Centers for Medicare & Medicaid Services

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

Version 3.0

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Organizations and Stakeholders

- Academy of Nutrition and Dietetics
- 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
- Kansas Department on Aging
- Leading Age
- National Association of Directors of Nursing Administration/Long Term Care
- National Association of Subacute and Post Acute Care
- The National Consumer Voice for Quality Long Term Care
- State Agency RAI Coordinators and RAI Automation Coordinators
- State Quality Improvement Organizations
- US Department of Veterans Affairs

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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.

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.

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

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

presumably, the new owner has assumed existing contractual rights and obligations, including those under the contract for submitting MDS information. All contractual agreements, regardless of their type, involving the MDS data should not violate the requirements of participation in the Medicare and/or Medicaid program, the Privacy Act of 1974 or any applicable State laws.

PRIVACY ACT STATEMENT – HEALTH CARE RECORDS
Long Term Care-Minimum Data Set (MDS) System of Records revised 04/28/2007

(Issued: 9-6-12, Implementation/Effective Date: 6-17-13)

THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974 (5 USC 552a). THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. **AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY.** Authority for maintenance of the system is given under Sections 1102(a), 1819(b)(3)(A), 1819(f), 1919(b)(3)(A), 1919(f) and 1864 of the Social Security Act.

The system contains information on all residents of long-term care (LTC) facilities that are Medicare and/or Medicaid certified, including private pay individuals and not limited to Medicare enrollment and entitlement, and Medicare Secondary Payer data containing other party liability insurance information necessary for appropriate Medicare claim payment.

Medicare and Medicaid participating LTC facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information is also used by the Centers for Medicare & Medicaid Services (CMS) to ensure that the facility meets quality standards and provides appropriate care to all residents. 42 CFR §483.20, requires LTC facilities to establish a database, the Minimum Data Set (MDS), of resident assessment information. The MDS data are required to be electronically transmitted to the CMS National Repository.

Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures. These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS LTC System of Records.

2. **PRINCIPAL PURPOSES OF THE SYSTEM FOR WHICH INFORMATION IS INTENDED TO BE USED.** The primary purpose of the system is to aid in the administration of the survey and certification, and payment of Medicare/Medicaid LTC services which include skilled nursing facilities (SNFs), nursing facilities (NFs) and non-critical access hospitals with a swing bed agreement.

Information in this system is also used to study and improve the effectiveness and quality of care given in these facilities. This system will only collect the minimum amount of personal data necessary to achieve the purposes of the MDS, reimbursement, policy and research functions.

3. ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM. The information collected will be entered into the LTC MDS System of Records, System No. 09-70-0528. This system will only disclose the minimum amount of personal data necessary to accomplish the purposes of the disclosure. Information from this system may be disclosed to the following entities under specific circumstances (routine uses), which include:

(1) To support Agency contractors, consultants, or grantees who have been contracted by the Agency to assist in accomplishment of a CMS function relating to the purposes for this system and who need to have access to the records in order to assist CMS;

(2) To assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent for purposes of contributing to the accuracy of CMS' proper payment of Medicare benefits and to enable such agencies to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds and for the purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State, and determine Medicare and/or Medicaid eligibility;

(3) To assist Quality Improvement Organizations (QIOs) in connection with review of claims, or in connection with studies or other review activities, conducted pursuant to Title XI or Title XVIII of the Social Security Act and in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans;

(4) To assist insurers and other entities or organizations that process individual insurance claims or oversees administration of health care services for coordination of benefits with the Medicare program and for evaluating and monitoring Medicare claims information of beneficiaries including proper reimbursement for services provided;

(5) To support an individual or organization to facilitate research, evaluation, or epidemiological projects related to effectiveness, quality of care, prevention of disease or disability, the restoration or maintenance of health, or payment related projects;

(6) To support litigation involving the agency, this information may be disclosed to The Department of Justice, courts or adjudicatory bodies;

(7) To support a national accrediting organization whose accredited facilities meet certain Medicare requirements for inpatient hospital (including swing beds) services;

(8) To assist a CMS contractor (including but not limited to fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program to combat fraud, waste and abuse in certain health benefit programs; and

(9) To assist another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any state or local governmental agency), that administers, or that has the authority to investigate potential fraud, waste and abuse in a health benefits program funded in whole or in part by Federal funds.

4. EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION. The information contained in the LTC MDS System of Records is generally necessary for the facility to provide appropriate and effective care to each resident.

If a resident fails to provide such information, e.g. thorough medical history, inappropriate and potentially harmful care may result. Moreover, payment for services by Medicare, Medicaid and third parties, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

NOTE: Residents or their representative must be supplied with a copy of the notice. This notice may be included in the admission packet for all new nursing home admissions, or distributed in other ways to residents or their representative(s). Although signature of receipt is NOT required, providers may request to have the Resident or his or her Representative sign a copy of this notice as a means to document that notice was provided and merely acknowledges that they have been provided with this information.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

_____ _____

Signature of Resident or Sponsor Date

NOTE: Providers may request to have the Resident or his or her Representative sign a copy of this notice as a means to document that notice was provided. Signature is NOT required. If the Resident or his or her Representative agrees to sign the form it merely acknowledges that they have been advised of the foregoing information. Residents or their Representative must be supplied with a copy of the notice. This notice may be included in the admission packet for all new nursing home admissions.

- The previous owner would complete a 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.
- 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 Medicare-required PPS 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 contractor 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 Medicare contractor 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).

RAI OBRA-required Assessment Summary

Assessment Type	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 another 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 another 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 another assessment
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 another assessment

(continued)

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.

- 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 assessment except an Admission and a SCPA, if it is identified that an uncorrected significant error occurred in a previous assessment that has already been submitted and accepted into the MDS 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 a 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 MDS database) 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 Medicare-required PPS assessment (see Sections 2.11 and 2.12 for details).

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:

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[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.

[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.

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 Discharge assessment as follows:

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

Assessment Management Requirements and Tips for Discharge Assessments:

- Must be completed when the resident is discharged from the facility (see definition of Discharge on page 2-10).
- 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 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 PPS Medicare required assessment when requirements for all assessments are met.
- For a Discharge assessment, the ARD (Item A2300) is not set prospectively as with other assessments. The ARD (Item A2300) for a Discharge assessment is always equal the Discharge date (Item A2000) and may be coded on the assessment any time during the Discharge assessment completion period (i.e., discharge date (A2000) + 14 calendar days). For **unplanned discharges**, the facility should complete the Discharge assessment to the best of its abilities. 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 Discharge assessment with another assessment(s) when requirements for all assessments are met.
  - 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 Discharge assessments.

— If the resident received therapy Friday, was not scheduled for therapy on Saturday or Sunday and refused therapy for Monday, Day 1 would be Saturday.

- May be combined with any scheduled PPS assessment. In such cases, the item set for the scheduled assessment should be used.
- The ARD for the End of Therapy OMRA may not precede the ARD of the first scheduled PPS assessment of the Medicare stay (5-day or readmission/return assessment).
  — For example: if the 5-day assessment is completed on day 8 and an EOT is completed in that window, the ARD for the EOT should be Day 8 as well.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days).
- Establishes a new non-therapy RUG classification and Medicare payment rate (Item Z0150A), which begins the day after the last day of therapy treatment regardless of day selected for ARD.
- Must be submitted electronically to the QIES ASAP system and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).
- In cases where a resident is discharged from the SNF ***on or prior to*** the third consecutive day of missed therapy services, then no EOT is required. More precisely, in cases where the date coded for Item A2000 is on or prior to the third consecutive day of missed therapy services, then no EOT OMRA is required. If a SNF chooses to complete the EOT OMRA in this situation, they may combine the EOT OMRA with the discharge assessment.
- In cases where the last day of the Medicare Part A benefit, that is the date used to code A2400C on the MDS, is prior to the third consecutive day of missed therapy services, then no EOT OMRA is required. If the date listed in A2400C is on or after the third consecutive day of missed therapy services, then an EOT OMRA would be required.
- In cases where the date used to code A2400C is equal to the date used to code A2000, that is cases where the discharge from Medicare Part A is the same day as the discharge from the facility, and this date is on or prior to the third consecutive day of missed therapy services, then no EOT OMRA is required. Facilities may choose to combine the EOT OMRA with the discharge assessment under the rules outlined for such combinations in Chapter 2 of the MDS RAI manual.
- If the EOT OMRA is performed because three or more consecutive days of therapy were missed, and it is determined that therapy will resume, there are three options for completion:
  1. Complete only the EOT OMRA and keep the resident in a non-Rehabilitation RUG category until the next scheduled PPS assessment is completed. For example:
     - Mr. K. was discharged from all therapy services on Day 22 of his SNF stay. The EOT OMRA was performed on Day 24 of his SNF stay and classified into HD1. Payment continued at HD1 until the 30- day assessment was completed. At that point, therapy resumed (with a new therapy evaluation) and the resident was classified into RVB.
  2. In cases where therapy resumes after an EOT OMRA is performed and more than 5 consecutive calendar days have passed since the last day of therapy provided, or therapy services will not resume at the same RUG-IV therapy classification level that had been in effect prior to the EOT OMRA, an SOT OMRA is required to classify the resident back into a RUG-IV therapy group and a new therapy evaluation is required as well. For example:

remained consistent with the patient's current RUG classification, then the COT OMRA would not be completed.

- If Day 7 of the COT observation period falls within the ARD window of a scheduled PPS Assessment, the SNF may choose to complete the PPS Assessment alone by setting the ARD of the scheduled PPS assessment for an allowable day that is ***on or prior to*** Day 7 of the COT observation period. This effectively resets the COT observation period to the 7 days following that scheduled PPS Assessment ARD. Alternatively, the SNF may choose to combine the COT OMRA and scheduled assessment following the instructions discussed in Section 2.10.
- In cases where a resident is discharged from the SNF ***on or prior to*** Day 7 of the COT observation period, then no COT OMRA is required. More precisely, in cases where the date coded for Item A2000 is on or prior to Day 7 of the COT observation period, then no COT OMRA is required. If a SNF chooses to complete the COT OMRA in this situation, they may combine the COT OMRA with the discharge assessment.
- The COT ARD may not precede the ARD of the first scheduled or unscheduled PPS assessment of the Medicare stay used to establish the patient's current RUG-IV therapy classification.
- When the most recent assessment used for PPS, excluding an End of Therapy OMRA, has a sufficient level of rehabilitation therapy to qualify for an Ultra High, Very High, High, Medium, or Low Rehabilitation category (even if the final classification index maximizes to a group below Rehabilitation), then a change in the provision of therapy services is evaluated in successive 7-day Change of Therapy observation periods until a new assessment used for PPS occurs.
- Must be completed (Item Z0500B) within 14 days after the ARD (ARD + 14 days)
- Establishes a new RUG-IV category. Payment begins on Day 1 of that COT observation period and continues for the remainder of the current payment period, unless the payment is modified by a subsequent COT OMRA or other PPS assessment.
- Must be submitted electronically and accepted into the QIES ASAP system within 14 days after completion (Item Z0500B) (completion + 14 days).

Significant Change in Status Assessment (SCSA)

- Is an OBRA required assessment. See Section 2.6 of this chapter for definition, guidelines in completion, and scheduling.
- May establish a new RUG-IV classification.
- When a SCSA for a SNF PPS resident is not combined with a PPS assessment (A0310A = 04 and A0310B = 99), the RUG-IV classification and associated payment rate begin on the ARD. For example, a SCSA is completed with an ARD of day 20 then the RUG-IV classification begins on day 20.
- When the SCSA is completed with a scheduled Medicare-required assessment and grace days are not used when setting the ARD, the RUG-IV classification begins on the ARD. For example, the SCSA is combined with the Medicare-required 14-day scheduled assessment and the ARD is set on day 13, the RUG-IV classification begins on day 13.
- When the SCSA is completed with a scheduled Medicare-required assessment and the ARD is set within the grace days, the RUG-IV classification begins on the first day of the payment period of the scheduled Medicare-required assessment standard payment period. For example, the SCSA is combined with the Medicare-required 30-day scheduled

assessment, which pays for days 31 to 60, and the ARD is set at day 33, the RUG-IV classification begins day 31.

Swing Bed Clinical Change Assessment

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

Significant Correction to Prior Comprehensive Assessment

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

Coding Tips and Special Populations

- When coding a standalone Change of Therapy OMRA (COT), a standalone End of Therapy OMRA (EOT), or a standalone Start of Therapy OMRA (SOT), the interview items may be coded using the responses provided by the resident on a previous assessment **only** if the DATE of the interview responses from the previous assessment (as documented in item Z0400) were obtained no more than 14 days prior to the DATE of completion for the interview items on the unscheduled assessment (as documented in item Z0400) for which those responses will be used.
- When coding a standalone Change of Therapy OMRA (COT), a standalone End of Therapy OMRA (EOT), or a standalone Start of Therapy OMRA (SOT), facilities must set the ARD for the assessment for a day within the allowable ARD window for that assessment type, but may only do so no more than two days after the window has passed. For example, if Day 7 of the COT observation period is May 23rd and the COT is required, then the ARD for this COT must be set for May 23rd and this must be done by May 25th. Facilities may still exercise the use of this flexibility period in cases where the resident discharges from the facility during that period.
- Note: In limited circumstances, it may not be practicable to conduct the resident interview portions of the MDS (Sections C, D, F, J) on or prior to the ARD for a standalone unscheduled PPS assessment. In such cases where the resident interviews (and not the staff assessment) are to be completed and the assessment is a standalone unscheduled assessment, providers may conduct the resident interview portions of that assessment up to two calendar days after the ARD (Item A2300).

2.10 Combining Medicare Scheduled and Unscheduled Assessments

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

When combining assessments, the more stringent requirements must be met. For example, when a nursing home Start of Therapy OMRA is combined with a 14-Day Medicare-required Assessment, the PPS item set must be used. The PPS item set contains all the required items for the 14-Day Medicare-required assessment, whereas the Start of Therapy OMRA item set consists of fewer items, thus the provider would need to complete the PPS item set. The ARD window (including grace days) for the 14-day assessment is days 13-18, therefore, the ARD must be set no later than day 18 to ensure that all required time frames are met. For a swing bed provider, the swing bed PPS item set would need to be completed.

If an unscheduled PPS assessment (OMRA, SCSA, SCPA, or Swing Bed CCA) is required in the assessment window (including grace days) of a scheduled PPS assessment that has not yet been performed, then facilities must combine the scheduled and unscheduled assessments by setting the ARD of the scheduled assessment for the same day that the unscheduled assessment is required. In such cases, facilities should provide the proper response to the A0310 items to indicate which assessments are being combined, as completion of the combined assessment will be taken to fulfill the requirements for both the scheduled and unscheduled assessments. A scheduled PPS assessment cannot occur after an unscheduled assessment in the assessment window—the scheduled assessment must be combined with the unscheduled assessment using the appropriate ARD for the unscheduled assessment. The purpose of this policy is to minimize the number of assessments required for SNF PPS payment purposes and to ensure that the assessments used for payment provide the most accurate picture of the resident's clinical condition and service needs. More details about combining PPS assessments are provided in this chapter and in Chapter 6, Section 30.3 of the Medicare Claims Processing Manual (CMS Pub. 100-04) available on the CMS web site. Listed below are some of the possible assessment combinations allowed. A provider may choose to combine more than two assessment types when all requirements are met. When entered directly into the software the coding of Item 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 2.15).

DEFINITIONS

USED FOR PAYMENT
An assessment is considered to be "used for payment" in that it either controls the payment for a given period or, with scheduled assessments may set the basis for payment for a given period.

In cases when a facility fails to combine a scheduled and unscheduled PPS assessment as required by the combined assessment policy, the payment is controlled by the unscheduled assessment. For example: if the ARD of an EOT OMRA is set for Day 14 and the ARD of a 14-day assessment is

set for Day 15, this would violate the combined assessment policy. Consequently, the EOT OMRA would control the payment. The EOT would begin payment on Day 12, and continue paying into the 14-day payment window until the next scheduled or unscheduled assessment used for payment.

PPS Scheduled Assessment and Start of Therapy OMRA

- ARD (Item A2300) must be set within the ARD window for the Medicare-required scheduled assessment **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest date). If both ARD requirements are not met, the assessments may not be combined.
- An SOT OMRA is not necessary if rehabilitation services start within the ARD window (including grace days) of the 5-day assessment, since the therapy rate will be paid starting Day 1 of the SNF stay.
- If the ARD for the SOT OMRA falls within the ARD window (including grace days) of a PPS scheduled assessment that has not been performed yet, the assessments MUST be combined.
- Complete the PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:

  A0310A = 99
  A0310B = 01, 02, 03, 04, 05, or 06 as appropriate
  A0310C = 1
  A0310D = 0 (Swing Beds only)

PPS Scheduled Assessment and End of Therapy OMRA

- ARD (Item A2300) must be set within the window for the Medicare scheduled assessment **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest date). If both ARD requirements are not met, the assessments may not be combined.
- If the ARD for the EOT OMRA falls within the ARD window (including grace days) of a PPS scheduled assessment that has not been performed yet, the assessments MUST be combined.
- Must complete the PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:

  A0310A = 99
  A0310B = 01, 02, 03, 04, 05, or 06 as appropriate
  A0310C = 2
  A0310D = 0 (Swing Beds only)

PPS Scheduled Assessment and Start and End of Therapy OMRA

- ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is latest). If all three ARD requirements are not met, the assessments may not be combined.

- If the ARD for the EOT and SOT OMRA falls within the ARD window (including grace days) of a PPS scheduled assessment that has not been performed yet, the assessments MUST be combined.
- Must complete the PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:

  A0310A = 99
  A0310B = 01, 02, 03, 04, 05, or 06 as appropriate
  A0310C = 3
  A0310D = 0 (Swing Beds only)

PPS Scheduled Assessment and Change of Therapy OMRA

- If Day 7 of the COT observation period falls within the ARD window (including grace days) of a scheduled PPS Assessment, and the ARD of the scheduled PPS assessment has not been set for a day that is prior to Day 7 of the COT observation period, and a COT OMRA is deemed necessary upon completion of the change of therapy evaluation, then the SNF must combine the COT OMRA and the scheduled assessment.
- Must complete the scheduled PPS assessment item set.
- Since the scheduled assessment is combined with the COT OMRA, the combined assessment will set payment at the new RUG-IV level beginning on Day 1 of the COT observation period and that payment will continue through the remainder of the current standard payment period and the next payment period appropriate to the given scheduled assessment, assuming no intervening assessments. For example:
  - Based on her 14-day assessment, Mrs. T is currently classified into group RVB. Based on the ARD set for the 14-day assessment, a change of therapy evaluation for Mrs. T is necessary on Day 28. The change of therapy evaluation reveals that the therapy services Mrs. T received during that COT observation period were only sufficient to qualify Mrs. T for RHB. Therefore, a COT OMRA is required. Since the facility has not yet completed a 30-day assessment for Mrs. T, the facility must combine the 30-day assessment with the required COT OMRA. The combined assessment confirms Mrs. T's appropriate classification into RHB. The payment for the revised RUG classification will begin on Day 22 and, assuming no intervening assessments, will continue until Day 60.

PPS Scheduled Assessment and Swing Bed Clinical Change Assessment

- ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment **and** within 14 days after the interdisciplinary team (IDT) determination that a change in the patient's condition constitutes a clinical change **and** the assessment must be completed (Item Z0500B) within 14 days after the IDT determines that a change in the patient's condition constitutes a clinical change. If all requirements are not met, the assessments may not be combined.
- If the ARD for the Swing Bed Clinical Change Assessment falls within the ARD (including grace days) of a PPS scheduled assessment that has not been completed yet, the assessments MUST be combined.
- Must complete the Swing Bed PPS item set.

- Code the Item A0310 of the MDS 3.0 as follows:
  A0310A = 99 (only value allowed for Swing Beds)
  A0310B = 01, 02, 03, 04, 05, or 06, as appropriate
  A0310C = 0
  A0310D = 1

Swing Bed Clinical Change Assessment and Start of Therapy OMRA

- ARD (Item A2300) must be set within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is earliest) **and** the assessment must be completed (Item Z0500B) within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change. If all requirements are not met, the assessments may not be combined.
- Must complete the Swing Bed PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:
  A0310A = 99
  A0310B = 07
  A0310C = 1
  A0310D = 1

Swing Bed Clinical Change Assessment and End of Therapy OMRA

- ARD (Item A2300) must be set within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** the assessment must be completed (Item Z0500B) within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change. If all requirements are not met, the assessments may not be combined.
- Must complete the Swing Bed PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:
  A0310A = 99
  A0310B = 07
  A0310C = 2
  A0310D = 1

Swing Bed Clinical Change Assessment and Start and End of Therapy OMRA

- ARD (Item A2300) must be set within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change **and** 5-7 days after the start of therapy (Item O0400A5 or O0400B5 or O0400C5, whichever is the earliest) **and** 1-3 days after the last day therapy was furnished (Item O0400A6 or O0400B6 or O0400C6, whichever is the latest) **and** the assessment must be completed (Item Z0500B) within 14 days after the IDT determination that a change in the patient's condition constitutes a clinical change. If all requirements are not met, the assessments may not be combined.
- Must complete the Swing Bed PPS item set.
- Code the Item A0310 of the MDS 3.0 as follows:
  A0310A = 99

A0310B = 07
A0310C = 3
A0310D = 1

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

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

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

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.

Minimum Required Item Set By Assessment Type for Skilled Nursing Facilities

	Comprehensive Item Set	Quarterly/ PPS* Item Sets	Other Required Assessments/Tracking Item Sets for Skilled Nursing Facilities
Stand-alone Assessment Types	• OBRA Admission • Annual • Significant Change in Status (SCSA) • Significant Correction to Prior Comprehensive (SCPA)	• Quarterly • Significant Correction to Prior Quarterly • PPS 5-Day (5-Day) • PPS 14-Day (14-Day) • PPS 30-Day (30-Day) • PPS 60-Day (60-Day) • PPS 90-Day (90-Day) • PPS Readmission/Return	• Entry Tracking Record • Discharge assessments • Death in Facility Tracking Record • Start of Therapy OMRA • Start of Therapy OMRA and Discharge • Change of Therapy OMRA • OMRA • OMRA and Discharge
Combined Assessment Types	• OBRA Admission and 5-Day • OBRA Admission and 14-Day • OBRA Admission and any OMRA • Annual and any Medicare-required • Annual and any OMRA • SCSA and any Medicare-required • SCSA and any OMRA • SCPA and any Medicare-required • SCPA and any OMRA • Any OBRA comprehensive and any Discharge	• Quarterly and any Medicare-scheduled • Quarterly and any OMRA • Significant Correction to Prior Quarterly and any Medicare-required • Significant Correction to Prior Quarterly and any OMRA • Any Discharge and any Medicare-required • Quarterly and any Discharge • Significant Correction to Prior Quarterly and any Discharge • Any Medicare-required and any Discharge	N/A

*Provider must check with State Agency to determine if the state requires additional items to be completed for the required OBRA Quarterly and PPS assessments.

Minimum Required Item Set By Assessment Type for Swing Bed Providers

	Swing Bed PPS	Other Required Assessments/Tracking Item Sets for Swing Bed Providers
Assessment Type	• PPS 5-Day (5-Day) • PPS 14-Day (14-Day) • PPS 30-Day (30-Day) • PPS 60-Day (60-Day) • PPS 90-Day (90-Day) • PPS Readmission/Return • Clinical Change Assessment	• Entry Record • Discharge assessments • Death in Facility record • Start of Therapy OMRA • Start of Therapy OMRA and Discharge • Change of Therapy OMRA • OMRA • OMRA and Discharge
Assessment Type	• Clinical Change and any Medicare-	N/A

Combinations	required • Any Medicare-required and any Discharge

Tracking records (Entry and Death in Facility) are never combined with other assessments.

The OMRA item sets are all unique item sets and are never completed when combining with other assessments, which require completion of additional items. For example, a **Start of Therapy OMRA** item set is completed only when an assessment is conducted to capture the start of therapy **and** assign a RUG-IV therapy group. In addition, a **Start of Therapy OMRA and Discharge** item set is only completed when the facility staff choose to complete an assessment to reflect the start of therapy and discharge from facility. If those assessments are completed in combination with another assessment type, an item set that contains all items required for both assessments must be selected.

2.12 Medicare and OBRA Assessment Combinations

Below are some of the possible assessment combinations allowed. A provider may choose to combine more than two assessment types when all requirements are met. The coding of Item 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 2.15).

Medicare-required 5-Day and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on days 1 through 5 of the Part A SNF stay.
- ARD may be extended up to day 8 using the designated grace days.
- Must be completed (Item Z0500B) by the end of day 14 of the stay (admission date plus 13 calendar days).
- See Section 2.7 for requirements for CAA process and care plan completion.

Medicare-required 14-Day and OBRA Admission Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on days 13 or 14 of the Part A SNF stay.
- ARD may not be extended from day 15 to day 18 (i.e., grace days may not be used).
- Must be completed (Item Z0500B) by the end of day 14 of the stay (admission date plus 13 calendar days).
- See Section 2.7 for requirements for CAA process and care plan completion.

Medicare-required Scheduled Assessment and OBRA Quarterly Assessment

- Quarterly item set as required by the State.
- ARD (Item A2300) must be set on a day that meets the requirements described earlier for each Medicare-required scheduled assessment in Section 2.9 and for the OBRA Quarterly assessment in Section 2.6.
- ARD may be extended to grace days as long as the requirement for the Quarterly ARD is met.
- See Section 2.6 for OBRA Quarterly assessment completion requirements.

Medicare-required Scheduled Assessment and Annual Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set on a day that meets the requirements described earlier for each Medicare-required scheduled assessment in Section 2.9 and for the OBRA Annual assessment in Section 2.6.
- ARD may be extended to grace days as long as the requirement for the Annual ARD is met.
- See Section 2.6 for OBRA Annual assessment completion requirements.
- See Section 2.7 for requirements for CAA process and care plan completion.

Medicare-required Scheduled Assessment and Significant Change in Status Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment and within 14 days after determination that criteria are met for a Significant Change in Status assessment.
- 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 for requirements for CAA process and care plan completion.

Medicare-required Scheduled Assessment and Significant Correction to Prior Comprehensive Assessment

- Comprehensive item set.
- ARD (Item A2300) must be set within the window for the Medicare-required scheduled assessment **and** within 14 days after the determination that an uncorrected significant error in the prior comprehensive assessment has occurred.
- 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 for requirements for CAA process and care plan completion.

Medicare-required Scheduled Assessment and Significant Correction to Prior Quarterly Assessment

- See Medicare-required Scheduled Assessment and OBRA Quarterly Assessment.

Medicare-required Scheduled Assessment and Discharge Assessment

- PPS item set.

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

Change of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment

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

Change of Therapy OMRA and Significant Correction to Prior Quarterly Assessment

- See COT OMRA and OBRA Quarterly Assessment.

Change of Therapy OMRA and Discharge Assessment

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

resident went to the emergency room at 11:00pm on November 9, returning on November 10, Day 7 of the COT observation period would remain November 14.

Moreover, a SNF may use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for an unscheduled PPS assessment, but only in the case where the ARD for the unscheduled assessment falls on a day that is not counted among the beneficiary's 100 days due to a leave of absence (LOA), as defined above, and the resident returns to the facility from the LOA on Medicare Part A. For example, Day 7 of the COT observation period occurs 7 days following the ARD of the most recent PPS assessment used for payment, regardless if a LOA occurs at any point during the COT observation period. If the ARD for a resident's 30-day assessment were set for November 7 and the resident went to the emergency room at 11:00pm on November 14, returning on November 15, Day 7 of the COT observation period would remain November 14 for purposes of coding the COT OMRA.

Finally, there may be cases in which a SNF plans to combine a scheduled and unscheduled assessment on a given day, but then that day becomes an LOA day for the resident. In such cases, while that day may still be used as the ARD of the unscheduled assessment, this day cannot be used as the ARD of the scheduled assessment. For example if the ARD for a resident's 5-day assessment were set for May 10 and the resident went to the emergency room at 1:00pm on May 17, returning on May 18, a facility could not complete a combined 14-day/COT OMRA with an ARD set for May 17. Rather, while the COT OMRA could still have an ARD of May 17, the 14-day assessment would need to have an ARD that falls on one of the resident's Medicare A benefit days.

Resident Leaves the Facility and Returns During an Observation Period

The ARD is not altered if the beneficiary is out of the facility for a temporary leave of absence during part of the observation period. In this case, the facility may include services furnished during the beneficiary's temporary absence (when permitted under MDS coding guidelines; see Chapter 3) but may not extend the observation period.

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

In the situation when a beneficiary is discharged from Medicare Part A services but remains in the facility in a Medicare and/or Medicaid certified bed with another pay source, the OBRA schedule will be continued. Since the beneficiary remained in a certified bed after the Medicare benefits were discontinued, the facility must continue with the OBRA schedule from the beneficiary's original date of admission. There is no reason to change the OBRA schedule when Part A benefits resume. If and when the Medicare Part A benefits resume, the Medicare schedule starts again with a 5-Day Medicare-required assessment, MDS Item A0310B = 01. See Chapter 6, Section 6.7 for greater detail to determine whether or not the resident is eligible for Part A SNF coverage.

The original date of entry (Item A1600) is retained. The beneficiary should be assessed to determine if there was a significant change in status. A SCSA could be completed with either the Medicare-required 5-day or 14-day assessment or separately.

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 early or late assessment scheduling practices may result in a review. The default rate takes the place of the otherwise applicable Federal rate. It is equal to the rate paid for the RUG group reflecting the lowest acuity level, and would generally be lower than the Medicare rate payable if the SNF had submitted an assessment in accordance with the prescribed assessment schedule.

Early PPS Assessment

An assessment should be completed according to the Medicare-required assessment schedule. **If an assessment is performed earlier than the schedule indicates (the ARD is not in the defined window), the provider will be paid at the default rate for the number of days the assessment was out of compliance.** For example, a Medicare-required 14-Day assessment with an ARD of day 12 (1 day early) would be paid at the default rate for the first day of the payment period that begins on day 15.

In the case of an early COT OMRA, the early COT would reset the COT calendar such that the next COT OMRA, if deemed necessary, would have an ARD set for 7 days from the early COT ARD. For example, a facility completes a 30-day assessment with an ARD of November 1 which classifies a resident into a therapy RUG. On November 8, which is Day 7 of the COT observation period, it is determined that a COT is required. A COT OMRA is completed for this resident with an ARD set for November 6, which is Day 5 of the COT observation period as opposed to November 8 which is Day 7 of the COT observation period. This COT OMRA would be considered an early assessment and, based on the ARD set for this early assessment would be paid at the default rate for the two days this assessment was out of compliance. The next seven day COT observation period would begin on November 7, and end on November 13.

DEFINITIONS

INTERVENING ASSESSMENT

Refers to an assessment with an ARD set for a day in the interim period between the last day of the appropriate ARD window for a late assessment (including grace days, when appropriate) and the actual ARD of the late assessment.

DAYS OUT OF COMPLIANCE

Refers to the number of days between the day following the last day of the available ARD window, including grace days when appropriate, and the late ARD (including the late ARD) of an assessment.

Late PPS Assessment

If the SNF fails to set the ARD within the defined ARD window for a Medicare-required assessment, including the grace days, 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.

If the ARD on the late assessment is set for **prior to the end of the period during which the late assessment would have controlled the payment,** had the ARD been set timely, and/or **no intervening assessments have occurred, 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 (including grace days when appropriate) 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 Medicare-required 30-day assessment with an ARD of Day 41 is out of compliance for 8 days and therefore would be paid at the default rate for 8 days and the HIPPS code from the late 30-day assessment until the next scheduled or unscheduled assessment that controls payment. In this example, if there are no other assessments until the 60-day assessment, the remaining 22 days are billed according to the HIPPS code on the late assessment.

A second example, involving a late unscheduled assessment would be if a COT OMRA was completed with an ARD of Day 39, while Day 7 of the COT observation period was Day 37. In this case, the COT OMRA would be considered 2 days late and the facility would bill the default rate for 2 days and then bill the HIPPS code from the late COT OMRA until the next scheduled or unscheduled assessment controls payment, in this case, for at least 5 days. NOTE: In such cases where a late assessment is completed and no intervening assessments occur, the late assessment is used to establish the COT calendar.

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

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

Missed PPS Assessment

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

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

Errors on a PPS Assessment

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

*These requirements/policies also apply to swing bed providers.

2.14 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 PPS assessment, a discharge, or death in facility. 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 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 blank cell indicates that the next record is expected to follow the prior record; a record order warning will ***not*** be issued for these combinations.

For the first MDS 3.0 record with event date on or after October 1, 2010, the last MDS 2.0 record (if available) should be used to determine if the record order is expected. The QIES ASAP system will find the last MDS 2.0 record and issue a warning if the order of these two records is unexpected.

Note that there are not any QIES ASAP record order warnings produced for Swing Bed MDS records.

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

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

DEFINITIONS

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

Steps for Assessment

1. Review the documentation in the medical record for the 7-day look-back period.
2. Talk with direct care staff from each shift that has cared for the resident to learn what the resident does for himself during each episode of each ADL activity definition as well as the type and level of staff assistance provided. Remind staff that the focus is on the 7-day look-back period only.
3. When reviewing records, interviewing staff, and observing the resident, be specific in evaluating each component as listed in the ADL activity definition. For example, when evaluating Bed Mobility, observe what the resident is able to do without assistance, and then determine the level of assistance the resident requires from staff for moving to and from a lying position, for turning the resident from side to side, and/or for positioning the resident in bed.

   To clarify your own understanding and observations about a resident's performance of an ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific. See page G-10 for an example of using probes when talking to staff.

Coding Instructions

For each ADL activity:

- Consider all episodes of the activity that occur over a 24-hour period during each day of the 7-day look-back period, as a resident's ADL self-performance and the support required may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations to occur, including but not limited to, mood, medical condition, relationship issues (e.g., willing to perform for a nursing assistant that he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day (i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well).

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

- In order to be able to promote the highest level of functioning among residents, clinical staff must first identify what the resident actually does for himself or herself, noting when assistance is received and clarifying the type (weight-bearing, non-weight-bearing, verbal cueing, guided maneuvering, etc.) and level of assistance (supervision, limited assistance, etc.) provided by all disciplines.
- If a resident uses special adaptive devices such as a walker, device to assist with donning socks, dressing stick, long-handled reacher, or adaptive eating utensils, code ADL Self-Performance and ADL Support Provided based on the level of assistance the resident requires when using such items.
- For the purposes of completing Section G, "facility staff" pertains to direct employees and facility-contracted employees (e.g. rehabilitation staff, nursing agency staff). Thus, does not include individuals hired, compensated or not, by individuals outside of the facility's management and administration. Therefore, facility staff does not include, for example, hospice staff, nursing/CNA students, etc. Not including these individuals as facility staff supports the idea that the facility retains the primary responsibility for the care of the resident outside of the arranged services another agency may provide to facility residents.
- The ADL Self-Performance coding level definitions are intended to reflect real world situations where slight variations in level of ADL self-performance are common.
- To assist in coding ADL Self-Performance items, facilities may augment the instructions with the algorithm on page G-7.
- This section involves a two-part ADL evaluation: Self-Performance, which measures how much of the ADL activity the resident can do for himself or herself, and Support Provided, which measures how much facility staff support is needed for the resident to complete the ADL. Each of these sections uses its own scale, therefore, it is recommended that the ADL Self-Performance evaluation (Column 1) be completed for all ADL activities before beginning the ADL Support evaluation (Column 2).

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

- Code 0, independent: if resident completed activity with no help or oversight **every time** during the 7-day look-back period and the activity occurred at least three times.
- Code 1, supervision: if oversight, encouragement, or cueing was provided **three or more times** during the last 7 days.
- Code 2, limited assistance: if resident was highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight-bearing assistance on **three or more times** during the last 7 days.
- Code 3, extensive assistance: if resident performed part of the activity over the last 7 days and help of the following type(s) was provided **three or more times**:
  - Weight-bearing support provided **three or more times, OR**
  - Full staff performance of activity **three or more times** during part but not all of the last 7 days.

