section O v1.16
to Chapter 3 Section O v1.17.1

Chapter	Section	Page	Change
3	O0400	O-28	~~O0400: Therapies~~ ~~(cont.)~~ ~~NOTE: When an EOT-R is completed, the Therapy Start Date (O0400A5, O0400B5, and O0400C5) on the~~ next ~~PPS assessment is the same as the Therapy Start Date on the EOT-R. If therapy is ongoing, the Therapy End Date (O0400A6, O0400B6, and O0400C6) would be dash filled.~~ ~~For example, Mr. T. was admitted to the nursing home following a fall that resulted in a hip fracture in May 2013. Occupational and Physical therapy started May 10, 2013. His physical therapy ended May 23, 2013 but the occupational therapy continued. Due to observed swallowing issues, he was referred to SLP on May 31, 2013 and the speech-language pathologist evaluated him on that day. Though Mr. T was able to receive both occupational therapy and speech therapy on June 12, he is unable to receive therapy on June 13 or June 14 due to a minor bout with the flu. The facility does not provide therapy on the weekends, which means that June 15, 2013 represents the third day of missed therapy, triggering an EOT OMRA. The therapy staff and nurses discuss Mr. T's condition and agree that Mr. T should be able to resume the same level of therapy beginning on June 18, 2013, so the facility decides to complete the EOT OMRA as an EOT-R, with an ARD of June 15, 2013.~~

Track Changes
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to Chapter 3 Section O v1.17.1

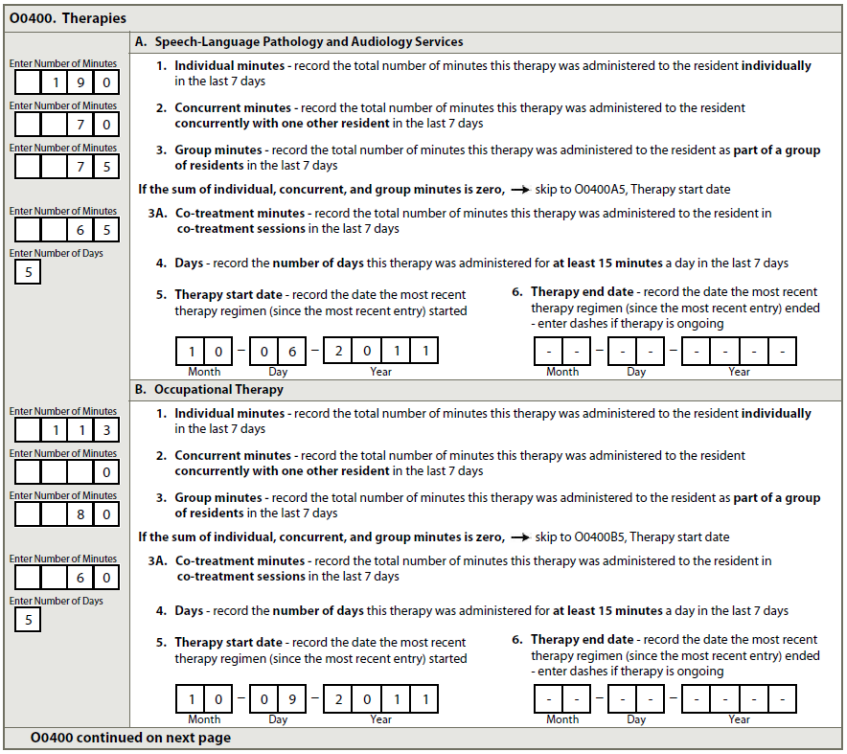
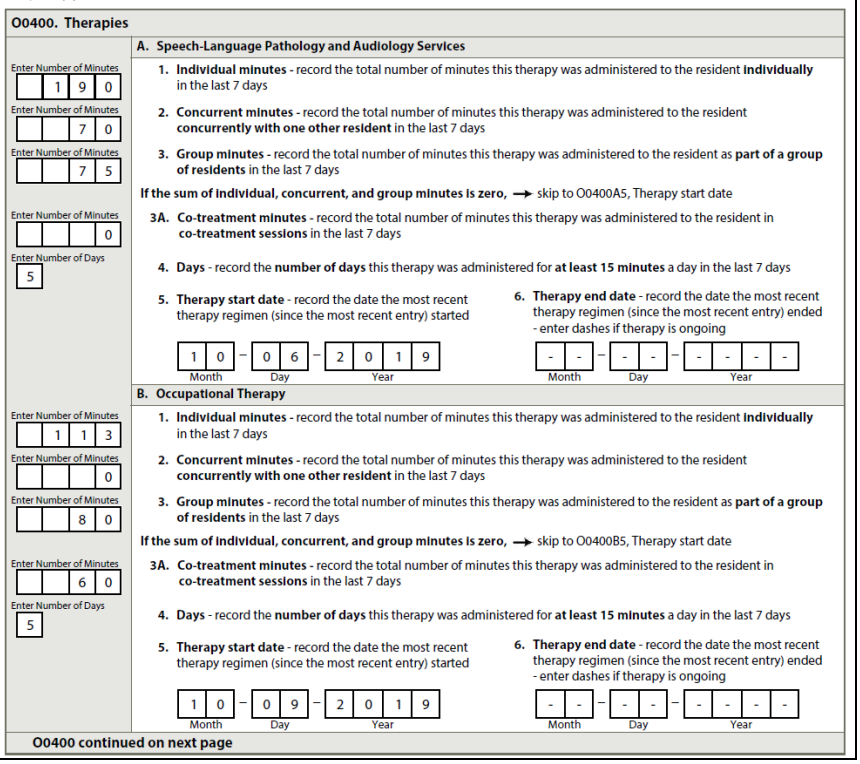
Chapter	Section	Page	Change
3	O0400	O-28	~~Coding values for Mr. T's EOT-R are:~~ ~~O0400A5 (SLP start date) is 05312013,~~ ~~O0400A6 (SLP end date) is 06122013,~~ ~~O0400B5 (OT start date) is 05102013,~~ ~~O0400B6 (OT end date) is 06122013,~~ ~~O0400C5 (PT start date) is 05102013, and~~ ~~O0400C6 (PT end date) is 05232013.~~ ~~Subsequent to the EOT-R, the next PPS assessment completed for Mr. T is the 30-day assessment, with an ARD of June 23, 2013. There were no changes in the therapy services delivered to Mr. T since the EOT-R was completed.~~ ~~Coding values for Mr. T's 30-day assessment are:~~ ~~O0400A5 (SLP start date) is 05312013,~~ ~~O0400A6 (SLP end date) is dash filled,~~ ~~O0400B5 (OT start date) is 05102013,~~ ~~O0400B6 (OT end date) is dash filled,~~ ~~O0400C5 (PT start date) is 05102013, and~~ ~~O0400C6 (PT end date) is 05232013.~~
3	O0400	O-28	**General Coding Example:** Following a stroke, Mrs. F. was admitted to the skilled nursing facility in stable condition for rehabilitation therapy on 10/06/~~1~~19 under Part A skilled nursing facility coverage. She had slurred speech, difficulty swallowing, severe weakness in both her right upper and lower extremities, and a Stage ~~II~~3 pressure ulcer on her left lateral malleolus. She was referred to SLP, OT, and PT with the long-term goal of returning home with her daughter and son-in-law. Her initial SLP evaluation was performed on 10/06/~~1~~19, the PT initial evaluation on 10/07/~~1~~19, and the OT initial evaluation on 10/09/~~1~~19. She was also referred to recreational therapy and respiratory therapy. The interdisciplinary team determined that 10/~~19~~13/~~1~~19 was an appropriate ARD for her ~~Medicare-required 14-day MDS~~5-Day assessment. During the look-back period she received the following:

Track Changes
from Chapter 3 Section O v1.16
to Chapter 3 Section O v1.17.1

Chapter	Section	Page	Change
3	O0400	O-28	• Individual speech techniques; Tuesday and Thursday for 20-minute sessions each day. **Coding:** O0400A1 would be **coded 190;** O0400A2 would be **coded 70;** O0400A3 would be **coded 75;** O0400A4 would be **coded 5;** O0400A5 would be **coded ~~10062011~~10062019;** and O0400A6 would be **coded with dashes**. **Rationale:** Individual minutes totaled 190 over the 7-day look-back period [(30 × 5) + (20 × 2) = 190]; concurrent minutes totaled 70 over the 7-day look-back period (35 × 2 = 70); and group minutes totaled 75 over the 7-day look-back period (25 × 3 = 75). Therapy was provided 5 out of the 7 days of the look-back period. Date speech-language pathology services began was 10-06-20~~1~~19, and dashes were used as the therapy end date value because the therapy was ongoing.
3	O0400	O-28	• Balance/coordination activities; Tuesday-Friday for 20 minutes each day in group sessions. **Coding:** O0400B1 would be coded 113, O0400B2 would be coded 0, O0400B3 would be coded 80, O0400B3A would be coded 60, O0400B4 would be coded 5, O0400B5 would be coded 100920~~1~~19, and O0400B6 would be coded with dashes.
3	O0400	O-29	**Rationale:** Individual minutes (including 60 co-treatment minutes) totaled 113 over the 7-day look-back period [(30 × 2) + 23 + 18 + 12 = 113]; concurrent minutes totaled 0 over the 7-day look-back period (0 × 0 = 0); and group minutes totaled 80 over the 7-day look-back period (20 × 4 = 80). Therapy was provided 5 out of the 7 days of the look-back period. Date occupational therapy services began was 10-09-20~~1~~19 and dashes were used as the therapy end date value because the therapy was ongoing.