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

- Code 4, total dependence: if there was **full staff performance** of an activity with no participation by resident for any aspect of the ADL activity and the activity occurred three or more times. The resident must be unwilling or unable to perform any part of the activity over the entire 7-day look-back period.
- Code 7, activity occurred only once or twice: if the activity occurred **fewer than three times**.
- Code 8, activity did not occur: if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day look-back period.

The Rule of 3

- The "Rule of 3" is a method that was developed to help determine the appropriate code to document ADL Self-Performance on the MDS.
- It is very important that staff who complete this section fully understand the components of each ADL, the ADL Self-Performance coding level definitions, and the Rule of 3.
- In order to properly apply the Rule of 3, the facility must first note which ADL activities occurred, how many times each ADL activity occurred, what type and what level of support was required for each ADL activity over the entire 7-day look-back period.
- The following ADL Self-Performance coding levels are exceptions to the Rule of 3:
  - **Code 0, Independent** – Coded only if the resident completed the ADL activity with no help or oversight **every time** the ADL activity occurred during the 7-day look-back period and the activity occurred at least three times.
  - **Code 4, Total dependence –** Coded only if the resident required **full staff performance** of the ADL activity **every time** the ADL activity occurred during the 7-day look-back period and the activity occurred three or more times.
  - **Code 7, Activity occurred only once or twice** – Coded if the ADL activity occurred **fewer than three times** in the 7-day look back period.
  - **Code 8, Activity did not occur –** Coded only if the ADL activity **did not occur** or **family and/or non-facility staff provided care 100% of the time** for that activity over the entire 7-day look-back period.

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

Instructions for the Rule of 3:

When an ADL activity has occurred **three or more times**, apply the steps of the Rule of 3 below **(keeping the ADL coding level definitions and the above exceptions in mind)** to determine the code to enter in Column 1, ADL Self-Performance. These steps must be used in sequence. Use the first instruction encountered that meets the coding scenario (e.g., if #1 applies, stop and code that level).

1. When an activity occurs **three or more times at any one level**, code that level.

2. When an activity occurs **three or more times at multiple levels, code the most dependent level that occurred three or more times**.

3. When an activity occurs **three or more times and at multiple levels, but not three times at any one level**, apply the following:

    a. Convert episodes of full staff performance to weight-bearing assistance when applying the third Rule of 3, as long as the full staff performance episodes did not occur every time the ADL was performed in the 7-day look-back period. It is only when **every** episode is full staff performance that Total dependence (4) can be coded. Remember, that weight-bearing episodes that occur three or more times or full staff performance that is provided three or more times during part but not all of the last 7 days are included in the ADL Self-Performance coding level definition for Extensive assistance (3).

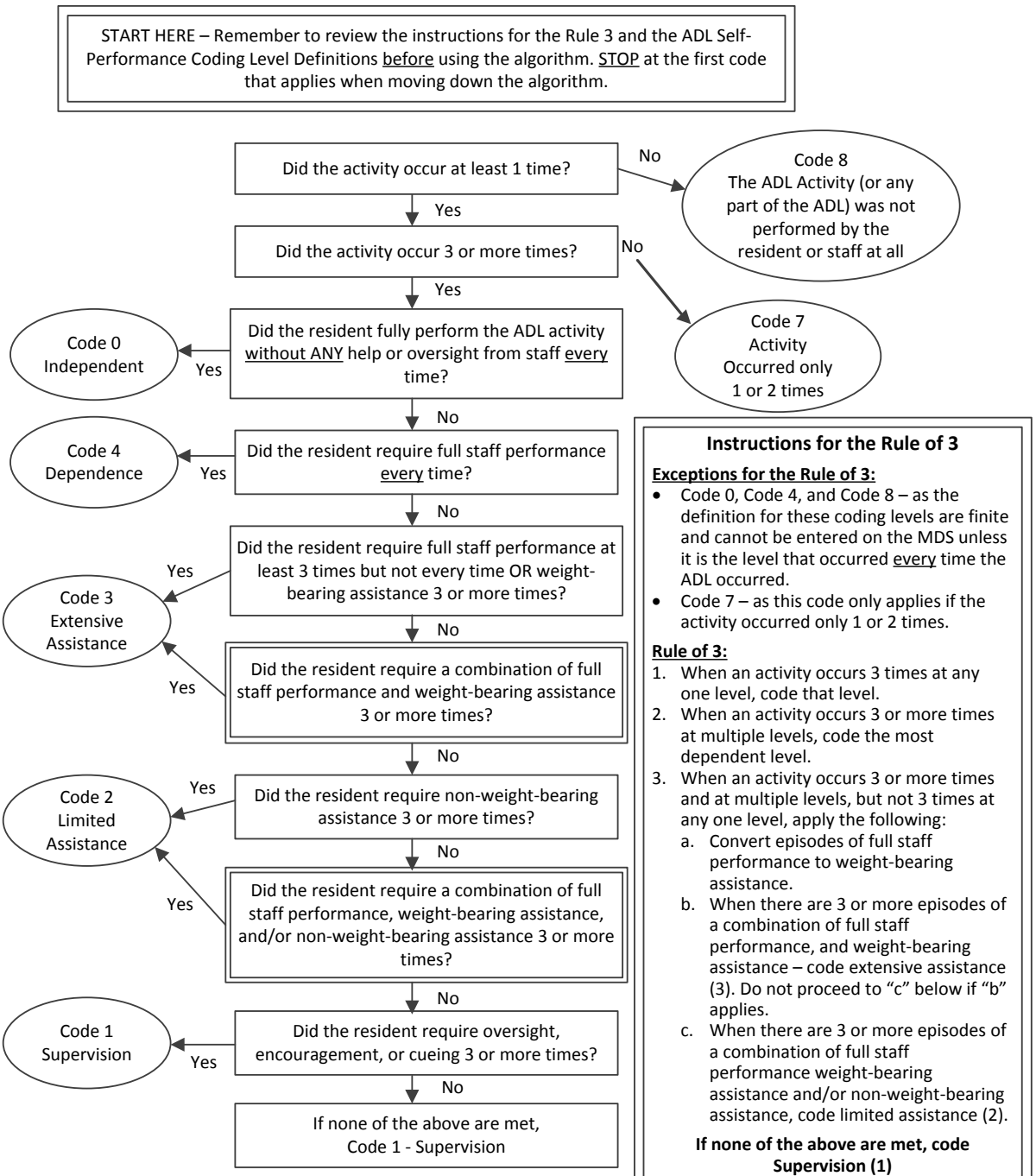
    b. When there is a combination of full staff performance and weight-bearing assistance that total three or more times—code extensive assistance (3).

    c. When there is a combination of full staff performance/weight-bearing assistance, and/or non-weight-bearing assistance that total three or more times—code limited assistance (2).

If none of the above are met, code supervision.

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

ADL Self-Performance Algorithm



Instructions for the Rule of 3

Exceptions for the Rule of 3:

- Code 0, Code 4, and Code 8 – as the definition for these coding levels are finite and cannot be entered on the MDS unless it is the level that occurred every time the ADL occurred.
- Code 7 – as this code only applies if the activity occurred only 1 or 2 times.

Rule of 3:

1. When an activity occurs 3 times at any one level, code that level.
2. When an activity occurs 3 or more times at multiple levels, code the most dependent level.
3. When an activity occurs 3 or more times and at multiple levels, but not 3 times at any one level, apply the following:
   a. Convert episodes of full staff performance to weight-bearing assistance.
   b. When there are 3 or more episodes of a combination of full staff performance, and weight-bearing assistance – code extensive assistance (3). Do not proceed to "c" below if "b" applies.
   c. When there are 3 or more episodes of a combination of full staff performance weight-bearing assistance and/or non-weight-bearing assistance, code limited assistance (2).

If none of the above are met, code Supervision (1)

*This box in the algorithm corresponds to a, b, and c under the third Rule of 3 above. The instruction in this box only applies when the third Rule of 3 applies, i.e., an activity occurs 3 times and at multiple levels, but not 3 times at any one level (e.g., 2 times non-weight-bearing, 2 times weight-bearing). If the coding scenario does not meet the third Rule of 3, do not apply a, b, or c of the third Rule of 3. Answer "No," and then continue down the algorithm.

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

Coding Instructions for G0110, Column 2, ADL Support

*Code for the **most** support provided over all shifts. Code regardless of how Column I ADL Self-Performance is coded.*

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

Coding Tips and Special Populations

- Some residents sleep on furniture other than a bed (for example, a recliner). Consider assistance received in this alternative bed when coding bed mobility.
- Do **NOT** include the emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag in G0110 I.
- **Differentiating between guided maneuvering and weight-bearing assistance:** determine **who** is supporting the weight of the resident's extremity or body. For example, if the staff member supports some of the weight of the resident's hand while helping the resident to eat (e.g., lifting a spoon or a cup to mouth), or performs part of the activity for the resident, this is "weight-bearing" assistance for this activity. If the resident can lift the utensil or cup, but staff assistance is needed to guide the resident's hand to his or her mouth, this is guided maneuvering.
- Do **NOT** record the staff's assessment of the resident's potential capability to perform the ADL activity. The assessment of potential capability is covered in **ADL Functional Rehabilitation Potential** Item (G0900).
- Do **NOT** record the type and level of assistance that the resident "should" be receiving according to the written plan of care. The level of assistance actually provided might be very different from what is indicated in the plan. Record what actually happened.
- Do **NOT** include assistance provided by family or other visitors.
- **Some examples for coding for ADL Support Setup Help when the activity involves the following:**
  - Bed Mobility—handing the resident the bar on a trapeze, staff raises the ½ rails for the resident's use and then provides no further help.

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

- — Transfer—giving the resident a transfer board or locking the wheels on a wheelchair for safe transfer.
- — Locomotion
  - o Walking—handing the resident a walker or cane.
  - o Wheeling—unlocking the brakes on the wheelchair or adjusting foot pedals to facilitate foot motion while wheeling.
- — Dressing—retrieving clothes from the closet and laying out on the resident's bed; handing the resident a shirt.
- — Eating—cutting meat and opening containers at meals; giving one food item at a time.
- — Toilet Use—handing the resident a bedpan or placing articles necessary for changing an ostomy appliance within reach.
- — Personal Hygiene—providing a washbasin and grooming articles.

- **Supervision**
  - — **Code Supervision** for residents seated together or in close proximity of one another during a meal who receive individual supervision with eating.
  - — General supervision of a dining room is not the same as individual supervision of a resident and **is not** captured in the coding for Eating.
- **Coding activity did not occur, 8:**
  - — **Toileting** would be **coded 8, activity did not occur**: only if elimination did not occur during the entire look-back period, or if family and/or non-facility staff toileted the resident 100% of the time over the entire 7-day look-back period.
  - — **Locomotion** would be **coded 8, activity did not occur**: if the resident was on bed rest and did not get out of bed, and there was no locomotion via bed, wheelchair, or other means during the look-back period or if locomotion assistance was provided by family and/or non-facility staff 100 % of the time over the entire 7-day look-back period.
  - — **Eating** would be **coded 8, activity did not occur**: if the resident received no nourishment by any route (oral, IV, TPN, enteral) during the 7-day look-back period, if the resident was not fed by facility staff during the 7-day look-back period, or if family and/or non-facility staff fed the resident 100% of the time over the entire 7-day look-back period.
- **Coding activity occurred only once or twice, 7:**
  - — Walk in corridor would be **coded 7, activity occurred only once or twice**: if the resident came out of the room and ambulated in the hallway for a weekly tub bath but otherwise stayed in the room during the 7-day look-back period.
  - — Locomotion off unit would be **coded 7, activity occurred only once or twice**: if the resident left the vicinity of his or her room only one or two times to attend an activity in another part of the building.

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

- **Residents with tube feeding, TPN, or IV fluids**
  - — **Code extensive assistance (1 or 2 persons):** if the resident with tube feeding, TPN, or IV fluids did not participate in management of this nutrition but did participate in receiving oral nutrition. This is the correct code because the staff completed a portion of the ADL activity for the resident (managing the tube feeding, TPN, or IV fluids).
  - — **Code totally dependent in eating:** only if resident was assisted in eating all food items and liquids at all meals and snacks (including tube feeding delivered totally by staff) and did not participate in any aspect of eating (e.g., did not pick up finger foods, did not give self tube feeding or assist with swallow or eating procedure).

Example of a Probing Conversation with Staff

1. Example of a probing conversation between the RN Assessment Coordinator and a nursing assistant (NA) regarding a resident's bed mobility assessment:

RN: "Describe to me how Mrs. L. moves herself in bed. By that I mean once she is in bed, how does she move from sitting up to lying down, lying down to sitting up, turning side to side and positioning herself?"
NA: "She can lay down and sit up by herself, but I help her turn on her side."
RN: "She lays down and sits up without any verbal instructions or physical help?"
NA: "No, I have to remind her to use her trapeze every time. But once I tell her how to do things, she can do it herself."
RN: "How do you help her turn side to side?"
NA: "She can help turn herself by grabbing onto her side rail. I tell her what to do. But she needs me to lift her bottom and guide her legs into a good position."
RN: "Do you lift her by yourself or does someone help you?"
NA: "I do it by myself."
RN: "How many times during the last 7 days did you give this type of help?"
NA: "Every day, probably 3 times each day."

In this example, the assessor inquired specifically how Mrs. L. moves to and from a lying position, how she turns from side to side, and how the resident positions herself while in bed. A resident can be independent in one aspect of bed mobility, yet require extensive assistance in another aspect, so be sure to consider each activity definition fully. If the RN did not probe further, he or she would not have received enough information to make an accurate assessment of the actual assistance Mrs. L. received. This information is important to know and document because accurate coding and supportive documentation provides the basis for reporting on the type and amount of care provided.

Coding: Bed Mobility ADL assistance would be coded 3 (self-performance) and 2 (support provided), extensive assistance with a one person assist.

Examples for G0110A, Bed Mobility

1. Mrs. D. can easily turn and position herself in bed and is able to sit up and lie down without any staff assistance at any time during the 7-day look-back period. She requires use of a single side rail that staff place in the up position when she is in bed.

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

Coding: G0110A1 would be coded 0, independent.
G0110A2 would be coded 1, setup help only.

Rationale: Resident is independent at all times in bed mobility during the 7-day look-back period and needs only setup help.

2. Resident favors lying on her right side. Because she has had a history of skin breakdown, staff must verbally remind her to reposition off her right side daily during the 7-day look-back period.

   Coding: G0110A1 would be coded 1, supervision.
   G0110A2 would be coded 0, no setup or physical help from staff.

   Rationale: Resident requires staff supervision, cueing, and reminders for repositioning more than three times during the look-back period.

3. Resident favors lying on her right side. Because she has had a history of skin breakdown, staff must sometimes cue the resident and guide (non-weight-bearing assistance) the resident to place her hands on the side rail and encourage her to change her position when in bed daily over the 7-day look-back period.

   Coding: G0110A1 would be coded 2, limited assistance.
   G0110A2 would be coded 2, one person physical assist.

   Rationale: Resident requires cueing and encouragement with setup and non-weight-bearing physical help daily during the 7-day look-back period.

4. Mr. Q. has slid to the foot of the bed four times during the 7-day look-back period. Two staff members had to physically lift and reposition him toward the head of the bed. Mr. Q. was able to assist by bending his knees and pushing with legs when reminded by staff.

   Coding: G0110A1 would be coded 3, extensive assistance.
   G0110A2 would be coded 3, two+ persons physical assist.

   Rationale: Resident required weight-bearing assistance of two staff members on four occasions during the 7-day look-back period with bed mobility.

5. Mrs. S. is unable to physically turn, sit up, or lie down in bed. Two staff members must physically turn her every 2 hours without any participation at any time from her at any time during the 7-day look-back period. She must be physically assisted to a seated position in bed when reading.

   Coding: G0110A1 would be coded 4, total dependence.
   G0110A2 would be coded 3, two+ persons physical assist.

   Rationale: Resident did not participate at any time during the 7-day look-back period and required two staff to position her in bed.

Examples for G0110B, Transfer

1. When transferring from bed to chair or chair back to bed, the resident is able to stand up from a seated position (without requiring any physical or verbal help) and walk from the bed to chair and chair back to the bed every day during the 7-day look back period.

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

Coding: G0110B1 would be coded 0, independent.

G0110B2 would be coded 0, no setup or physical help from staff.

Rationale: Resident is independent each and every time she transferred during the 7-day look-back period and required no setup or physical help from staff.

2. Staff must supervise the resident as she transfers from her bed to wheelchair daily. Staff must bring the chair next to the bed and then remind her to hold on to the chair and position her body slowly.

   Coding: G0110B1 would be coded 1, supervision.

   G0110B2 would be coded 1, setup help only.

   Rationale: Resident requires staff supervision, cueing, and reminders for safe transfer. This activity happened daily over the 7-day look-back period.

3. Mrs. H. is able to transfer from the bed to chair when she uses her walker. Staff place the walker near her bed and then assist the resident with guided maneuvering as she transfers. The resident was noted to transfer from bed to chair six times during the 7-day look-back period.

   Coding: G0110B1 would be coded 2, limited assistance.

   G0110B2 would be coded 2, one person physical assist.

   Rationale: Resident requires staff to set up her walker and provide non-weight-bearing assistance when she is ready to transfer. The activity happened six times during the 7-day look-back period.

4. Mrs. B. requires weight-bearing assistance of one staff member to partially lift and support her when being transferred. The resident was noted to have been transferred 14 times in the 7-day look-back period and each time required weight-bearing assistance.

   Coding: G0110B1 would be coded 3, extensive assistance.

   G0110B2 would be coded 2, one person physical assist.

   Rationale: Resident partially participates in the task of transferring. The resident was noted to have transferred 14 times during the 7-day look-back period, each time requiring weight-bearing assistance of one staff member.

5. Mr. T. is in a physically debilitated state due to surgery. Two staff members must physically lift and transfer him to a reclining chair daily using a mechanical lift. Mr. T. is unable to assist or participate in any way.

   Coding: G0110B1 would be coded 4, total dependence.

   G0110B2 would be coded 3, two+ persons physical assist.

   Rationale: Resident did not participate and required two staff to transfer him out of his bed. The resident was transferred out of bed to the chair daily during the 7-day look-back period.

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

6. Mrs. D. is post-operative for extensive surgical procedures. Because of her ventilator dependent status in addition to multiple surgical sites, her physician has determined that she must remain on total bed rest. During the 7-day look-back period the resident was not moved from the bed.

   Coding: G0110B1 would be coded 8, activity did not occur.
   G0110B2 would be coded 8, ADL activity itself did not occur during entire period.
   Rationale: Activity did not occur.

7. Mr. M. has Parkinson's disease and needs weight-bearing assistance of two staff to transfer from his bed to his wheelchair. During the 7-day look-back period, Mr. M. was transferred once from the bed to the wheelchair and once from wheelchair to bed.

   Coding: G0110B1 would be coded 7, activity occurred only once or twice.
   G0110B2 would be coded 3, two+ persons physical assist.
   Rationale: The activity happened only twice during the look-back period, with the support of two staff members.

Examples for G0110C, Walk in Room

1. Mr. R. is able to walk freely in his room (obtaining clothes from closet, turning on TV) without any cueing or physical assistance from staff at all during the entire 7-day look-back period.

   Coding: G0110C1 would be coded 0, independent.
   G0110C2 would be coded 0, no setup or physical help from staff.
   Rationale: Resident is independent.

2. Mr. B. was able to walk in his room daily, but a staff member needed to cue and stand by during ambulation because the resident has had a history of an unsteady gait.

   Coding: G0110C1 would be coded 1, supervision.
   G0110C2 would be coded 0, no setup or physical help from staff.
   Rationale: Resident requires staff supervision, cueing, and reminders daily while walking in his room, but did not need setup or physical help from staff.

3. Mr. K. is able to walk in his room, and, with hand-held assist from one staff member, the resident was noted to ambulate daily during the 7-day look-back period.

   Coding: G0110C1 would be coded 2, limited assistance.
   G0110C2 would be coded 2, one person physical assist.
   Rationale: Resident requires hand-held (non-weight-bearing) assistance of one staff member daily for ambulation in his room.

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

4. Mr. A. has a bone spur on his heel and has difficulty ambulating in his room. He requires staff to help support him when he selects clothing from his closet. During the 7-day look-back period the resident was able to ambulate with weight-bearing assistance from one staff member in his room four times.

   Coding: G0110C1 would be coded 3, extensive assistance.
   G0110C2 would be coded 2, one person physical assist.

   Rationale: The resident was able to ambulate in his room four times during the 7-day look-back period with weight-bearing assistance of one staff member.

5. Mr. J. is attending physical therapy for transfer and gait training. He does not ambulate on the unit or in his room at this time. He calls for assistance to stand pivot to a commode next to his bed.

   Coding: G0110C1 would be coded 8, activity did not occur.
   G0110C2 would be coded 8, ADL activity itself did not occur during entire period.

   Rationale: Activity did not occur.

Examples for G0110D, Walk in Corridor

1. Mr. X. ambulated daily up and down the hallway on his unit with a cane and did not require any setup or physical help from staff at any time during the 7-day look-back period.

   Coding: G0110D1 would be coded 0, independent.
   G0110D2 would be coded 0, no setup or physical help from staff.

   Rationale: Resident requires no setup or help from the staff at any time during the entire 7-day look-back period.

2. Staff members provided verbal cueing while resident was walking in the hallway every day during the 7-day look-back period to ensure that the resident walked slowly and safely.

   Coding: G0110D1 would be coded 1, supervision.
   G0110D2 would be coded 0, no setup or physical help from staff.

   Rationale: Resident requires staff supervision, cueing, and reminders daily while ambulating in the hallway during the 7-day look-back period.

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

3. A resident had back surgery 2 months ago. Two staff members must physically support the resident as he is walking down the hallway because of his unsteady gait and balance problem. During the 7-day look-back period the resident was ambulated in the hallway three times with physical assist of two staff members.

   Coding: G0110D1 would be coded 3, extensive assistance.
   G0110D2 would be coded 3, two+ persons physical assist.

   Rationale: The resident was ambulated three times during the 7-day look-back period, with the resident partially participating in the task. Two staff members were required to physically support the resident so he could ambulate.

4. Mrs. J. ambulated in the corridor once with supervision and once with non-weight-bearing assistance of one staff member during the 7-day look-back period.

   Coding: G0110D1 would be coded 7, activity occurred only once or twice.
   G0110D2 would be coded 2, one person physical assist.

   Rationale: The activity occurred only twice during the look-back period. It does not matter that the level of assistance provided by staff was at different levels. During ambulation, the most support provided was physical help by one staff member.

Examples for G0110E, Locomotion on Unit

1. Mrs. L. is on complete bed rest. During the 7-day look-back period she did not get out of bed or leave the room.

   Coding: G0110E1 would be coded 8, activity did not occur.
   G0110E2 would be coded 8, ADL activity itself did not occur during entire period.

   Rationale: The resident was on bed rest during the look-back period and never left her room.

Examples for G0110F, Locomotion off Unit

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

   Coding: G0110F1 would be coded 8, activity did not occur.
   G0110F2 would be coded 8, ADL activity itself did not occur during entire period.

   Rationale: Activity did not occur at all.

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

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

   Coding: G0110F1 would be coded 7, activity occurred only once or twice.
   G0110F2 would be coded 0, no setup or physical help from staff.

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

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

   Coding: G0110F1 would be coded 1, supervision.
   G0110F2 would be coded 2, one person physical assist.

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

Examples for G0110G, Dressing

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

   Coding: G0110G1 would be coded 2, limited assistance.
   G0110G2 would be coded 2, one person physical assist.

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

Examples for G0110H, Eating

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

   Coding: G0110H1 would be coded 0, independent.
   G0110H2 would be coded 0, no setup or physical help from staff.

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

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

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

   Coding: G0110H1 would be coded 1, supervision.
   G0110H2 would be coded 0, no setup or physical help from staff.

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

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

   Coding: G0110H1 would be coded 2, limited assistance.
   G0110H2 would be coded 2, one person physical assist.

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

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

   Coding: G0110H1 would be coded 3, extensive assistance.
   G0110H2 would be coded 2, one person physical assist.

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

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

   Coding: G0110H1 would be coded 4, total dependence.
   G0110H2 would be coded 2, one person physical assist.

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

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

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

   Coding: G0110H1 would be coded 4, total dependence.
   G0110H2 would be coded 2, one person physical assist.
   Rationale: During the 7-day look-back period, she did not participate in eating and/or receiving of her tube feed during the entire period. She required full staff performance of these functions.

Examples for G0110I, Toilet Use

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

   Coding: G0110I1 would be coded 0, independent.
   G0110I2 would be coded 0, no setup or physical help from staff.
   Rationale: Resident was independent in all her toileting tasks.

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

   Coding: G0110I1 would be coded 1, supervision.
   G0110I2 would be coded 0, no setup or physical help from staff.
   Rationale: Resident required staff supervision, cueing and reminders daily.

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

   Coding: G0110I1 would be coded 2, limited assistance.
   G0110I2 would be coded 2, one person physical assist.
   Rationale: Resident required staff to perform non-weight-bearing activities to complete the task multiple times each day during the 7-day look-back period.

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

   Coding: G0110I1 would be coded 3, extensive assistance.
   G0110I2 would be coded 2, one person physical assist.
   Rationale: During the 7-day look-back period, the resident required weight-bearing assistance with the support of one staff member to use the commode four times.

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

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

   Coding: G0110I1 would be coded 4, total dependence.
   G0110I2 would be coded 2, one person physical assist.

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

Examples for G0110J, Personal Hygiene

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

   Coding: G0110J1 would be coded 1, supervision.
   G0110J2 would be coded 1, setup help only.

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

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

   Coding: G0110J1 would be coded 3, extensive assistance.
   G0110J2 would be coded 2, one person physical assist.

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

Scenario Examples

1. Scenario: The following dressing assistance was provided to Mr. X during the look-back period: Two times, he required guided maneuvering of his arms to don his shirt; this assistance was non-weight-bearing assistance. Four times, he required the staff to assist him to put his shirt on due to pain in his shoulders. During these four times that the staff had to assist Mr. X to put his shirt on, the staff had to physically assist him by lifting each of his arms. This component of the dressing activity occurred six times in the 7-day look-back period. There were two times where Mr. X required non-weight-bearing assistance and four times where he required weight-bearing assistance, therefore the appropriate code to enter on the MDS is Extensive assistance (3).

   Rationale: This ADL activity component occurred six times in the 7-day look-back period. Mr. X required limited assistance two times and weight-bearing (extensive) assistance four times. Lifting the resident's arms is considered weight-bearing assistance. The ADL activity component occurred three or more times at one level, extensive - thus, this weight-bearing assistance is the highest level of dependence identified that occurred three or more times. The scenario is consistent with the ADL

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

Self-Performance coding level definition of Extensive assistance and meets the first Rule of 3. The assessor uses the steps in the Rule of 3 in sequence and stops once one has been identified as applying to the scenario. Therefore the final code that should be entered in Column 1, ADL Self-Performance, G0110G – Dressing is Extensive assistance (3).

2. Scenario: The following assistance was provided to Mrs. C over the last seven days: Four times, she required verbal cueing for hand placement during stand-pivot transfers to her wheelchair and three times she required weight-bearing assistance to help her rise from the wheelchair, steady her and help her turn with her back to the edge of the bed. Once she was at the edge of the bed and put her hand on her transfer bar, she was able to sit. She completed the activity without assistance the 14 remaining instances during the 7-day look-back period. The four times that she required verbal cueing from the staff for hand placement are considered supervision. The three times that the staff had to physically support Mrs. C during a portion of the transfer are considered weight-bearing assistance. This ADL occurred 21 times over the 7-day look-back period. There were three or more times where supervision was required, and three times where weight-bearing assistance was required; therefore, the appropriate code to enter on the MDS is Extensive assistance (3).

   Rationale: The ADL activity occurred 21 times over the 7-day look-back period. Mrs. C required supervision four times and weight-bearing assistance was provided three times during the 7-day look-back period. The ADL activity also occurred three or more times at multiple levels (four times with supervision, three times with weight-bearing assistance, and 14 times without assistance). Weight-bearing assistance is also the highest level of dependence identified that occurred three or more times. The first Rule of 3 does not apply because the ADL activity occurred three or more times at multiple levels, not three or more times at any one level. Because the ADL activity occurred three or more times at multiple levels, the scenario meets the second Rule of 3 and the assessor will apply the most dependent level that occurred three or more times. Note that this scenario does meet the definition of Extensive assistance as well, since the activity occurred at least three times and there was weight-bearing support provided three times. The final code that should be entered in Column 1, ADL Self-Performance, G0110B – Transfer is Extensive assistance (3).

3. Scenario: Mrs. F. was in the nursing home for only one day prior to transferring to another facility. While there, she was unable to complete a component of the eating ADL activity without assistance three times. The following assistance was provided: Twice she required weight-bearing assistance to help lift her fork to her mouth. One time in the evening, the staff fed Mrs. F. because she could not scoop the food on her plate with the fork, nor could she lift the fork to her mouth. The three times that Mrs. F. could not complete the activity, the staff had to physically assist her by either holding her hand as she brought the fork to her mouth, or by actually feeding her. There were two times where the staff provided weight-bearing assistance and one time where they provided full staff performance. This component of the ADL eating activity where assistance was required, occurred three times in the look-back period,

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

but not three times at any one level. Based on the third Rule of 3, the final code determination is Extensive assistance (3).

Rationale: Eating occurred three times in the look-back period during the day that Mrs. F was in the nursing home. Mrs. F performed part of the activity by scooping the food and holding her fork two times, but staff had to assist by lifting her arm to her mouth resulting in two episodes of weight-bearing assistance. The other time, the staff had to feed Mrs. F. The first Rule of 3 does not apply because even though the ADL assistance occurred three or more times, it did not occur three times at any one level. The second Rule of 3 does not apply because even though the ADL assistance occurred three or more times it did not occur three or more times at multiple levels. The third Rule of 3 applies since the ADL assistance occurred three times at multiple levels but not three times at any one level. Sub-item "a" under the third Rule of 3 states to convert episodes of full staff performance to weight-bearing assistance as long as the full staff performance episodes did not occur every time the ADL was performed in the 7-day look-back period. Therefore, the one episode of full staff performance is considered weight-bearing assistance and can be added to the other two episodes of weight-bearing assistance. This now totals three episodes of weight-bearing assistance. Therefore, according to the application of the third Rule of 3 and the first two sub-items, "a" and "b," the correct code to enter in Column 1, ADL Self-Performance, G0110H, Eating is Extensive assistance (3). Note that none of the ADL Self-Performance coding level definitions apply directly to this scenario. It is only through the application of the third Rule of 3 and the first two sub-items that the facility is able to code this item as extensive assistance.

4. Scenario: Mr. N was admitted to the facility, but was sent to the hospital on the 2nd day he was there. The following assistance was provided to Mr. N over the look-back period: Weight-bearing assistance one time to lift Mr. N's right arm into his shirt sleeves when dressing in the morning on day one, non-weight-bearing assistance one time to button his shirt in the morning on day two, and full staff performance one time on day two to put on his pants on after resting in bed in the afternoon. Mr. N was independent in the evening on day one when undressing and getting his bed clothes on. Based on the application of the third Rule of 3s sub-items, the final code determination is Limited assistance (2).

   Rationale: There was one episode where Mr. N required full staff performance to put his pants on, one episode of weight-bearing assistance to put his right arm into his shirt sleeve, and one episode of non-weight-bearing assistance to button his shirt. The first Rule of 3 does not apply because even though the ADL assistance occurred three times, it did not occur three times at any one level. The second Rule of 3 does not apply because even though the ADL assistance occurred three times it did not occur three times at multiple levels. The third Rule of 3 applies because the activity occurred three times, and at multiple levels but not three times at any one level. The third Rule of 3, sub-item "a," instructs providers to convert episodes of full staff performance to weight-bearing assistance. Therefore, there are now two weight-bearing episodes and

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

one non-weight-bearing episode. The third Rule of 3, sub-item "b," does not apply because even though there are two episodes of weight-bearing assistance, there are not enough weight-bearing episodes to consider it Extensive assistance. There is one episode of non-weight-bearing assistance that can be accounted for. The third sub-item, "c," under the third Rule of 3 applies because there is a combination of full staff performance/weight-bearing assistance and/or non-weight-bearing assistance that together total three times (two episodes of weight-bearing assistance and one episode of non-weight-bearing assistance). Therefore, the appropriate code is Limited assistance (2) which is the correct code to enter in Column 1, ADL Self-Performance, G0110G, Dressing. Note that none of the ADL Self-Performance coding level definitions apply directly to this scenario. It is only through the application of the third Rule of 3, working through all of the sub-items, that the facility is able to code this item as Limited assistance.

5. Scenario: During the look-back period, Mr. S was able to toilet independently without assistance 18 times. The other two times toileting occurred during the 7-day look-back period, he required the assistance of staff to pull the zipper up on his pants. This assistance is classified as non-weight-bearing assistance. The assessor determined that the appropriate code for G0100I, Toilet use was Code 1, Supervision.

   Rationale: Toilet use occurred 20 times during the look-back period. Non-weight-bearing assistance was provided two times and 18 times the resident used the toilet independently. When the assessor began looking at the ADL Self-Performance coding level definitions, she determined that Independent (i.e., Code 0) cannot be the code entered on the MDS for this ADL activity because in order to be coded as Independent (0), the resident must complete the ADL without any help or oversight from staff every time. Since Mr. S did require assistance to complete the ADL two times, Code 0 does not apply. Code 7, Activity occurred only once or twice, did not apply to this scenario because even though assistance was provided twice during the look-back period, the activity itself actually occurred 20 times. The assessor also determined that the assistance provided to the resident does not meet the definition for Limited Assistance (2) because even though the assistance was non-weight-bearing, it was only provided twice in the look-back period, and that the ADL Self-Performance coding level definitions for Codes 1, 3 and 4 did not apply directly to this scenario either. The assessor continued to apply the coding instructions, looking at the Rule of 3. The first Rule of 3 does not apply because even though the ADL activity occurred three or more times, the non-weight-bearing assistance occurred only twice. The second Rule of 3 does not apply because even though the ADL occurred three or more times it did not occur three times at multiple levels and the third Rule of 3 does not apply because even though the ADL occurred three or more times, it did not occur at multiple levels or three times at any one level. Since the third Rule of 3 did not apply, the assessor knew not to apply any of the sub-items. However, there is one final instruction to the provider, that when none of the ADL Self-Performance coding level definitions and the Rule of 3 do not apply, the appropriate code to enter in Column 1, ADL Self-Performance, is Supervision (1); therefore, in G0110I, Toilet use the code Supervision (1) was entered.

G0120: Bathing

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

DEFINITIONS

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

Coding Instructions for G0120A, Self-Performance

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

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

Coding Instructions for G0120B, Support Provided

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

G0120: Bathing (cont.)

Coding Tips

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

Examples

1. Resident received verbal cueing and encouragement to take twice-weekly showers. Once staff walked resident to bathroom, he bathed himself with periodic oversight.

   Coding: G0120A would be coded 1, supervision.
   G0120B would be coded 0, no setup or physical help from staff.

   Rationale: Resident needed only supervision to perform the bathing activity with no setup or physical help from staff.

2. For one bath, the resident received physical help of one person to position self in bathtub. However, because of her fluctuating moods, she received total help for her other bath from one staff member.

   Coding: G0120A would be coded 4, total dependence.
   G0120B would be coded 2, one person physical assist.

   Rationale: Coding directions for bathing state, "code for most dependent in self-performance and support." Resident's most dependent episode during the 7-day look-back period was total help with the bathing activity with assist from one staff person.

3. On Monday, one staff member helped transfer resident to tub and washed his legs. On Thursday, the resident had physical help of one person to get into tub but washed himself completely.

   Coding: G0120A would be coded 3, physical help in part of bathing activity.
   G0120B would be coded 2, one person physical assist.

   Rationale: Resident's most dependent episode during the 7-day look-back period was assistance with part of the bathing activity from one staff person.

G0300: Balance During Transitions and Walking

G0300. Balance During Transitions and Walking		
After observing the resident, **code the following walking and transition items for most dependent**		
	↓ Enter Codes in Boxes	
Coding: 0. **Steady at all times** 1. **Not steady, but able to stabilize without staff assistance** 2. **Not steady, only able to stabilize with staff assistance** 8. **Activity did not occur**	☐	**A. Moving from seated to standing position**
	☐	**B. Walking** (with assistive device if used)
	☐	**C. Turning around** and facing the opposite direction while walking
	☐	**D. Moving on and off toilet**
	☐	**E. Surface-to-surface transfer** (transfer between bed and chair or wheelchair)

Item Rationale

Health-related Quality of Life

- Individuals with impaired balance and unsteadiness during transitions and walking
  - — are at increased risk for falls;
  - — often are afraid of falling;
  - — may limit their physical and social activity, becoming socially isolated and despondent about limitations; and
  - — can become increasingly immobile.

DEFINITIONS

INTERDISCIPLINARY TEAM
Refers to a team that includes staff from multiple disciplines such as nursing, therapy, physicians, and other advanced practitioners.

Planning for Care

- Individuals with impaired balance and unsteadiness should be evaluated for the need for
  - — rehabilitation or assistive devices;
  - — supervision or physical assistance for safety; and/or
  - — environmental modification.
- Care planning should focus on preventing further decline of function, and/or on return of function, depending on resident-specific goals.
- Assessment should identify all related risk factors in order to develop effective care plans to maintain current abilities, slow decline, and/or promote improvement in the resident's functional ability.

Steps for Assessment

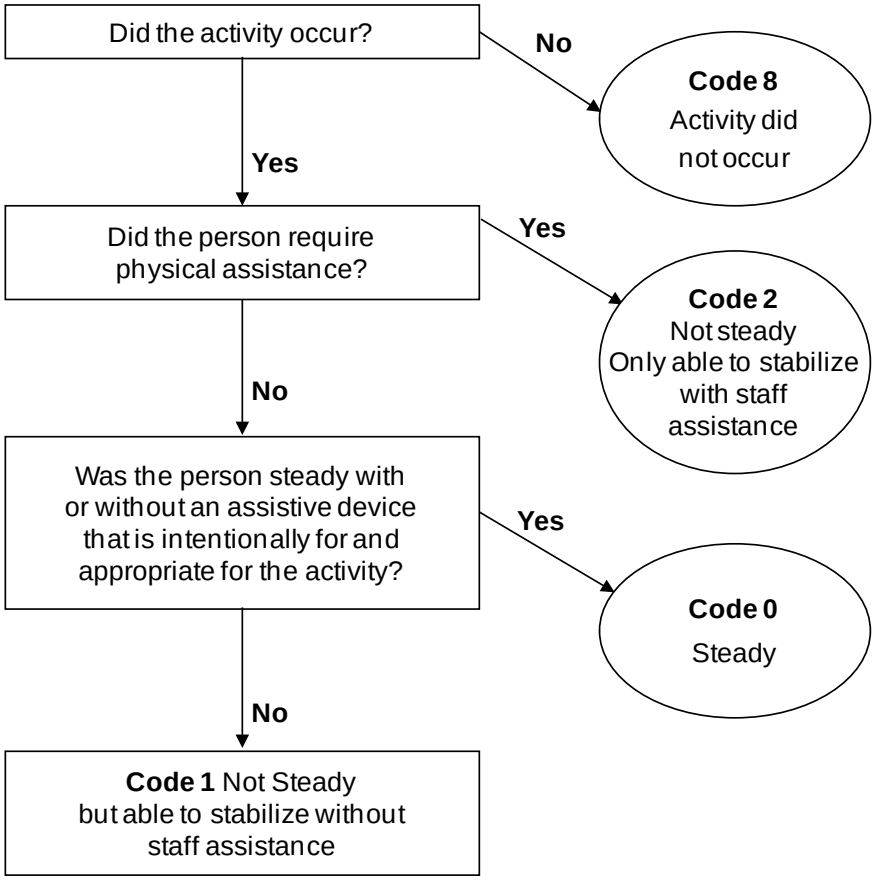
1. Complete this assessment for all residents.
2. Throughout the 7-day look-back period, interdisciplinary team members should carefully observe and document observations of the resident during transitions from sitting to standing, walking, turning, transferring on and off toilet, and transferring from wheelchair to bed and bed to wheelchair (for residents who use a wheelchair).

G0300: Balance During Transitions and Walking (cont.)

3. If staff have not systematically documented the resident's stability in these activities at least once during the 7-day look-back period, use the following process to code these items:

   a. Before beginning the activity, explain what the task is and what you are observing for.
   b. Have assistive devices the resident normally uses available.
   c. Start with the resident sitting up on the edge of his or her bed, in a chair or in a wheelchair (if he or she generally uses one).
   d. Ask the resident to stand up and stay still for 3-5 seconds. **Moving from seated to standing position (G0300A) should be rated at this time.**
   e. Ask the resident to walk approximately 15 feet using his or her usual **assistive device**. **Walking (G0300B) should be rated at this time.**
   f. Ask the resident to turn around. **Turning around (G0300C) should be rated at this time.**
   g. Ask the **resident to walk or wheel** from a starting point in his or her room into the bathroom, **prepare for toileting** as he or she normally does (including taking down pants or other clothes; underclothes can be kept on for this observation), and sit on the toilet. **Moving on and off toilet (G0300D) should be rated at this time.**
   h. Ask residents who are not ambulatory and who use a wheelchair for mobility to transfer from a seated position in the wheelchair to a seated position on the bed. **Surface-to-surface transfer should be rated at this time (G0300E).**

Balance During Transitions and Walking Algorithm



G0300: Balance During Transitions and Walking (cont.)

Coding Instructions G0300A, Moving from Seated to Standing Position

Code for the least steady episode, using assistive device if applicable.

- Code 0, steady at all times:
  - — If all of the transitions from seated to standing position and from standing to seated position observed during the 7-day look-back period are steady.
  - — If resident is stable when standing up using the arms of a chair or an assistive device identified for this purpose (such as a walker, locked wheelchair, or grab bar).
  - — If an assistive device or equipment is used, the resident appropriately plans and integrates the use of the device into the transition activity.
  - — If resident appears steady and not at risk of a fall when standing up.
- Code 1, not steady, but able to stabilize without staff assistance:
  - — If any of transitions from seated to standing position or from standing to seated position during the 7-day look-back period are not steady, but the resident is able to stabilize without assistance from staff or object (e.g., a chair or table).
  - — If the resident is unsteady using an assistive device but does not require staff assistance to stabilize.
  - — If the resident attempts to stand, sits back down, then is able to stand up and stabilize without assistance from staff or object.
  - — Residents coded in this category appear at increased risk for falling when standing up.

DEFINITIONS

UNSTEADY Residents may appear unbalanced or move with a sway or with uncoordinated or jerking movements that make them unsteady. They might exhibit unsteady gaits such as fast gaits with large, careless movements; abnormally slow gaits with small shuffling steps; or wide-based gaits with halting, tentative steps.

- Code 2, not steady, only able to stabilize with staff assistance:
  - — If any of transitions from seated to standing or from standing to sitting are not steady, and the resident cannot stabilize without assistance from staff.
  - — If the resident cannot stand but can transfer unassisted without staff assistance.
  - — If the resident returned back to a seated position or was unable to move from a seated to standing or from standing to sitting position during the look-back period.
  - — Residents coded in this category appear at high risk for falling during transitions.
  - — If a lift device (a mechanical device operated by another person) is used because the resident requires staff assistance to stabilize, code as 2.
- Code 8, activity did not occur: if the resident did not move from seated to standing position during the 7-day look-back period.

G0300: Balance During Transitions and Walking (cont.)

Examples for G0300A, Moving from Seated to Standing Position

1. A resident sits up in bed, stands, and begins to sway, but steadies herself and sits down smoothly into her wheelchair.

   Coding: G0300A would be coded 1, not steady, but able to stabilize without staff assistance.
   Rationale: Resident was unsteady, but she was able to stabilize herself without assistance from staff.

2. A resident requires the use of a gait belt and physical assistance in order to stand.

   Coding: G0300A would be coded 2, not steady, only able to stabilize with staff assistance.
   Rationale: Resident required staff assistance to stand during the observation period.

3. A resident stands steadily by pushing himself up using the arms of a chair.

   Coding: G0300A would be coded 0, steady at all times.
   Rationale: Even though the resident used the arms of the chair to push himself up, he was steady at all times during the activity.

4. A resident locks his wheelchair and uses the arms of his wheelchair to attempt to stand. On the first attempt, he rises about halfway to a standing position then sits back down. On the second attempt, he is able to stand steadily.

   Coding: G0300A would be coded 1, not steady, but able to stabilize without staff assistance.
   Rationale: Even though the second attempt at standing was steady, the first attempt suggests he is unsteady and at risk for falling during this transition.

Coding Instructions G0300B, Walking (with Assistive Device if Used)

Code for the least steady episode, using assistive device if applicable.

- Code 0, steady at all times:
  - If during the 7-day look-back period the resident's walking (with assistive devices if used) is steady at all times.
  - If an assistive device or equipment is used, the resident appropriately plans and integrates the use of the device and is steady while walking with it.
  - Residents in this category do not appear at risk for falls.
  - Residents who walk with an abnormal gait and/or with an assistive device can be steady, and if they are they should be coded in this category.
- Code 1, not steady, but able to stabilize without staff assistance:
  - If during the 7-day look-back period the resident appears unsteady while walking (with assistive devices if used) but does not require staff assistance to stabilize.
  - Residents coded in this category appear at risk for falling while walking.

G0300: Balance During Transitions and Walking (cont.)

- Code 2, not steady, only able to stabilize with staff assistance:
  - — If during the-7-day look-back period the resident at any time appeared unsteady and required staff assistance to be stable and safe while walking.
  - — If the resident fell when walking during the look-back period.
  - — Residents coded in this category appear at high risk for falling while walking.
- Code 8, activity did not occur:
  - — If the resident did not walk during the 7-day look-back period.

Examples for G0300B, Walking (with Assistive Device if Used)

1. A resident with a recent stroke walks using a hemi-walker in her right hand because of left-sided weakness. Her gait is slow and short-stepped and slightly unsteady as she walks, she leans to the left and drags her left foot along the ground on most steps. She has not had to steady herself using any furniture or grab bars.

   Coding: G0300B would be coded 1, not steady, but able to stabilize without staff assistance.

   Rationale: Resident's gait is unsteady with or without an assistive device but does not require staff assistance.

2. A resident with Parkinson's disease ambulates with a walker. His posture is stooped, and he walks slowly with a short-stepped shuffling gait. On some occasions, his gait speeds up, and it appears he has difficulty slowing down. On multiple occasions during the 7-day observation period he has to steady himself using a handrail or a piece of furniture in addition to his walker.

   Coding: G0300B would be coded 1, not steady, but able to stabilize without staff assistance.

   Rationale: Resident has an unsteady gait but can stabilize himself using an object such as a handrail or piece of furniture.

3. A resident who had a recent total hip replacement ambulates with a walker. Although she is able to bear weight on her affected side, she is unable to advance her walker safely without staff assistance.

   Coding: G0300B would be coded 2, not steady, only able to stabilize with staff assistance.

   Rationale: Resident requires staff assistance to walk steadily and safely at any time during the observation period.

4. A resident with multi-infarct dementia walks with a short-stepped, shuffling-type gait. Despite the gait abnormality, she is steady.

   Coding: G0300B would be coded 0, steady at all times.

   Rationale: Resident walks steadily (with or without a normal gait and/or the use of an assistive device) at all times during the observation period.

G0300: Balance During Transitions and Walking (cont.)

Coding Instructions G0300C, Turning Around and Facing the Opposite Direction while Walking

Code for the least steady episode, using an assistive device if applicable.

- Code 0, steady at all times:
  - If all observed turns to face the opposite direction are steady without assistance of a staff during the 7-day look-back period.
  - If the resident is stable making these turns when using an assistive device.
  - If an assistive device or equipment is used, the resident appropriately plans and integrates the use of the device into the transition activity.
  - Residents coded as 0 should not appear to be at risk of a fall during a transition.
- Code 1, not steady, but able to stabilize without staff assistance:
  - If any transition that involves turning around to face the opposite direction is not steady, but the resident stabilizes without assistance from a staff.
  - If the resident is unstable with an assistive device but does not require staff assistance.
  - Residents coded in this category appear at increased risk for falling during transitions.
- Code 2, not steady, only able to stabilize with staff assistance:
  - If any transition that involves turning around to face the opposite direction is not steady, and the resident cannot stabilize without assistance from a staff.
  - If the resident fell when turning around to face the opposite direction during the look-back period.
  - Residents coded in this category appear at high risk for falling during transitions.
- Code 8, activity did not occur:
  - If the resident did not turn around to face the opposite direction while walking during the 7-day look-back period.

Examples for G0300C, Turning Around and Facing the Opposite Direction while Walking

1. A resident with Alzheimer's disease frequently wanders on the hallway. On one occasion, a nursing assistant noted that he was about to fall when turning around. However, by the time she got to him, he had steadied himself on the handrail.

   Coding: G0300C would be coded 1, Not steady, but able to stabilize without staff assistance.

   Rationale: The resident was unsteady when turning but able to steady himself on an object, in this instance, a handrail.

G0300: Balance During Transitions and Walking (cont.)

2. A resident with severe arthritis in her knee ambulates with a single-point cane. A nursing assistant observes her lose her balance while turning around to sit in a chair. The nursing assistant is able to get to her before she falls and lowers her gently into the chair.

   Coding: G0300C would be coded 2, not steady, only able to stabilize with staff assistance.

   Rationale: The resident was unsteady when turning around and would have fallen without staff assistance.

Coding for G0300D, Moving on and off Toilet

Code for the least steady episode of moving on and off a toilet or portable commode, using an assistive device if applicable. Include stability while manipulating clothing to allow toileting to occur in this rating.

- Code 0, steady at all times:
  - If all of the observed transitions on and off the toilet during the 7-day look-back period are steady without assistance of a staff.
  - If the resident is stable when transferring using an assistive device or object identified for this purpose.
  - If an assistive device is used (e.g., grab bar), the resident appropriately plans and integrates the use of the device into the transition activity.
  - Residents coded as 0 should not appear to be at risk of a fall during a transition.
- Code 1, not steady, but able to stabilize without staff assistance:
  - If any transitions on or off the toilet during the7-day look-back period are not steady, **but** the resident stabilizes **without** assistance from a staff.
  - If resident is unstable with an assistive device but does not require staff assistance.
  - Residents coded in this category appear at increased risk for falling during transitions.
- Code 2, not steady, only able to stabilize with staff assistance:
  - If any transitions on or off the toilet during the 7-day look-back period are not steady, and the resident cannot stabilize without assistance from a staff.
  - If the resident fell when moving on or off the toilet during the look-back period.
  - Residents coded in this category appear at high risk for falling during transitions.
  - If lift device is used.
- Code 8, activity did not occur:
  - If the resident did not transition on and off the toilet during the 7-day look-back period.

G0300: Balance During Transitions and Walking (cont.)

Examples for G0300D, Moving on and off Toilet

1. A resident sits up in bed, stands up, pivots and grabs her walker. She then steadily walks to the bathroom where she pivots, pulls down her underwear, uses the grab bar and smoothly sits on the commode using the grab bar to guide her. After finishing, she stands and pivots using the grab bar and smoothly ambulates out of her room with her walker.

   Coding: G0300D would be coded 0, steady at all times.

   Rationale: This resident's use of the grab bar was not to prevent a fall after being unsteady, but to maintain steadiness during her transitions. The resident was able to smoothly and steadily transfer onto the toilet, using a grab bar.

2. A resident wheels her wheelchair into the bathroom, stands up, begins to lift her dress, sways, and grabs onto the grab bar to steady herself. When she sits down on the toilet, she leans to the side and must push herself away from the towel bar to sit upright steadily.

   Coding: G0300D would be coded 1, not steady, but able to stabilize without staff assistance.

   Rationale: The resident was unsteady when disrobing to toilet but was able to steady herself with a grab bar.

3. A resident wheels his wheelchair into the bathroom, stands, begins to pull his pants down, sways, and grabs onto the grab bar to steady himself. When he sits down on the toilet, he leans to the side and must push himself away from the sink to sit upright steadily. When finished, he stands, sways, and then is able to steady himself with the grab bar.

   Coding: G0300D would be coded 1, not steady, but able to stabilize without staff assistance.

   Rationale: The resident was unsteady when disrobing to toilet but was able to steady himself with a grab bar.

Coding Instructions G0300E, Surface-to-Surface Transfer (Transfer between Bed and Chair or Wheelchair)

Code for the least steady episode.

- Code 0, steady at all times:
  - — If all of the observed transfers during the 7-day look-back period are steady without assistance of a staff.
  - — If the resident is stable when transferring using an assistive device identified for this purpose.
  - — If an assistive device or equipment is used, the resident uses it independently and appropriately plans and integrates the use of the device into the transition activity.
  - — Residents **coded 0** should not appear to be at risk of a fall during a transition.

G0300: Balance During Transitions and Walking (cont.)

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

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

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

   Coding: G0300E would be coded 0, steady at all times.

   Rationale: The resident was steady when transferring from bed to wheelchair.

2. A resident who needs assistance ambulating transfers to his chair from the bed. He is observed to stand halfway up and then sit back down on the bed. On a second attempt, a nursing assistant helps him stand up straight, pivot, and sit down in his chair.

   Coding: G0300E would be coded 2, not steady, only able to stabilize with staff assistance.

   Rationale: The resident was unsteady when transferring from bed to chair and required staff assistance to make a steady transfer.

3. A resident with an above-the-knee amputation sits on the edge of the bed and, using his locked wheelchair due to unsteadiness and the nightstand for leverage, stands and transfers to his wheelchair rapidly and almost misses the seat. He is able to steady himself using the nightstand and sit down into the wheelchair without falling to the floor.

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

G0300: Balance During Transitions and Walking (cont.)

Rationale: The resident was unsteady when transferring from bed to wheelchair but did not require staff assistance to complete the activity.

4. A resident who uses her wheelchair for mobility stands up from the edge of her bed, sways to the right, but then is quickly able to pivot and sits in her locked wheelchair in a steady fashion.

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

   Rationale: The resident was unsteady when transferring from bed to wheelchair but was able to steady herself without staff assistance or an object.

Additional examples for G0300A-E, Balance during Transitions and Walking

1. A resident sits up in bed, stands up, pivots and sits in her locked wheelchair. She then wheels her chair to the bathroom where she stands, pivots, lifts gown and smoothly sits on the commode.

   Coding: G0300A, G0300D, G0300E would be coded 0, steady at all times.

   Rationale: The resident was steady during each activity.

G0400: Functional Limitation in Range of Motion

G0400. Functional Limitation in Range of Motion		
Code for limitation that interfered with daily functions or placed resident at risk of injury		
Coding: 0. **No impairment** 1. **Impairment on one side** 2. **Impairment on both sides**	↓ **Enter Codes in Boxes**	
	☐	**A. Upper extremity** (shoulder, elbow, wrist, hand)
	☐	**B. Lower extremity** (hip, knee, ankle, foot)

Intent: The intent of G0400 is to determine whether functional limitation in range of motion (ROM) interferes with the resident's activities of daily living or places him or her at risk of injury. When completing this item, staff should refer back to item G0110 and view the limitation in ROM taking into account activities that the resident is able to perform.

DEFINITIONS

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.

Item Rationale

Health-related Quality of Life

- Functional impairment could place the resident at risk of injury or interfere with performance of activities of daily living.

Planning for Care

- Individualized care plans should address possible reversible causes such as de-conditioning and adverse side effects of medications or other treatments.

G0400: Functional Limitation in Range of Motion (cont.)

Steps for Assessment

1. Review the medical record for references to functional range of motion limitation during the 7-day look-back period.
2. Talk with staff members who work with the resident as well as family/significant others about any impairment in functional ROM.
3. Coding for functional ROM limitations is a 3 step process:
   - Test the resident's upper and lower extremity ROM (See #6 below for examples).
   - If the resident is noted to have limitation of upper and/or lower extremity ROM, review G0110 and/or directly observe the resident to determine if the limitation interferes with function or places the resident at risk for injury.
   - Code G0400 A/B as appropriate based on the above assessment.
4. Assess the resident's ROM bilaterally at the shoulder, elbow, wrist, hand, hip, knee, ankle, foot, and other joints unless contraindicated (e.g., recent fracture, joint replacement or pain).
5. Staff observations of various activities, including ADLs, may be used to determine if any ROM limitations impact the resident's functional abilities.
6. Although this item codes for the presence or absence of functional limitation related to ROM; thorough assessment ought to be comprehensive and follow standards of practice for evaluating ROM impairment. Below are some suggested assessment strategies:
   - Ask the resident to follow your verbal instructions for each movement.
   - Demonstrate each movement (e.g., ask the resident to do what you are doing).
   - Actively assist the resident with the movements by supporting his or her extremity and guiding it through the joint ROM.

   Lower Extremity – includes hip, knee, ankle, and foot

   While resident is lying supine in a flat bed, instruct the resident to flex (pull toes up towards head) and extend (push toes down away from head) each foot. Then ask the resident to lift his or her leg one at a time, bending it at the knee to a right angle (90 degrees) Then ask the resident to slowly lower his or her leg and extend it flat on the mattress. If assessing lower extremity ROM by observing the resident, the flexion and extension of the foot mimics the motion on the pedals of a bicycle. Extension might also be needed to don a shoe. If assessing bending at the knee, the motion would be similar to lifting of the leg when donning lower body clothing.

   Upper Extremity – includes shoulder, elbow, wrist, and fingers

   For each hand, instruct the resident to make a fist and then open the hand. With resident seated in a chair, instruct him or her to reach with both hands and touch palms to back of head. Then ask resident to touch each shoulder with the opposite hand. Alternatively, observe the resident donning or removing a shirt over the head. If assessing upper extremity ROM by observing the resident, making a fist mimics useful actions for grasping and letting go of utensils. When an individual reaches both hands to the back of the head, this mimics the action needed to comb hair.

G0400: Functional Limitation in Range of Motion (cont.)

Coding Tips

- Do not look at limited ROM in isolation. You must determine if the limited ROM impacts functional ability or places the resident at risk for injury. For example, if the resident has an amputation it does not automatically mean that they are limited in function. He/she may not have a particular joint in which certain range of motion can be tested, however, it does not mean that the resident with an amputation has a limitation in completing activities of daily living, nor does it mean that the resident is automatically at risk of injury. There are many amputees who function extremely well and can complete all activities of daily living either with or without the use of prosthetics. If the resident with an amputation does indeed have difficulty completing ADLs and is at risk for injury, the facility should code this item as appropriate. This item is coded in terms of function and risk of injury, not by diagnosis or lack of a limb or digit.

Coding Instructions for G0400A, Upper Extremity (Shoulder, Elbow, Wrist, Hand); G0400B, Lower Extremity (Hip, Knee, Ankle, Foot)

- Code 0, no impairment: if resident has full functional range of motion on the right and left side of upper/lower extremities.
- Code 1, impairment on one side: if resident has an upper and/or lower extremity impairment on one side that interferes with daily functioning or places the resident at risk of injury.
- Code 2, impairment on both sides: if resident has an upper and/or lower extremity impairment on both sides that interferes with daily functioning or places the resident at risk of injury.

Examples for G0400A, Upper Extremity (Shoulder, Elbow, Wrist, Hand); G0400B, Lower Extremity (Hip, Knee, Ankle, Foot)

1. The resident can perform all arm, hand, and leg motions on the right side, with smooth coordinated movements. She is able to perform grooming activities (e.g. brush teeth, comb her hair) with her right upper extremity, and is also able to pivot to her wheelchair with the assist of one person. She is, however, unable to voluntarily move her left side (limited arm, hand and leg motion) as she has a flaccid left hemiparesis from a prior stroke.

   Coding: G0400A would be coded 1, upper extremity impairment on one side. G0400B would be coded 1, lower extremity impairment on one side.

   Rationale: Impairment due to left hemiparesis affects both upper and lower extremities on one side. Even though this resident has limited ROM that impairs function on the left side, as indicated above, the resident can perform ROM fully on the right side. Even though there is impairment on one side, the facility should always attempt to provide the resident with assistive devices or physical assistance that allows for the resident to be as independent as possible.

G0400: Functional Limitation in Range of Motion (cont.)

2. The resident had shoulder surgery and can't brush her hair or raise her right arm above her head. The resident has no impairment on the lower extremities.

   Coding: G0400A would be coded 1, upper extremity impairment on one side. G0400B would be coded 0, no impairment.

   Rationale: Impairment due to shoulder surgery affects only one side of her upper extremities.

3. The resident has a diagnosis of Parkinson's and ambulates with a shuffling gate. The resident has had 3 falls in the past quarter and often forgets his walker which he needs to ambulate. He has tremors of both upper extremities that make it very difficult to feed himself, brush his teeth or write.

   Coding: G0400A would be coded 2, upper extremity impairment on both sides. G0400B would be coded 2, lower extremity impairment on both sides.

   Rationale: Impairment due to Parkinson's disease affects the resident at the upper and lower extremities on both sides.

G0600: Mobility Devices

G0600. Mobility Devices	
↓ Check all that were normally used	
☐	A. Cane/crutch
☐	B. Walker
☐	C. Wheelchair (manual or electric)
☐	D. Limb prosthesis
☐	Z. None of the above were used

Item Rationale

Health-related Quality of Life

- Maintaining independence is important to an individual's feelings of autonomy and self-worth. The use of devices may assist the resident in maintaining that independence.

Planning for Care

- Resident ability to move about his or her room, unit or nursing home may be directly related to the use of devices. It is critical that nursing home staff assure that the resident's independence is optimized by making available mobility devices on a daily basis, if needed.

G0600: Mobility Devices (cont.)

Steps for Assessment

1. Review the medical record for references to locomotion during the 7-day look-back period.
2. Talk with staff members who work with the resident as well as family/significant others about devices the resident used for mobility during the look-back period.
3. Observe the resident during locomotion.

Coding Instructions

Record the type(s) of mobility devices the resident normally uses for locomotion (in room and in facility). Check all that apply:

- Check G0600A, cane/crutch: if the resident used a cane or crutch, including single prong, tripod, quad cane, etc.
- Check G0600B, walker: if the resident used a walker or hemi-walker, including an enclosed frame-wheeled walker with/without a posterior seat and lap cushion. Also check this item if the resident walks while pushing a wheelchair for support.
- Check G0600C, wheelchair (manual or electric): if the resident normally sits in wheelchair when moving about. Include hand-propelled, motorized, or pushed by another person.
- Check G0600D, limb prosthesis: if the resident used an artificial limb to replace a missing extremity.
- Check G0600Z, none of the above: if the resident used none of the mobility devices listed in G0600 or locomotion did not occur during the look-back period.

Examples

1. The resident uses a quad cane daily to walk in the room and on the unit. The resident uses a standard push wheelchair that she self-propels when leaving the unit due to her issues with endurance.

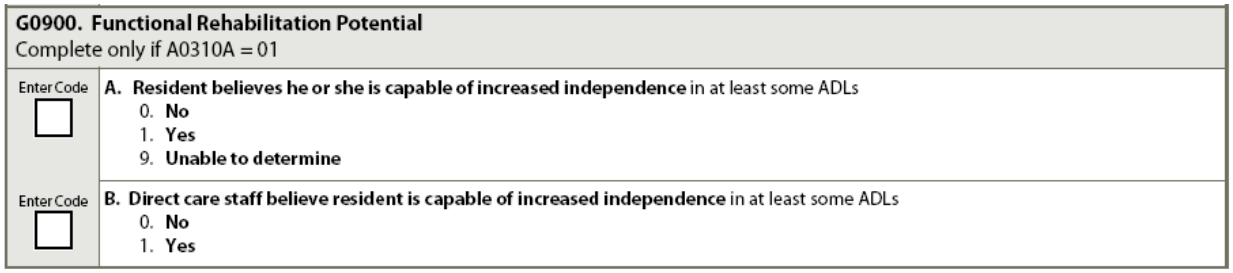
   Coding: G0600A, use of cane/crutch**,** and G0600C, wheelchair, would be checked.
   Rationale: The resident uses a quad cane in her room and on the unit and a wheelchair off the unit.

2. The resident has an artificial leg that is applied each morning and removed each evening. Once the prosthesis is applied the resident is able to ambulate independently.

   Coding: G0600D, limb prosthesis**,** would be checked.
   Rationale: The resident uses a leg prosthesis for ambulating.

G0900: Functional Rehabilitation Potential

Complete only on OBRA Admission Assessment (A0310A = 1)



G0900. Functional Rehabilitation Potential Complete only if A0310A = 01	
Enter Code ☐	**A. Resident believes he or she is capable of increased independence** in at least some ADLs 0. **No** 1. **Yes** 9. **Unable to determine**
Enter Code ☐	**B. Direct care staff believe resident is capable of increased independence** in at least some ADLs 0. **No** 1. **Yes**

Item Rationale

Health-related Quality of Life

- Attaining and maintaining independence is important to an individual's feelings of autonomy and self-worth.
- Independence is also important to health status, as decline in function can trigger all of the complications of immobility, depression, and social isolation.

Planning for Care

- Beliefs held by the resident and staff that the resident has the capacity for greater independence and involvement in self-care in at least some ADL areas may be important clues to assist in setting goals.
- Even if highly independent in an activity, the resident or staff may believe the resident can gain more independence (e.g., walk longer distances, shower independently).
- Disagreement between staff beliefs and resident beliefs should be explored by the interdisciplinary team.

Steps for Assessment: Interview Instructions for G0900A, Resident Believes He or She Is Capable of Increased Independence in at Least Some ADLs

1. Ask if the resident thinks he or she could be more self-sufficient given more time.
2. Listen to and record what the resident believes, even if it appears unrealistic.
   - It is sometimes helpful to have a conversation with the resident that helps him/her break down this question. For example, you might ask the resident what types of things staff assist him with and how much of those activities the staff do for the resident. Then ask the resident, "Do you think that you could get to a point where you do more or all of the activity yourself?"

Coding Instructions for G0900A, Resident Believes He or She Is Capable of Increased Independence in at Least Some ADLs

- Code 0, no: if the resident indicates that he or she believes he or she will probably stay the same and continue with his or her current needs for assistance.

G0900: Functional Rehabilitation Potential (cont.)

- Code 1, yes: if the resident indicates that he or she thinks he or she can improve. Code even if the resident's expectation appears unrealistic.
- Code 9, unable to determine: if the resident cannot indicate any beliefs about his or her functional rehabilitation potential.

Example for G0900A, Resident Believes He or She Is Capable of Increased Independence in at Least Some ADLs

1. Mr. N. is cognitively impaired and receives limited physical assistance in locomotion for safety purposes. However, he believes he is capable of walking alone and often gets up and walks by himself when staff are not looking.

   Coding: G0900A would be coded 1, yes.
   Rationale: The resident believes he is capable of increased independence.

Steps for Assessment for G0900B, Direct Care Staff Believe Resident Is Capable of Increased Independence in at Least Some ADLs

1. Discuss in interdisciplinary team meeting.
2. Ask staff who routinely care for or work with the resident if they think he or she is capable of greater independence in at least some ADLs.

Coding Instructions for G0900B, Direct Care Staff Believe Resident Is Capable of Increased Independence in at Least Some ADLs

- Code 0, no: if staff believe the resident probably will stay the same and continue with current needs for assistance. Also **code 0** if staff believe the resident is likely to experience a decrease in his or her capacity for ADL care performance.
- Code 1, yes: if staff believe the resident can gain greater independence in ADLs or if staff indicate they are not sure about the potential for improvement, because that indicates some potential for improvement.

Example for G0900B, Direct Care Staff Believe Resident Is Capable of Increased Independence in at Least Some ADLs

1. The nurse assistant who totally feeds Mrs. W. has noticed in the past week that Mrs. W. has made several attempts to pick up finger foods. She believes Mrs. W. could become more independent in eating if she received close supervision and cueing in a small group for restorative care in eating.

   Coding: G0900B would be coded 1, yes.
   Rationale: Based upon observation of the resident, the nurse assistant believes Mrs. W. is capable of increased independence.

H0200: Urinary Toileting Program (cont.)

Steps for Assessment: H0200C, Current Toileting Program or Trial

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

Coding Instructions H0200A, Toileting Program Trial

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

Coding Instructions H0200B, Toileting Program Trial Response

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

H0200: Urinary Toileting Program (cont.)

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

   Coding: H0200A would be coded as 1, yes.
   H0200B would be coded as 9, unable to determine or trial in progress
   H0200C would be coded as 1, current toileting program or trial.

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

H0300: Urinary Continence

H0300. Urinary Continence	
Enter Code ☐	**Urinary continence -** Select the one category that best describes the resident 0. **Always continent** 1. **Occasionally incontinent** (less than 7 episodes of incontinence) 2. **Frequently incontinent** (7 or more episodes of urinary incontinence, but at least one episode of continent voiding) 3. **Always incontinent** (no episodes of continent voiding) 9. **Not rated,** resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days

Item Rationale

Health-related Quality of Life

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

DEFINITIONS

URINARY INCONTINENCE
The involuntary loss of urine.

CONTINENCE
Any void that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting.

K0510: Nutritional Approaches (cont.)

  - — IV fluids can be coded in K0510A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration. Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record.
- **The following items are NOT to be coded in K0510A:**
  - — IV Medications—**Code these when appropriate in O0100H, IV Medications.**
  - — IV fluids used to reconstitute and/or dilute medications for IV administration.
  - — IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay.
  - — IV fluids administered solely as flushes.
  - — Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis.
- Guidelines on basic fluid and electrolyte replacement can be found online at http://guidelines.gov/content.aspx?id=15590&search=fluid+and+electrolyte+replacement+amda.
- Enteral feeding formulas:
  - — Should not be coded as a mechanically altered diet.
  - — Should only be coded as **K0510D, Therapeutic Diet** when the enteral formula is altered to manage problematic health conditions, e.g. enteral formulas specific to diabetics.

Coding Tips for K0510D

- Therapeutic diets are not defined by the content of what is provided or when it is served, but ***why*** the diet is required. Therapeutic diets provide the corresponding treatment that addresses a particular disease or clinical condition which is manifesting an altered nutritional status by providing the specific nutritional requirements to remedy the alteration.
- A nutritional supplement (house supplement or packaged) given as part of the treatment for a disease or clinical condition manifesting an altered nutrition status, does not constitute a therapeutic diet, but may be ***part*** of a therapeutic diet. Therefore, supplements (whether given with, in-between, or instead of meals) are only coded in K0510D, Therapeutic Diet when they are being administered as part of a therapeutic diet to manage problematic health conditions (e.g. supplement for protein-calorie malnutrition).
- Food elimination diets related to food allergies (e.g. peanut allergy) can be coded as a therapeutic diet.

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			
1. While NOT a Resident Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only enter a code in 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*** **3. During Entire 7 Days** Performed during the entire ***last 7 days***	**1. While NOT a Resident**	**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	☐	☐	☐

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.

K0710: Percent Intake by Artificial Route (cont.)

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

Example

1. **Calculation for Proportion of Total Calories from IV or Tube Feeding**

   Mr. H has had a feeding tube since his surgery two weeks ago. He is currently more alert and feeling much better. He is very motivated to have the tube removed. He has been taking soft solids by mouth, but only in small to medium amounts. For the past 7 days, he has been receiving tube feedings for nutritional supplementation. The dietitian has totaled his calories per day as follows:

Oral and Tube Feeding Intake		
	Oral	Tube
Sun.	500	2,000
Mon.	250	2,250
Tues.	250	2,250
Wed.	350	2,250
Thurs.	500	2,000
Fri.	250	2,250
Sat.	350	2,000
Total	2,450	15,000

K0710: Percent Intake by Artificial Route (cont.)

Coding: K0710A columns 2 and 3 would be coded **3, 51% or more.**

Rationale: Total Oral intake is 2,450 calories
Total Tube intake is 15,000 calories
Total calories is 2,450 + 15,000 = 17,450
Calculation of the percentage of total calories by tube feeding:
15,000/17,450 = .859 X 100 = 85.9%
Mr. H received 85.9% of his calories by tube feeding, therefore K0710A **code 3**, **51% or more** is correct.