Track Changes
from Chapter 3 Section O v1.16
to Chapter 3 Section O v1.17.1

Chapter	Section	Page	Change
3	O0400	O-29	• Concurrent therapeutic exercises; Monday-Friday for 20 minutes each day. **Coding:** O0400C1 would be **coded 287,** O0400C2 would be **coded 100,** O0400C3 would be **coded 0**, O0400C3A would be **coded 60**, O0400C4 would be **coded 5**, O0400C5 would be **coded 10072041~~1~~9**, and O0400C6 would be **coded with dashes**. **Rationale:** Individual minutes (including 60 co-treatment minutes) totaled 287 over the 7-day look-back period [(30 × 2) + (35 × 5) + (22 - 5) + 7 + (27 - 6) + 7 = 287]; concurrent minutes totaled 100 over the 7-day look-back period (20 × 5 = 100); and group minutes totaled 0 over the 7-day look-back period (0 × 0 = 0). Therapy was provided 5 out of the 7 days of the look-back period. Date physical therapy services began was 10-07-201~~1~~9, and dashes were used as the therapy end date value because the therapy was ongoing.

3	O0400	O-31	Replaced screenshot. OLD  NEW 

Track Changes
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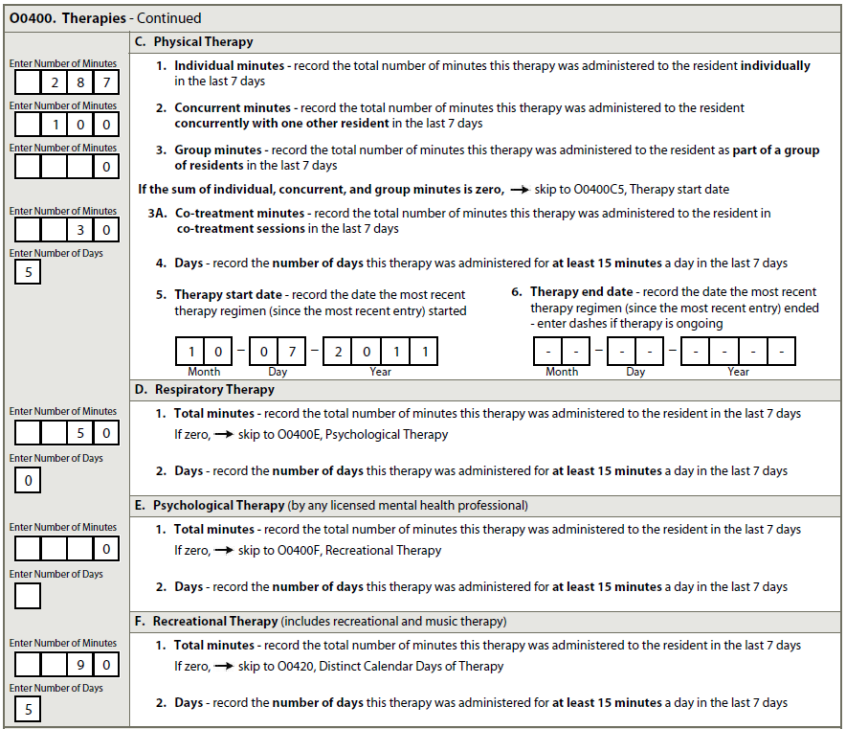
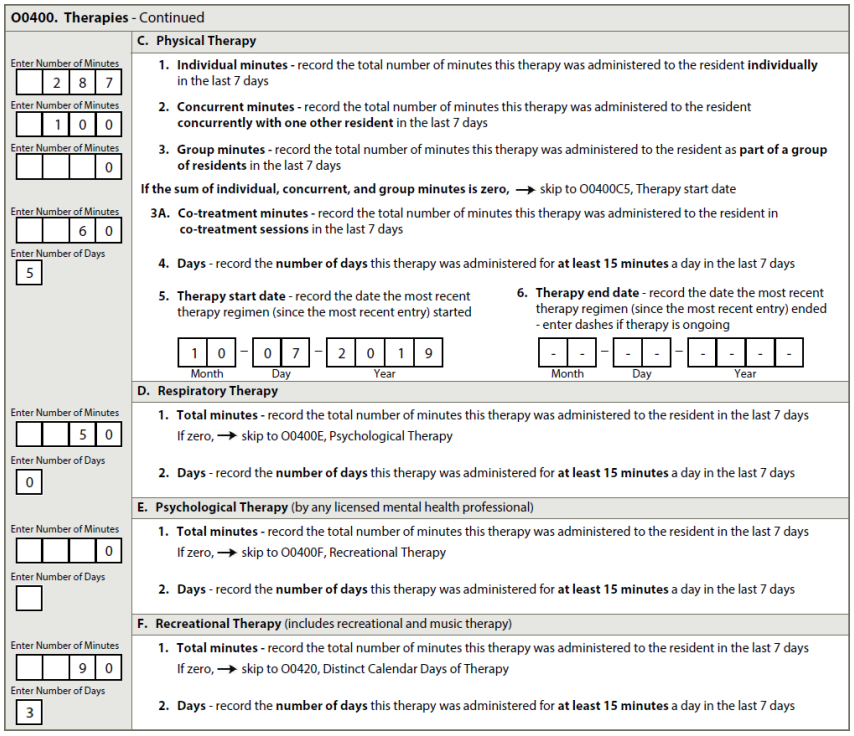
Chapter	Section	Page	Change
3	O0400	O-32	Replaced screenshot. OLD  NEW 

Track Changes
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Chapter	Section	Page	Change
3	O0425	O-34	# 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)
3	O0425	O-34	## 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.

Chapter	Section	Page	Change
3	O0425	O-35	O0425: Part A Therapies (cont.) • Rehabilitation (i.e., via Speech-Language Pathology Services and Occupational and Physical Therapies) and respiratory, psychological, and recreational therapy can help residents to attain or maintain their highest level of well-being and improve their quality of life.
3	O0425	O-35	**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 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. • **For definitions of the types of therapies listed in this section, please refer to the Glossary in Appendix A.**
3	O0425	O-35	**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, recreation therapy notes, mental health professional progress notes), and consult with each of the qualified care providers to collect the information required for this item.

Chapter	Section	Page	Change
3	O0425	O-35	NOTE: The look back 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.
3	O0425	O-35	**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 O0400 above.)

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Chapter	Section	Page	Change
3	O0425	O-36	O0425: Part A Therapies (cont.) • **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 O0400 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 O0400 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 O0400 above.)

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Chapter	Section	Page	Change
3	O0425	O-36	• **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. • **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.

Chapter	Section	Page	Change
3	O0425	O-37	## O0425: Part A Therapies (cont.) • **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.
3	O0425	O-37	## 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 O0400 above.
3	O0425	O-37	## 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).