K0710B, Average Fluid Intake per Day by IV or Tube Feeding

Steps for Assessment

1. Review intake records from the last 7 days.
2. Add up the total amount of fluid received each day by IV and/or tube feedings only.
3. Divide the week's total fluid intake by 7 to calculate the average of fluid intake per day.
4. Divide by 7 even if the resident did not receive IV fluids and/or tube feeding on each of the 7 days.

Coding Instructions

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

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

Examples

1. **Calculation for Average Daily Fluid Intake**

   Ms. A, 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

K0710: Percent Intake by Artificial Route (cont.)

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. **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.

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

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.

M0210: Unhealed Pressure Ulcer(s)

M0210. Unhealed Pressure Ulcer(s)	
Enter Code ☐	**Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?** 0. **No** → Skip to M0900, Healed Pressure Ulcers 1. **Yes** → Continue to M0300, Current Number of Unhealed Pressure Ulcers at Each Stage

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

DEFINITIONS

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

Steps for Assessment

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

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

Step 3: Determine "Present on Admission"

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

DEFINITIONS

ON ADMISSION
As close to the actual time of admission as possible.

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

M0300A: Number of Stage 1 Pressure Ulcers

M0300. Current Number of Unhealed Pressure Ulcers at Each Stage

Enter Number ☐

A. Number of Stage 1 pressure ulcers
Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

Item Rationale

Health-related Quality of Care

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

Planning for Care

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

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

Coding Instructions for M0300G

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

Coding Tips

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

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

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

M0700: Most Severe Tissue Type for Any Pressure Ulcer

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

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

Coding Instructions for M0700

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

DEFINITIONS

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

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

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

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

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

Coding Tips and Special Populations

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

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

Examples

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

   Coding: Code M0700 as 2, Granulation tissue.

   Rationale: Coding for M0700 is based on the sacral ulcer, because it is the pressure ulcer with the most severe tissue type. Code 2, (Granulation tissue), is selected because this is the most severe tissue present in the wound.

2. A resident has a Stage 2 pressure ulcer on the right heel and no other pressure ulcers.

   Coding: Code M0700 as 1, Epithelial tissue.

   Rationale: Coding for M0700 is Code 1, (Epithelial tissue) because epithelial tissue is consistent with identification of this pressure ulcer as a Stage 2 pressure ulcer.

3. A resident has a pressure ulcer on the left trochanter that has 25% black eschar tissue present, 75% granulation tissue present, and some epithelialization at the edges of the wound.

   Coding: Code M0700 as 4, Eschar.

   Rationale: Coding is for the most severe tissue type present, which is not always the majority of type of tissue. Therefore, Coding for M0700 is Code 4, Eschar).

Scenarios for Pressure Ulcer Coding (cont.)

14-Day PPS:

Coding:

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

O0400: Therapies

O0400. Therapies

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** 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 O0400A5, 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

B. Occupational 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 O0400B5, 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

O0400 continued on next page

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, which contribute to diminished quality of life. The qualified therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents.
- Rehabilitation (i.e., via Speech-Language Pathology Services and Occupational and Physical Therapies) and respiratory, psychological, and recreational therapy can help residents to attain or maintain their highest level of well-being and improve their quality of life.

O0400: Therapies (cont.)

Planning for Care

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

Steps for Assessment

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

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

- **Individual minutes**—Enter the total number of minutes of therapy that were provided on an individual basis in the last 7 days. **Enter 0** if none were provided. Individual services are provided by one therapist or assistant to one resident at a time.
- **Concurrent minutes**—Enter the total number of minutes of therapy that were provided on a concurrent basis in the last 7 days. **Enter 0** if none were provided. Concurrent therapy is defined as the treatment of 2 residents at the same time, when the residents are not performing the same or similar activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant for Medicare Part A. When a Part A resident receives therapy that meets this definition, it is defined as concurrent therapy for the Part A resident regardless of the payer source for the second resident. For Part B, residents may not be treated concurrently: a therapist may treat one resident at a time, and the minutes during the day when the resident is treated individually are added, even if the therapist provides that treatment intermittently (first to one resident and then to another). For all other payers, follow Medicare Part A instructions.
- **Group minutes**—Enter the total number of minutes of therapy that were provided in a group in the last 7 days. **Enter 0** if none were provided. Group therapy is defined for Part A as the treatment of 4 residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals. For Medicare Part B, treatment of two patients (or more), regardless of payer source, at the same time is documented as group treatment. For all other payers, follow Medicare Part A instructions.

O0400: Therapies (cont.)

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

Coding Instructions for Respiratory, Psychological, and Recreational Therapies

- **Total Minutes**—Enter the actual number of minutes therapy services were provided in the last 7 days. **Enter 0** if none were provided.
- **Days**—Enter the number of days therapy services were provided in the last 7 days. A day of therapy is defined as treatment for 15 minutes or more in the day.

  Enter 0 if therapy was provided but for less than 15 minutes every day for the last 7 days. If the total number of minutes during the last 7 days is 0, skip this item and leave blank.

Coding Tips and Special Populations

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

O0400: Therapies (cont.)

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

Minutes of therapy

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

O0400: Therapies (cont.)

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

O0400: Therapies (cont.)

- For purposes of the MDS, providers should record services for respiratory, psychological, and recreational therapies (Item O0400D, E, and F) when the following criteria are met:
  - — the physician orders the therapy;
  - — the physician's order includes a statement of frequency, duration, and scope of treatment;
  - — the services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by qualified personnel (See Glossary in Appendix A for definitions of respiratory, psychological and recreational therapies);
  - — the services are required and provided by qualified personnel (See Glossary in Appendix A for definitions of respiratory, psychological and recreational therapies);
  - — the services must be reasonable and necessary for treatment of the resident's condition.

Non-Skilled Services

- Services provided at the request of the resident or family that are not medically necessary (sometimes referred to as family-funded services) shall **not** be counted in item O0400 **Therapies**, even when performed by a therapist or an assistant.
- As noted above, therapy services can include the actual performance of a maintenance program in those instances where the skills of a qualified therapist are needed to accomplish this safely and effectively. However, when the performance of a maintenance program does not require the skills of a therapist because it could be accomplished safely and effectively by the patient or with the assistance of non-therapists (including unskilled caregivers), such services are not considered therapy services in this context. Sometimes a nursing home may nevertheless elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services even when the involvement of a qualified therapist is not medically necessary. In these situations, the services shall **not** be coded as therapy in item O0400 **Minutes**, since the specific interventions would be considered restorative nursing care when performed by nurses or aides. Services provided by therapists, licensed or not, that are not specifically listed in this manual or on the MDS item set shall **not** be coded as therapy in Item 0400. These services should be documented in the resident's medical record.
- In situations where the ongoing performance of a safe and effective maintenance program does not require any skilled services, once the qualified therapist has designed the maintenance program and discharged the resident from a rehabilitation (i.e., skilled) therapy program, the services performed by the therapist and the assistant are **not** to be reported in item O0400A, B, or C **Therapies** The services may be reported on the MDS assessment in item O0500 **Restorative Nursing Care**, provided the requirements for restorative nursing program are met.
- Services provided by therapy aides are **not** skilled services (see therapy aide section below).
- When a resident refuses to participate in therapy, it is important for care planning purposes to identify why the resident is refusing therapy. However, the time spent investigating the refusal or trying to persuade the resident to participate in treatment is not a skilled service and shall not be included in the therapy minutes.

O0400: Therapies (cont.)

Co-treatment

For Part A:

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

For Part B:

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

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

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

Therapy Aides and Students

Therapy Aides

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

O0400: Therapies (cont.)

Therapy Students

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

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

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

Modes of Therapy

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

O0400: Therapies (cont.)

Individual Therapy

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

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

Example:

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

Concurrent Therapy

Medicare Part A

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

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

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

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

O0400: Therapies (cont.)

Medicare Part B

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

Examples:

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

Group Therapy

Medicare Part A

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

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

O0400: Therapies (cont.)

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

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

Medicare Part B

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

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

Examples:

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

O0400: Therapies (cont.)

  - — Mr. S. received group therapy (Medicare Part B definition) for 24 minutes and individual therapy for 10 minutes. (Please refer to the **Medicare Benefit Policy Manual**, Chapter 15, and the **Medicare Claims Processing Manual**, Chapter 5, for coverage and billing requirements under the Medicare Part B benefit.)

- Mr. A. and Mr. B., whose stays are covered by Medicare Part A, begin working with a physical therapist on two different therapy interventions. After 30 minutes, Mr. A. and Mr. B are joined by Mr. T. and Mr. E., whose stays are also covered by Medicare Part A., and the therapist begins working with all of them on the same therapy goals as part of a group session. After 15 minutes in this group session, Mr. A. becomes ill and is forced to leave the group, while the therapist continues working with the remaining group members for an additional 15 minutes. Based on the information above, the therapist would code each individual's MDS for this day of treatment as follows:
  - — Mr. A. received concurrent therapy for 30 minutes and group therapy for 15 minutes.
  - — Mr. B. received concurrent therapy for 30 minutes and group therapy for 30 minutes.
  - — Mr. T. received group therapy for 30 minutes.
  - — Mr. E. received group therapy for 30 minutes.

Therapy Modalities

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

Dates of Therapy

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

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

O0400: Therapies (cont.)

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

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

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

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

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

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

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

O0400: Therapies (cont.)

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

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

General Coding Example:

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

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

  Coding:
  O0400A1 would be coded 190; O0400A2 would be coded 70; O0400A3 would be coded 75; O0400A4 would be coded 5; O0400A5 would be coded 10062011; and O0400A6 would be coded with dashes.
  Rationale:
  Individual minutes totaled 190 over the 7-day look-back period [(30 × 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 10-06-2011, and dashes were used as the therapy end date value because the therapy was ongoing.

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

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

O0400: Therapies (cont.)

Coding:
O0400B1 would be coded 113, O0400B2 would be coded 0, O0400B3 would be coded 80, O0400B3A would be coded 60, O0400B4 would be coded 5, O0400B5 would be coded 10092011, and O0400B6 would be coded with dashes.
Rationale:
Individual minutes (including 60 co-treatment minutes) totaled 113 over the 7-day look-back period [(30 × 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 10-09-2011 and dashes were used as the therapy end date value because the therapy was ongoing.

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

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

  Coding:
  O0400C1 would be coded 287, O0400C2 would be coded 100, O0400C3 would be coded 0, O0400C3A would be coded 60, O0400C4 would be coded 5, O0400C5 would be coded 10072011, and O0400C6 would be coded with dashes.
  Rationale:
  Individual minutes (including 60 co-treatment minutes) totaled 287 over the 7-day look-back period [(30 × 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 10-07-2011, and dashes were used as the therapy end date value because the therapy was ongoing.

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

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

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

O0400: Therapies (cont.)

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

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

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

Coding:
O0400E1 would be coded 0, O0400E2 would be left blank.
Rationale:
There were no minutes or days of psychological therapy services provided over the 7-day look-back period.

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

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

Coding:
O0400F1 would be coded 90, O0400F2 would be coded 3.
Rationale:
Total minutes were 90 over the 7-day look-back period (30 × 3 = 90). Sessions provided were longer than 15 minutes each day, therefore each day recreational therapy was performed can be counted.

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: 65

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 – 2011
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 – 2011
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

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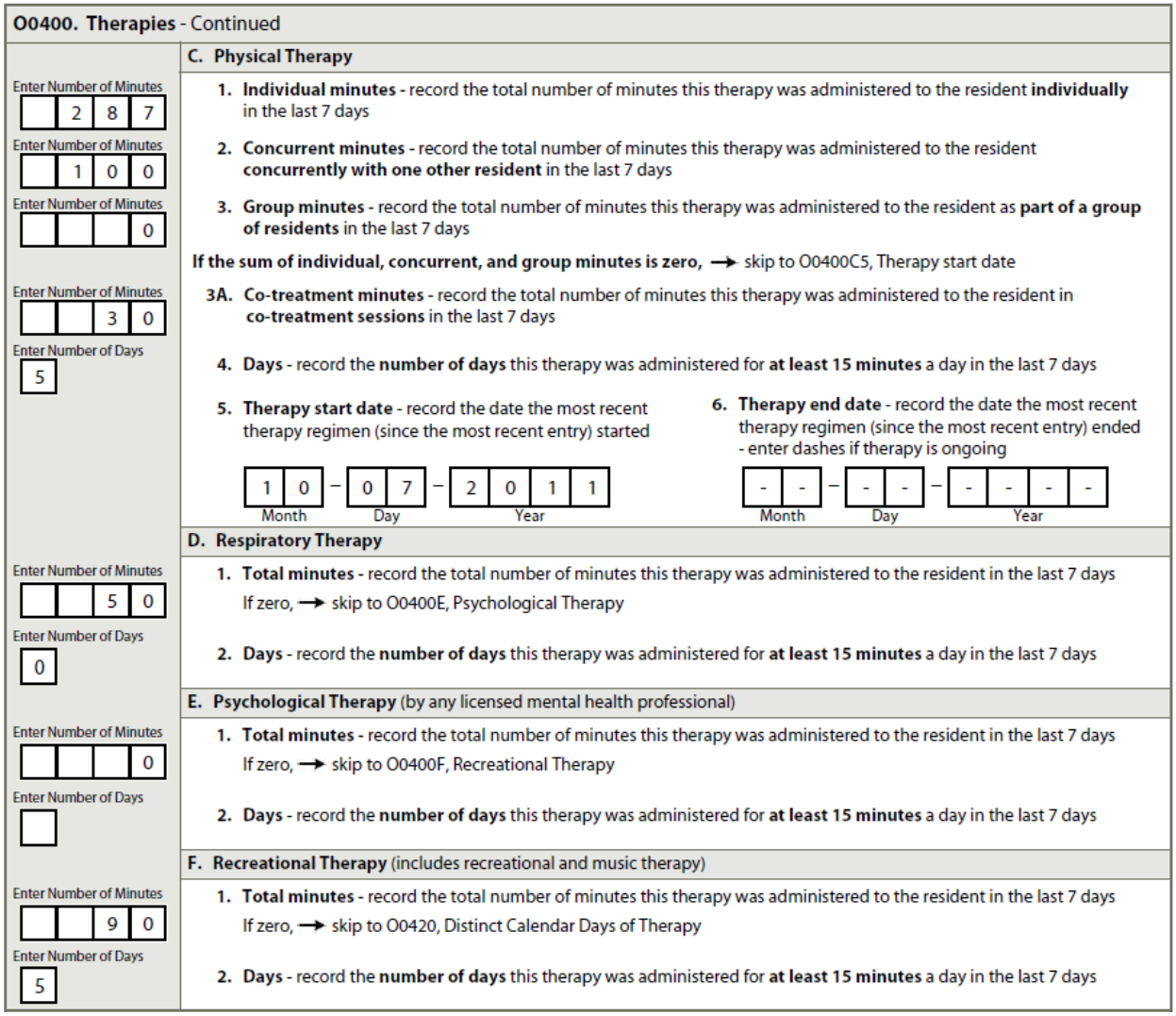
Month Day Year

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: 30

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: 2011

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

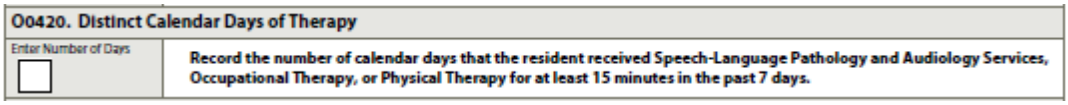
1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days

If zero, → skip to O0420, Distinct Calendar Days of Therapy

Enter Number of Days: 5

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 3 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 4 distinct calendar days during the 7-day look-back period (i.e., Monday, Wednesday, and Friday).

O0450: Resumption of Therapy

O0450. Resumption of Therapy - Complete only if A0310C = 2 or 3 and A0310F = 99

Enter Code ☐

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** → Skip to O0500, Restorative Nursing Programs
1. **Yes**

B. Date on which therapy regimen resumed:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Item Rationale

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

Coding Instructions:

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

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

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

O0500: Restorative Nursing Programs

O0500. Restorative Nursing Programs	
Record the **number of days** each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)	
Number of Days	Technique
☐	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.

Planning for Care

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

Steps for Assessment

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

O0500: Restorative Nursing Programs (cont.)

- Measureable objective and interventions must be documented in the care plan and in the medical record. If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this reassessment should be documented in the resident's medical record.
- Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record. When not contraindicated by state practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established.
- Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity.
- A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a restorative nursing program. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents. Restorative nursing does not require a physician's order. Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In situations where such services do not actually require the involvement of a qualified therapist, the services may not be coded as therapy in item O0400, Therapies, because the specific interventions are considered restorative nursing services (see item O0400, Therapies). The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.
- This category does not include groups with more than four residents per supervising helper or caregiver.

Coding Instructions

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

O0500: Restorative Nursing Programs (cont.)

Technique

Activities provided by restorative nursing staff.

- O0500A, Range of Motion (Passive)

  Code provision of passive movements in order to maintain flexibility and useful motion in the joints of the body. These exercises must be individualized to the resident's needs, planned, monitored, evaluated and documented in the resident's medical record.

- O0500B, Range of Motion (Active)

  Code exercises performed by the resident, with cueing, supervision, or physical assist by staff that are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record. Include active ROM and active-assisted ROM.

- O0500C, Splint or Brace Assistance

  Code provision of (1) verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint; or (2) a scheduled program of applying and removing a splint or brace. These sessions are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

Training and Skill Practice

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

- O0500D, Bed Mobility

  Code activities provided to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side and positioning himself or herself in bed. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- O0500E, Transfer

  Code activities provided to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- O0500F, Walking

  Code activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

O0500: Restorative Nursing Programs (cont.)

- O0500G, Dressing and/or Grooming

  Code activities provided to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- O0500H, Eating and/or Swallowing

  Code activities provided to improve or maintain the resident's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- O0500I, Amputation/ Prosthesis Care

  Code activities provided to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket). Dentures are not considered to be prostheses for coding this item. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

- O0500J, Communication

  Code activities provided to improve or maintain the resident's self-performance in functional communication skills or assisting the resident in using residual communication skills and adaptive devices. These activities are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

Coding Tips and Special Populations

- For range of motion (passive): the caregiver moves the body part around a fixed point or joint through the resident's available range of motion. The resident provides no assistance.
- For range of motion (active): any participation by the resident in the ROM activity should be coded here.
- For both active and passive range of motion: movement by a resident that is incidental to dressing, bathing, etc., does not count as part of a formal restorative nursing program. For inclusion in this section, active or passive range of motion must be a component of an individualized program that is planned, monitored evaluated, and documented in the resident's medical record. Range of motion should be delivered by staff who are trained in the procedures.
- For splint or brace assistance: assess the resident's skin and circulation under the device, and reposition the limb in correct alignment.
- The use of continuous passive motion (CPM) devices in a restorative nursing program is coded when the following criteria are met: (1) ordered by a physician, (2) nursing staff

O0500: Restorative Nursing Programs (cont.)

have been trained in technique (e.g., properly aligning resident's limb in device, adjusting available range of motion), and (3) monitoring of the device. Nursing staff should document the application of the device and the effects on the resident. Do not include the time the resident is receiving treatment in the device. Include only the actual time staff were engaged in applying and monitoring the device.

- Remember that persons with dementia learn skills best through repetition that occurs multiple times per day.
- Grooming programs, including programs to help residents learn to apply make-up, may be considered restorative nursing programs when conducted by a member of the activity staff. These grooming programs would need to be individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record.

Examples

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

   Coding: Both **Splint or Brace Assistance** item (O0500C), and **Range of Motion (Passive)** item (O0500A), would be coded 7**.**
   Rationale: Because this was the number of days these restorative nursing techniques were provided.

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

   Coding: **Range of motion (active)** item (O0500B), would be coded 7**.**
   Rationale: Because this was the number of days restorative nursing training and skill practice for active ROM were provided.

O0500: Restorative Nursing Programs (cont.)

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

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

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

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

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

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

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

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

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

O0500: Restorative Nursing Programs (cont.)

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

   Coding: **Eating and/or Swallowing** item (O0500H), would be coded 0**.**
   Rationale: Because restorative nursing skill and practice training for eating and/or swallowing were not provided over the last 7 days.

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

   Coding: **Communication** item (O0500J), would be coded 0.
   Rationale: Because the resident has mastered the skill of communication, restorative nursing skill and practice training for communication was no longer needed or provided over the last 7 days.

O0600: Physician Examinations

O0600. Physician Examinations	
Enter Days ☐☐	Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) examine the resident?**

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

O0600: Physician Examinations (cont.)

Steps for Assessment

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

Coding Instructions

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

Coding Tips and Special Populations

- Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law.
- Examination (partial or full) can occur in the facility or in the physician's office. Included in this item are telehealth visits as long as the requirements are met for physician/practitioner type as defined above and whether it qualifies as a telehealth billable visit. For eligibility requirements and additional information about Medicare telehealth services refer to:
  - Chapter 15 of the ***Medicare Benefit Policy Manual*** (Pub. 100-2) and Chapter 12 of the ***Medicare Claims Processing Manual*** (Pub. 100-4) may be accessed at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html.
- Do not include physician examinations that occurred prior to admission or readmission to the facility (e.g., during the resident's acute care stay).
- Do not include physician examinations that occurred during an emergency room visit or hospital observation stay.
- If a resident is evaluated by a physician off-site (e.g., while undergoing dialysis or radiation therapy), it can be coded as a physician examination as long as documentation of the physician's evaluation is included in the medical record. The physician's evaluation can include partial or complete examination of the resident, monitoring the resident for response to the treatment, or adjusting the treatment as a result of the examination.
- The licensed psychological therapy by a Psychologist (PhD) should be recorded in O0400E, **Psychological Therapy**.
- Does not include visits made by Medicine Men.

O0700: Physician Orders

O0700. Physician Orders	
Enter Days ☐☐	Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) change the resident's orders?**

Item Rationale

Health-related Quality of Life

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

Planning for Care

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

Steps for Assessment

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

Coding Instructions

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

Coding Tips and Special Populations

- Includes orders written by medical doctors, doctors of osteopathy, podiatrists, dentists, and physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law.
- Includes written, telephone, fax, or consultation orders for new or altered treatment. Does **not** include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. Orders written on the day of admission as a result for an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.
- The prohibition against counting standard admission or readmission orders applies regardless of whether or not the orders are given at one time or are received at different times on the date of admission or readmission.
- Do not count orders prior to the date of admission or re-entry.
- A sliding scale dosage schedule that is written to cover different dosages depending on lab values, does **not** count as an order change simply because a different dose is administered based on the sliding scale guidelines.

O0700: Physician Orders (cont.)

- When a PRN (as needed) order was already on file, the potential need for the service had already been identified. Notification of the physician that the PRN order was activated does **not** constitute a new or changed order and may **not** be counted when coding this item.
- A Medicare Certification/Recertification is a renewal of an existing order and should **not** be included when coding this item.
- If a resident has multiple physicians (e.g., surgeon, cardiologist, internal medicine), and they all visit and write orders on the same day, the MDS must be coded as 1 day during which a physician visited, and 1 day in which orders were changed.
- Orders requesting a consultation by another physician may be counted. However, the order must be reasonable (e.g., for a new or altered treatment).
- An order written on the last day of the MDS observation period for a consultation planned 3-6 months in the future should be carefully reviewed.
- Orders written to increase the resident's RUG classification and facility payment are **not** acceptable.
- Orders for transfer of care to another physician may **not** be counted.
- Do **not** count orders written by a pharmacist.

SECTION Q: PARTICIPATION IN ASSESSMENT AND GOAL SETTING

Intent: The items in this section are intended to record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals. Discharge planning follow-up is already a regulatory requirement (CFR 483.20 (i) (3)). Section Q of the MDS uses a person-centered approach and to insure that all individuals have the opportunity to learn about home and community based services and have an opportunity to receive long term care in the least restrictive setting possible. Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.

Q0100: Participation in Assessment

Q0100. Participation in Assessment	
Enter Code ☐	A. Resident participated in assessment 0. No 1. Yes
Enter Code ☐	B. Family or significant other participated in assessment 0. No 1. Yes 9. Resident has no family or significant other
Enter Code ☐	C. Guardian or legally authorized representative participated in assessment 0. No 1. Yes 9. Resident has no guardian or legally authorized representative

Item Rationale

Health-related Quality of Life

- Residents who actively participate in the assessment process and in developing their care plan through interview and conversation often experience improved quality of life and higher quality care based on their needs, goals, and priorities.

Planning for Care

- Each care plan should be individualized and resident-driven. Whenever possible, the resident should be actively involved-except in unusual circumstances such as if the individual is unable to understand the proceedings or is comatose. Involving the resident in all assessment interviews and care planning meetings is also important to address dignity and self-determination survey and certification requirements (CFR §483.15 Quality of Life).

DEFINITIONS

RESIDENT'S PARTICIPATION IN ASSESSMENT

The resident actively engages in interviews and conversations to meaningfully contribute to the completion of the MDS 3.0. Interdisciplinary team members should engage the resident during assessment in order to determine the resident's expectations and perspective during assessment.

Q0100: Participation in Assessment (cont.)

- Code 1, Yes: if the family or significant other(s) did participate in the assessment process.
- Code 9, Resident has no family or significant other: Resident has no family or significant other.

Coding Instructions for Q0100C, Guardian or Legally Authorized Representative Participated in Assessment

Record the participation of the guardian or legally authorized representative in the assessment process.

- Code 0, No: if guardian or legally authorized representative did not participate in the assessment process.
- Code 1, Yes: if guardian or legally authorized representative did participate in the assessment process.
- Code 9, Resident has no guardian or legally authorized representative: Resident has no guardian or legally authorized representative.

Coding Tips

- While family, significant others, or, if necessary, the guardian or legally authorized representative can be involved, the response selected must reflect the resident's perspective if he or she is able to express it.
- Significant other does not include nursing home staff.

Q0300: Resident's Overall Expectation

Complete only when A0310E=1. (First assessment on admission/entry or reentry).

Q0300. Resident's Overall Expectation Complete only if A0310E = 1	
Enter Code ☐	**A. Select one for resident's overall goal established during assessment process** 1. Expects to be **discharged to the community** 2. Expects to **remain in this facility** 3. Expects to be **discharged to another facility/institution** 9. **Unknown or uncertain**
Enter Code ☐	**B. Indicate information source for Q0300A** 1. **Resident** 2. If not resident, then **family or significant other** 3. If not resident, family, or significant other, then **guardian or legally authorized representative** 9. **Unknown or uncertain**

Q0500: Return to Community

For Admission, Quarterly, and Annual Assessments.

Q0500. Return to Community	
Enter Code ☐	**B. Ask the resident** (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): **"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"** 0. **No** 1. **Yes** 9. **Unknown or uncertain**

Item Rationale

The goal of follow-up action is to initiate and maintain collaboration between the nursing home and the local contact agency to support the resident's expressed interest in being transitioned to community living. This includes the nursing home supporting the resident in achieving his or her highest level of functioning and the local contact agency providing informed choices for community living and assisting the resident in transitioning to community living. The underlying intention of the return to the community item is to insure that all individuals have the opportunity to learn about home and community based services and have an opportunity to receive long term services and supports in the least restrictive setting. CMS has found that in many cases individuals requiring long term services, and/or their families, are unaware of community based services and supports that could adequately support individuals in community living situations.

Health-related Quality of Life

- Returning home or to a non-institutional setting can be very important to the resident's health and quality of life.
- This item identifies the resident's desire to speak with someone about returning to community living. Based on the Americans with Disabilities Act and the 1999 U.S. Supreme Court decision in **Olmstead v. L.C.,** residents needing long-term care services have a right to receive services in the least restrictive and most integrated setting.
- Item Q0500B requires that the resident be asked the question directly and formalizes the opportunity for the resident to be informed of and consider his or her options to return to community living. This ensures that the resident's desire to learn about the possibility of returning to the community will be obtained and appropriate follow-up measures will be taken.
- The goal is to obtain the informed choice and preferences expressed by the resident and to provide information about available community supports and services.

Planning for Care

- Many nursing home residents may be able to return to the community if they are provided appropriate assistance to facilitate care in a non-institutional setting.

Q0550: Resident's Preference to Avoid Being Asked Question Q0500B again

Q0550. Resident's Preference to Avoid Being Asked Question Q0500B Again	
Enter Code ☐	**A. Does the resident** (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond) **want to be asked about returning to the community on all assessments?** (Rather than only on comprehensive assessments.) 0. **No** - then document in resident's clinical record and ask again only on the next comprehensive assessment 1. **Yes** 8. **Information not available**
Enter Code ☐	**B. Indicate information source for Q0550A** 1. **Resident** 2. If not resident, then **family or significant other** 3. If not resident, family or significant other, then **guardian or legally authorized representative** 8. **No information source available**

Item Rationale

Some individuals, such as those with cognitive impairments, mental illness, or end-stage life conditions, may be upset by asking them if they want to return to the community. CMS pilot tested Q0500 language and determined that respondents would be less likely to be upset by being asked if they want to talk to someone about returning to the community if they were given the opportunity to opt-out of being asked the question every quarter. The intent of the item is to achieve a better balance between giving residents a voice and a choice about the services they receive, while being sensitive to those individuals who may be unable to voice their preferences or be upset by being asked question Q0500B in the assessment process.

Coding Instructions for Q0550A, Does the resident, (or family or significant other or guardian or legally authorized representative if resident is unable to respond) want to be asked about returning to the community on all assessments? (Rather than only on comprehensive assessments.)

- Code 0, No: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does not want to be asked again on quarterly assessments about returning to the community. Then document in resident's clinical record and ask question Q0500B again only on the next comprehensive assessment.
- Code 1, Yes: if the resident (or family or significant other, or guardian or legally authorized representative) states that he or she does want to be asked the return to community question Q0500B on all assessments.
- Code **8**, Information not available: if the resident cannot respond and the family or significant other is not available to respond on the resident's behalf and a guardian or legally authorized representative is not available or has not been appointed by the court.

Z0400: Signatures of Persons Completing the Assessment (cont.)

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 item 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.
- 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 or tracking record 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 will generally be 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.
- 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.

Once communication is established with the QIES ASAP system, the provider can access the CMS MDS Welcome Page in the MDS system. This site allows providers to submit MDS assessment data and access various information sources such as Bulletins and Questions and Answers. The *Minimum Data Set (MDS) 3.0 Provider User's Guide* provides more detailed information about the MDS system. It is available on the QTSO MDS 3.0 web site at https://www.qtso.com/mds30.html.

When the transmission file is received by the QIES ASAP system, the system performs a series of validation edits to evaluate whether or not the data submitted meet the required standards. MDS records are edited to verify that clinical responses are within valid ranges and are consistent, dates are reasonable, and records are in the proper order with regard to records that were previously accepted by the QIES ASAP system for the same resident. The provider is notified of the results of this evaluation by error and warning messages on a Final Validation Report. All error and warning messages are detailed and explained in the *Minimum Data Set (MDS) 3.0 Provider User's Guide*.

5.2 Timeliness Criteria

In accordance with the requirements at 42 CFR §483.20(f)(1), (f)(2), and (f)(3), long-term care facilities participating in the Medicare and Medicaid programs must meet the following conditions:

- **Completion Timing:**
  - For all non-admission OBRA and PPS assessments, the MDS Completion Date (Z0500B) must be no later than 14 days after the Assessment Reference Date (ARD) (A2300).
  - For the Admission assessment, the MDS Completion Date (Z0500B) must be no later than 13 days after the 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 record).
- **State Requirements:** Many states have established additional MDS requirements for Medicaid payment and/or quality monitoring purposes. For information on state requirements, contact your State RAI Coordinator. (See Appendix B for a list of state RAI coordinators.)
- **Encoding Data:** Within 7 days after completing a resident's MDS assessment or tracking information, the provider should encode the MDS data (i.e., enter the information into the facility MDS software). The encoding requirements are as follows:

— for 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/she was previously treated for in a hospital.

Physician Certification

The attending physician or a physician on the staff of the skilled nursing home 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 home.

- **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 beneficiary's assignment to one of the upper RUG-IV (Top 52) groups is correct.
- **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.
  — Subsequent re-certifications are required at no later than 30 days 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 RUG-IV 66-Group Model Calculation Worksheet for SNFs

The purpose of this RUG-IV Version 1.00 calculation worksheet for the 66-group model is to provide a step-by-step walk-through to manually determine the appropriate RUG-IV Classification based on the data from an MDS assessment. The worksheet takes the grouper logic and puts it into words. We have carefully reviewed the worksheet to ensure that it represents the standard logic.

In the RUG-IV 66-group model, there are 23 different Rehabilitation Plus Extensive Services and Rehabilitation groups, representing 10 different levels of rehabilitation services. In the 66-group model, the residents in the Rehabilitation Plus Extensive Services groups have the highest level of combined nursing and rehabilitation need, while residents in the Rehabilitation groups have the next highest level of need. Therefore, the 66-group model has the Rehabilitation Plus Extensive Services groups first followed by the Rehabilitation groups, the Extensive Services groups, the Special Care High groups, the Special Care Low groups, the Clinically Complex groups, the Behavioral Symptoms and Cognitive Performance groups, and the Reduced Physical Function groups.

There are two basic approaches to RUG-IV Classification: (1) hierarchical classification and (2) index maximizing classification. The current worksheet was developed for the hierarchical methodology. Instructions for adapting this worksheet to the index maximizing approach are

- **Very High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

    1. In the last 7 days:
        Total Therapy Minutes (calculated on page 6-25 - 6-28) of 500 minutes or more
        and
        At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days
    2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**
        Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 100 and 143 minutes

RUG-IV ADL Score	RUG-IV Class
11-16	RVX
2-10	RVL

- **High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

    1. In the last 7 days:
        Total Therapy Minutes (calculated on page 6-25 - 6-28) of 325 minutes or more
        and
        At least 1 discipline (O0400A4, O0400B4, or O0400C4) for at least 5 days
    2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**
        Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 65 and 99 minutes

RUG-IV ADL Score	RUG-IV Class
11-16	RHX
2-10	RHL

- **Medium Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

    1. In the last 7 days:
        Total Therapy Minutes (calculated on page 6-25 - 6-28) of 150 minutes or more
        and
        At least 5 distinct calendar days of any combination of the three disciplines (O0400A4 plus O0400B4 plus O0400C4)
    2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**
        Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 30 and 64 minutes

RUG-IV ADL Score	RUG-IV Class
11-16	RMX
2-10	RML

- **Low Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied):

  1. In the last 7 days:
     Total Therapy Minutes (calculated on page 6-25 - 6-28) of 45 minutes or more
     and
     At least 3 distinct calendar days of any combination of the 3 disciplines (O0400A4, plus O0400B4 plus O0400C4)
     and
     Two or more restorative nursing services* received for 6 or more days for at least 15 minutes a day

  2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**
     Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 15 and 29 minutes

*Restorative Nursing Services
H0200C, H0500** Urinary toileting program and/or bowel toileting program
O0500A,B** Passive and/or active ROM
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

RUG-IV ADL Score	**RUG-IV Class**
2-16	RLX

RUG-IV Classification _____

If the resident does not classify in the Rehabilitation Plus Extensive Services Category, proceed to Category II.