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Chapter	Section	Page	Change
3	O0425	O-37	**Individual Therapy** For a detailed definition and example of individual therapy, please refer to the discussion of item O0400 above. **Concurrent Therapy** For a detailed definition and example of concurrent therapy, please refer to the discussion of item O0400 above.
3	O0425	O-38	O0425: Part A Therapies (cont.) **Group Therapy** For a detailed definition and example of group therapy, please refer to the discussion of item O0400 above. **Therapy Modalities** For a detailed definition and explanation of therapy modalities, please refer to the discussion of item O0400 above.
3	O0425	O-38	**General Coding Example:** Following a bilateral knee replacement, Mrs. 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, she exhibited some short-term memory difficulties specifically affecting orientation. She was non-weight bearing, had reduced range of motion, and had difficulty with ADLs. She was referred to SLP, OT, and PT with the long-term goal of returning home with her husband. Her initial SLP evaluation was performed on 10/06/19, and the OT and PT initial evaluations were done on 10/07/19. She was also referred to recreational therapy. She was in the SNF for 14 days and was discharged home on 10/19/2019. Mrs. G received the following rehabilitation services during her stay in the SNF.

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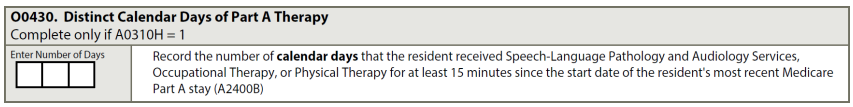
Chapter	Section	Page	Change
3	O0425	O-38	Speech-language pathology services that were provided over the SNF stay: • Individual cognitive training; six sessions for 45 minutes each day. • Discharged from SLP services on 10/14/2019. **Coding:** O0425A1 would be **coded 270;** O0425A2 would be **coded 0;** 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 × 6 days); concurrent minutes totaled 0 over the stay (0 × 0 = 0); and group minutes totaled 0 over the stay (0 × 0 = 0). Therapy was provided 6 days of the stay.
3	O0425	O-38	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.
3	O0425	O-39	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 × 12) + 53 = 413]; concurrent minutes totaled 0 over the stay (0 × 0 = 0); and group minutes totaled 200 over the stay (20 × 10 = 200). Therapy was provided 12 days of the stay.

Chapter	Section	Page	Change
3	O0425	O-39	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 stay [(45 × 13) + (7 + 22 + 18) = 632]; concurrent minutes totaled 200 over the stay (20 × 10 = 200); and group minutes totaled 180 over the stay (30 × 6 = 180). Therapy was provided 13 days of the stay.
3	O0430	O-40	## 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.

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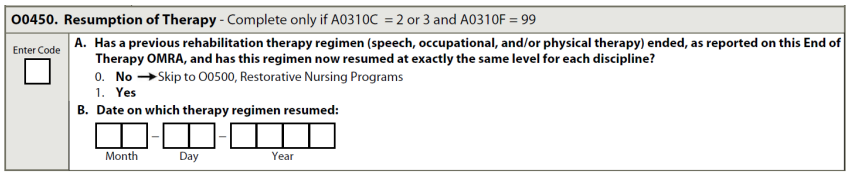
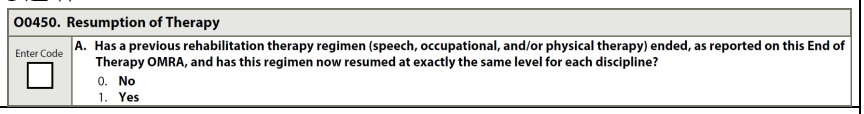
Chapter	Section	Page	Change
3	O0430	O-40	**Coding Instructions:** Enter the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes during the SNF Part A stay (i.e., from the date in A2400B 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: Mrs. T was admitted to the SNF on Sunday 10/06/18 and discharged on Saturday 10/26/18. She received 60 minutes of physical therapy every Monday, Wednesday, and Friday during the SNF stay. Mrs. T also received 45 minutes of occupational therapy every Monday, Tuesday, and Friday during the stay. Given the therapy services received by Mrs. 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).
3	O0450	O-41	Replaced screenshot. OLD  NEW 
3	O0450	O-41	**CMS does not require completion of this item; however, some States continue to require its completion. It is important to know your State's requirements for completing this item.**

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to Chapter 3 Section O v1.17.1

Chapter	Section	Page	Change
3	O0450	O-41	**Coding Instructions:** When an EOT OMRA has been performed, determine whether therapy will resume. If it will, determine whether therapy will resume no more than five consecutive calendar days after the last day of therapy was provided AND whether the therapy services will resume at the same level for each discipline. If No, **skip to O0500**, Restorative Nursing Programs. If Yes, **code item O0450A as 1**. ~~Determine when therapy will resume and code item **O0450B with the date** that therapy will resume.~~ For example:
3	O0450	O-41	• Mrs. A. who was in RVL did not receive therapy on Saturday and Sunday because the facility did not provide weekend services and she missed therapy on Monday because of a doctor's appointment. She resumed therapy on Tuesday, November 13, 2011. The IDT determined that her RUG-IV therapy classification level did not change as she had not had any significant clinical changes during the lapsed therapy days. When the EOT was filled out, item **O0450 A was coded as 1** because therapy was resuming within 5 days from the last day of therapy and it was resuming at the same RUG-IV classification level. ~~Item **O0450B was coded as 11132011** because therapy resumed on November 13, 2011.~~
3	O0450	O-41	NOTE: If the EOT OMRA has not been accepted in the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system when therapy resumes, code the EOT-R item~~s~~ (O0450A ~~and O0450B~~) on the assessment and submit the record. If the EOT OMRA without the EOT-R item~~s~~ ha~~ves~~ been accepted into the QIES ASAP system, then submit a modification request for that EOT OMRA with the only changes being the completion of the Resumption of Therapy item~~s~~ (O0450A ~~and O0450B~~) and check X0900E~~E~~Z ~~to~~and indicate that the reason for modification is the addition of the Resumption of Therapy ~~date~~item.

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Chapter	Section	Page	Change
3	O0500	O-42	**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.
3	O0500	O-43	• A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a restorative nursing program. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents. Restorative nursing does not require a physician's order. Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In situations where such services do not actually require the involvement of a qualified therapist, the services may not be coded as therapy in item O0400, Therapies or O0425, Part A Therapies, because the specific interventions are considered restorative nursing services (see item O0400, Therapies 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.
3	O0500	O-44	**Coding Instructions** • This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in **Speech-Language Pathology and Audiology Services** item O0400A or O0425A, **Occupational Therapy** item O0400B or O0425B, and **Physical Therapy** item O0400C or O0425C.

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from Chapter 3 Section V v1.16
to Chapter 3 Section V v1.17.1

Chapter	Section	Page	Change
3	V0100	V-2	Replaced screenshot. OLD **V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment** Complete only if A0310E = 0 and if the following is true for the **prior assessment**: A0310A = 01- 06 or A0310B = 01- 05 Enter Code **A. Prior Assessment Federal OBRA Reason for Assessment** (A0310A value from prior assessment) 01. **Admission** assessment (required by day 14) 02. **Quarterly** review assessment 03. **Annual** assessment 04. **Significant change in status** assessment 05. **Significant correction** to **prior comprehensive** assessment 06. **Significant correction** to **prior quarterly** assessment 99. None of the above Enter Code **B. Prior Assessment PPS Reason for Assessment** (A0310B value from prior assessment) 01. **5-day** scheduled assessment 02. **14-day** scheduled assessment 03. **30-day** scheduled assessment 04. **60-day** scheduled assessment 05. **90-day** scheduled assessment 07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment) 99. None of the above **C. Prior Assessment Reference Date** (A2300 value from prior assessment) Month – Day – Year Enter Score **D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score** (C0500 value from prior assessment) Enter Score **E. Prior Assessment Resident Mood Interview (PHQ-9©) Total Severity Score** (D0300 value from prior assessment) Enter Score **F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score** (D0600 value from prior assessment) NEW **V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment** Complete only if A0310E = 0 and if the following is true for the **prior assessment**: A0310A = 01- 06 or A0310B = 01 Enter Code **A. Prior Assessment Federal OBRA Reason for Assessment** (A0310A value from prior assessment) 01. **Admission** assessment (required by day 14) 02. **Quarterly** review assessment 03. **Annual** assessment 04. **Significant change in status** assessment 05. **Significant correction** to **prior comprehensive** assessment 06. **Significant correction** to **prior quarterly** assessment 99. None of the above Enter Code **B. Prior Assessment PPS Reason for Assessment** (A0310B value from prior assessment) 01. **5-day** scheduled assessment 08. **IPA** - Interim Payment Assessment 99. None of the above **C. Prior Assessment Reference Date** (A2300 value from prior assessment) Month – Day – Year Enter Score **D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score** (C0500 value from prior assessment) Enter Score **E. Prior Assessment Resident Mood Interview (PHQ-9©) Total Severity Score** (D0300 value from prior assessment) Enter Score **F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score** (D0600 value from prior assessment)

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from Chapter 3 Section V v1.16
to Chapter 3 Section V v1.17.1

Chapter	Section	Page	Change
3	V0100	V-3	**Coding Instructions for V0100B, Prior Assessment PPS Reason for Assessment (A0310B Value from Prior Assessment)** • Record in V0100B the value for A0310B (PPS Assessment) from the most recent prior OBRA or scheduled PPS assessment, if one is available (see "Item Rationale," above, for details). One of the available values (01 ~~through 05~~ or 0~~7~~8 or 99) must be selected. **Note:** The values for V0100A and V0100B cannot both be 99, indicating that the prior assessment is neither an OBRA nor a PPS assessment. If the value of V0100A is 99 (None of the above), then the value for V0100B must be 01 ~~through 05~~ or 0~~7~~8, indicating a PPS assessment. If the value of V0100B is 99 (None of the above), then the value for V0100A must be 01 through 06, indicating an OBRA assessment.