RUG-IV ADL Score	RUG-IV Class
11-16	RVC
6-10	RVB
0-5	RVA

C. **High Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:
   Total Therapy Minutes (calculated on page 6-25 - 6-28) of 325 minutes or more
   and
   At least 1 discipline (O0400A4, O0400B4 or O0400C4) for at least 5 days
2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**
   Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 65 and 99 minutes

RUG-IV ADL Score	RUG-IV Class
11-16	RHC
6-10	RHB
0-5	RHA

D. **Medium Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied)

1. In the last 7 days:
   Total Therapy Minutes (calculated on page 6-25 - 6-28) of 150 minutes or more
   and
   At least 5 distinct calendar days of any combination of the three disciplines (O0400A4, plus O0400B4 plus O0400C4)
2. **If the Medicare Short Stay Assessment Indicator (determined on page 6-20) is "Yes":**
   Medicare Short Stay Average Therapy Minutes (see page 6-19) of between 30 and 64 minutes

RUG-IV ADL Score	RUG-IV Class
11-16	RMC
6-10	RMB
0-5	RMA

E. **Low Intensity Criteria** (the resident qualifies if either [1] or [2] is satisfied):

1. In the last 7 days:
   Total Therapy Minutes (calculated on page 6-25 - 6-28) of 45 minutes or more
   and
   At least 3 distinct calendar days of any combination of the three disciplines (O0400A4 plus O0400B4 plus O0400C4)
   and
   Two or more restorative nursing services* received for 6 or more days for at least 15 minutes a day

CATEGORY IV: SPECIAL CARE HIGH
RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

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, ADLs	Comatose and completely ADL dependent or ADL did not occur (G0110A1, G0110B1, G0110H1, and G0110I1 all equal 4 or 8)
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, ADL Score	Quadriplegia with ADL score >= 5
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 Category V now.

STEP # 2

If at least **one** of the special care conditions above is coded and the resident has a total RUG-IV ADL score of 2 or more, he or she classifies as Special Care High. **Move to Step #3. If the resident's ADL score is 0 or 1, he or she classifies as Clinically Complex. Skip to Category VI, Step #2.**

CATEGORY V: SPECIAL CARE LOW
RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

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, ADL Score	Cerebral palsy, with ADL score >=5
I5200, ADL Score	Multiple sclerosis, with ADL score >=5
I5300, ADL Score	Parkinson's disease, with ADL score >=5
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 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 Category VI now.

ADJUSTMENT FOR START OF THERAPY OMRA
RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

A Start of Therapy (SOT) OMRA is a Medicare assessment used to initiate a Medicare payment level in either a Rehabilitation Plus Extensive or Rehabilitation group after rehabilitation therapy starts. The SOT OMRA is an abbreviated assessment that does not contain all of the items used for RUG-IV classification. The SOT OMRA only contains the RUG-IV items necessary for a Rehabilitation Plus Extensive or Rehabilitation classification. Classifications below the Rehabilitation category cannot be determined from an SOT OMRA unless it is combined with an assessment that contains all of the RUG-IV items (i.e., an OBRA assessment or other type of PPS assessment).

MEDICARE ADJUSTMENTS

Adjustments are performed for Medicare classification (Item Z0100A) on an SOT OMRA. There are three different situations relevant to Medicare classification adjustments as follows:

Situation 1

If an assessment is an SOT OMRA, indicated by MDS Item A0310C = 1 or 3, whether or not it is combined with other types of assessments, then the Medicare Index Maximized RUG-IV classification in item Z0100A must be a Rehabilitation Plus Extensive Services group or a Rehabilitation group. Lower classifications are not valid for Z0100A on an SOT OMRA.

If the Z0100A classification for any SOT OMRA (Item A0310C = 1 or 3) ***is not*** in a Rehabilitation Plus Extensive Services group or a Rehabilitation group, then the following adjustment should be made:

1. The Medicare RUG-IV group reported in Item Z0100A should be ***adjusted to AAA*** (the default group), the assessment should marked as invalid, and the assessment should be barred from submission. The Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system will ***reject the assessment*** if submitted.

Situation 2

If the Z0100A classification for an SOT OMRA (Item A0310C = 1), ***not combined*** with an OBRA assessment or other PPS assessment, ***is not*** in a Rehabilitation Plus Extensive Services group or a Rehabilitation group, then the following adjustment applies:

1. The Medicare Non-Therapy RUG-IV group reported in Item Z0150A should be ***adjusted to AAA*** (the default group).

Situation 3

If the Z0100A classification for an SOT OMRA, ***combined*** with an OBRA assessment or other PPS assessment, ***is*** in a Rehabilitation Plus Extensive Services group or a Rehabilitation group, then ***no adjustment*** is necessary.

SNF must bill the default code for the applicable payment period. For covered days associated with the Medicare-required 30-day, 60-day, or 90-day assessments, the SNF must have a valid OBRA assessment (except a stand-alone discharge assessment) in the QIES ASAP system that falls within the ARD window of the PPS assessment (including grace days) in order to receive full payment at the RUG category in which the resident grouped. If the ARD of the valid OBRA assessment falls outside the ARD window of the PPS assessment (including grace days), the SNF must bill the default code.

Under all situations other than exceptions 1-5, the following apply when the SNF failed to set the ARD prior to the end of the last day of the ARD window, including grace days, or later and the resident was already discharged from Medicare Part A when this was discovered:

1. If a valid OBRA assessment (except a stand-alone discharge assessment) exists in the QIES ASAP system with an ARD that is within the ARD window of the PPS assessment (including grace days), the SNF may bill the RUG category in which the resident classified.
2. If a valid OBRA assessment (except a stand-alone discharge assessment) exists in the QIES ASAP system with an ARD that is outside the ARD window of the Medicare-required assessment (including grace days), the SNF may not bill for any days associated with the missing PPS assessment.
3. If a valid OBRA assessment (except a stand-alone discharge assessment) does not exist in the QIES ASAP system, the SNF may not bill for any days associated with the missing PPS assessment.

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

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 scheduled 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/her SNF benefit period. The SNF must set the ARD for the PPS assessment on December 11, 12, or 13 to bill for the RUG category associated with the assessment.

A SNF may use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for an unscheduled PPS assessment, but only in the case where the ARD for the unscheduled assessment falls on a day that is not counted among the beneficiary's 100 days due to a leave of absence (LOA), as defined in Chapter 2, sections 2.4 and 2.13, and the resident returns to the facility from the LOA on Medicare Part A. For example, Day 7 of the COT observation period occurs 7 days following the ARD of the most recent PPS assessment used for payment, regardless if a LOA occurs at any point during the COT observation period. If the ARD for a resident's 30-day assessment were set for November 7 and the resident went to the emergency room at 11:00pm on November 14, returning on November 15, Day 7 of the COT observation period would remain November 14 for purposes of coding the COT OMRA.

Term	Abbreviation	Definition
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.
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.

(continued)

APPENDIX F

MDS ITEM MATRIX

Item matrix for October 2013					Nursing Home Item Subsets									Swing Bed Item Subsets								Item Groups								New D/C	
MDS Item	Description	Skip trigger items	NOA item	Submitted Item	NC - Comp	NQ - Quart	NP - PPS	NS - OMRA SOT	NSD-OMRA SOT+DC	NO - OMRA other	NOD - OMRA other + DC	ND - Disch	NT - Tracking	SP - PPS	SS - OMRA SOT	SSD-OMRA SOT+DC	SO - OMRA other	SOD - OMRA other + DC	SD - Disch	ST - Tracking	XX - Inactivation	Demog/Admin	QI items	QM items	CAA items	RUG rehab grp	RUG non-rehab	RUG-III items	S&C items	PDC - Planned D/C	UPD - Unplanned D/C
A0050	Type of Record	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
A0100A	Facility National Provider Identifier (NPI)			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A0100B	Facility CMS Certification Number (CCN)			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A0100C	State provider number			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A0200	Type of provider	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x				x		x	x
A0310A	Type of assessment: OBRA	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x	x	x	x	x	x	x	x
A0310B	Type of assessment: PPS			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x		x	x	x	x	x	x
A0310C	Type of assessment: OMRA			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x				x				x	x
A0310D	Swing bed clinical change assessment			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x				x	x			x	x
A0310E	First assessment since most recent entry	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A0310F	Entry/discharge reporting	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x						x	x
A0310G	Planned/unplanned discharge	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A0410	Submission requirement			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A0500A	Resident first name			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A0500B	Resident middle initial			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A0500C	Resident last name			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A0500D	Resident name suffix			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A0600A	Social Security Number			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A0600B	Resident Medicare/railroad insurance number			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A0700	Resident Medicaid number			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A0800	Gender			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A0900	Birthdate	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A1000A	Ethnicity: American Indian or Alaska Native			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A1000B	Ethnicity: Asian			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A1000C	Ethnicity: Black or African American			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A1000D	Ethnicity: Hispanic or Latino			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A1000E	Ethnicity: Native Hawaiian/Pacific Islander			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A1000F	Ethnicity: White			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A1100A	Does the resident need or want an interpreter	x		x	x	x	x		x	x	x	x		x		x	x	x	x			5								x	x
A1100B	Preferred language			x	x	x	x		x	x	x	x		x		x	x	x	x			5								x	x
A1200	Marital status			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A1300A	Medical record number			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A1300B	Room number			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A1300C	Name by which resident prefers to be addressed			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A1300D	Lifetime occupation(s)			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A1500	Resident evaluated by PASRR	x		x	x	x	x		x		x	x																		x	x
A1510A	Level II PASRR conditions: Serious Mental Illness			x	x	x	x		x		x	x																		x	x
A1510B	Level II PASRR conditions: Mental Retardation			x	x	x	x		x		x	x																		x	x
A1510C	Level II PASRR conditions: Other related conditions			x	x	x	x		x		x	x																		x	x
A1550A	ID/DD status: Down syndrome			x	x	x	x		x		x	x																	x	x	x
A1550B	ID/DD status: Autism			x	x	x	x		x		x	x																	x	x	x
A1550C	ID/DD status: Epilepsy			x	x	x	x		x		x	x																	x	x	x
A1550D	ID/DD status: other organic MR/DD condition			x	x	x	x		x		x	x																	x	x	x
A1550E	ID/DD status: MR/DD with no organic condition			x	x	x	x		x		x	x																	x	x	x
A1550Z	ID/DD status: none of the above		x	x	x	x	x		x		x	x																		x	x
A1600	Entry date (date of admission/reentry in facility)	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x					x	x	x
A1700	Type of entry			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x						x	x
A1800	Entered from			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A2000	Discharge date			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x	x	x						x	x
A2100	Discharge status			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x

Item matrix for October 2013					Nursing Home Item Subsets									Swing Bed Item Subsets								Item Groups								New D/C	
MDS Item	Description	Skip trigger items	NOA item	Submitted Item	NC - Comp	NQ - Quart	NP - PPS	NS - OMRA SOT	NSD-OMRA SOT+DC	NO - OMRA other	NOD - OMRA other + DC	ND - Disch	NT - Tracking	SP - PPS	SS - OMRA SOT	SSD-OMRA SOT+DC	SO - OMRA other	SOD - OMRA other + DC	SD - Disch	ST - Tracking	XX - Inactivation	Demog/Admin	QI items	QM items	CAA items	RUG rehab grp	RUG non-rehab	RUG-III items	S&C items	PDC - Planned D/C	UPD - Unplanned D/C
A2200	Previous asmt reference date for signif correction			x	x	x	x							x								1									
A2300	Assessment reference date	x		x	x	x	x	x	x	x	x	x		x	x	x	x	x	x			2	x	x		x	x			x	x
A2400A	Has resident had Medicare-covered stay	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
A2400B	Start date of most recent Medicare stay			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x				x				x	x
A2400C	End date of most recent Medicare stay			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x				x				x	x
B0100	Comatose	x		x	x	x	x		x	x	x	x		x		x	x	x	x					x			x	x		x	x
B0200	Hearing			x	x	x	x							x											x				x		
B0300	Hearing aid			x	x	x	x							x															x		
B0600	Speech clarity			x	x	x	x							x																	
B0700	Makes self understood			x	x	x	x			x	x			x			x	x							x		x	x			
B0800	Ability to understand others			x	x	x	x							x											x						
B1000	Vision			x	x	x	x							x											x				x		
B1200	Corrective lenses			x	x	x	x							x															x		
C0100	BIMS: should resident interview be conducted	x		x	x	x	x		x	x	x	x		x		x	x	x	x					+			+	+	x	x	
C0200	BIMS res interview: repetition of three words			x	x	x	x		x	x	x	x		x		x	x	x	x					+			+	+	x	x	
C0300A	BIMS res interview: able to report correct year			x	x	x	x		x	x	x	x		x		x	x	x	x					+			+	+	x	x	
C0300B	BIMS res interview: able to report correct month			x	x	x	x		x	x	x	x		x		x	x	x	x					+			+	+	x	x	
C0300C	BIMS res interview: can report correct day of week			x	x	x	x		x	x	x	x		x		x	x	x	x					+			+	+	x	x	
C0400A	BIMS res interview: able to recall "sock"			x	x	x	x		x	x	x	x		x		x	x	x	x					+			+	+	x	x	
C0400B	BIMS res interview: able to recall "blue"			x	x	x	x		x	x	x	x		x		x	x	x	x					+			+	+	x	x	
C0400C	BIMS res interview: able to recall "bed"			x	x	x	x		x	x	x	x		x		x	x	x	x					+			+	+	x	x	
C0500	BIMS res interview: summary score	x		x	x	x	x		x	x	x	x		x		x	x	x	x					x	x		x	x	x	x	
C0600	Staff asmt mental status: conduct asmt	x		x	x	x	x		x	x	x	x		x		x	x	x	x								+	+		x	x
C0700	Staff asmt mental status: short-term memory OK			x	x	x	x		x	x	x	x		x		x	x	x	x					x	x		x	x	x	x	x
C0800	Staff asmt mental status: long-term memory OK			x	x	x	x							x											x				x		
C0900A	Staff asmt mental status: recall current season			x	x	x	x							x																	
C0900B	Staff asmt mental status: recall location of room			x	x	x	x							x																	
C0900C	Staff asmt mental status: recall staff names/faces			x	x	x	x							x																	
C0900D	Staff asmt mental status: recall in nursing home			x	x	x	x							x																	
C0900Z	Staff asmt mental status: none of above recalled		x	x	x	x	x							x																	
C1000	Cognitive skills for daily decision making			x	x	x	x		x	x	x	x		x		x	x	x	x					x	x		x	x	x	x	x
C1300A	Signs of delirium: inattention			x	x	x	x		x		x	x		x		x		x	x						x				x	x	x
C1300B	Signs of delirium: disorganized thinking			x	x	x	x		x		x	x		x		x		x	x						x				x	X	x
C1300C	Signs of delirium: altered level of consciousness			x	x	x	x		x		x	x		x		x		x	x						x				x	x	x
C1300D	Signs of delirium: psychomotor retardation			x	x	x	x		x		x	x		x		x		x	x						x				x	x	x
C1600	Acute onset mental status change			x	x	x	x		x		x	x		x		x		x	x						x					x	x
D0100	PHQ: should resident mood interview be conducted	x		x	x	x	x		x	x	x	x		x		x	x	x	x									+	+		x	
D0200A1	PHQ res: little interest or pleasure - presence	x		x	x	x	x		x	x	x	x		x		x	x	x	x						x			+	+	x	x	
D0200A2	PHQ res: little interest or pleasure - frequency			x	x	x	x		x	x	x	x		x		x	x	x	x					x				+	+		x	
D0200B1	PHQ res: feeling down, depressed - presence	x		x	x	x	x		x	x	x	x		x		x	x	x	x									+	+	x	x	
D0200B2	PHQ res: feeling down, depressed - frequency			x	x	x	x		x	x	x	x		x		x	x	x	x					x				+	+		x	
D0200C1	PHQ res: trouble with sleep - presence	x		x	x	x	x		x	x	x	x		x		x	x	x	x									+	+	x	x	

Item matrix for October 2013					Nursing Home Item Subsets									Swing Bed Item Subsets								Item Groups								New D/C	
MDS Item	Description	Skip trigger items	NOA item	Submitted Item	NC - Comp	NQ - Quart	NP - PPS	NS - OMRA SOT	NSD-OMRA SOT+DC	NO - OMRA other	NOD - OMRA other + DC	ND - Disch	NT - Tracking	SP - PPS	SS - OMRA SOT	SSD-OMRA SOT+DC	SO - OMRA other	SOD - OMRA other + DC	SD - Disch	ST - Tracking	XX - Inactivation	Demog/Admin	QI items	QM items	CAA items	RUG rehab grp	RUG non-rehab	RUG-III items	S&C items	PDC - Planned D/C	UPD - Unplanned D/C
D0200C2	PHQ res: trouble with sleep - frequency			x	x	x	x		x	x	x	x		x		x	x	x	x					x			+	+		x	
D0200D1	PHQ res: feeling tired/little energy - presence	x		x	x	x	x		x	x	x	x		x		x	x	x	x								+	+	x	x	
D0200D2	PHQ res: feeling tired/little energy - frequency			x	x	x	x		x	x	x	x		x		x	x	x	x					x			+	+		x	
D0200E1	PHQ res: poor appetite or overeating - presence	x		x	x	x	x		x	x	x	x		x		x	x	x	x								+	+	x	x	
D0200E2	PHQ res: poor appetite or overeating - frequency			x	x	x	x		x	x	x	x		x		x	x	x	x					x			+	+		x	
D0200F1	PHQ res: feeling bad about self - presence	x		x	x	x	x		x	x	x	x		x		x	x	x	x								+	+	x	x	
D0200F2	PHQ res: feeling bad about self - frequency			x	x	x	x		x	x	x	x		x		x	x	x	x					x			+	+		x	
D0200G1	PHQ res: trouble concentrating - presence	x		x	x	x	x		x	x	x	x		x		x	x	x	x								+	+	x	x	
D0200G2	PHQ res: trouble concentrating - frequency			x	x	x	x		x	x	x	x		x		x	x	x	x					x			+	+		x	
D0200H1	PHQ res: slow, fidgety, restless - presence	x		x	x	x	x		x	x	x	x		x		x	x	x	x								+	+	x	x	
D0200H2	PHQ res: slow, fidgety, restless - frequency			x	x	x	x		x	x	x	x		x		x	x	x	x					x			+	+		x	
D0200I1	PHQ res: thoughts better off dead - presence	x		x	x	x	x		x	x	x	x		x		x	x	x	x						x		+	+	x	x	
D0200I2	PHQ res: thoughts better off dead - frequency			x	x	x	x		x	x	x	x		x		x	x	x	x					x			+	+		x	
D0300	PHQ res: total mood severity score	x		x	x	x	x		x	x	x	x		x		x	x	x	x					x	x		x	x	x	x	
D0350	PHQ res: safety notification			x	x	x	x		x	x	x	x		x		x	x	x	x											x	
D0500A1	PHQ staff: little interest or pleasure - presence			x	x	x	x		x	x	x	x		x		x	x	x	x						x		+	+	x	x	
D0500A2	PHQ staff: little interest or pleasure - frequency			x	x	x	x		x	x	x	x		x		x	x	x	x					x			+	+		x	
D0500B1	PHQ staff: feeling down, depressed - presence			x	x	x	x		x	x	x	x		x		x	x	x	x								+	+	x	x	
D0500B2	PHQ staff: feeling down, depressed - frequency			x	x	x	x		x	x	x	x		x		x	x	x	x					x			+	+		x	
D0500C1	PHQ staff: trouble with sleep - presence			x	x	x	x		x	x	x	x		x		x	x	x	x								+	+	x	x	
D0500C2	PHQ staff: trouble with sleep - frequency			x	x	x	x		x	x	x	x		x		x	x	x	x					x			+	+		x	
D0500D1	PHQ staff: feeling tired/little energy - presence			x	x	x	x		x	x	x	x		x		x	x	x	x								+	+	x	x	
D0500D2	PHQ staff: feeling tired/little energy - frequency			x	x	x	x		x	x	x	x		x		x	x	x	x					x			+	+		x	
D0500E1	PHQ staff: poor appetite or overeating - presence			x	x	x	x		x	x	x	x		x		x	x	x	x								+	+	x	x	
D0500E2	PHQ staff: poor appetite or overeating - frequency			x	x	x	x		x	x	x	x		x		x	x	x	x					x			+	+		x	
D0500F1	PHQ staff: feeling bad about self - presence			x	x	x	x		x	x	x	x		x		x	x	x	x								+	+	x	x	
D0500F2	PHQ staff: feeling bad about self - frequency			x	x	x	x		x	x	x	x		x		x	x	x	x					x			+	+		x	
D0500G1	PHQ staff: trouble concentrating - presence			x	x	x	x		x	x	x	x		x		x	x	x	x								+	+	x	x	
D0500G2	PHQ staff: trouble concentrating - frequency			x	x	x	x		x	x	x	x		x		x	x	x	x					x			+	+		x	
D0500H1	PHQ staff: slow, fidgety, restless - presence			x	x	x	x		x	x	x	x		x		x	x	x	x								+	+	x	x	
D0500H2	PHQ staff: slow, fidgety, restless - frequency			x	x	x	x		x	x	x	x		x		x	x	x	x					x			+	+		x	
D0500I1	PHQ staff: thoughts better off dead - presence	x		x	x	x	x		x	x	x	x		x		x	x	x	x						x		+	+	x	x	
D0500I2	PHQ staff: thoughts better off dead - frequency			x	x	x	x		x	x	x	x		x		x	x	x	x					x			+	+		x	
D0500J1	PHQ staff: short-tempered - presence			x	x	x	x		x	x	x	x		x		x	x	x	x								+	+	x	x	
D0500J2	PHQ staff: short-tempered - frequency			x	x	x	x		x	x	x	x		x		x	x	x	x					x			+	+		x	
D0600	PHQ staff: total mood severity score			x	x	x	x		x	x	x	x		x		x	x	x	x					x	x		x	x	x	x	
D0650	PHQ staff: safety notification			x	x	x	x		x	x	x	x		x		x	x	x	x											x	
E0100A	Psychosis: hallucinations			x	x	x	x		x	x	x	x		x		x	x	x	x				x				x	x		x	x
E0100B	Psychosis: delusions			x	x	x	x		x	x	x	x		x		x	x	x	x				x				x	x		x	x
E0100Z	Psychosis: none of the above		x	x	x	x	x		x	x	x	x		x		x	x	x	x								+	+		x	x
E0200A	Physical behav symptoms directed toward others	x		x	x	x	x		x	x	x	x		x		x	x	x	x				x		x		x	x	x	x	x
E0200B	Verbal behavioral symptoms directed toward others	x		x	x	x	x		x	x	x	x		x		x	x	x	x				x		x		x	x	x	x	x

Item matrix for October 2013					Nursing Home Item Subsets									Swing Bed Item Subsets									Item Groups								New D/C	
MDS Item	Description	Skip trigger items	NOA item	Submitted Item	NC - Comp	NQ - Quart	NP - PPS	NS - OMRA SOT	NSD-OMRA SOT+DC	NO - OMRA other	NOD - OMRA other + DC	ND - Disch	NT - Tracking	SP - PPS	SS - OMRA SOT	SSD-OMRA SOT+DC	SO - OMRA other	SOD - OMRA other + DC	SD - Disch	ST - Tracking	XX - Inactivation	Demog/Admin	QI items	QM items	CAA items	RUG rehab grp	RUG non-rehab	RUG-III items	S&C items	PDC - Planned D/C	UPD - Unplanned D/C
E0200C	Other behav symptoms not directed toward others	x		x	x	x	x		x	x	x	x		x		x	x	x	x				x		x		x	x	x	x	x
E0300	Overall presence of behavioral symptoms	x		x	x	s	s																		x				x		
E0500A	Behav symptoms put res at risk for illness/injury			x	x	s	s																								
E0500B	Behav symptoms interfere with resident care			x	x	s	s																								
E0500C	Behav symptoms interfere with social activities			x	x	s	s																								
E0600A	Behav symptoms put others at risk for injury			x	x	s	s																								
E0600B	Behav symptoms intrude on privacy of others			x	x	s	s																								
E0600C	Behav symptoms disrupt care or living environment			x	x	s	s																								
E0800	Rejection of care: presence and frequency			x	x	x	x		x	x	x	x		x		x	x	x	x				x		x		x	x	x	x	x
E0900	Wandering: presence and frequency	x		x	x	x	x		x	x	x	x		x		x	x	x	x				x		x		x	x	x	x	x
E1000A	Wandering: risk of getting to dangerous place			x	x	s	s																								
E1000B	Wandering: intrude on privacy of others			x	x	s	s																								
E1100	Change in behavioral or other symptoms			x	x	s	s																		x						
F0300	Conduct res interview for daily/activity prefs	x		x	x	s	s																								
F0400A	Res interview: choose clothes to wear	x		x	x	s	s																								
F0400B	Res interview: take care of personal belongings	x		x	x	s	s																								
F0400C	Res interview: choose tub, bath, shower, sponge	x		x	x	s	s																								
F0400D	Res interview: have snacks between meals	x		x	x	s	s																								
F0400E	Res interview: choose own bedtime	x		x	x	s	s																								
F0400F	Res interview: discuss care with family/friend	x		x	x	s	s																								
F0400G	Res interview: use phone in private	x		x	x	s	s																								
F0400H	Res interview: lock things to keep them safe	x		x	x	s	s																								
F0500A	Res interview: have books, newspaper, mags to read	x		x	x	s	s																		x						
F0500B	Res interview: listen to music	x		x	x	s	s																		x						
F0500C	Res interview: be around animals/pets	x		x	x	s	s																		x						
F0500D	Res interview: keep up with news	x		x	x	s	s																		x						
F0500E	Res interview: do things with groups of people	x		x	x	s	s																		x						
F0500F	Res interview: do favorite activities	x		x	x	s	s																		x						
F0500G	Res interview: go outside when good weather	x		x	x	s	s																		x						
F0500H	Res interview: participate in religious practices	x		x	x	s	s																		x						
F0600	Primary respondent: daily/activities prefs			x	x	s	s																		x						
F0700	Conduct staff assessment for daily/activity prefs	x		x	x	s	s																								
F0800A	Staff assessment: choosing clothes to wear			x	x	s	s																								
F0800B	Staff assessment: caring for personal belongings			x	x	s	s																								
F0800C	Staff assessment: receiving tub bath			x	x	s	s																								
F0800D	Staff assessment: receiving shower			x	x	s	s																								
F0800E	Staff assessment: receiving bed bath			x	x	s	s																								
F0800F	Staff assessment: receiving sponge bath			x	x	s	s																								
F0800G	Staff assessment: snacks between meals			x	x	s	s																								
F0800H	Staff assessment: staying up past 8PM			x	x	s	s																								
F0800I	Staff assessment: discuss care with family/other			x	x	s	s																								
F0800J	Staff assessment: use phone in private			x	x	s	s																								

Item matrix for October 2013					Nursing Home Item Subsets									Swing Bed Item Subsets								Item Groups								New D/C	
MDS Item	Description	Skip trigger items	NOA item	Submitted Item	NC - Comp	NQ - Quart	NP - PPS	NS - OMRA SOT	NSD-OMRA SOT+DC	NO - OMRA other	NOD - OMRA other + DC	ND - Disch	NT - Tracking	SP - PPS	SS - OMRA SOT	SSD-OMRA SOT+DC	SO - OMRA other	SOD - OMRA other + DC	SD - Disch	ST - Tracking	XX - Inactivation	Demog/Admin	QI items	QM items	CAA items	RUG rehab grp	RUG non-rehab	RUG-III items	S&C items	PDC - Planned D/C	UPD - Unplanned D/C
F0800K	Staff assessment: place to lock personal things			x	x	s	s																								
F0800L	Staff assessment: reading books, newspapers, mags			x	x	s	s																		x						
F0800M	Staff assessment: listening to music			x	x	s	s																		x						
F0800N	Staff assessment: being around animals/pets			x	x	s	s																		x						
F0800O	Staff assessment: keeping up with news			x	x	s	s																		x						
F0800P	Staff assessment: doing things with groups			x	x	s	s																		x						
F0800Q	Staff assessment: participate favorite activities			x	x	s	s																		x						
F0800R	Staff assessment: spend time away from nursng home			x	x	s	s																		x						
F0800S	Staff assessment: spend time outdoors			x	x	s	s																		x						
F0800T	Staff assessment: participate religious activities			x	x	s	s																		x						
F0800Z	Staff assessment: none of above activities		x	x	x	s	s																								
G0110A1	Bed mobility: self-performance			x	x	x	x	x	x	x	x	x		x	x	x	x	x	x					x	x	x	x	x		x	x
G0110A2	Bed mobility: support provided			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x	x			
G0110B1	Transfer: self-performance			x	x	x	x	x	x	x	x	x		x	x	x	x	x	x					x	x	x	x	x	x	x	x
G0110B2	Transfer: support provided			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x	x			
G0110C1	Walk in room: self-performance			x	x	x	x		x		x	x		x		x		x	x						x				x	x	x
G0110C2	Walk in room: support provided			x	x	x	x							x																	
G0110D1	Walk in corridor: self-performance			x	x	x	x		x		x	x		x		x		x	x						x				x	x	x
G0110D2	Walk in corridor: support provided			x	x	x	x							x																	
G0110E1	Locomotion on unit: self-performance			x	x	x	x		x		x	x		x		x		x	x					x	x					x	x
G0110E2	Locomotion on unit: support provided			x	x	x	x							x																	
G0110F1	Locomotion off unit: self-performance			x	x	x	x		x		x	x		x		x		x	x						x					x	x
G0110F2	Locomotion off unit: support provided			x	x	x	x							x																	
G0110G1	Dressing: self-performance			x	x	x	x		x		x	x		x		x		x	x						x				x	x	x
G0110G2	Dressing: support provided			x	x	x	x							x																	
G0110H1	Eating: self-performance			x	x	x	x	x	x	x	x	x		x	x	x	x	x	x					x	x	x	x	x	x	x	x
G0110H2	Eating: support provided			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x				
G0110I1	Toilet use: self-performance			x	x	x	x	x	x	x	x	x		x	x	x	x	x	x					x	x	x	x	x	x	x	x
G0110I2	Toilet use: support provided			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x	x			
G0110J1	Personal hygiene: self-performance			x	x	x	x		x		x	x		x		x		x	x						x					x	x
G0110J2	Personal hygiene: support provided			x	x	x	x							x																	
G0120A	Bathing: self-performance			x	x	x	x		x		x	x		x		x		x	x						x				x	x	x
G0120B	Bathing: support provided			x	x	x	x							x																	
G0300A	Balance: moving from seated to standing position			x	x	x	x							x											x						
G0300B	Balance: walking (with assistive device if used)			x	x	x	x							x											x						
G0300C	Balance: turning around while walking			x	x	x	x							x											x						
G0300D	Balance: moving on and off toilet			x	x	x	x							x											x						
G0300E	Balance: surface-to-surface transfer			x	x	x	x							x											x						
G0400A	ROM limitation: upper extremity			x	x	x	x							x															x		
G0400B	ROM limitation: lower extremity			x	x	x	x							x															x		
G0600A	Mobility devices: cane/crutch			x	x	x	x							x															x		
G0600B	Mobility devices: walker			x	x	x	x							x															x		

Item matrix for October 2013					Nursing Home Item Subsets									Swing Bed Item Subsets								Item Groups								New D/C	
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G0600C	Mobility devices: wheelchair (manual or electric)			x	x	x	x							x																	
G0600D	Mobility devices: limb prosthesis			x	x	x	x							x																	
G0600Z	Mobility devices: none of the above		x	x	x	x	x							x																	
G0900A	Resident believes capable of increased independ			x	x																				x						
G0900B	Staff believes res capable of increased independ			x	x																				x						
H0100A	Appliances: indwelling catheter			x	x	x	x		x		x	x		x		x		x	x					x	x				x	x	x
H0100B	Appliances: external catheter			x	x	x	x		x		x	x		x		x		x	x						x				x	x	x
H0100C	Appliances: ostomy			x	x	x	x		x		x	x		x		x		x	x					x						x	x
H0100D	Appliances: intermittent catheterization			x	x	x	x		x		x	x		x		x		x	x						x					x	x
H0100Z	Appliances: none of the above		x	x	x	x	x		x		x	x		x		x		x	x											x	x
H0200A	Urinary toileting program: has been attempted	x		x	x	x	x	x	x	x	x			x	x	x	x	x											x		
H0200B	Urinary toileting program: response			x	x	s	s																									
H0200C	Urinary toileting program: current program/trial			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x	x			
H0300	Urinary continence			x	x	x	x		x		x	x		x		x		x	x					x	x				x	x	x
H0400	Bowel continence			x	x	x	x		x		x	x		x		x		x	x					x	x				x	x	x
H0500	Bowel toileting program being used			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x	x	x		
H0600	Constipation			x	x	s	s																			x						
I0100	Cancer (with or without metastasis)			x	x	s	s																									
I0200	Anemia			x	x	x	x							x																		
I0300	Atrial fibrillation and other dysrhythmias			x	x	s	s																									
I0400	Coronary artery disease (CAD)			x	x	s	s																									
I0500	Deep venous thrombosis (DVT), PE, or PTE			x	x	s	s																									
I0600	Heart failure			x	x	x	x							x																		
I0700	Hypertension			x	x	x	x							x																		
I0800	Orthostatic hypotension			x	x	x	x							x																		
I0900	Peripheral vascular disease (PVD) or PAD			x	x	x	x		x		x	x		x		x		x	x					x						x	x
I1100	Cirrhosis			x	x	s	s																									
I1200	Gastroesophageal reflux disease (GERD) or ulcer			x	x	s	s																									
I1300	Ulcerative colitis, Chrohn's, inflam bowel disease			x	x	s	s																									
I1400	Benign prostatic hyperplasia (BPH)			x	x	s	s																									
I1500	Renal insufficiency, renal failure, ESRD			x	x	s	s																									
I1550	Neurogenic bladder			x	x	x	x		x		x	x		x		x		x	x					x						x	x
I1650	Obstructive uropathy			x	x	x	x		x		x	x		x		x		x	x					x						x	x
I1700	Multidrug resistant organism (MDRO)			x	x	x	x							x											x				x		
I2000	Pneumonia			x	x	x	x			x	x			x			x	x							x		x	x	x		
I2100	Septicemia			x	x	x	x			x	x			x			x	x							x		x	x	x		
I2200	Tuberculosis			x	x	x	x							x											x				x		
I2300	Urinary tract infection (UTI) (LAST 30 DAYS)			x	x	x	x		x		x	x		x		x		x	x					x	x				x	x	x
I2400	Viral hepatitis (includes type A, B, C, D, and E)			x	x	x	x																		x				x		
I2500	Wound infection (other than foot)			x	x	x	x							x											x				x		
I2900	Diabetes mellitus (DM)			x	x	x	x		x	x	x	x		x		x	x	x	x					x			x	x		x	x
I3100	Hyponatremia			x	x	x	x							x																	

Item matrix for October 2013					Nursing Home Item Subsets									Swing Bed Item Subsets									Item Groups								New D/C	
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I3200	Hyperkalemia			x	x	x	x							x																	
I3300	Hyperlipidemia (e.g., hypercholesterolemia)			x	x	x	x							x																	
I3400	Thyroid disorder			x	x	s	s																								
I3700	Arthritis			x	x	s	s																								
I3800	Osteoporosis			x	x	s	s																								
I3900	Hip fracture			x	x	x	x							x															x		
I4000	Other fracture			x	x	x	x							x															x		
I4200	Alzheimer's disease			x	x	x	x																		x				x		
I4300	Aphasia			x	x	x	x																					x			
I4400	Cerebral palsy			x	x	x	x			x	x			x			x	x									x	x			
I4500	Cerebrovascular accident (CVA), TIA, or stroke			x	x	x	x							x																	
I4800	Non-Alzheimer's Dementia			x	x	x	x							x											x				x		
I4900	Hemiplegia or hemiparesis			x	x	x	x			x	x			x			x	x									x	x			
I5000	Paraplegia			x	x	x	x							x																	
I5100	Quadriplegia			x	x	x	x			x	x			x			x	x									x	x			
I5200	Multiple sclerosis			x	x	x	x			x	x			x			x	x									x	x			
I5250	Huntington's disease			x	x	x	x		x		x	x		x		x		x	x				x							x	x
I5300	Parkinson's disease			x	x	x	x			x	x			x			x	x									x				
I5350	Tourette's syndrome			x	x	x	x		x		x	x		x		x		x	x				x							x	x
I5400	Seizure disorder or epilepsy			x	x	x	x							x																	
I5500	Traumatic brain injury (TBI)			x	x	x	x							x																	
I5600	Malnutrition (protein, calorie), risk of malnutrit			x	x	x	x		x		x	x		x		x		x	x					x						x	x
I5700	Anxiety disorder			x	x	x	x		x		x	x		x		x		x	x				x						x	x	x
I5800	Depression (other than bipolar)			x	x	x	x							x															x		
I5900	Manic depression (bipolar disease)			x	x	x	x		x		x	x		x		x		x	x				x						x	x	x
I5950	Psychotic disorder (other than schizophrenia)			x	x	x	x		x		x	x		x		x		x	x				x						x	x	x
I6000	Schizophrenia			x	x	x	x		x		x	x		x		x		x	x				x						x	x	x
I6100	Post-traumatic stress disorder PTSD)			x	x	x	x		x		x	x		x		x		x	x				x							x	x
I6200	Asthma (COPD) or chronic lung disease			x	x	x	x			x	x			x			x	x									x				
I6300	Respiratory failure			x	x	x	x			x	x			x			x	x									x				
I6500	Cataracts, glaucoma, or macular degeneration			x	x	s	s																		x						
I7900	None of above active diseases within last 7 days		x	x	x	s	s																								
I8000A	Additional active ICD diagnosis 1			x	x	x	x		x		x	x		x		x		x	x			3		x						x	x
I8000B	Additional active ICD diagnosis 2			x	x	x	x		x		x	x		x		x		x	x			3		x						x	x
I8000C	Additional active ICD diagnosis 3			x	x	x	x		x		x	x		x		x		x	x			3		x						x	x
I8000D	Additional active ICD diagnosis 4			x	x	x	x		x		x	x		x		x		x	x			3		x						x	x
I8000E	Additional active ICD diagnosis 5			x	x	x	x		x		x	x		x		x		x	x			3		x						x	x
I8000F	Additional active ICD diagnosis 6			x	x	x	x		x		x	x		x		x		x	x			3		x						x	x
I8000G	Additional active ICD diagnosis 7			x	x	x	x		x		x	x		x		x		x	x			3		x						x	x
I8000H	Additional active ICD diagnosis 8			x	x	x	x		x		x	x		x		x		x	x			3		x						x	x
I8000I	Additional active ICD diagnosis 9			x	x	x	x		x		x	x		x		x		x	x			3		x						x	x
I8000J	Additional active ICD diagnosis 10			x	x	x	x		x		x	x		x		x		x	x			3		x						x	x

Item matrix for October 2013					Nursing Home Item Subsets									Swing Bed Item Subsets									Item Groups								New D/C	
MDS Item	Description	Skip trigger items	NOA item	Submitted Item	NC - Comp	NQ - Quart	NP - PPS	NS - OMRA SOT	NSD-OMRA SOT+DC	NO - OMRA other	NOD - OMRA other + DC	ND - Disch	NT - Tracking	SP - PPS	SS - OMRA SOT	SSD-OMRA SOT+DC	SO - OMRA other	SOD - OMRA other + DC	SD - Disch	ST - Tracking	XX - Inactivation	Demog/Admin	QI items	QM items	CAA items	RUG rehab grp	RUG non-rehab	RUG-III items	S&C items	PDC - Planned D/C	UPD - Unplanned D/C
J0100A	Pain: Received scheduled pain med regimen			x	x	x	x		x		x	x		x		x		x	x					x						x	x
J0100B	Pain: received PRN pain medications			x	x	x	x		x		x	x		x		x		x	x										x	x	x
J0100C	Pain: received non-medication intervention			x	x	x	x		x		x	x		x		x		x	x										x	x	x
J0200	Should pain assessment interview be conducted	x		x	x	x	x		x		x	x		x		x		x	x					+						x	x
J0300	Res pain interview: presence	x		x	x	x	x		x		x	x		x		x		x	x					x						x	
J0400	Res pain interview: frequency	x		x	x	x	x		x		x	x		x		x		x	x					x	x					x	
J0500A	Res pain interview: made it hard to sleep			x	x	x	x		x		x	x		x		x		x	x						x					x	
J0500B	Res pain interview: limited daily activities			x	x	x	x		x		x	x		x		x		x	x						x					x	
J0600A	Res pain interview: intensity rating scale			x	x	x	x		x		x	x		x		x		x	x					x	x					x	
J0600B	Res pain interview: verbal descriptor scale			x	x	x	x		x		x	x		x		x		x	x					x	x					x	
J0700	Should staff assessment for pain be conducted	x		x	x	x	x							x											+						
J0800A	Staff pain asmt: non-verbal sounds			x	x	x	x							x											x						
J0800B	Staff pain asmt: vocal complaints of pain			x	x	x	x							x											x						
J0800C	Staff pain asmt: facial expressions			x	x	x	x							x											x						
J0800D	Staff pain asmt: protective movements/postures			x	x	x	x							x											x						
J0800Z	Staff pain asmt: none of these signs observed	x	x	x	x	x	x							x											+						
J0850	Staff pain asmt: frequency of pain			x	x	x	x							x																	
J1100A	Short breath/trouble breathing: with exertion			x	x	x	x		x		x	x		x		x		x	x											x	x
J1100B	Short breath/trouble breathing: sitting at rest			x	x	x	x		x		x	x		x		x		x	x											x	x
J1100C	Short breath/trouble breathing: lying flat			x	x	x	x		x	x	x	x		x		x	x	x	x								x			x	x
J1100Z	Short breath/trouble breathing: none of above		x	x	x	x	x		x		x	x		x		x		x	x											x	x
J1300	Current tobacco use			x	x	s	s																								
J1400	Prognosis: life expectancy of less than 6 months			x	x	x	x		x		x	x		x		x		x	x					x						x	x
J1550A	Problem conditions: fever			x	x	x	x		x	x	x	x		x		x	x	x	x						x		x	x		x	x
J1550B	Problem conditions: vomiting			x	x	x	x		x	x	x	x		x		x	x	x	x						x		x	x		x	x
J1550C	Problem conditions: dehydrated			x	x	x	x		x		x	x		x		x		x	x						x			x	x	x	x
J1550D	Problem conditions: internal bleeding			x	x	x	x		x		x	x		x		x		x	x						x			x		x	x
J1550Z	Problem conditions: none of the above		x	x	x	x	x		x		x	x		x		x		x	x						+			+		x	x
J1700A	Fall history: fall during month before admission			x	x	x	x							x											x				x		
J1700B	Fall history: fall 2-6 months before admission			x	x	x	x							x											x						
J1700C	Fall history: fracture from fall 6 month pre admit			x	x	x	x							x																	
J1800	Falls since admit/prior asmt: any falls	x		x	x	x	x		x		x	x		x		x		x	x				x	x	x				x	x	x
J1900A	Falls since admit/prior asmt: no injury			x	x	x	x		x		x	x		x		x		x	x											x	x
J1900B	Falls since admit/prior asmt: injury (not major)			x	x	x	x		x		x	x		x		x		x	x										x	x	x
J1900C	Falls since admit/prior asmt: major injury			x	x	x	x		x		x	x		x		x		x	x					x					x	x	x
K0100A	Swallow disorder: loss liquids/solids from mouth			x	x	x	x																						x		
K0100B	Swallow disorder: holds food in mouth/cheeks			x	x	x	x																								
K0100C	Swallow disorder: cough/choke with meals/meds			x	x	x	x																								
K0100D	Swallow disorder: difficulty or pain swallowing			x	x	x	x																								
K0100Z	Swallow disorder: none of the above		x	x	x	x	x																								
K0200A	Height (in inches)			x	x	x	x		x		x	x		x		x		x	x					x	x					x	x
K0200B	Weight (in pounds)			x	x	x	x		x		x	x		x		x		x	x					x	x					x	x

Item matrix for October 2013					Nursing Home Item Subsets									Swing Bed Item Subsets								Item Groups								New D/C	
MDS Item	Description	Skip trigger items	NOA item	Submitted Item	NC - Comp	NQ - Quart	NP - PPS	NS - OMRA SOT	NSD-OMRA SOT+DC	NO - OMRA other	NOD - OMRA other + DC	ND - Disch	NT - Tracking	SP - PPS	SS - OMRA SOT	SSD-OMRA SOT+DC	SO - OMRA other	SOD - OMRA other + DC	SD - Disch	ST - Tracking	XX - Inactivation	Demog/Admin	QI items	QM items	CAA items	RUG rehab grp	RUG non-rehab	RUG-III items	S&C items	PDC - Planned D/C	UPD - Unplanned D/C
K0300	Weight loss			x	x	x	x		x	x	x	x		x		x	x	x	x					x	x		x	x	x	x	x
K0310	Weight Gain			x	x	x	x		x	x	x	x		x		x	x	x	x						x					x	x
K0510A1	Nutrition approach: Not Res: parenteral /IV feeding	x		x	x	x	x		x	x	x	x		x		x	x	x	x						x		x	x		x	x
K0510A2	Nutrition approach: Res: parenteral /IV feeding	x		x	x	x	x		x	x	x	x		x		x	x	x	x						x		x	x	x	x	x
K0510B1	Nutrition approach: Not Res: feeding tube	x		x	x	x	x		x	x	x	x		x		x	x	x	x						x		x	x		x	x
K0510B2	Nutrition approach: Res: feeding tube	x		x	x	x	x		x	x	x	x		x		x	x	x	x						x		x	x	x	x	x
K0510C1	Nutrition approach: Not Res: mechanically altered diet			x	x	x	x		x		x	x		x		x		x	x						x					x	
K0510C2	Nutrition approach: Res: mechanically altered diet			x	x	x	x		x		x	x		x		x		x	x						x				x	x	
K0510D1	Nutrition approach: Not Res: therapeutic diet			x	x	x	x		x		x	x		x		x		x	x						x					x	
K0510D2	Nutrition approach: Res: therapeutic diet			x	x	x	x		x		x	x		x		x		x	x						x				x	x	
K0510Z1	Nutrition approach: Not Res: none of the above		x	x	x	x	x		x		x	x		x		x		x	x						+					x	
K0510Z2	Nutrition approach: Res: none of the above		x	x	x	x	x		x		x	x		x		x		x	x						+				+	x	
K0710A1	Prop calories parenteral/tube feed: not resident			x	x	x	x			x	x			x			x	x													
K0710A2	Prop calories parenteral/tube feed: while resident			x	x	x	x			x	x			x			x	x													
K0710A3	Prop calories parenteral/tube feed: 7 days			x	x	x	x			x	x			x			x	x								x		x			
K0710B1	Avg fluid intake per day IV/tube: not resident			x	x	x	x			x	x			x			x	x													
K0710B2	Avg fluid intake per day IV/ tube: while resident			x	x	x	x			x	x			x			x	x													
K0710B3	Avg fluid intake per day IV/tube: 7 days			x	x	x	x			x	x			x			x	x								x		x			
L0200A	Dental: broken or loosely fitting denture			x	x	x	x																		x				x		
L0200B	Dental: no natural teeth or tooth fragment(s)			x	x	s	s																		x						
L0200C	Dental: abnormal mouth tissue			x	x	s	s																		x						
L0200D	Dental: cavity or broken natural teeth			x	x	s	s																		x						
L0200E	Dental: inflamed/bleeding gums or loose teeth			x	x	s	s																		x						
L0200F	Dental: pain, discomfort, difficulty chewing			x	x	x	x																		x						
L0200G	Dental: unable to examine			x	x	s	s																								
L0200Z	Dental: none of the above		x	x	x	s	s																								
M0100A	Risk determination: has ulcer, scar, or dressing			x	x	x	x		x		x	x		x		x		x	x											x	x
M0100B	Risk determination: formal assessment			x	x	x	x							x																	
M0100C	Risk determination: clinical assessment			x	x	x	x							x																	
M0100Z	Risk determination: none of the above		x	x	x	x	x							x																	
M0150	Is resident at risk of developing pressure ulcer			x	x	x	x							x											x						
M0210	Resident has Stage 1 or higher pressure ulcers	x		x	x	x	x		x	x	x	x		x		x	x	x	x												
M0300A	Stage 1 pressure ulcers: number present			x	x	x	x							x											x			x			
M0300B1	Stage 2 pressure ulcers: number present	x		x	x	x	x		x	x	x	x		x		x	x	x	x					x	x		x	x	x	x	x
M0300B2	Stage 2 pressure ulcers: number at admit/reentry			x	x	x	x							x															x		
M0300B3	Stage 2 pressure ulcers: date of oldest			x	x	x	x							x																	
M0300C1	Stage 3 pressure ulcers: number present	x		x	x	x	x		x	x	x	x		x		x	x	x	x					x	x		x	x	x	x	x
M0300C2	Stage 3 pressure ulcers: number at admit/reentry			x	x	x	x							x															x		
M0300D1	Stage 4 pressure ulcers: number present	x		x	x	x	x		x	x	x	x		x		x	x	x	x					x	x		x	x	x	x	x
M0300D2	Stage 4 pressure ulcers: number at admit/reentry			x	x	x	x							x															x		
M0300E1	Unstaged due to dressing: number present	x		x	x	x	x		x		x	x		x		x		x	x						x					x	x
M0300E2	Unstaged due to dressing: number at admit/reentry			x	x	x	x							x																	

Item matrix for October 2013					Nursing Home Item Subsets									Swing Bed Item Subsets								Item Groups								New D/C	
MDS Item	Description	Skip trigger items	NOA item	Submitted Item	NC - Comp	NQ - Quart	NP - PPS	NS - OMRA SOT	NSD-OMRA SOT+DC	NO - OMRA other	NOD - OMRA other + DC	ND - Disch	NT - Tracking	SP - PPS	SS - OMRA SOT	SSD-OMRA SOT+DC	SO - OMRA other	SOD - OMRA other + DC	SD - Disch	ST - Tracking	XX - Inactivation	Demog/Admin	QI items	QM items	CAA items	RUG rehab grp	RUG non-rehab	RUG-III items	S&C items	PDC - Planned D/C	UPD - Unplanned D/C
M0300F1	Unstaged slough/eschar: number present	x		x	x	x	x		x	x	x	x		x		x	x	x	x						x		x	x		x	x
M0300F2	Unstaged slough/eschar: number at admit/reentry			x	x	x	x							x																	
M0300G1	Unstageable - deep tissue: number present	x		x	x	x	x		x		x	x		x		x		x	x						x					x	x
M0300G2	Unstageable - deep tissue: number at admit/reentry			x	x	x	x		x		x	x		x		x		x	x											x	x
M0610A	Stage 3 or 4 pressure ulcer longest length			x	x	x	x		x		x	x		x		x		x	x											x	x
M0610B	Stage 3 or 4 pressure ulcer width (same ulcer)			x	x	x	x		x		x	x		x		x		x	x											x	x
M0610C	Stage 3 or 4 pressure ulcer depth (same ulcer)			x	x	x	x		x		x	x		x		x		x	x											x	x
M0700	Tissue type for ulcer at most advanced			x	x	x	x							x																	
M0800A	Worsened since prior asmt: Stage 2 pressure ulcers			x	x	x	x		x		x	x		x		x		x	x					x	x					x	x
M0800B	Worsened since prior asmt: Stage 3 pressure ulcers			x	x	x	x		x		x	x		x		x		x	x					x	x					x	x
M0800C	Worsened since prior asmt: Stage 4 pressure ulcers			x	x	x	x		x		x	x		x		x		x	x					x	x					x	x
M0900A	Pressure ulcers on prior assessment	x		x	x	x	x		x		x	x		x		x		x	x											x	x
M0900B	Healed pressure ulcers: Stage 2			x	x	x	x		x		x	x		x		x		x	x											x	x
M0900C	Healed pressure ulcers: Stage 3			x	x	x	x		x		x	x		x		x		x	x											x	x
M0900D	Healed pressure ulcers: Stage 4			x	x	x	x		x		x	x		x		x		x	x											x	x
M1030	Number of venous and arterial ulcers			x	x	x	x			x	x			x			x	x									x	x			
M1040A	Other skin probs: infection of the foot			x	x	x	x			x	x			x			x	x							x		x	x	x		
M1040B	Other skin probs: diabetic foot ulcer(s)			x	x	x	x			x	x			x			x	x									x	x			
M1040C	Other skin probs: other open lesion(s) on the foot			x	x	x	x			x	x			x			x	x									x	x			
M1040D	Other skin probs: lesions not ulcers, rashes, cuts			x	x	x	x			x	x			x			x	x									x	x			
M1040E	Other skin probs: surgical wound(s)			x	x	x	x			x	x			x			x	x									x	x			
M1040F	Other skin probs: burns (second or third degree)			x	x	x	x			x	x			x			x	x									x	x			
M1040G	Skin Tear(s)			x	x	x	x			x	x			x			x	x													
M1040H	Moisture Associated Skin Damage (MASD)			x	x	x	x			x	x			x			x	x							x						
M1040Z	Other skin probs: none of the above		x	x	x	x	x			x	x			x			x	x									+	+			
M1200A	Skin/ulcer treat: pressure reduce device for chair			x	x	x	x			x	x			x			x	x									x	x	x		
M1200B	Skin/ulcer treat: pressure reducing device for bed			x	x	x	x			x	x			x			x	x									x	x	x		
M1200C	Skin/ulcer treat: turning/repositioning			x	x	x	x			x	x			x			x	x									x	x	x		
M1200D	Skin/ulcer treat: nutrition/hydration			x	x	x	x			x	x			x			x	x									x	x	x		
M1200E	Skin/ulcer treat: pressure ulcer care			x	x	x	x			x	x			x			x	x									x	x	x		
M1200F	Skin/ulcer treat: surgical wound care			x	x	x	x			x	x			x			x	x									x	x	x		
M1200G	Skin/ulcer treat: application of dressings			x	x	x	x			x	x			x			x	x									x	x	x		
M1200H	Skin/ulcer treat: apply ointments/medications			x	x	x	x			x	x			x			x	x									x	x	x		
M1200I	Skin/ulcer treat: apply dressings to feet			x	x	x	x			x	x			x			x	x									x	x	x		
M1200Z	Skin/ulcer treat: none of the above		x	x	x	x	x			x	x			x			x	x									+	+	+		
N0300	Number of days injectable medications received	x		x	x	x	x			x	x			x			x	x										x	x			
N0350A	Insulin: insulin injections			x	x	x	x			x	x			x			x	x									x					
N0350B	Insulin: orders for insulin			x	x	x	x			x	x			x			x	x									x					
N0410A	Medication received: Days: antipsychotic			x	x	x	x		x		x	x		x		x		x	x				x		x				x	x	x
N0410B	Medication received: Days: antianxiety			x	x	x	x		x		x	x		x		x		x	x				x		x				x	x	x
N0410C	Medication received: Days: antidepressant			x	x	x	x		x		x	x		x		x		x	x						x				x	x	x
N0410D	Medication received: Days: hypnotic			x	x	x	x		x		x	x		x		x		x	x				x		x				x	x	x

Item matrix for October 2013					Nursing Home Item Subsets									Swing Bed Item Subsets								Item Groups								New D/C	
MDS Item	Description	Skip trigger items	NOA item	Submitted Item	NC - Comp	NQ - Quart	NP - PPS	NS - OMRA SOT	NSD-OMRA SOT+DC	NO - OMRA other	NOD - OMRA other + DC	ND - Disch	NT - Tracking	SP - PPS	SS - OMRA SOT	SSD-OMRA SOT+DC	SO - OMRA other	SOD - OMRA other + DC	SD - Disch	ST - Tracking	XX - Inactivation	Demog/Admin	QI items	QM items	CAA items	RUG rehab grp	RUG non-rehab	RUG-III items	S&C items	PDC - Planned D/C	UPD - Unplanned D/C
N0410E	Medication received: Days: anticoagulant			x	x	x	x		x		x	x		x		x		x	x											x	x
N0410F	Medication received: Days: antibiotic			x	x	x	x		x		x	x		x		x		x	x											x	x
N0410G	Medication received: Days: diuretic			x	x	x	x		x		x	x		x		x		x	x											x	x
O0100A1	Treatment: chemotherapy - while not resident			x	x	x	x																					x	x		
O0100A2	Treatment: chemotherapy - while resident			x	x	x	x			x	x			x			x	x									x	x	x		
O0100B1	Treatment: radiation - while not resident			x	x	x	x																					x	x		
O0100B2	Treatment: radiation - while resident			x	x	x	x			x	x			x			x	x									x	x	x		
O0100C1	Treatment: oxygen therapy - while not resident			x	x	x	x																					x	x		
O0100C2	Treatment: oxygen therapy - while resident			x	x	x	x			x	x			x			x	x									x	x	x		
O0100D1	Treatment: suctioning - while not resident			x	x	x	x																					x	x		
O0100D2	Treatment: suctioning - while resident			x	x	x	x																					x	x		
O0100E1	Treatment: tracheostomy care - while not resident			x	x	x	x																					x	x		
O0100E2	Treatment: tracheostomy care - while resident			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x	x	x		
O0100F1	Treatment: vent/respirator - while not resident			x	x	x	x																					x	x		
O0100F2	Treatment: vent/respirator - while resident			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x	x	x		
O0100G1	Treatment: BiPAP/CPAP - while not resident			x	x	s	s																						x		
O0100G2	Treatment: BIPAP/CPAP - while resident			x	x	s	s																						x		
O0100H1	Treatment: IV medications - while not resident			x	x	x	x																					x	x		
O0100H2	Treatment: IV medications - while resident			x	x	x	x			x	x			x			x	x									x	x	x		
O0100I1	Treatment: transfusions - while not resident			x	x	x	x																					x	x		
O0100I2	Treatment: transfusions - while resident			x	x	x	x			x	x			x			x	x									x	x	x		
O0100J1	Treatment: dialysis - while not resident			x	x	x	x																					x	x		
O0100J2	Treatment: dialysis - while resident			x	x	x	x			x	x			x			x	x									x	x	x		
O0100K1	Treatment: hospice care - while not resident			x	x	s	s																						x		
O0100K2	Treatment: hospice care - while resident			x	x	x	x		x		x	x		x		x		x	x					x					x	x	x
O0100L2	Treatment: respite care - while resident			x	x	s	s																								
O0100M1	Treatment: isolate/quarantine - while not resident			x	x	s	s																								
O0100M2	Treatment: isolate/quarantine - while resident			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x				
O0100Z1	Treatment: none of above - while not resident		x	x	x	s	s																								
O0100Z2	Treatment: none of above - while resident		x	x	x	s	s																								
O0250A	Was influenza vaccine received	x		x	x	x	x		x		x	x		x		x		x	x					x					x	x	x
O0250B	Date influenza vaccine received.			x	x	x	x							x															x		
O0250C	If influenza vaccine not received, state reason			x	x	x	x		x		x	x		x		x		x	x					x					x	x	x
O0300A	Is pneumococcal vaccination up to date	x		x	x	x	x		x		x	x		x		x		x	x					x					x	x	x
O0300B	If pneumococcal vacc not received, state reason			x	x	x	x		x		x	x		x		x		x	x					x					x	x	x
O0400A1	Speech-language/audiology: individ minutes	x		x	x	x	x	x	x	x	x			x	x	x	x	x								x		x	x		
O0400A2	Speech-language/audiology: concur minutes	x		x	x	x	x	x	x	x	x			x	x	x	x	x								x		x	x		
O0400A3	Speech-language/audiology: group minutes	x		x	x	x	x	x	x	x	x			x	x	x	x	x								x		x	x		
O0400A3A	Speech-language/audiology: co-treatment minutes				x	x	x	x	x	x	x			x	x	x	x	x													
O0400A4	Speech-language/audiology: number of days			x	x	x	x	x	x	x	x			x	x	x	x	x								x		x		x	x
O0400A5	Speech-language/audiology: start date			x	x	x	x	x	x	x	x	x		x	x	x	x	x	x							x				x	x
O0400A6	Speech-language/audiology: end date			x	x	x	x	x	x	x	x	x		x	x	x	x	x	x							x				x	x

Item matrix for October 2013					Nursing Home Item Subsets									Swing Bed Item Subsets								Item Groups								New D/C	
MDS Item	Description	Skip trigger items	NOA item	Submitted Item	NC - Comp	NQ - Quart	NP - PPS	NS - OMRA SOT	NSD-OMRA SOT+DC	NO - OMRA other	NOD - OMRA other + DC	ND - Disch	NT - Tracking	SP - PPS	SS - OMRA SOT	SSD-OMRA SOT+DC	SO - OMRA other	SOD - OMRA other + DC	SD - Disch	ST - Tracking	XX - Inactivation	Demog/Admin	QI items	QM items	CAA items	RUG rehab grp	RUG non-rehab	RUG-III items	S&C items	PDC - Planned D/C	UPD - Unplanned D/C
O0400B1	Occupational therapy: individ minutes	x		x	x	x	x	x	x	x	x			x	x	x	x	x								x		x	x		
O0400B2	Occupational therapy: concur minutes	x		x	x	x	x	x	x	x	x			x	x	x	x	x								x		x	x		
O0400B3	Occupational therapy: group minutes	x		x	x	x	x	x	x	x	x			x	x	x	x	x								x		x	x		
O0400B3A	Occupational therapy: co-treatment minutes				x	x	x	x	x	x	x			x	x	x	x	x													
O0400B4	Occupational therapy: number of days			x	x	x	x	x	x	x	x			x	x	x	x	x								x		x		x	x
O0400B5	Occupational therapy: start date			x	x	x	x	x	x	x	x	x		x	x	x	x	x	x							x				x	x
O0400B6	Occupational therapy: end date			x	x	x	x	x	x	x	x	x		x	x	x	x	x	x							x				x	x
O0400C1	Physical therapy: individ minutes	x		x	x	x	x	x	x	x	x			x	x	x	x	x								x		x	x		
O0400C2	Physical therapy: concur minutes	x		x	x	x	x	x	x	x	x			x	x	x	x	x								x		x	x		
O0400C3	Physical therapy: group minutes	x		x	x	x	x	x	x	x	x			x	x	x	x	x								x		x	x		
O0400C3A	Physical therapy: co-treatment minutes				x	x	x	x	x	x	x			x	x	x	x	x													
O0400C4	Physical therapy: number of days			x	x	x	x	x	x	x	x			x	x	x	x	x								x		x		x	x
O0400C5	Physical therapy: start date			x	x	x	x	x	x	x	x	x		x	x	x	x	x	x							x				x	x
O0400C6	Physical therapy: end date			x	x	x	x	x	x	x	x	x		x	x	x	x	x	x							x				x	x
O0400D1	Respiratory therapy: number of minutes	x		x	x	s	s																						x		
O0400D2	Respiratory therapy: number of days			x	x	x	x			x	x			x			x	x									x	x			
O0400E1	Psychological therapy: number of minutes	x		x	x	s	s																								
O0400E2	Psychological therapy: number of days			x	x	x	x																								
O0400F1	Recreational therapy: number of minutes	x		x	x	s	s																								
O0400F2	Recreational therapy: number of days			x	x	s	s																								
O0420	Distinct calendar days of therapy				x	x	x	x	x	x	x			x	x	x	x	x								x					
O0450A	Resumption of Therapy: has it resumed	x		x	x	x	x	x	x	x	x			x	x	x	x	x								x					
O0450B	Resumption of Therapy: date resumed			x	x	x	x	x	x	x	x			x	x	x	x	x								x					
O0500A	Range of motion (passive): number of days			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x	x			
O0500B	Range of motion (active): number of days			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x	x			
O0500C	Splint or brace assistance: number of days			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x	x	x		
O0500D	Bed mobility training: number of days			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x	x			
O0500E	Transfer training: number of days			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x	x			
O0500F	Walking training: number of days			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x	x			
O0500G	Dressing and/or grooming training: number of days			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x	x			
O0500H	Eating and/or swallowing training: number of days			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x	x	x		
O0500I	Amputation/prosthesis training: number of days			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x	x			
O0500J	Communication training: number of days			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x	x			
O0600	Physician examinations: number of days			x	x	x	x							x														x			
O0700	Physician orders: number of days			x	x	x	x							x														x			
P0100A	Restraints used in bed: bed rail			x	x	x	x		x		x	x		x		x		x	x						x				x	x	x
P0100B	Restraints used in bed: trunk restraint			x	x	x	x		x		x	x		x		x		x	x					x	x				x	x	x
P0100C	Restraints used in bed: limb restraint			x	x	x	x		x		x	x		x		x		x	x					x	x				x	x	x
P0100D	Restraints used in bed: other			x	x	x	x		x		x	x		x		x		x	x						x				x	x	x
P0100E	Restraints in chair/out of bed: trunk restraint			x	x	x	x		x		x	x		x		x		x	x					x	x				x	x	x
P0100F	Restraints in chair/out of bed: limb restraint			x	x	x	x		x		x	x		x		x		x	x					x	x				x	x	x
P0100G	Restraints in chair/out of bed: chair stops rising			x	x	x	x		x		x	x		x		x		x	x					x	x				x	x	x

Item matrix for October 2013					Nursing Home Item Subsets									Swing Bed Item Subsets								Item Groups								New D/C	
MDS Item	Description	Skip trigger items	NOA item	Submitted Item	NC - Comp	NQ - Quart	NP - PPS	NS - OMRA SOT	NSD-OMRA SOT+DC	NO - OMRA other	NOD - OMRA other + DC	ND - Disch	NT - Tracking	SP - PPS	SS - OMRA SOT	SSD-OMRA SOT+DC	SO - OMRA other	SOD - OMRA other + DC	SD - Disch	ST - Tracking	XX - Inactivation	Demog/Admin	QI items	QM items	CAA items	RUG rehab grp	RUG non-rehab	RUG-III items	S&C items	PDC - Planned D/C	UPD - Unplanned D/C
P0100H	Restraints in chair/out of bed: other			x	x	x	x		x		x	x		x		x		x	x						x				x	x	x
Q0100A	Resident participated in assessment			x	x	x	x	x	x	x	x			x	x	x	x	x				2									
Q0100B	Family/signif other participated in assessment			x	x	x	x	x	x	x	x			x	x	x	x	x				2									
Q0100C	Guardian/legal rep participated in assessment			x	x	x	x	x	x	x	x			x	x	x	x	x				2									
Q0300A	Resident's overall goal			x	x	x	x							x								3									
Q0300B	Information source for resident's goal			x	x	x	x							x								3									
Q0400A	Active discharge plan for return to community	x		x	x	x	x		x		x	x		x		x		x	x											x	x
Q0490	Resident's preference to avoid being asked	x		x	x	x	x							x																	
Q0500B	Do you want to talk about returning to community			x	x	x	x							x																	
Q0550A	Reasking resident preference			x	x	x	x							x																	
Q0550B	Reasking resident preference source			x	x	x	x							x																	
Q0600	Referral been made to local contact agency			x	x	x	x		x		x	x		x		x		x	x						x					x	x
V0100A	Prior OBRA reason for assessment			x	x	s	s																								
V0100B	Prior PPS reason for assessment			x	x	s	s																								
V0100C	Prior assessment reference date			x	x	s	s																								
V0100D	Prior assessment BIMS summary score			x	x	s	s																		x						
V0100E	Prior asmt PHQ res: total mood severity score			x	x	s	s																		x						
V0100F	Prior asmt PHQ staff: total mood score			x	x	s	s																		x						
V0200A01A	CAA-Delirium: triggered			x	x	s	s																		x						
V0200A01B	CAA-Delirium: plan			x	x	s	s																		x						
V0200A02A	CAA-Cognitive loss/dementia: triggered			x	x	s	s																		x						
V0200A02B	CAA-Cognitive loss/dementia: plan			x	x	s	s																		x						
V0200A03A	CAA-Visual function: triggered			x	x	s	s																		x						
V0200A03B	CAA-Visual function: plan			x	x	s	s																		x						
V0200A04A	CAA-Communication: triggered			x	x	s	s																		x						
V0200A04B	CAA-Communication: plan			x	x	s	s																		x						
V0200A05A	CAA-ADL functional/rehab potential: triggered			x	x	s	s																		x						
V0200A05B	CAA-ADL functional/rehab potential: plan			x	x	s	s																		x						
V0200A06A	CAA-Urinary incont/indwell catheter: triggered			x	x	s	s																		x						
V0200A06B	CAA-Urinary incont/indwell catheter: plan			x	x	s	s																		x						
V0200A07A	CAA-Psychosocial well-being: triggered			x	x	s	s																		x						
V0200A07B	CAA-Psychosocial well-being: plan			x	x	s	s																		x						
V0200A08A	CAA-Mood state: triggered			x	x	s	s																		x						
V0200A08B	CAA-Mood state: plan			x	x	s	s																		x						
V0200A09A	CAA-Behavioral symptoms: triggered			x	x	s	s																		x						
V0200A09B	CAA-Behavioral symptoms: plan			x	x	s	s																		x						
V0200A10A	CAA-Activities: triggered			x	x	s	s																		x						
V0200A10B	CAA-Activities: plan			x	x	s	s																		x						
V0200A11A	CAA-Falls: triggered			x	x	s	s																		x						
V0200A11B	CAA-Falls: plan			x	x	s	s																		x						
V0200A12A	CAA-Nutritional status: triggered			x	x	s	s																		x						
V0200A12B	CAA-Nutritional status: plan			x	x	s	s																		x						

Item matrix for October 2013					Nursing Home Item Subsets									Swing Bed Item Subsets									Item Groups								New D/C	
MDS Item	Description	Skip trigger items	NOA item	Submitted Item	NC - Comp	NQ - Quart	NP - PPS	NS - OMRA SOT	NSD-OMRA SOT+DC	NO - OMRA other	NOD - OMRA other + DC	ND - Disch	NT - Tracking	SP - PPS	SS - OMRA SOT	SSD-OMRA SOT+DC	SO - OMRA other	SOD - OMRA other + DC	SD - Disch	ST - Tracking	XX - Inactivation	Demog/Admin	QI items	QM items	CAA items	RUG rehab grp	RUG non-rehab	RUG-III items	S&C items	PDC - Planned D/C	UPD - Unplanned D/C
V0200A13A	CAA-Feeding tubes: triggered			x	x	s	s																		x						
V0200A13B	CAA-Feeding tubes: plan			x	x	s	s																		x						
V0200A14A	CAA-Dehydration/fluid maintenance: triggered			x	x	s	s																		x						
V0200A14B	CAA-Dehydration/fluid maintenance: plan			x	x	s	s																		x						
V0200A15A	CAA-Dental care: triggered			x	x	s	s																		x						
V0200A15B	CAA-Dental care: plan			x	x	s	s																		x						
V0200A16A	CAA-Pressure ulcer: triggered			x	x	s	s																		x						
V0200A16B	CAA-Pressure ulcer: plan			x	x	s	s																		x						
V0200A17A	CAA-Psychotropic drug use: triggered			x	x	s	s																		x						
V0200A17B	CAA-Psychotropic drug use: plan			x	x	s	s																		x						
V0200A18A	CAA-Physical restraints: triggered			x	x	s	s																		x						
V0200A18B	CAA-Physical restraints: plan			x	x	s	s																		x						
V0200A19A	CAA-Pain: triggered			x	x	s	s																		x						
V0200A19B	CAA-Pain: plan			x	x	s	s																		x						
V0200A20A	CAA-Return to community referral: triggered			x	x	s	s																		x						
V0200A20B	CAA-Return to community referral: plan			x	x	s	s																		x						
V0200B1	CAA-Assessment process RN signature				x	s	s																								
V0200B2	CAA-Assessment process signature date			x	x	s	s																								
V0200C1	CAA-Care planning signature				x	s	s																								
V0200C2	CAA-Care planning signature date			x	x	s	s																								
X0150	Correction: type of provider	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X0200A	Correction: resident first name			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X0200C	Correction: resident last name			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X0300	Correction: resident gender			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X0400	Correction: resident birth date			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X0500	Correction: resident social security number			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X0600A	Correction: OBRA reason for assessment			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X0600B	Correction: PPS reason for assessment			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X0600C	Correction: OMRA assessment			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X0600D	Correction: Swing bed clinical change asmt			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X0600F	Correction: entry/discharge reporting	x		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X0700A	Correction: assessment reference date			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X0700B	Correction: discharge date			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X0700C	Correction: entry date			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X0800	Correction: correction number			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X0900A	Correction: modif reasons - transcription error			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X0900B	Correction: modif reasons - data entry error			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X0900C	Correction: modif reasons - software error			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X0900D	Correction: modif reasons - item coding error			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X0900E	Correction: Modif reasons - resume therapy			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X0900Z	Correction: modif reasons - other error			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X1050A	Correction: inact reasons - event did not occur			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x

Item matrix for October 2013					Nursing Home Item Subsets									Swing Bed Item Subsets								Item Groups								New D/C	
MDS Item	Description	Skip trigger items	NOA item	Submitted Item	NC - Comp	NQ - Quart	NP - PPS	NS - OMRA SOT	NSD-OMRA SOT+DC	NO - OMRA other	NOD - OMRA other + DC	ND - Disch	NT - Tracking	SP - PPS	SS - OMRA SOT	SSD-OMRA SOT+DC	SO - OMRA other	SOD - OMRA other + DC	SD - Disch	ST - Tracking	XX - Inactivation	Demog/Admin	QI items	QM items	CAA items	RUG rehab grp	RUG non-rehab	RUG-III items	S&C items	PDC - Planned D/C	UPD - Unplanned D/C
X1050Z	Correction: inact reasons - other reason			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X1100A	Correction: attestor first name			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X1100B	Correction: attestor last name			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X1100C	Correction: attestor title				x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X1100D	Correction: attestor signature				x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
X1100E	Correction: attestation date			x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x								x	x
Z0100A	Medicare Part A: HIPPS code			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x				
Z0100B	Medicare Part A: RUG version code			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x				
Z0100C	Medicare Part A: Medicare short stay asmt			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x				
Z0150A	Medicare Part A: non-therapy HIPPS code			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x				
Z0150B	Medicare Part A: non-therapy RUG version code			x	x	x	x	x	x	x	x			x	x	x	x	x								x	x				
Z0200A	State case mix: RUG group			x	x	x	x															1									
Z0200B	State case mix: RUG version code			x	x	x	x															1									
Z0250A	State case mix: Alternate RUG group			x	x	x	x															1									
Z0250B	State case mix: Alternate RUG version code			x	x	x	x															1									
Z0300A	Insurance Billing: Billing Code				x	x	x	x	x	x	x	x		x	x	x	x	x	x			2								x	x
Z0300B	Insurance Billing: Billing Version				x	x	x	x	x	x	x	x		x	x	x	x	x	x			2								x	x
Z0400A	Attestation signature, title, sections, date				x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
Z0400B	Attestation signature, title, sections, date				x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
Z0400C	Attestation signature, title, sections, date				x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x		x								x	x
Z0400D	Attestation signature, title, sections, date				x	x	x	x	x	x	x	x		x	x	x	x	x	x			2								x	x
Z0400E	Attestation signature, title, sections, date				x	x	x	x	x	x	x	x		x	x	x	x	x	x			2								x	x
Z0400F	Attestation signature, title, sections, date				x	x	x	x	x	x	x	x		x	x	x	x	x	x			2								x	x
Z0400G	Attestation signature, title, sections, date				x	x	x	x	x	x	x	x		x	x	x	x	x	x			2								x	x
Z0400H	Attestation signature, title, sections, date				x	x	x	x	x	x	x	x		x	x	x	x	x	x			2								x	x
Z0400I	Attestation signature, title, sections, date				x	x	x	x	x	x	x	x		x	x	x	x	x	x			2								x	x
Z0400J	Attestation signature, title, sections, date				x	x	x	x	x	x	x	x		x	x	x	x	x	x			2								x	x
Z0400K	Attestation signature, title, sections, date				x	x	x	x	x	x	x	x		x	x	x	x	x	x			2								x	x
Z0400L	Attestation signature, title, sections, date				x	x	x	x	x	x	x	x		x	x	x	x	x	x			2								x	x
Z0500A	Attestation signature, title, sections, date				x	x	x	x	x	x	x	x		x	x	x	x	x	x			2								x	x
Z0500B	Date RN signed assessment as complete			x	x	x	x	x	x	x	x	x		x	x	x	x	x	x			2								x	x
	Number of federally required items	90	19	604	627	491	491	142	339	269	385	293	72	455	142	329	269	375	283	72	29	72	26	85	182	58	93	110	171	295	231

Notes:
1 = Needed on nursing home compehensive and quarterly for payment/administration.
2 = Needed on all assessments for documentation.
3 = Needed on all non-OMRA assessments for clinical and/or payment documentation.
4 = QM item not needed on discharge.
5 = Items needed on all assessments that include resident interview
+ = Supporting items (e.g., triggers for skip patterns, none-of-the-above items, component item for summary score)
s = State-optional item.