Track Changes
from Chapter 3 Section X v1.16
to Chapter 3 Section X v1.17.1

Chapter	Section	Page	Change
3	X	—	Standardized wording/usage of term "QIES ASAP system" throughout the section. Also standardized usage of the phrase "record accepted into the QIES ASAP system" throughout the section.
3	X	X-1	**Intent:** The purpose of Section X is to identify an MDS record to be modified or inactivated. The following items identify the existing assessment record that is in error. Section X is only completed if Item A0050, Type of Record, is coded a 2 (Modify existing record) or a 3 (Inactivate existing record). In Section X, the facility must reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the ~~National MDS Database~~Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system.
3	X0200	X-2	**Coding Instructions for X0200A, First Name** • Enter the first name of the resident exactly as submitted for item A0500A "Legal Name of Resident—First Name" on the prior erroneous record to be modified/inactivated. Start entry with the leftmost box. ~~If the first name was left blank on the prior record, leave X0200A blank.~~
3	X0570–X0800	X-4–X-8	Page length changed due to revised content.
3	X0570	X-4	X0570: Optional State Assessment (A0300A/B on existing record to be modified/inactivated) **X0570. Optional State Assessment** (A0300A/B on existing record to be modified/inactivated) Enter Code ☐ **A. Is this assessment for state payment purposes only?** 0. **No** 1. **Yes** Enter Code ☐ **B. Assessment type** 1. **Start of therapy** assessment 2. **End of therapy** assessment 3. **Both Start and End of therapy** assessment 4. **Change of therapy** assessment 5. **Other payment** assessment **Item Rationale** • This item contains the reasons for assessment from the prior erroneous Optional State Assessment record to be modified/inactivated.

Track Changes
from Chapter 3 Section X v1.16
to Chapter 3 Section X v1.17.1

Chapter	Section	Page	Change
3	X0570	X-4	**Coding Instructions for X0570A, Is this assessment for state payment purposes only?** • Fill in the box with the state payment purpose code exactly as submitted for item A0300A "**Is this assessment for state payment purposes only?**" on the prior erroneous record to be modified/inactivated. • Note that the state payment purpose code in X0570A must match the current value of A0300A on the modification request. **Coding Instructions for X0570B, Assessment Type** • Fill in the box with the assessment type code exactly as submitted for item A0300B "**Assessment Type**" on the prior erroneous record to be modified/inactivated. • Note that the assessment type code in X0570B must match the current value of A0300B on the modification request.

Track Changes
from Chapter 3 Section X v1.16
to Chapter 3 Section X v1.17.1

Chapter	Section	Page	Change
3	X0600	X-5	Replaced screenshot.

OLD

X0600. Type of Assessment (A0310 on existing record to be modified/inactivated)

Enter Code

A. Federal OBRA Reason for Assessment
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **None of the above**

Enter Code

B. PPS Assessment
PPS Scheduled Assessments for a Medicare Part A Stay
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
PPS Unscheduled Assessments for a Medicare Part A Stay
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
Not PPS Assessment
99. **None of the above**

Enter Code

C. PPS Other Medicare Required Assessment - OMRA
0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment
4. **Change of therapy** assessment

X0600 continued on next page

X0600. Type of Assessment - Continued

Enter Code

D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2
0. **No**
1. **Yes**

Enter Code

F. Entry/discharge reporting
01. **Entry** tracking record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** tracking record
99. **None of the above**

Enter Code

H. Is this a SNF Part A PPS Discharge Assessment?
0. **No**
1. **Yes**

NEW

X0600. Type of Assessment (A0310 on existing record to be modified/inactivated)

Enter Code

A. Federal OBRA Reason for Assessment
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **None of the above**

Enter Code

B. PPS Assessment
PPS Scheduled Assessment for a Medicare Part A Stay
01. **5-day** scheduled assessment
PPS Unscheduled Assessment for a Medicare Part A Stay
08. **IPA** - Interim Payment Assessment
Not PPS Assessment
99. **None of the above**

Enter Code

F. Entry/discharge reporting
01. **Entry** tracking record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** tracking record
99. **None of the above**

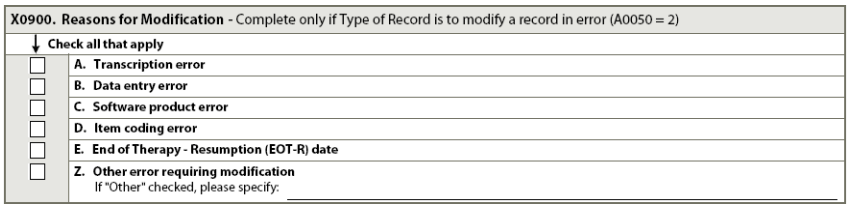
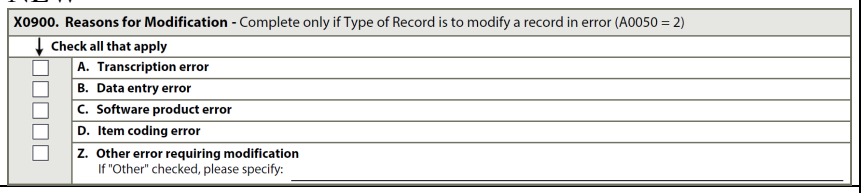
Enter Code

H. Is this a SNF Part A PPS Discharge Assessment?
0. **No**
1. **Yes**

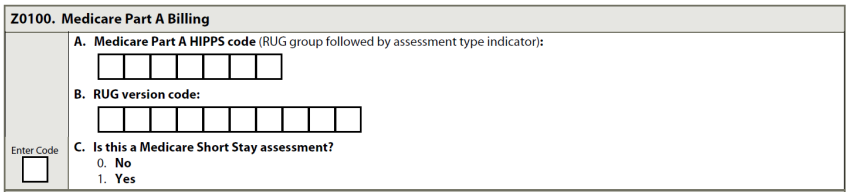
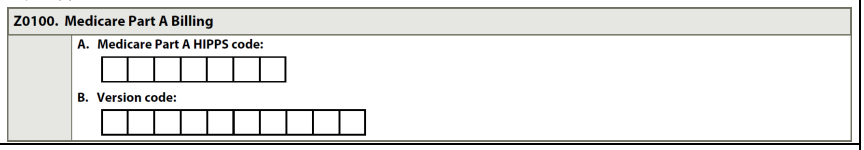
Track Changes
from Chapter 3 Section X v1.16
to Chapter 3 Section X v1.17.1

Chapter	Section	Page	Change
3	X0600	X-5	**~~Coding Instructions for X0600C,~~ ~~PPS Other Medicare Required Assessment—OMRA~~** • ~~Fill in the boxes with the PPS OMRA code exactly as submitted for item A0310C "PPS—OMRA" on the prior erroneous record to be modified/inactivated.~~ • ~~Note that the PPS OMRA code in X0600C must match the current value of A0310C on a modification request.~~ • ~~If item A0310C was incorrect on an assessment that was previously submitted and accepted by the QIES ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).~~
3	X0600	X-5	**~~Coding Instructions for X0600D,~~ ~~Is this a Swing Bed clinical change assessment? (Complete only if X0150=2)~~** • ~~Enter the code exactly as submitted for item A0310D "Is this a Swing Bed clinical change assessment?" on the prior erroneous record to be modified/inactivated.~~ • ~~**Code 0, no:** if the assessment submitted was not coded as a swing bed clinical change assessment.~~ • ~~**Code 1, yes:** if the assessment submitted was coded as a swing bed clinical change assessment.~~ • ~~Note that the code in X0600D must match the current value of A0310D on a modification request.~~ • ~~If item A0310D was incorrect on an assessment that was previously submitted and accepted by the QIES ASAP system, then the original assessment must be modified or inactivated per the instructions in Chapter 5 (Section 5.7).~~

Track Changes
from Chapter 3 Section X v1.16
to Chapter 3 Section X v1.17.1

Chapter	Section	Page	Change
3	X0900	X-9	Replaced screenshot. OLD  NEW 
3	X1050–X1100	X-10–X-12	Page length changed due to revised content.
3	X0900	X-10	~~**Coding Instructions for X0900E, End of Therapy-Resumption (EOT-R) date**~~ ~~• Check the box if the End of Therapy-Resumption (EOT-R) date (item O0450B) has been added with the modified record (i.e., the provider has determined that the EOT-R policy was applicable after submitting the original EOT record not indicating a resumption of therapy date in item O0450B).~~ ~~• Do not check this box if the modification is correcting the End of Therapy Resumption date (item O0450B) in a previous EOT-R assessment. In this case, the reason for modification is an item Coding Error and box X0900D should be checked.~~
3	X0900	X-10	**Coding Instructions for X0900Z, Other Error Requiring Modification** • Check the box if any errors in the prior QIES ASAP record were caused by other types of errors not included in Items X0900A through X0900~~E~~D.

Track Changes
from Chapter 3 Section Z v1.16
to Chapter 3 Section Z v1.17.1

Chapter	Section	Page	Change
3	Z0100	Z-1	Replaced screenshot. OLD  NEW 
3	Z0100	Z-1	**Item Rationale** • Used to capture the ~~Resource Utilization Group (RUG)~~Patient Driven Payment Model (PDPM) case mix version code followed by Health Insurance Prospective Payment System (HIPPS) modifier based on type of assessment.

Track Changes
from Chapter 3 Section Z v1.16
to Chapter 3 Section Z v1.17.1

Chapter	Section	Page	Change
3	Z0100	Z-1	**Coding Instructions for Z0100A, Medicare Part A HIPPS Code** • Typically, the software data entry product will calculate this value. • The HIPPS code is a Skilled Nursing Facility (SNF) Part A five-position billing code ~~and is composed of a five-position representing the RUG group code, plus a two-position assessment type indicator~~; the first four positions represent the PDPM case mix version code and the fifth is an assessment type indicator. For information on HIPPS, access: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/index.html. • If the value for Z0100A is not automatically calculated by the software data entry product, enter the HIPPS code in the spaces provided (see Chapter 6 of this Manual, Medicare Skilled Nursing Home Prospective Payment System, for a step-by-step worksheet for manually determining the ~~RUG~~PDPM case mix version code and a table that defines the assessment type indicator). • Note that the ~~RUG~~version code included in this HIPPS code takes into account all MDS items used in the ~~RUG~~PDPM logic and is the "normal" group since the classification considers the rehabilitation therapy received. ~~This classification uses all reported speech/language pathology and auditory services, occupational therapy, and physical therapy values in Item O0400 (Therapies).~~
3	Z0100	Z-1	**DEFINITION** **HIPPS CODE** Health Insurance Prospective Payment System code is comprised of the ~~RUG category calculated by the assessment~~ PDPM case mix code, which is calculated from the assessment data. The first four positions of the HIPPS code contain the PDPM classification codes for each PDPM component to be billed for Medicare reimbursement, followed by an indicator of the type of assessment that was completed.
3	Z0100–Z0500	Z-2–Z-7	Page length changed due to revised content.

Track Changes
from Chapter 3 Section Z v1.16
to Chapter 3 Section Z v1.17.1

Chapter	Section	Page	Change
3	Z0100	Z-2	**Coding Instructions for Z0100B, ~~RUG~~ Version Code** • Typically the software data entry product will calculate this value. • If the value for Z0100B is not automatically calculated by the software data entry product, enter the ~~RUG~~ PDPM version code in the spaces provided. ~~This is the version code appropriate to the RUG included in the Medicare Part A HIPPS code in Item Z0100A.~~ • ~~With MDS 3.0 implementation on October 1, 2010, the initial Medicare RUG-IV Version Code is "1.0066."~~
3	Z0100	Z-2	~~**DEFINITION**~~ ~~**MEDICARE SHORT STAY ASSESSMENT** is a Start of Therapy Other Medicare Required Assessment (OMRA) and is used for a short Medicare Part A stay that was not long enough to allow a complete rehabilitation therapy regimen to be established. This type of assessment allows an alternative Medicare Short Stay assessment RUG rehabilitation therapy classification as described in Chapter 6, Medicare Skilled Nursing Home Prospective Payment System.~~
3	Z0100	Z-2	~~**Coding Instructions for Z0100C, Is This a Medicare Short Stay Assessment?**~~ • ~~**Code 0, No:** if this is not a Medicare Short Stay Assessment.~~ • ~~**Code 1, Yes:** if this is a Medicare Short Stay Assessment.~~ ~~**Coding Tip**~~ • ~~The CMS standard RUG-IV grouper automatically determines whether or not this is a Medicare Short Stay Assessment. MDS software typically makes this determination automatically. If the value for Z0100C is not automatically calculated by the software data entry product, use the definition found in Chapter 6 to determine the correct response.~~

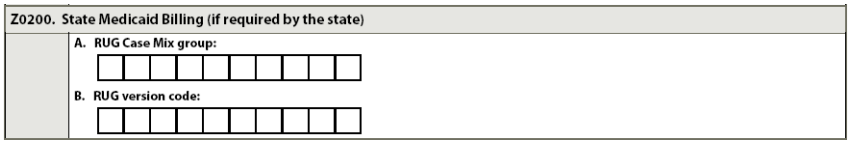
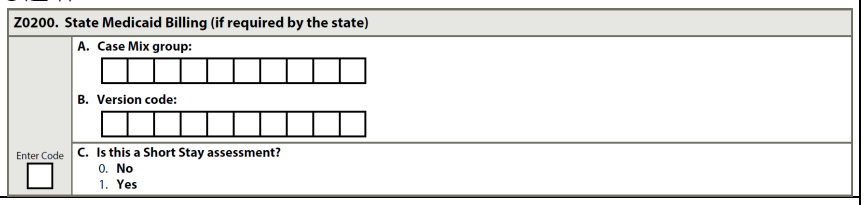
Track Changes
from Chapter 3 Section Z v1.16
to Chapter 3 Section Z v1.17.1

Chapter	Section	Page	Change
3	Z0150	Z-2	~~Z0150: Medicare Part A Non-Therapy Billing~~ **Z0150. Medicare Part A Non-Therapy Billing** **A. Medicare Part A non-therapy HIPPS code** (RUG group followed by assessment type indicator): ☐☐☐☐☐☐☐ **B. RUG version code:** ☐☐☐☐☐☐☐☐☐☐ ~~**Item Rationale**~~ ~~Used to capture the Resource Utilization Group non-therapy (RUG) followed by Health Insurance Prospective Payment System (HIPPS) modifier based on type of assessment. The non-therapy RUG is the code obtained when all rehabilitation therapy is ignored and will be limited to the Extensive Services, Special Care High, Special Care Low, Clinically Complex, Behavior and Cognitive Performance, and the Physical Function codes.~~

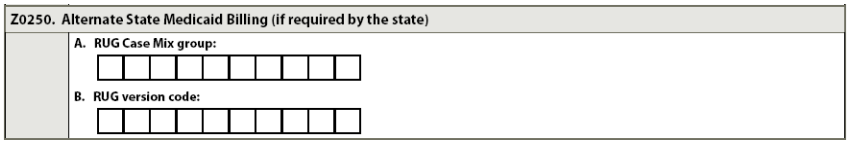
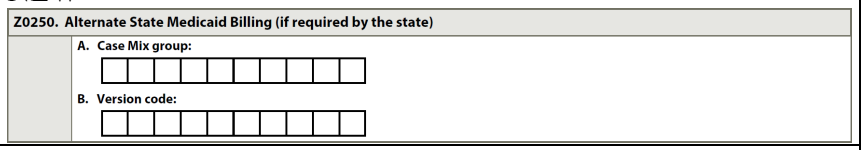
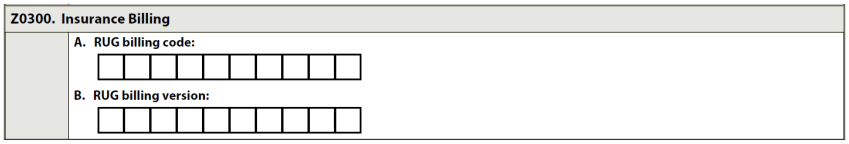
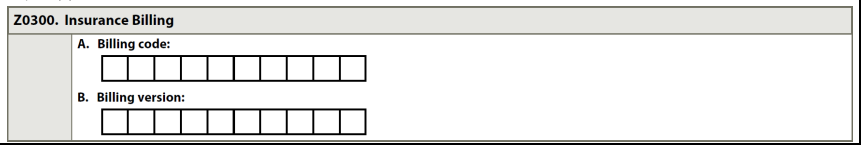
Track Changes
from Chapter 3 Section Z v1.16
to Chapter 3 Section Z v1.17.1