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1	-	i	**Chapter 1: Resident Assessment Instrument (RAI) (V1.1~~0~~1)**
2	-	i	**Chapter 2: Assessments for the Resident Assessment Instrument (RAI) (V1.1~~0~~1)** 2.10 Combining Medicare Scheduled and Unscheduled Assessments ..... 2-5~~2~~3
3	-	i & ii	**Chapter 3: Overview to the Item-by-Item Guide to the MDS 3.0** 3.1 Using this Chapter ..... 3-1 3.2 Becoming Familiar with the MDS-recommended Approach ..... 3.2 3.3 Coding Conventions ..... 3.3 Section G Functional Status (V1.1~~0~~1) ..... G-1 Section H Bladder and Bowel (V1.1~~0~~1) ..... H-1 Section K Swallowing/Nutritional Status (V1.1~~0~~1) ..... K-1 Section M Skin Conditions (V1.1~~0~~1) ..... M-1 Section O Special Treatments, Procedures, and Programs (V1.1~~0~~1) ..... O-1 Section Q Participation in Assessment and Goal Setting (V1.1~~0~~1) ..... Q-1 Section Z Assessment Administration (V1.1~~0~~1) Z-1
5	-	ii	**Chapter 5: Submission and Correction of the MDS Assessments (V1.1~~0~~1)**
6	-	ii	**Chapter 6: Medicare Skilled Nursing Facility Prospective Payment System (SNF PPS) (V1.~~09~~11)**
Appendices		ii	**Appendices** Appendix A: Glossary and Common Acronyms (V1.~~09~~11) .. A-1 Appendix F: Item Matrix (V1.~~03~~11) ..... F-1 Appendix H: MDS 3.0 Forms (V1.11) H-1

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Chapter	Section	Page	Change
—	—	1-2	~~IFMC~~ **Telligen** • Gloria Batts • Debra Weiland, BSN, RN • Jean Eby, BS • Debra Cory, BS • Kathy Langenberg, RN
—	—	1-3	**RTI International** • Roberta Constantine, RN, PhD • Rajiv Ramakrishnan, BA • Nathaniel Breg, BA • Karen Reilly, Sc.D.
—	—	1-4	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~~http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS30Appendix_B.pdf~~.
1	1.3	1-7	• **Consumer Access to Nursing Home Information**. Consumers are also able to access information about every Medicare- and/or Medicaid-certified nursing home in the country. The Nursing Home Compare tool (http://www.medicare.gov/nursinghomecompare/~~http://www.medicare.gov/NHCompare~~) provides public access to nursing home characteristics, staffing and quality of care measures for certified nursing homes.
1	1.8	1-16, 1-17 & I-18	**PRIVACY ACT STATEMENT – HEALTH CARE RECORDS** **Long Term Care-Minimum Data Set (MDS) System of Records revised 04/28/2007** ~~**PRIVACY ACT STATEMENT – HEALTH CARE RECORDS (7/14/2005)**~~ **(Issued: 9-6-12, Implementation/Effective Date: 6-17-13)** THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974 (5 USC 552a). THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU. ~~*THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.*~~ **1. AUTHORITY FOR COLLECTION OF INFORMATION,**

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			INCLUDING SOCIAL SECURITY NUMBER AND WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY. Authority for maintenance of the system is given under Sections 1102(a), 1819(b)(3)(A), 1819(f), 1919(b)(3)(A), 1919(f) and 1864 of the Social Security Act. The system contains information on all residents of long-term care (LTC) facilities that are Medicare and/or Medicaid certified, including private pay individuals and not limited to Medicare enrollment and entitlement, and Medicare Secondary Payer data containing other party liability insurance information necessary for appropriate Medicare claim payment. Medicare and Medicaid participating LTC facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information is also used by the Centers for Medicare & Medicaid Services (CMS) to ensure that the facility meets quality standards and provides appropriate care to all residents. 42 CFR §483.20, requires LTC facilities to establish a database, the Minimum Data Set (MDS), of resident assessment information. The MDS data are required to be electronically transmitted to the CMS National Repository. Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures. These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS LTC System of Records. ~~**1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)**~~ ~~Sections 1819(f), 1919(f), 1819(b)(3)(A), 1919(b)(3)(A), and 1864 of the Social Security Act.~~ **2. PRINCIPAL PURPOSES OF THE SYSTEM FOR WHICH INFORMATION IS INTENDED TO BE USED.** The primary purpose of the system is to aid in the administration of the survey and certification, and payment of Medicare/Medicaid LTC services which include skilled nursing facilities (SNFs), nursing facilities (NFs) and non-critical access hospitals with a swing bed agreement. Information in this system is also used to study and improve the effectiveness and quality of care given in these facilities. This system will only collect the minimum amount of personal data necessary to achieve the purposes of the MDS, reimbursement, policy and research functions. ~~**2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED**~~ ~~This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate tracking of changes in your health and functional status over time for purposes of evaluating and assuring the quality of care provided by nursing homes that participate in Medicare or Medicaid.~~ **3. ROUTINE USES OF RECORDS MAINTAINED IN THE SYSTEM.** The information collected will be entered into the LTC MDS System of Records, System No. 09-70-0528. This system will only disclose the minimum amount of personal data necessary to accomplish the purposes of the disclosure. Information from this system may be disclosed to the following entities under

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			specific circumstances (routine uses), which include: (1) To support Agency contractors, consultants, or grantees who have been contracted by the Agency to assist in accomplishment of a CMS function relating to the purposes for this system and who need to have access to the records in order to assist CMS; (2) To assist another Federal or state agency, agency of a state government, an agency established by state law, or its fiscal agent for purposes of contributing to the accuracy of CMS' proper payment of Medicare benefits and to enable such agencies to fulfill a requirement of a Federal statute or regulation that implements a health benefits program funded in whole or in part with Federal funds and for the purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State, and determine Medicare and/or Medicaid eligibility; (3) To assist Quality Improvement Organizations (QIOs) in connection with review of claims, or in connection with studies or other review activities, conducted pursuant to Title XI or Title XVIII of the Social Security Act and in performing affirmative outreach activities to individuals for the purpose of establishing and maintaining their entitlement to Medicare benefits or health insurance plans; (4) To assist insurers and other entities or organizations that process individual insurance claims or oversees administration of health care services for coordination of benefits with the Medicare program and for evaluating and monitoring Medicare claims information of beneficiaries including proper reimbursement for services provided; (5) To support an individual or organization to facilitate research, evaluation, or epidemiological projects related to effectiveness, quality of care, prevention of disease or disability, the restoration or maintenance of health, or payment related projects; (6) To support litigation involving the agency, this information may be disclosed to The Department of Justice, courts or adjudicatory bodies; (7) To support a national accrediting organization whose accredited facilities meet certain Medicare requirements for inpatient hospital (including swing beds) services; (8) To assist a CMS contractor (including but not limited to fiscal intermediaries and carriers) that assists in the administration of a CMS-administered health benefits program, or to a grantee of a CMS-administered grant program to combat fraud, waste and abuse in certain health benefit programs; and (9) To assist another Federal agency or to an instrumentality of any governmental jurisdiction within or under the control of the United States (including any state or local governmental agency), that administers, or that has the authority to investigate potential fraud, waste and abuse in a health benefits program funded in whole or in

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			part by Federal funds. ~~**3. ROUTINE USES**~~ ~~The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long-term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose. The information collected will be entered into the Long-Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1517. Information from this system may be disclosed, under specific circumstances (routine uses), which include: To the Census Bureau and to: (1) Agency contractors, or consultants who have been engaged by the Agency to assist in accomplishment of a CMS function, (2) another Federal or State agency, agency of a State government, an agency established by State law, or its fiscal agent to administer a Federal health program or a Federal/State Medicaid program and to contribute to the accuracy of reimbursement made for such programs, (3) to Quality Improvement Organizations (QIOs) to perform Title XI or Title XVIII functions, (4) to insurance companies, underwriters, third party administrators (TPA), employers, self-insurers, group health plans, health maintenance organizations (HMO) and other groups providing protection against medical expenses to verify eligibility for coverage or to coordinate benefits with the Medicare program, (5) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease of disability, or the restoration of health, or payment related projects, (6) to a member of Congress or congressional staff member in response to an inquiry from a constituent, (7) to the Department of Justice, (8) to a CMS contractor that assists in the administration of a CMS-administered health benefits program or to a grantee of a CMS-administered grant program, (9) to another Federal agency or to an instrumentality of any governmental jurisdiction that administers, or that has the authority to investigate potential fraud or abuse in a health benefits program funded in whole or in part by Federal funds to prevent, deter, and detect fraud and abuse in those programs, (10) to national accrediting organizations, but only for those facilities that these accredit and that participate in the Medicare program.~~
			4. EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION. The information contained in the LTC MDS System of Records is generally necessary for the facility to provide appropriate and effective care to each resident. If a resident fails to provide such information, e.g. thorough medical history, inappropriate and potentially harmful care may result. Moreover, payment for services by Medicare, Medicaid and third parties, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment. **NOTE**: Residents or their representative must be supplied with a copy of the notice. This notice may be included in the admission packet for all new nursing home admissions, or distributed in other ways to residents or their representative(s). Although signature of receipt is NOT required, providers may request to have the Resident or his or her Representative sign a copy of this notice as a means to document that notice was provided and merely acknowledges that they have been provided with this information. ~~**4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY**~~

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			~~**AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION**~~ ~~For Nursing Home residents residing in a certified Medicare/Medicaid nursing facility the requested information is mandatory because of the need to assess the effectiveness and quality of care given in certified facilities and to assess the appropriateness of provided services. If the requested information is not furnished the determination of beneficiary services and resultant reimbursement may not be possible.~~Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you. _____ _____ Signature of Resident or Sponsor Date

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2	2.3	2-5	— More information on emergency preparedness can be found at: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html
2	2.6	2-15	**CAA Completion Date (Item V0200B2) No Later Than** 14th calendar day of the resident's admission (admission date + 13 calendar days)~~Same as MDS Completion Date~~ ARD + 14 calendar days~~Same as MDS Completion Date~~ 14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)~~Same as MDS Completion Date~~ 14th calendar day after determination that significant error in prior comprehensive assessment occurred (determination date + 14 calendar days)~~Same as MDS Completion Date~~
2	2.6	2-18	• 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.
2	2.6	2-36	• For a Discharge assessment, the ARD (Item A2300) is not set prospectively as with other assessments. The ARD (Item A2300) for a Discharge assessment is always equal the Discharge date (Item A2000) and may be coded on the assessment any time during the Discharge assessment completion period (i.e., discharge date (A2000) + 14 calendar days).~~Discharge date (Item A2000) must be the ARD (Item A2300) of the Discharge assessment.~~
2	2.9	2-48	• ~~In cases where a resident is classified into a Rehabilitation or Rehabilitation plus Extensive Services RUG category and experiences a planned or unplanned discontinuation of therapy services for three or more consecutive calendar days and the resident is discharged from the facility ***on*** the third day of missed therapy services, then no EOT OMRA is required. If the facility chooses to complete an EOT OMRA in this situation, it may be combined with the discharge assessment.~~ • In cases where the last day of the Medicare Part A benefit, that is the date used to code A2400C on the MDS, is prior to the third consecutive day of missed therapy services, then no EOT OMRA is required. If the date listed in A2400C is on or after the third consecutive day of missed therapy services, then an EOT OMRA would be required. • In cases where the date used to code A2400C is equal to the date used to code A2000, that is cases where the discharge from Medicare Part A is the same day as the discharge from the

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			facility, and this date is on or prior to the third consecutive day of missed therapy services, then no EOT OMRA is required. Facilities may choose to combine the EOT OMRA with the discharge assessment under the rules outlined for such combinations in Chapter 2 of the MDS RAI manual.
2	2.9	2-50	***Change of Therapy (COT) OMRA*** Required when the resident was receiving ~~any amount of skilled therapy services~~a sufficient level of rehabilitation therapy to qualify for an Ultra High, Very High, High, Medium, or Low Rehabilitation category and when the intensity of therapy (as indicated by the total reimbursable therapy minutes (RTM) delivered, and other therapy qualifiers such as number of therapy days and disciplines providing therapy) changes to such a degree that it would no longer reflect the RUG-IV classification and payment assigned for a given SNF resident based on the most recent assessment used for Medicare payment.
2	2.9	2-51	• When the most recent assessment used for PPS, excluding an End of Therapy OMRA, has a sufficient level of rehabilitation therapy to qualify for an Ultra High, Very High, High, Medium, or Low Rehabilitation category (even if the final classification index maximizes to a group below Rehabilitation), then a change in the provision of therapy services is evaluated in successive 7-day Change of Therapy observation periods until a new assessment used for PPS occurs.
2	2.9	2-52	Page length change.
2	2.9	2-52	• Note: In limited circumstances, it may not be practicable to conduct the resident interview portions of the MDS (Sections C, D, F, J) on or prior to the ARD for a standalone unscheduled PPS assessment. In such cases where the resident interviews (and not the staff assessment) are to be completed and the assessment is a standalone unscheduled assessment, providers may conduct the resident interview portions of that assessment up to two calendar days after the ARD (Item A2300).
2	-	2-55 thru 2-60	Page length change.
2	2.13	2-69	~~***Change of Therapy OMRA and Significant Correction to Prior Comprehensive Assessment***~~ ***Change of Therapy OMRA and Significant Correction to***

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			Prior Comprehensive Assessment
2	2.13	2-72	Moreover, a SNF may use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for an unscheduled PPS assessment, but only in the case where the ARD for the unscheduled assessment falls on a day that is not counted among the beneficiary's 100 days due to a leave of absence (LOA), as defined above, and the resident returns to the facility from the LOA on Medicare Part A. For example, Day 7 of the COT observation period occurs 7 days following the ARD of the most recent PPS assessment used for payment, regardless if a LOA occurs at any point during the COT observation period. If the ARD for a resident's 30-day assessment were set for November 7 and the resident went to the emergency room at 11:00pm on November 14, returning on November 15, Day 7 of the COT observation period would remain November 14 for purposes of coding the COT OMRA. Finally, there may be cases in which a SNF plans to combine a scheduled and unscheduled assessment on a given day, but then that day becomes an LOA day for the resident. In such cases, while that day may still be used as the ARD of the unscheduled assessment, this day cannot be used as the ARD of the scheduled assessment. For example if the ARD for a resident's 5-day assessment were set for May 10 and the resident went to the emergency room at 1:00pm on May 17, returning on May 18, a facility could not complete a combined 14-day/COT OMRA with an ARD set for May 17. Rather, while the COT OMRA could still have an ARD of May 17, the 14-day assessment would need to have an ARD that falls on one of the resident's Medicare A benefit days.
2	-	2-73 & 2-74	Page length change.
2	2.13	2-75	***Errors on a~~n + Medicare~~PPS Assessment***

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to Chapter 3, Section G V1.11

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3	G-0110	G-3	3. When reviewing records, interviewing staff, and observing the resident, be specific in evaluating each component as listed in the ADL activity definition. For example, when evaluating Bed Mobility, observe what the resident is able to do without assistance, and then determine the level of assistance the resident required~~s~~ from staff for moving~~the resident~~ to and from a lying position, for turning the resident from side to side, and/or for positioning the resident in bed. To clarify your own understanding and observations about a resident's performance of an ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific. See page G-~~9~~10 for an example of using probes when talking to staff.
3	G-0110	G-3 & G-4	**Coding Instructions** • ~~To assist in coding ADL self-performance items, please use the algorithm on page G-6.~~ • Consider all~~each~~ episodes of the activity that occur~~red~~ over a 24-hour period during each day of the 7-day look-back period, as a resident's ADL self-performance and the support required may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations to occur, including but not limited to, mood, medical condition, relationship issues (e.g., willing to perform for a nursing assistant that he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day (i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well). • In order to be able to promote the highest level of functioning among residents, clinical staff must first identify what the resident actually does for himself or herself, noting when assistance is received and clarifying the type (weight-bearing, non-weight-bearing, verbal cueing, guided maneuvering, etc.) and level ~~levels~~ of assistance (supervision, limited assistance, etc.) provided ~~(verbal cueing, physical support, etc.)~~ by all disciplines. • If a resident uses~~Code based on the resident's level of assistance when using~~ special adaptive devices such as a walker, device to assist with donning socks, dressing stick, long-handled reacher, or adaptive eating utensils, code ADL

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			Self-Performance and ADL Support Provided based on the level of assistance the resident requires when using such items.
3	G-0110	G-4	~~• A resident's ADL self-performance may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a nursing assistant that he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day (i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well).~~ • The ADL ~~s~~Self-~~p~~Performance coding level definitions~~options~~ are intended to reflect real world situations where slight variations in level of ADL self-performance are common. ~~Refer to the algorithm on page G-6 for assistance in determining the most appropriate self-performance code.~~ ~~• Although it is not necessary to know the actual number of times the activity occurred, it is necessary to know whether or not the activity occurred three or more times within the last 7 days.~~ • To assist in coding ADL Self-Performance items, facilities may augment the instructions with the algorithm on page G-7. • ~~Because t~~This section involves a two-part ADL evaluation: ~~(ADL~~ Self-Performance, which measures how much of the ADL activity the resident can do for himself or herself, and ~~ADL~~ Support Provided, which measures how much facility staff support is needed for the resident to complete the ADL. Each of these sections ~~), each~~ uses~~ing~~ its own scale, therefore, it is recommended that the ADL Self-Performance evaluation (Column 1) be completed for all ADL activities before beginning the ADL Support evaluation (Column 2).
3	G-0110	G-4 & G-5	~~**• Instructions for the Rule of Three:**~~ ~~– When an activity occurs three times at any one given level, code that level.~~ ~~– When an activity occurs three times at multiple levels, **code the most dependent**.~~ ~~o Example, three times extensive assistance (3) and three times limited assistance (2) – code extensive assistance (3).~~ ~~Exceptions are as follows:~~

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			~~o Total dependence (4) – activity must require full assist every time, and~~ ~~o Activity did not occur (8) – activity must not have occurred at all or family and/or non-facility staff provided care 100% of the time for the activity over the entire 7-day period.~~ ~~– When an activity occurs at more than one level, but not three times at any one level, apply the following:~~ ~~o Episodes of full staff performance are considered to be weight-bearing assistance (when every episode is full staff performance – this is total dependence).~~ ~~o When there are three or more episodes of a combination of full staff performance and weight-bearing assistance – code extensive assistance (3).~~ ~~o When there are three or more episodes of a combination of full staff performance, weight-bearing assistance, and/or non-weight-bearing assistance – code limited assistance (2).~~ ~~**• If none of the above are met, code supervision.**~~
3	G-0110	G-4	**Coding Instructions for G0110, Column 1, ADL Self-Performance** • Code 0, independent: if resident completed activity with no help or oversight **every time** during the 7-day look-back period and the activity occurred at least three times. • Code 1, supervision: if oversight, encouragement, or cueing was provided **three or more times** during the last 7 days. • Code 2, limited assistance: if resident was highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight-bearing assistance on **three or more times** during the last 7 days. • Code 3, extensive assistance: if resident performed part of the activity over the last 7 days~~,~~ and help of the following type(s) was provided **three or more times**: ~~three or more times:~~ — Weight-bearing support provided **three or more times, OR** — Full staff performance of activity **three or more times** during part ~~(**three or more times**~~ but not all of the last 7 days~~)~~. • Code 4, total dependence: if there was **full staff performance** of an activity with no participation by resident for any aspect of the ADL activity and the activity occurred three or more times. The resident must be unwilling or unable

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			to perform any part of the activity over the entire 7-day look-back period.
3	G-0110	G-5	• Code 7, activity occurred only once or twice: if the activity occurred ~~but not~~**fewer than three times**~~ or more~~. • Code 8, activity did not occur: if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day look-back period. **The Rule of 3** • The "Rule of 3" is a method that was developed to help determine the appropriate code to document ADL Self-Performance on the MDS. • It is very important that staff who complete this section fully understand the components of each ADL, the ADL Self-Performance coding level definitions, and the Rule of 3. • In order to properly apply the Rule of 3, the facility must first note which ADL activities occurred, how many times each ADL activity occurred, what type, and what level of support was required for each ADL activity over the entire 7-day look-back period. • The following ADL Self-Performance coding levels are exceptions to the Rule of 3: – **Code 0, Independent** – Coded only if the resident completed the ADL activity **with no help or oversight every time** the ADL activity occurred during the 7-day look-back period and the activity occurred at least three times. – **Code 4, Total dependence –** Coded only if the resident required **full staff performance** of the ADL activity **every time** the ADL activity occurred during the 7-day look-back period and the activity occurred three or more times. – **Code 7, Activity occurred only once or twice** – Coded if the ADL activity occurred **fewer than three times** in the 7-day look back period. – **Code 8, Activity did not occur –** Coded only if the ADL activity **did not occur** or **family and/or non-facility staff provided care 100% of the time** for that activity over the entire 7-day look-back period.

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3	G-0110	G-6	~~• **Instructions for the Rule of Three:**~~ **Instructions for the Rule of 3:** When an ADL activity has occurred **three or more times**, apply the steps of the Rule of 3 below **(keeping the ADL coding level definitions and the above exceptions in mind)** to determine the code to enter in Column 1, ADL Self-Performance. These steps must be used in sequence. Use the first instruction encountered that meets the coding scenario (e.g., if #1 applies, stop and code that level). 1. When an activity occurs **three or more times at any one level**, code that level. 2. When an activity occurs **three or more times at multiple levels, code the most dependent level that occurred three or more times**. 3. When an activity occurs **three or more times and at multiple levels, but not three times at any one level**, apply the following: a. Convert episodes of full staff performance to weight-bearing assistance when applying the third Rule of 3, as long as the full staff performance episodes did not occur every time the ADL was performed in the 7-day look-back period. It is only when **every** episode is full staff performance that Total dependence (4) can be coded. Remember, that weight-bearing episodes that occur three or more times or full staff performance that is provided three or more times during part but not all of the last 7 days are included in the ADL Self-Performance coding level definition for Extensive assistance (3). b. When there is a combination of full staff performance and weight-bearing assistance that total three or more times—code extensive assistance (3). c. When there is a combination of full staff performance /weight-bearing assistance and/or non-weight-bearing assistance that total three or more times—code limited assistance (2). **If none of the above are met, code supervision.**

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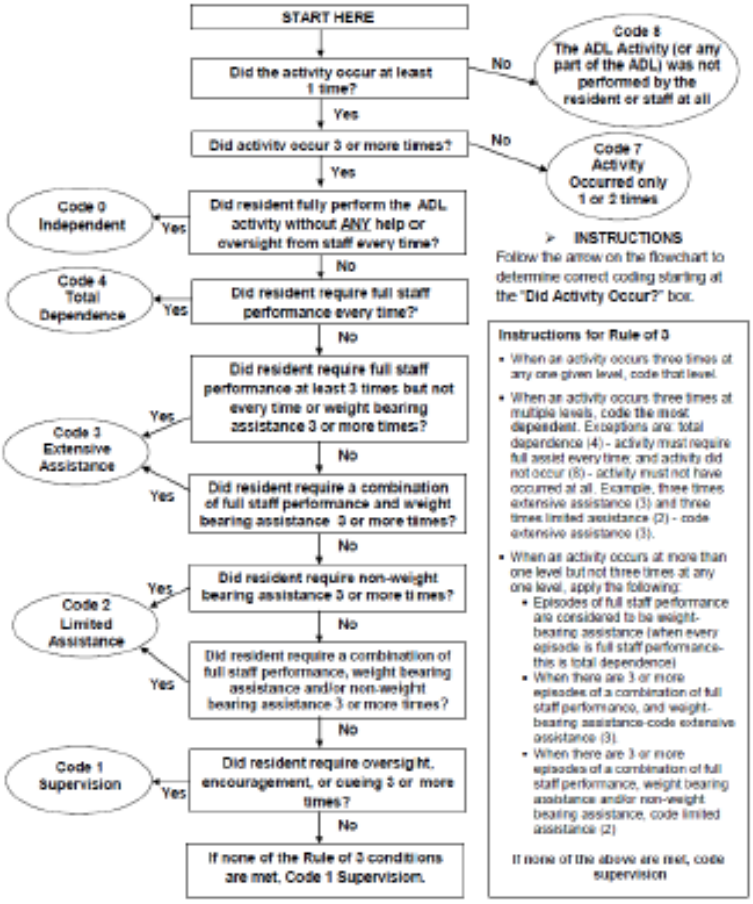
Chapter	Section	Page	Change
3	G-0110	G-7	**ADL Self-Performance Algorithm** Algorithm revised. **OLD:**  (continued)

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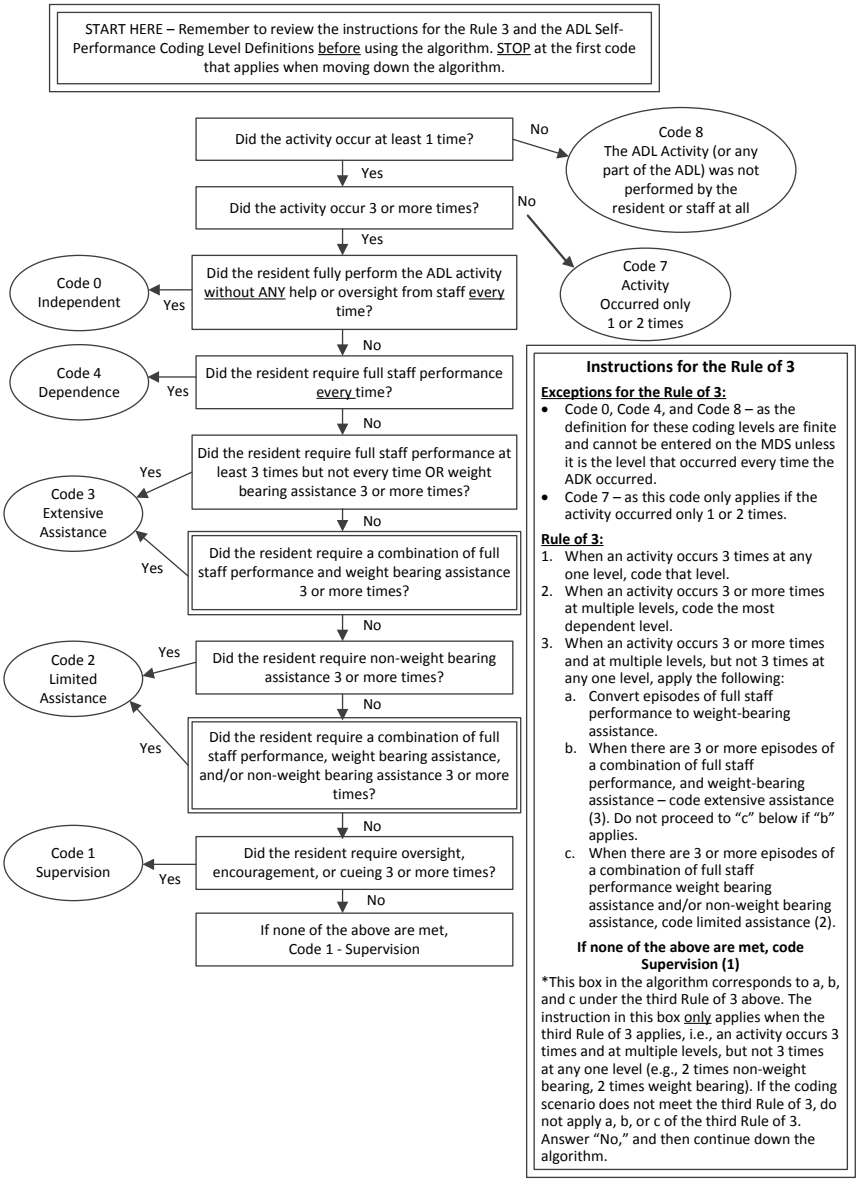
Chapter	Section	Page	Change
3	G-0110	G-7	**NEW:**



Track Changes
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Chapter	Section	Page	Change
3	G-0110	G-8	*Code for the **most** support provided over all shifts~~;~~. ~~e~~Code regardless of how Column I~~resident's~~ ADL S~~s~~elf-~~p~~Performance~~classification~~ is coded.*
3	G-0110	G-9	— **Locomotion** would be **coded 8, activity did not occur**: if the resident was on bed rest and did not get out of bed, and there was no locomotion via bed, wheelchair, or other means during the look-back period or if locomotion assistance was provided by family and/or non-facility staff 100 % of the time over the entire 7-day look-back period.
3	G-0110	G-10	In this example, the assessor inquired specifically how Mrs. L. moves to and from a lying position, how she turns from side to side, and how the resident positions herself while in bed. A resident can be independent in one aspect of bed mobility, yet require extensive assistance in another aspect, so be sure to consider each activity definition fully. If the RN did not probe further, he or she would not have received enough information to make an accurate assessment of the actual assistance Mrs. L. received. This information is important to know and document b~~B~~ecause accurate coding and supportive documentation ~~is important as a~~ provides the basis for reporting on the type and amount of care provided.~~, be sure to consider each activity definition fully.~~
3	-	G-11 thru G-18	Page length change.
3	G-0110	G16	3. Mr. H. enjoyed walking in the nursing home garden when weather permitted. Due to inclement weather during the assessment period, he required multiple~~various~~ levels of assistance on the days he walked through the garden. On two occasions, he required limited assistance for balance of one staff person and on another occasion he only required supervision. On one day he was able to walk through the garden completely by himself.
3	G-0110	G-19 thru G-22	**Scenario Examples** 1. Scenario: The following dressing assistance was provided to Mr. X during the look-back period: Two times, he required guided maneuvering of his arms to don his shirt; this assistance was non-weight-bearing assistance. Four times, he required the staff to assist him to put his shirt on due to pain in his shoulders. During these four times that the staff had to assist Mr. X to put his shirt on, the staff had to physically assist him by lifting each of his arms. This component of the dressing

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			activity occurred six times in the 7-day look-back period. There were two times where Mr. X required non-weight-bearing assistance and four times where he required weight-bearing assistance, therefore the appropriate code to enter on the MDS is Extensive assistance (3). Rationale: This ADL activity component occurred six times in the 7-day look-back period. Mr. X required limited assistance two times and weight-bearing (extensive) assistance four times. Lifting the resident's arms is considered weight-bearing assistance. The ADL activity component occurred three or more times at one level, extensive - thus, this weight-bearing assistance is the highest level of dependence identified that occurred three or more times. The scenario is consistent with the ADL Self-Performance coding level definition of Extensive assistance and meets the first Rule of 3. The assessor uses the steps in the Rule of 3 in sequence and stops once one has been identified as applying to the scenario. Therefore the final code that should be entered in Column 1, ADL Self-Performance, G0110G – Dressing is Extensive assistance (3). 2. Scenario: The following assistance was provided to Mrs. C over the last seven days: Four times, she required verbal cueing for hand placement during stand-pivot transfers to her wheelchair and three times she required weight-bearing assistance to help her rise from the wheelchair, steady her and help her turn with her back to the edge of the bed. Once she was at the edge of the bed and put her hand on her transfer bar, she was able to sit. She completed the activity without assistance the 14 remaining instances during the 7-day look-back period. The four times that she required verbal cueing from the staff for hand placement are considered supervision. The three times that the staff had to physically support Mrs. C during a portion of the transfer are considered weight-bearing assistance. This ADL occurred 21 times over the 7-day look-back period. There were three or more times where supervision was required, and three times where weight-bearing assistance was required; therefore, the appropriate code to enter on the MDS is Extensive assistance (3). Rationale: The ADL activity occurred 21 times over the 7-day look-back period. Mrs. C required supervision four times and weight-bearing assistance was provided three times during the 7-day look-back period. The ADL activity also occurred three or more times at multiple levels (four times with