Chapter	Section	Page	Change
3	Z0150	Z-2	**~~Coding Instructions for Z0150A,~~ ~~Medicare Part A Non-therapy HIPPS Code~~** • ~~Typically the software data entry product will calculate this value.~~ • ~~The HIPPS code is a SNF Part A billing code and is comprised of a five-position code representing the RUG code, plus a two-position assessment type indicator. For information on HIPPS, access https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/index.html.~~ • ~~If the value for Z0150A is not automatically calculated by the software data entry product, enter the HIPPS code in the spaces provided (see Chapter 6 of this manual, Medicare Skilled Nursing Home Prospective Payment System, for a step-by-step worksheet for manually determining the RUG-IV group and a table that defines assessment type indicator). Note that the RUG included in this HIPPS code is the "non- therapy" group and classification ignores the rehabilitation therapy received. This classification ignores all reported speech/language pathology and auditory services, occupational therapy, and physical therapy values in Item O0400 (Therapies).~~ • ~~In some instances, this non-therapy HIPPS code may be required for Medicare SNF Part A billing by the provider.~~ • ~~Left-justify the 5-character HIPPS code. The extra two spaces are supplied for future use, if necessary.~~
3	Z0150	Z-2	**~~Coding Instructions for Z0150B,~~ ~~RUG Version Code~~** • ~~Typically the software data entry product will calculate this value.~~ • ~~If the value for Z0150B is not automatically calculated by the software data entry product, enter the RUG version code in the spaces provided. This is the version code appropriate to the RUG included in the Medicare Part A non-therapy HIPPS code in Item Z0150A.~~ • ~~With MDS 3.0 implementation on October 1, 2010, the initial Medicare RUG-IV Version Code is "1.0066."~~

Track Changes
from Chapter 3 Section Z v1.16
to Chapter 3 Section Z v1.17.1

Chapter	Section	Page	Change
3	Z0200	Z-2	Replaced screenshot. OLD  NEW 
3	Z0200	Z-2	**Coding Instructions for Z0200A, ~~RUG~~ Case Mix Group** • If the state has selected a standard ~~RUG~~payment model, this item will usually be populated automatically by the software data entry product. Otherwise, enter the case-mix code calculated based on the MDS assessment. **Coding Instructions for Z0200B, ~~RUG~~ Version Code** • If the state has selected a standard ~~RUG~~payment model, this item will usually be populated automatically by the software data entry product. Otherwise, enter the case mix version code in the spaces provided. This is the version code appropriate to the code in Item Z0200A.
3	Z0200	Z-2	**Coding Instructions for Z0200C, Is this a Short Stay assessment?** • **Code 0, no:** if this is not a Short Stay assessment. • **Code 1, yes:** if this is a Medicare Short Stay assessment. **Coding Tip** • The standard RUG-IV grouper automatically determines whether or not this is a Short Stay assessment. MDS software typically makes this determination automatically.

Track Changes
from Chapter 3 Section Z v1.16
to Chapter 3 Section Z v1.17.1

Chapter	Section	Page	Change
3	Z0250	Z-3	Replaced screenshot. OLD  NEW 
3	Z0250	Z-3	**Coding Instructions for Z0250A, ~~RUG~~ Case Mix Group** • If the state has selected a standard ~~RUG~~payment model, this item will usually be populated automatically by the software data entry product. Otherwise, enter the case-mix code calculated based on the MDS assessment. **Coding Instructions for Z0250B, ~~RUG~~ Version Code** • If the state has selected a standard ~~RUG~~payment model, this item will usually be populated automatically by the software data entry product. Otherwise, enter the case mix version code in the spaces provided. This is the version code appropriate to the code in Item Z0250A.
3	Z0300	Z-3	Replaced screenshot. OLD  NEW 

Track Changes
from Chapter 3 Section Z v1.16
to Chapter 3 Section Z v1.17.1

Chapter	Section	Page	Change
3	Z0300	Z-3–Z-4	**Coding Instructions for Z0300A, ~~RUG b~~Billing Code** • If the other payer has selected a standard ~~RUG~~payment model, this item may be populated automatically by the software data entry product. Otherwise, enter the billing code in the space provided. This code is for use by other payment systems such as private insurance or the Department of Veterans Affairs. **Coding Instructions for Z0300B, ~~RUG b~~Billing Version** • If the other pay~~e~~er has selected a standard ~~RUG~~payment model, this item may be populated automatically by the software data entry product. Otherwise, enter an appropriate billing version in the spaces provided. This is the billing version appropriate to the billing code in Item Z0300A.
3	Z0500	Z-6	**Coding Instructions** • For Z0500B, use the actual date that the MDS was completed, reviewed, and signed as complete by the RN assessment coordinator. This date ~~will generally~~must be equal to the latest date at Z0400 or later than the date(s) at Z0400, which documents when portions of the assessment information were completed by assessment team members. • If for some reason the MDS cannot be signed by the RN assessment coordinator on the date it is completed, the RN assessment coordinator should use the actual date that it is signed.

Track Changes
from Chapter 4 v1.16
to Chapter 4 v1.17.1

<table>
<tr><th>Chapter</th><th>Section</th><th>Page</th><th>Change</th></tr>
<tr><td>4</td><td>4.3</td><td>4-3</td><td>
<table>
<tr><td>1. Delirium</td><td>2. Cognitive Loss/Dementia</td></tr>
<tr><td>3. Visual Function</td><td>4. Communication</td></tr>
<tr><td>5. Activity of Daily Living (ADL) Functional / Rehabilitation Potential</td><td>6. Urinary Incontinence and Indwelling Catheter</td></tr>
<tr><td>7. Psychosocial Well-Being</td><td>8. Mood State</td></tr>
<tr><td>9. Behavioral Symptoms</td><td>10. Activities</td></tr>
<tr><td>11. Falls</td><td>12. Nutritional Status</td></tr>
<tr><td>13. Feeding Tubes</td><td>14. Dehydration/Fluid Maintenance</td></tr>
<tr><td>15. Dental Care</td><td>16. Pressure Ulcer/Injury</td></tr>
<tr><td>17. Psychotropic Medication Use</td><td>18. Physical Restraints</td></tr>
<tr><td>19. Pain</td><td>20. Return to Community Referral</td></tr>
</table>
</td></tr>
<tr><td>4</td><td>4.4</td><td>4-4</td><td>A risk factor increases the chances of having a negative outcome or complication. For example, impaired bed mobility may increase the risk of getting a pressure ulcer/injury. In this example, impaired bed mobility is the risk factor, unrelieved pressure is the effect of the compromised bed mobility, and the potential pressure ulcer is the complication.</td></tr>
</table>

Track Changes
from Chapter 4 v1.16
to Chapter 4 v1.17.1

Chapter	Section	Page	Change
4	4.10	4-32	6. Mechanically altered diet ~~while NOT a resident or~~ while a resident is used as nutritional approach as indicated by: **~~K0510C1 = 1 OR~~ K0510C2 = 1** 7. Therapeutic diet ~~while NOT a resident or~~ while a resident is used as nutritional approach as indicated by: **~~K0510D1 = 1 OR~~ K0510D2 = 1**
4	4.10	4-32–4-33	Page length changed due to revised content.
4	4.10	4-36	16. Pressure Ulcer/Injury A pressure ulcer can be defined as a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction. Pressure ulcers can have serious consequences for the elderly and are costly and time consuming to treat. They are a common preventable and treatable condition among elderly people with restricted mobility. When this CAA is triggered, nursing home staff should follow their facility's chosen protocol or policy for performing the CAA. **Pressure Ulcer/Injury CAT Logic Table**
4	4.10	4-37	~~8. Resident has one or more pressure ulcer(s) that has gotten worse since prior assessment as indicated by:~~ **~~(M0800A > 0 AND M0800A <= 9) OR~~** **~~(M0800B > 0 AND M0800B <= 9) OR~~** **~~(M0800C > 0 AND M0800C <= 9)~~** 8. Trunk restraint used in bed has value of 1 or 2 as indicated by: **P0100B = 1 OR P0100B = 2** 9. Trunk restraint used in chair or out of bed has value of 1 or 2 as indicated by: **P0100E = 1 OR P0100E = 2**

Track Changes
from Chapter 5 v1.16
to Chapter 5 v1.17.1

Chapter	Section	Page	Change
5	5.1	5-1	**5.1 Transmitting MDS Data** All Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. Required MDS records are those assessments and tracking records that are mandated under OBRA and SNF PPS. Providers will submit the Optional State Assessment (OSA) records to the QIES ASAP system just as they submit all other MDS assessments. The OSA is not a Federally required assessment. Each State will determine if the OSA is required and when this assessment must be completed. Assessments that are completed for purposes other than OBRA and SNF PPS reasons are not to be submitted, e.g., private insurance, including but not limited to Medicare Advantage Plans.
5	5.1	5-1	Providers must establish communication with the QIES ASAP system in order to submit a file. This is accomplished by using specialized communications software and hardware and the CMS wide area network. Details about these processes are available on the QIES Technical Support Office (QTSO) website at: ~~https://www.qtso.com~~https://qtso.cms.gov/.
5	5.1	5-2	Once communication is established with the QIES ASAP system, the provider can access the Welcome to the CMS QIES Systems for Providers page in the MDS system. This site allows providers to submit MDS assessment data and access various information sources such as Bulletins and Questions and Answers. The *Minimum Data Set (MDS) 3.0 Provider User's Guide* provides more detailed information about the MDS system. It is available on the Welcome to the CMS QIES Systems for Providers page and on the QTSO MDS 3.0 website at ~~https://www.qtso.com/mds30.html~~https://qtso.cms.gov/providers/nursing-home-mdsswing-bed-providers/reference-manuals.
5	5.2–5.8	5-4–5-16	Page length changed due to revised content.

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from Chapter 5 v1.16
to Chapter 5 v1.17.1

<table>
<tr><th>Chapter</th><th>Section</th><th>Page</th><th>Change</th></tr>
<tr><td>5</td><td>5.2</td><td>5-4</td><td>In Submission Time Frame for MDS Records Table, updated row for PPS Assessment.
<table>
<tr><th>Type of Assessment/ Tracking</th><th>Primary Reason (A0310A)</th><th>Secondary Reason (A0310B)</th><th>Entry/ Discharge Reporting (A0310F)</th><th>Final Completion or Event Date</th><th>Submit By</th></tr>
<tr><td>PPS Assessment</td><td>99</td><td>01 ~~through 07~~ or 08</td><td>10, 11, 99</td><td>Z0500B</td><td>Z0500B + 14</td></tr>
</table></td></tr>
<tr><td>5</td><td>5.2</td><td>5-4</td><td>In Submission Time Frame for MDS Records Table, updated row for Entry Tracking.
<table>
<tr><th>Type of Assessment/ Tracking</th><th>Primary Reason (A0310A)</th><th>Secondary Reason (A0310B)</th><th>Entry/ Discharge Reporting (A0310F)</th><th>Final Completion or Event Date</th><th>Submit By</th></tr>
<tr><td>Entry Tracking</td><td>99</td><td>99</td><td>01</td><td>A1600</td><td>A1600 + 14</td></tr>
</table></td></tr>
<tr><td>5</td><td>5.3</td><td>5-5</td><td>Fatal Record Errors result in rejection of individual records by the QIES ASAP system. The provider is informed of Fatal Record Errors on the Final Validation Report. Rejected records must be corrected and resubmitted, unless the Fatal Error is due to submission of a duplicate assessment.</td></tr>
<tr><td>5</td><td>5.4</td><td>5-6</td><td>As stated in CFR §413.343(a) and (b), providers reimbursed under the SNF PPS “are required to submit the resident assessment data described at §483.20…. in the manner necessary to administer the payment rate methodology described in §413.337.” This provision includes the frequency, scope, and number of assessments required in accordance with the methodology described in CFR §413.337(c) related to the adjustment of the Federal rates for case mix. SNFs must submit assessments according to a standard schedule. This schedule must include performance of resident assessments ~~in~~at specified windows ~~near the 5th, 14th, 30th, 60th, and 90th days of the~~during the Medicare Part A stay.</td></tr>
</table>

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from Chapter 5 v1.16
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Chapter	Section	Page	Change
5	5.4	5-6	**HIPPS Codes:** Health Insurance Prospective Payment System (HIPPS) codes are billing codes used when submitting Medicare Part A SNF payment claims to the Part A/Part B Medicare Administrative Contractor (A/B MAC). The HIPPS code consists of five positions. Under PDPM, ~~T~~the first ~~three~~ position represents the Physical Therapy/Occupational Therapy (PT/OT) Payment Group, the second position represents the Speech Language Pathology (SLP) Payment Group, the third position represents the Nursing Payment Group, the fourth position represents the Non-therapy Ancillary (NTA) Payment Group, and the fifth position represents the ~~positions represent the Resource Utilization Group-IV (RUG-IV) case mix code for the SNF resident, and the last two positions are an~~ Assessment Indicator (AI) code indicating which type of assessment was completed. Standard "grouper" logic and software for ~~RUG-IV~~PDPM and the AI code are provided by CMS on the MDS 3.0 website.
5	5.4	5-6	The standard grouper uses MDS 3.0 items to determine both the ~~RUG-IV~~PDPM group and the AI code. It is anticipated that MDS 3.0 software used by the provider will incorporate the standard grouper to automatically calculate the ~~RUG-IV~~PDPM group and AI code. Detailed logic for determining the ~~RUG-IV~~PDPM group and AI code is provided in Chapter 6. ~~The HIPPS codes to be used for Medicare Part A SNF claims are included on the MDS. There are two different HIPPS codes.~~ ~~1.~~ The Medicare Part A HIPPS code (Item Z0100A) is most often used on the claim. The ~~RUG-IV~~PDPM version code in Item Z0100B documents which version of ~~RUG-IV~~PDPM was used to determine the ~~RUG-IV~~PDPM payment groups represented in the Medicare Part A HIPPS code.

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Chapter	Section	Page	Change
5	5.4	5-6	~~2. The Medicare non-therapy Part A HIPPS code (Item Z0150A) is used when the provider is required to bill the non-therapy HIPPS. An example when the non-therapy HIPPS is to be billed is when the resident has been receiving rehabilitation therapy (physical therapy, occupational therapy, and/or speech-language pathology services), all rehabilitation therapy ends, and the resident continues on Part A (see Chapter 6 for details, including other instances when this HIPPS code is used for billing purposes). The RUG version code in Item Z0150B documents which version of RUG-IV was used to determine the RUG-IV group in the Medicare non-therapy Part A HIPPS code.~~ ~~There is also a Medicare Short Stay indicator (Item Z0100C) on the MDS. For a qualifying Medicare short stay, the RUG-IV grouper uses alternative rehabilitation classification logic when there has been insufficient time to establish a full rehabilitation regime. The standard grouper uses MDS 3.0 items to determine the Medicare short stay indicator. See Chapter 6 for details.~~
5	5.4	5-6	~~Both~~The HIPPS codes~~s~~ (Z0100A~~ and Z0150A), the RUG~~and PDPM version codes (Z0100B~~ and Z0150B), and the Medicare Short Stay indicator (Z0100C)~~ must be submitted to the QIES ASAP system on all Medicare PPS assessment records (indicated by A0310B = 01~~, 02, 03, 04, 05,~~ or 0~~7~~8). ~~All~~Both of these values are validated by the QIES ASAP system. The ~~F~~final ~~V~~validation ~~R~~report will indicate if any of these items is in error and the correct value for an incorrect item. Note that an error in one of these items is usually a non-fatal warning and the record will still be accepted in the QIES ASAP system. ~~A record will receive a fatal error (-3804) if the record is a Start of Therapy (SOT) Other Medicare Required Assessment (OMRA) (A0310C = 1 or 3) and the QIES ASAP system calculated value for the Medicare Part A HIPPS code (Z0100A) is not a group that begins with 'R', i.e., Rehabilitation Plus Extensive Services or Rehabilitation group.~~

Track Changes
from Chapter 5 v1.16
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Chapter	Section	Page	Change
5	5.6	5-9	If the assessment was performed for Medicare purposes only (A0310A = 99 and A0310B = 01 ~~through~~or 0~~7~~8) or for a discharge (A0310A = 99 and A0310F = 10 or 11), no Significant Change in Status Assessment or Significant Correction to Prior Assessment is required. The provider would determine if the Medicare-required or Discharge assessment should be modified or inactivated. Care Area Assessments (Section V) and updated care planning are not required with Medicare- only and Discharge assessments.
5	5.7	5-9	Facilities should correct any errors necessary to ensure that the information in the QIES ASAP system accurately reflects the resident's identification, location, overall clinical status, or payment status. A correction can be submitted for any accepted record within ~~3~~2 years of the target date of the record for facilities that are still open. If a facility is terminated, then corrections must be submitted within 2 years of the facility termination date. A record may be corrected even if subsequent records have been accepted for the resident.
5	5.7	5-11	• ~~A stand-alone Discharge assessment (ISC = ND) was completed and accepted into the ASAP system. The provider later (that is, after the day of discharge) determined that the assessment should have been a 30-day PPS assessment combined with a Discharge assessment (ISC = NP). This modification would not be allowed as the ISC for the Discharge assessment combined with the 30-day PPS is different than the stand-alone Discharge ISC. This is an example of a missing 30-day assessment.~~
5	5.7	5-11	• An Admission assessment (ISC = NC) was completed and accepted into the QIES ASAP system. The provider intended to code the assessment as an Admission and a 5-day PPS assessment (ISC = NC). The modification process could be used in this case as the ISC would not change.

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to Chapter 5 v1.17.1

<table>
<tr><th>Chapter</th><th>Section</th><th>Page</th><th>Change</th></tr>
<tr><td>5</td><td>5.7</td><td>5-12</td><td>
The 10/01/2019 Cross-Over Rule

A unique situation exists that will prevent providers from correcting the target date of any assessment crossing over October 1, 2019. That is, providers may not submit a modification to change a target date on an assessment completed prior to October 1, 2019 to a target date on or after October 1, 2019, nor can they submit a modification to change a target date on an assessment completed on or after October 1, 2019 to a target date prior to October 1, 2019.
The item sets that are effective October 1, 2019 have had significant changes, including the omission and addition of many items. It is the target date of the assessment that identifies the required version of the item set, and, because of the substantial changes in the item sets, they are not interchangeable. Therefore, providers may not change target dates on assessments crossing over October 1, 2019.
Modification records that contain a target date crossing over October 1, 2019 will result in a FATAL error and be REJECTED from the QIES ASAP system. However, all corrections to target dates that align with policies in Section 5.7 of this chapter and do not violate this rule will be allowed.
To correct the target date of the assessment that violates the cross-over rule, providers must inactivate the incorrect assessment and submit a replacement assessment.

Examples of potential scenarios that will and will not be allowed are identified below:
<table>
<tr><th>Original Assessment Target Date</th><th>Modified Assessment Target Date</th><th>Allowed or Not Allowed</th></tr>
<tr><td>8/15/19</td><td>9/30/19</td><td>Allowed</td></tr>
<tr><td>10/1/19</td><td>11/1/19</td><td>Allowed</td></tr>
<tr><td>9/15/19</td><td>10/15/19</td><td>Not Allowed</td></tr>
<tr><td>10/15/19</td><td>9/15/19</td><td>Not Allowed</td></tr>
</table>
</td></tr>
</table>

Track Changes
from Chapter 6 v1.16
to Chapter 6 v1.17.1

Chapter	Section	Page	Change
6	6.1–6.8	6-1–6-53	This chapter has been extensively revised for this year's manual. Due to the scope of the revisions, individual changes have not been recorded and tracked in this Change Table. Users are encouraged to review the chapter in its entirety.

Track Changes
from Appendix A v1.16
to Appendix A v1.17.1

Chapter	Section	Page	Change
App. A	—	A-1	Activities of Daily Living ADLs Activities of daily living are those needed for self-care~~:~~ and include activities such as bathing, dressing, grooming, oral care, mobility (e.g., ambulation), toileting, eating, ~~and~~transferring, and communicating. Select self-care and mobility items from Section GG are utilized to classify a resident into the PT, OT, and nursing components for PDPM.~~The late-loss ADLs (eating, toileting, bed mobility, and transferring) are used to classify a patient into a RUG-IV group.~~
App. A	—	A-8	Health Insurance Prospective Payment System HIPPS Billing codes used when submitting claims to the MACs (previously FIs) for Medicare payment. Codes comprise the ~~RUG category~~PDPM group calculated by the assessment followed by an indicator to indicate which assessment was completed.
App. A	—	A-4–A-10	Page length changed due to revised content.
App. A	—	A-10	Interrupted Stay Interrupted Stay is a Medicare Part A SNF stay in which a resident is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay) and subsequently resumes SNF care in the **same** SNF for a Medicare Part A-covered stay during the interruption window.

Track Changes
from Appendix A v1.16
to Appendix A v1.17.1

Chapter	Section	Page	Change
App. A	—	A-10	Interruption Window The interruption window is a 3-day period, starting with the calendar day of discharge and including the 2 immediately following calendar days. In other words, if a resident in a Medicare Part A SNF stay is discharged from Part A, the resident must resume Part A services, or return to the **same** SNF (if physically discharged) to resume Part A services, by 11:59 p.m. at the end of the third calendar day after their Part A-covered stay ended. The interruption window begins with the first non-covered day following a Part A-covered stay and ends at 11:59 p.m. on the third consecutive non-covered day following a Part A-covered SNF stay. If these conditions are met, the subsequent stay is considered a continuation of the previous Medicare Part A-covered stay for the purposes of both the variable per diem schedule and PPS assessment completion.
App. A	—	A-15	Patient Driven Payment Model PDPM The Patient Driven Payment Model (PDPM) is a new case-mix classification system for classifying skilled nursing facility (SNF) residents in a Medicare Part A covered stay into payment groups under the SNF Prospective Payment System. Effective beginning October 1, 2019, PDPM will replace the current case-mix classification system, the Resource Utilization Group, Version IV (RUG-IV).

Track Changes
from Appendix A v1.16
to Appendix A v1.17.1

Chapter	Section	Page	Change
App. A	—	A-18	**Resource Utilization Group, Version IV** **RUG-IV** A category-based classification system in which nursing facility residents classify into one of 66, ~~or~~ 57, or 47 RUG-IV groups. Residents in each group utilize similar quantities and patterns of resources. Assignment of a resident to a RUG-IV group is based on certain item responses on the MDS 3.0. Some states utilize the RUG-IV system for Medicaid payment in nursing facilities. ~~Medicare Part A uses the 66-group classification.~~
App. A	—	A-23–A-25	Page length changed due to revised content.
App. A	—	A-24	IPA Interim Payment Assessment
App. A	—	A-24	NTA Non-Therapy Ancillary
App. A	—	A-24	OSA Optional State Assessment
App. A	—	A-25	PDPM Patient Driven Payment Model
App. A	—	A-25	PHQ-9-OV© PHQ-9© Observational Version
App. A	—	A-25	SNF QRP Skilled Nursing Facility Quality Reporting Program
App. A	—	A-25	SSN Social Security Number
App. A	—	A-25	TPN Total Parenteral Nutrition

Track Changes
from Appendix C v1.16
to Appendix C v1.17.1

Chapter	Section	Page	Change
App. C	—	C-53	• Pressure ulcers/injuries (M0300)
App. C	—	C-85	• Alzheimer's Association Resources: ~~http://www.alz.org/professionals_and_researchers_14899.asp~~ https://www.alz.org/;

Track Changes
from Appendix G v1.16
to Appendix G v1.17.1

Chapter	Section	Page	Change
App. G	—	G-2	Centers for Medicare & Medicaid Services: Minimum Data Set (MDS) 3.0 Provider User's Guide. Available from ~~https://www.qtso.com/mds30.html~~ https://qtso.cms.gov/reference-and-manuals/mds-30-provider-users-guide
App. G	—	G-3	Quality Improvement and Evaluation System (QIES) Technical Support Office: QIES Technical Support Office Web site. Retrieved ~~Nov. 18~~April 2, 20~~0~~19, from https://www.qtso.com/ https://qtso.cms.gov/