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			supervision, three times with weight-bearing assistance, and 14 times without assistance). Weight-bearing assistance is also the highest level of dependence identified that occurred three or more times. The first Rule of 3 does not apply because the ADL activity occurred three or more times at multiple levels, not three or more times at any one level. Because the ADL activity occurred three or more times at multiple levels, the scenario meets the second Rule of 3 and the assessor will apply the most dependent level that occurred three or more times. Note that this scenario does meet the definition of Extensive assistance as well, since the activity occurred at least three times and there was weight-bearing support provided three times. The final code that should be entered in Column 1, ADL Self-Performance, G0110B – Transfer is Extensive assistance (3). 3. Scenario: Mrs. F. was in the nursing home for only one day prior to transferring to another facility. While there, she was unable to complete a component of the eating ADL activity without assistance three times. The following assistance was provided: Twice she required weight-bearing assistance to help lift her fork to her mouth. One time in the evening, the staff fed Mrs. F. because she could not scoop the food on her plate with the fork, nor could she lift the fork to her mouth. The three times that Mrs. F. could not complete the activity, the staff had to physically assist her by either holding her hand as she brought the fork to her mouth, or by actually feeding her. There were two times where the staff provided weight-bearing assistance and one time where they provided full staff performance. This component of the ADL eating activity where assistance was required, occurred three times in the look-back period, but not three times at any one level. Based on the third Rule of 3, the final code determination is Extensive assistance (3). Rationale: Eating occurred three times in the look-back period during the day that Mrs. F was in the nursing home. Mrs. F performed part of the activity by scooping the food and holding her fork two times, but staff had to assist by lifting her arm to her mouth resulting in two episodes of weight-bearing assistance. The other time, the staff had to feed Mrs. F. The first Rule of 3 does not apply because even though the ADL assistance occurred three or more times, it did not occur three times at any one level. The second Rule of 3 does not apply because even though the ADL assistance occurred three or

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			more times it did not occur three or more times at multiple levels. The third Rule of 3 applies since the ADL assistance occurred three times at multiple levels but not three times at any one level. Sub-item "a" under the third Rule of 3 states to convert episodes of full staff performance to weight-bearing assistance as long as the full staff performance episodes did not occur every time the ADL was performed in the 7-day look-back period. Therefore, the one episode of full staff performance is considered weight-bearing assistance and can be added to the other two episodes of weight-bearing assistance. This now totals three episodes of weight-bearing assistance. Therefore, application of the third Rule of 3 and the first two sub-items, "a" and "b," the correct code to enter in Column 1, ADL Self-Performance, G0110H, Eating is Extensive assistance (3). Note that none of the ADL Self-Performance coding level definitions apply directly to this scenario. It is only through the application of the third Rule of 3 and the first two sub-items that the facility is able to code this scenario as extensive assistance. 4. Scenario: Mr. N was admitted to the facility, but was sent to the hospital on the 2nd day he was there. The following assistance was provided to Mr. N over the look-back period: Weight-bearing assistance one time to lift Mr. N's right arm into his shirt sleeves when dressing in the morning on day one, non-weight-bearing assistance one time to button his shirt in the morning on day two, and full staff performance one time on day two to put on his pants on after resting in bed in the afternoon. Mr. N was independent in the evening on day one when undressing and getting his bed clothes on. Based on the application of the third Rule of 3s sub-items, the final code determination is Limited assistance (2). Rationale: There was one episode where Mr. N required full staff performance to put his pants on, one episode of weight-bearing assistance to put his right arm into his shirt sleeve, and one episode of non-weight-bearing assistance to button his shirt. The first Rule of 3 does not apply because even though the ADL assistance occurred three times, it did not occur three times at any one level. The second Rule of 3 does not apply because even though the ADL assistance occurred three times it did not occur three times at multiple levels. The third Rule of 3 applies because the activity occurred three times, and at multiple levels but not three times at any one level. The third Rule of 3, sub-item "a," instructs

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			providers to convert episodes of full staff performance to weight-bearing assistance. Therefore, there are now two weight-bearing episodes and one non-weight-bearing episode. The third Rule of 3, sub-item "b," does not apply because even though there are two episodes of weight-bearing assistance, there are not enough weight-bearing episodes to consider it Extensive assistance. There is one episode of non-weight-bearing assistance that can be accounted for. The third sub-item, "c," under the third Rule of 3 applies because there is a combination of full staff performance/weight-bearing assistance and/or non-weight-bearing assistance that together total three times (two episodes of weight-bearing assistance and one episode of non-weight-bearing assistance). Therefore, the appropriate code is Limited assistance (2) which is the correct code to enter in Column 1, ADL Self-Performance, G0110G, Dressing. Note that none of the ADL Self-Performance coding level definitions apply directly to this scenario. It is only through the application of the third Rule of 3, working through all of the sub-items, that the facility is able to code this item as Limited assistance. 5. Scenario: During the look-back period, Mr. S was able to toilet independently without assistance 18 times. The other two times toileting occurred during the 7-day look-back period, he required the assistance of staff to pull the zipper up on his pants. This assistance is classified as non-weight-bearing assistance. The assessor determined that the appropriate code for G0100I, Toilet use was Code 1, Supervision. Rationale: Toilet use occurred 20 times during the look-back period. Non-weight-bearing assistance was provided two times and 18 times the resident used the toilet independently. When the assessor began looking at the ADL Self-Performance coding level definitions, she determined that Independent (i.e., Code 0) cannot be the code entered on the MDS for this ADL activity because in order to be coded as Independent (0), the resident must complete the ADL without any help or oversight from staff every time. Since Mr. S did require assistance to complete the ADL two times, Code 0 does not apply. Code 7, Activity occurred only once or twice, did not apply to this scenario because even though assistance was provided twice during the look-back period, the activity itself actually occurred 20 times. The assessor also determined that the assistance provided to the resident does not meet the definition for Limited Assistance (2) because even though the assistance

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			was non-weight-bearing, it was only provided twice in the look-back period, and that the ADL Self-Performance coding level definitions for Codes 1, 3 and 4 did not apply directly to this scenario either. The assessor continued to apply the coding instructions, looking at the Rule of 3. The first Rule of 3 does not apply because even though the ADL activity occurred three or more times, the non-weight-bearing assistance occurred only twice. The second Rule of 3 does not apply because even though the ADL occurred three or more times it did not occur three times at multiple levels and the third Rule of 3 does not apply because even though the ADL occurred three or more times, it did not occur at multiple levels or three times at any one level. Since the third Rule of 3 did not apply, the assessor knew not to apply any of the sub-items. However, there is one final instruction to the provider, that when none of the ADL Self-Performance coding level definitions and the Rule of 3 do not apply, the appropriate code to enter in Column 1, ADL Self-Performance, is Supervision (1); therefore, in G0110I, Toilet use the code Supervision (1) was entered.
3	G-0120	G-23	**Coding Instructions for G0120A, Self-Performance**
3	G-0120	G-24	Rationale: Coding directions for bathing state, "code for most dependent in self-performance and support." Resident's most dependent episode during the 7-day look-back period was total help with the bathing activity with assist from one staff person.
3	G-0120	G-25 thru G-40	Page length/number change.

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from Chapter 3, Section H V1.10
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3	H0200	H-5	Coding Instructions H0200A, **Toileting Program Trial** • Code 1, yes: for residents who underwent a trial of an individualized, resident- centered toileting program at least once since the most recent admission/entry or reentry or since urinary incontinence was first noted within the facility. ~~for residents who underwent a trial of an individualized, resident- centered toileting program at least once since admission/readmission, prior assessment, or when urinary incontinence was first noted.~~
3	H0300	H-7	DEFINITIONS URINARY INCONTINENCE The involuntary loss of urine. CONTINENCE ~~Any void into a commode, urinal, or bedpan that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting.~~ Any void that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting.

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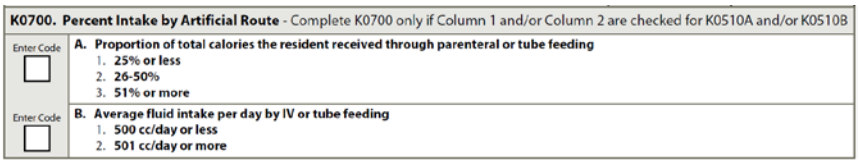
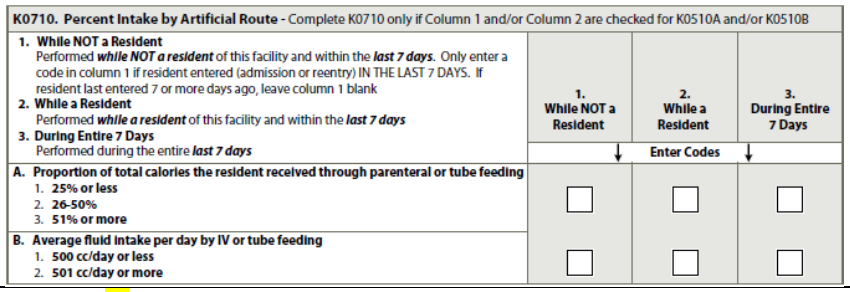
3	K0510	K-12	**Coding Tips for K0510D** • Food elimination diets related to food allergies (e.g. peanut allergy) can be coded as a therapeutic diet.
3	K0710	K-13	K07~~0~~10: Percent Intake by Artificial Route *Complete K07~~0~~10 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B.* Replaced screen shot: **OLD**  **K0700. Percent Intake by Artificial Route** - Complete K0700 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B Enter Code ☐ A. Proportion of total calories the resident received through parenteral or tube feeding 1. 25% or less 2. 26-50% 3. 51% or more Enter Code ☐ B. Average fluid intake per day by IV or tube feeding 1. 500 cc/day or less 2. 501 cc/day or more **NEW**  **K0710. Percent Intake by Artificial Route** - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B 1. While NOT a Resident — Performed *while NOT a resident* of this facility and within the *last 7 days*. Only enter a code in 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* 3. During Entire 7 Days — Performed during the entire *last 7 days* 1. While NOT a Resident / 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
3	K0710	K-14	K07~~0~~10: Percent Intake by Artificial Route (cont.)
3	K0710	K-14	**K07~~0~~10A, Proportion of Total Calories the Resident Received through Parental or Tube Feedings ~~in the Last 7 Days~~**
3	K0710	K-14 & K-15	**Example** 1. **Calculation for Proportion of Total Calories from IV or Tube Feeding** Mr. H has had a feeding tube since his surgery two weeks ago. He is currently more alert and feeling much better. He is very motivated to have the tube removed. He has been taking soft solids by mouth, but only in small to medium amounts. For the past 7 days, he has been receiving tube feedings for nutritional supplementation. The dietitian has totaled his calories per day as follows: Coding: K07~~0~~10A columns 2 and 3 would be coded **3, 51% or more.** Rationale: Total Oral intake is 2,450 calories

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			Total Tube intake is 15,000 calories Total calories is 2,450 + 15,000 = 17,450 Calculation of the percentage of total calories by tube feeding: 15,000/17,450 = .859 X 100 = 85.9% Mr. H received 85.9% of his calories by tube feeding, therefore K07~~0~~10A **code 3**, **51% or more** is correct.
3	K0710	K-15	K07~~0~~10: Percent Intake by Artificial Route (cont.)
3	K0710	K-15	**K07~~0~~10B, Average Fluid Intake per Day by IV or Tube Feeding ~~in the Last 7 Days.~~**
3	K0710	K-15 & K-16	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. Coding: K07~~0~~10B 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.
3	K0710	K-16	K07~~0~~10: Percent Intake by Artificial Route (cont.)
3	K0710	K-16	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. ~~during the 7-day assessment period. She~~ She received no other intake via IV or tube feeding during the last 7 days~~assessment period~~. Coding: K07~~0~~10~~b~~B 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

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			142.9 cc is less than 500 cc, therefore **code 1**, **500 cc/day or less** is correct.

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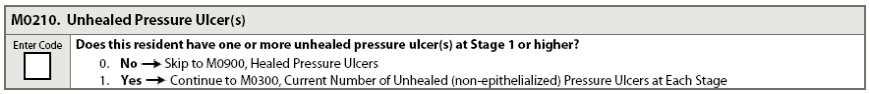
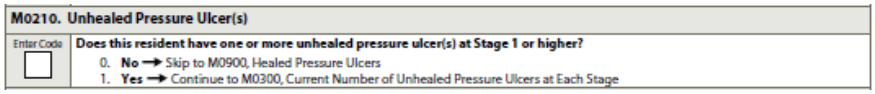
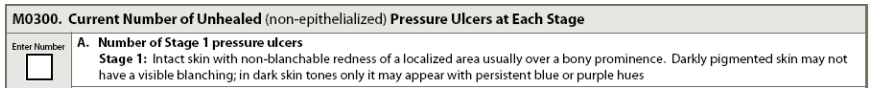
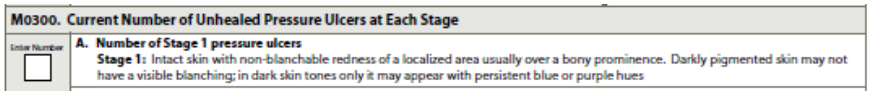
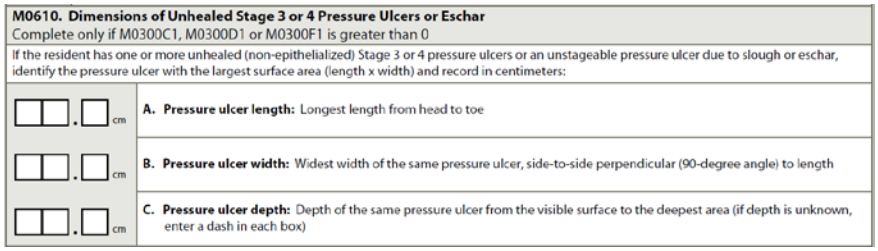
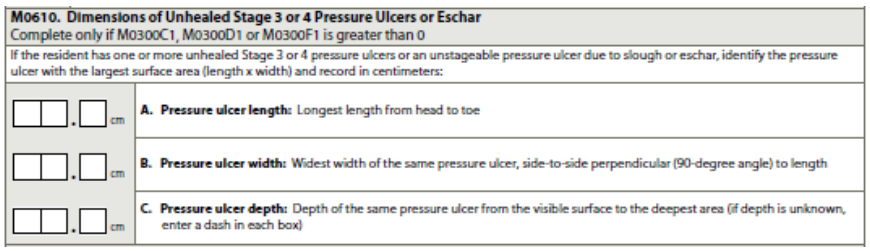
Chapter	Section	Page	Change
3	M0210	M-4	Replaced screen shot. OLD  NEW 
3	M0300	M-7	Replaced screen shot. OLD  NEW 
3	M0610	M-20	Replaced screen shot. OLD  NEW 

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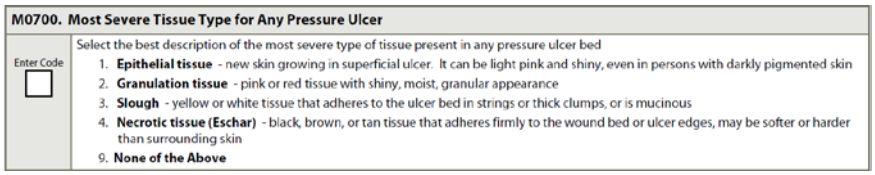
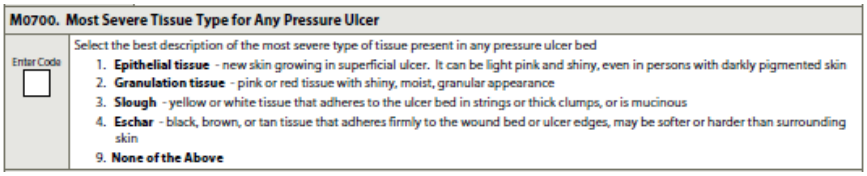
Chapter	Section	Page	Change
3	M0700	M-23	Replaced screen shot. OLD  **M0700. Most Severe Tissue Type for Any Pressure Ulcer** Enter Code ☐ Select the best description of the most severe type of tissue present in any pressure ulcer bed 1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin 2. **Granulation tissue** - pink or red tissue with shiny, moist, granular appearance 3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous 4. **Necrotic tissue (Eschar)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin 9. **None of the Above** NEW  **M0700. Most Severe Tissue Type for Any Pressure Ulcer** Enter Code ☐ Select the best description of the most severe type of tissue present in any pressure ulcer bed 1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin 2. **Granulation tissue** - pink or red tissue with shiny, moist, granular appearance 3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous 4. **Eschar** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin 9. **None of the Above**
3	M0700	M-23	• Code 4, ~~Necrotic tissue (e~~Eschar~~)~~: if there is any eschar tissue present.
3	M0700	M-23	DEFINITIONS EPITHELIAL TISSUE New skin that is light pink and shiny (even in person's with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound. GRANULATION TISSUE Red tissue with "cobblestone" or bumpy appearance, bleeds easily when injured. SLOUGH TISSUE Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed. ~~NECROTIC TISSUE (ESCHAR)~~ESCHAR Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. ~~Necrotic tissue and eschar are~~ Eschar is usually firmly adherent to the base of the wound and often the sides/edges of the wound.

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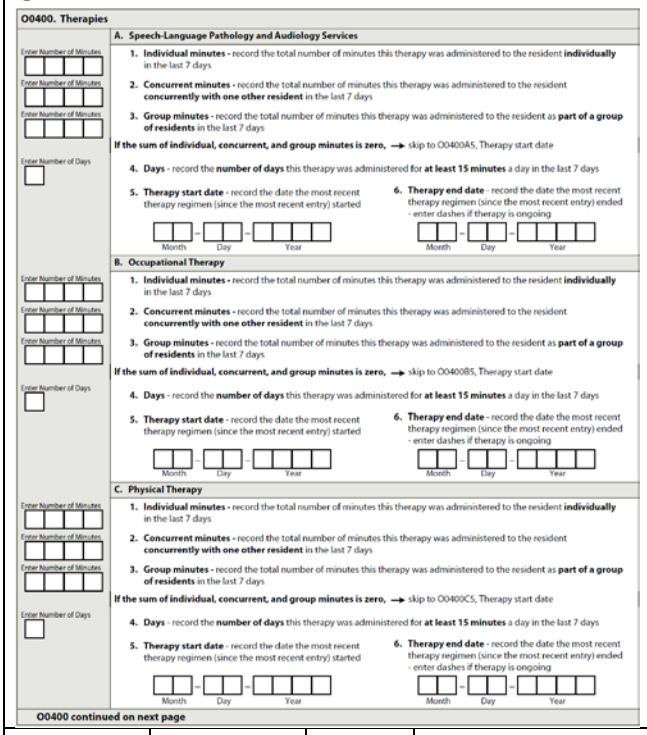
to Chapter 3, Section M V1.11

Chapter	Section	Page	Change
3	M0700	M-24	3. A resident has a pressure ulcer on the left trochanter that has 25% black eschar tissue present, 75% granulation tissue present, and some epithelialization at the edges of the wound. Coding: Code M0700 as 4, ~~Necrotic tissue (e~~Eschar~~)~~**.** Rationale: Coding is for the most severe tissue type present, which is not always the majority of type of tissue. Therefore, Coding for M0700 is Code 4, ~~[Necrotic tissue (e~~Eschar~~)]~~.
3	M1200	M-48	• M0300E1 (**Unstageable**: Non-removable dressing), Code 0 and skip to M0300F (Unstageable: Slough and/or ~~e~~Eschar). • M0300F1 (**Unstageable**: Slough and/or ~~e~~Eschar), Code 0 and skip to M0300G (Unstageable: Deep tissue).

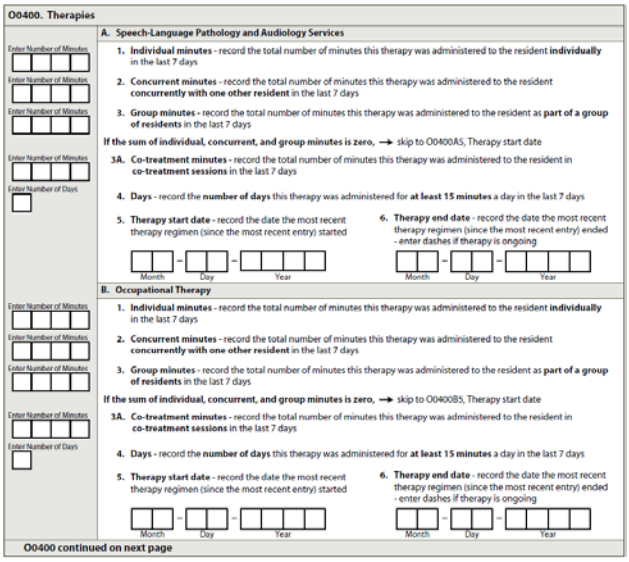
Track Changes
from Chapter 3, Section O V1.10
to Chapter 3, Section O V1.11

Chapter	Section	Page	Change
3	O0400	O-14	Replaced screen shot

OLD



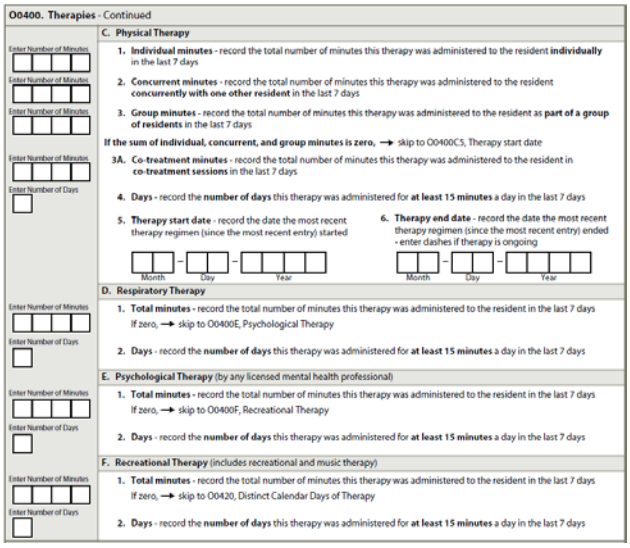
NEW



3	O0400	O-15	Replaced screen shot

OLD

NEW



Track Changes
from Chapter 3, Section O V1.10
to Chapter 3, Section O V1.11

Chapter	Section	Page	Change
3	O0400	O-16	Page length change.
3	O0400	O-17	• **Co-treatment minutes**—Enter the total number of minutes each discipline of therapy was administered to the resident in co-treatment sessions in the last 7 days. Enter 0 if none were provided.
3	—	O-18	Page length change.
3	O0400	O-19	— the services must be provided with the expectation, based on the assessment of the resident's restoration potential made by the physician, that the condition of the patient will improve materially in a reasonable and generally predictable period of time;~~,~~ or, the services must be necessary for the ~~establishment~~ *establishment* of a safe and effective maintenance program; or, the services must require the skills of a qualified therapist for the *performance* of a safe and effective maintenance program.
3	O0400	O-20	• As noted above, therapy services can include the actual performance of a maintenance program in those instances where the skills of a qualified therapist are needed to accomplish this safely and effectively. However, when the performance of a maintenance program does not require the skills of a therapist because it could be accomplished safely and effectively by the patient or with the assistance of non-therapists (including unskilled caregivers), such services are not considered therapy services in this context. Sometimes anursing home may nevertheless elect to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services even when the involvement of a qualified therapist is not medically necessary. • In situations where the ongoing performance of a safe and effective maintenance program does not require any skilled services, ~~O~~once the qualified therapist has designed the~~a~~ 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.
3	—	O-21 thru O-26	Page length change.

Track Changes
from Chapter 3, Section O V1.10
to Chapter 3, Section O V1.11

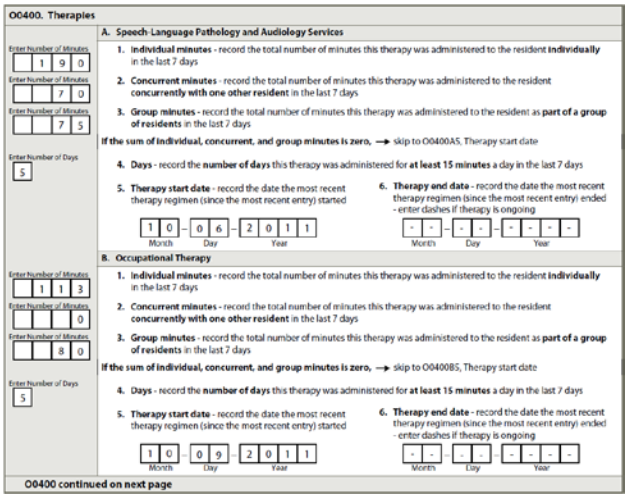
Chapter	Section	Page	Change
3	O0400	O-27	• ~~Item~~ O0400A5 (SLP start date) is 02102012
3	O0400	O-27 & O-28	~~NOTE: When an EOT-R is completed, the Therapy Start Date (O0400A5, O0400B5, and O0400C5) on the next PPS assessment is the same as the Resumption of Therapy Date (O0450B) Therapy Start Date on the EOT-R. If therapy is ongoing, the Therapy End Date (O0400A6, O0400B6, and O0400C6) would be filled out with dashes.~~ 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 ~~filled out with dashes~~. For example, Mr. T. was admitted to the nursing home following a fall that resulted in a hip fracture in May 2013. Occupational and Physical therapy started May 10, 2013. His physical therapy ended May 23, 2013 but the occupational therapy continued. Due to observed swallowing issues, he was referred to SLP on May 31, 2013 and the speech-language pathologist evaluated him on that day. Though Mr. T was able to receive both occupational therapy and speech therapy on June 12, he is unable to receive therapy on June 13 or June 14 due to a minor bout with the flu. The facility does not provide therapy on the weekends, which means that June 15, 2013 represents the third day of missed therapy, triggering an EOT OMRA. The therapy staff and nurses discuss Mr. T's condition and agree that Mr. T should be able to resume the same level of therapy beginning on June 18, 2013, so the facility decides to complete the EOT OMRA as an EOT-R, with an ARD of June 15, 2013. Coding values for Mr. T's EOT-R are: • O0400A5 (SLP start date) is 05312013, • O0400A6 (SLP end date) is 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. 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:

Chapter	Section	Page	Change
			• 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-29	Coding: O0400B1 would be coded 113, O0400B2 would be coded 0, O0400B3 would be coded 80, O0400B3A would be coded 60, O0400B4 would be coded 5, O0400B5 would be coded 10092011, and O0400B6 would be coded with dashes. Rationale: Individual minutes (including 60 co-treatment minutes) totaled 113 over the 7-day look-back period [(30 × 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 10-09-2011 and dashes were used as the therapy end date value because the therapy was ongoing. Coding: O0400C1 would be coded 287, O0400C2 would be coded 100, O0400C3 would be coded 0, O0400C3A would be coded 60, O0400C4 would be coded 5, O0400C5 would be coded 10072011, and O0400C6 would be coded with dashes. Rationale: Individual minutes (including 60 co-treatment minutes) totaled 287 over the 7-day look-back period [(30 × 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 10-07-2011, and dashes were used as the therapy end date value because the therapy was ongoing.
3	O0400	O-30	Page length change.

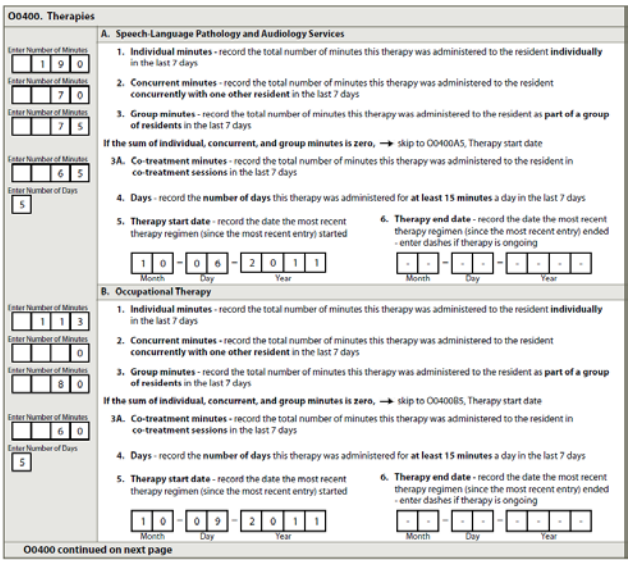
Track Changes
from Chapter 3, Section O V1.10
to Chapter 3, Section O V1.11

Chapter	Section	Page	Change
3	O0400	O-31	New screen shot.

OLD

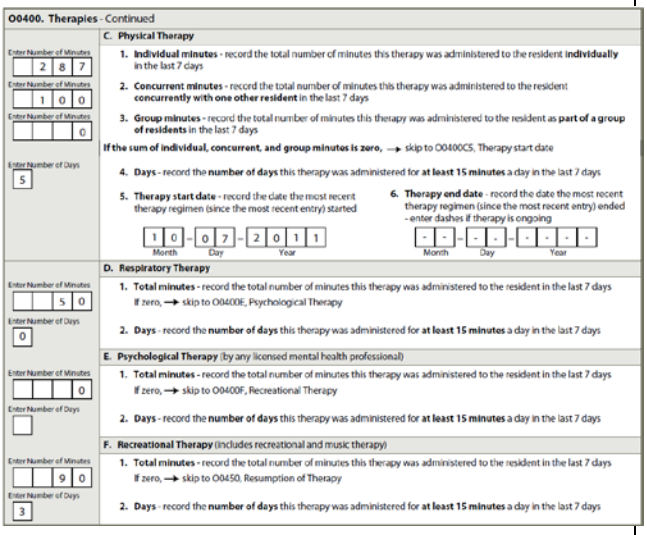


NEW

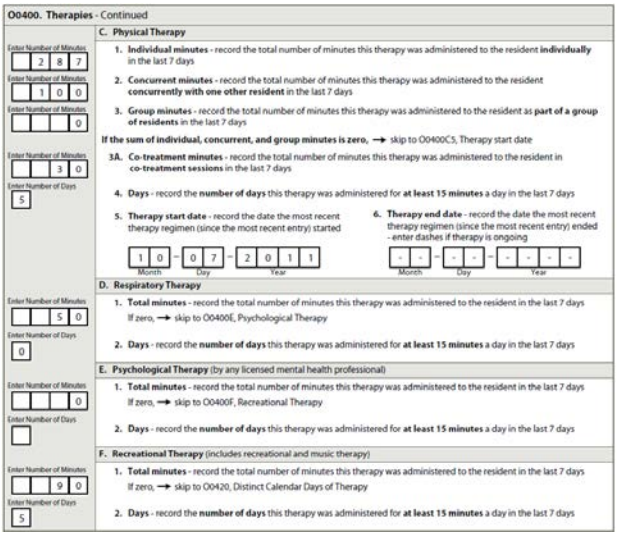


3	O0400	O-32	New screen shot.

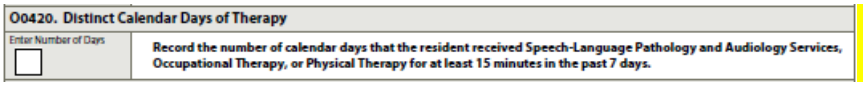
OLD



NEW



3	O0420	O-32 & O-33	O0420: Distinct Calendar Days of Therapy



Item Rationale

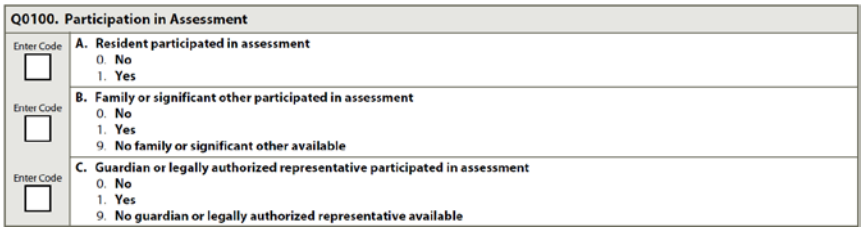
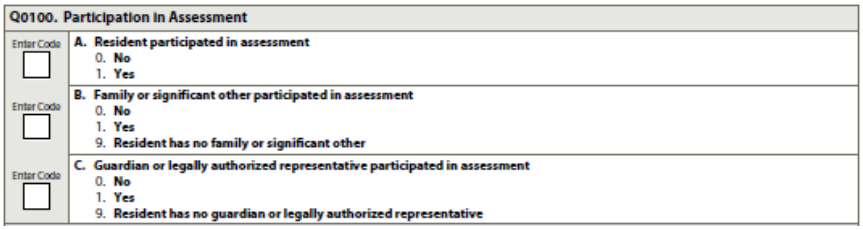
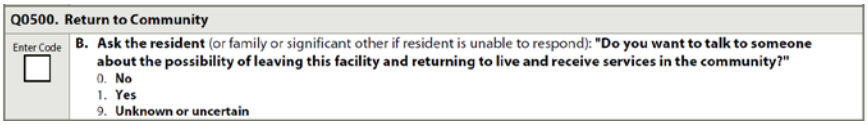
To record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services,

Chapter	Section	Page	Change
			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 3 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 4 distinct calendar days during the 7-day look-back period (i.e., Monday, Wednesday, and Friday).
3	O0450	O-34	~~NOTE: When an EOT-R is completed, the Therapy Start Date (O0400A5, O0400B5, and O0400C5) on the next assessment is the same as the Resumption of Therapy Date (O0450B) on the EOT-R. If therapy is ongoing, the Therapy End Date (O0400A6, O0400B6, and O0400C6) would be filled out with dashes.~~
3	—	O-35	Page number change.
3	O0500	O-36	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.

Track Changes
from Chapter 3, Section O V1.10
to Chapter 3, Section O V1.11

Chapter	Section	Page	Change
			Restorative nursing does not require a physician's order. Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services. In ~~these situations,~~ situations where such services do not actually require the involvement of a qualified therapist, the services may not be coded as therapy in item O0400, Therapies, because the specific interventions are considered restorative nursing services (see item O0400, Therapies). The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.
3	—	O-37 thru O-44	Page number change.

Track Changes
from Chapter 3, Section Q V1.10
to Chapter 3, Section Q V1.11

Chapter	Section	Page	Change
3	Q0100	Q-1	Replaced screen shot. OLD  NEW 
3	Q0100	Q-3	**Coding Instructions for Q0100B, Family or Significant Other Participated in Assessment** • Code 9, Resident has n~~N~~o family or significant other~~ available~~: ~~None of the above – r~~Resident has no family or significant other.
3	Q0100	Q-3	**Coding Instructions for Q0100C, Guardian or Legally Authorized Representative Participated in Assessment** • Code 9, Resident has n~~N~~o guardian or legally authorized representative~~ available~~: ~~None of the above – r~~Resident has no guardian or legally authorized representative.
3	Q0100	Q-3	**Coding Tips** • ~~No family or significant other available means the individual resident has no family or significant other, not that they were not consulted.~~
3	Q0500	Q-14	Replaced screen shot. OLD 

Track Changes
from Chapter 3, Section Q V1.10
to Chapter 3, Section Q V1.11

Chapter	Section	Page	Change
			NEW **Q0500. Return to Community** Enter Code ☐ **B. Ask the resident** (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond): **"Do you want to talk to someone about the possibility of leaving this facility and returning to live and receive services in the community?"** 0. **No** 1. **Yes** 9. **Unknown or uncertain**
3	Q0550	Q-18	Replaced screen shot. OLD **Q0550. Resident's Preference to Avoid Being Asked Question Q0500B Again** Enter Code ☐ **A. Does the resident** (or family or significant other or guardian, if resident is unable to respond) **want to be asked about returning to the community on all assessments?** (Rather than only on comprehensive assessments.) 0. **No** - then document in resident's clinical record and ask again only on the next comprehensive assessment 1. **Yes** 8. **Information not available** Enter Code ☐ **B. Indicate information source for Q0550A** 1. **Resident** 2. If not resident, then **family or significant other** 3. If not resident, family or significant other, then **guardian or legally authorized representative** 8. **No information source available** NEW **Q0550. Resident's Preference to Avoid Being Asked Question Q0500B Again** Enter Code ☐ **A. Does the resident** (or family or significant other or guardian or legally authorized representative if resident is unable to understand or respond) **want to be asked about returning to the community on all assessments?** (Rather than only on comprehensive assessments.) 0. **No** - then document in resident's clinical record and ask again only on the next comprehensive assessment 1. **Yes** 8. **Information not available** Enter Code ☐ **B. Indicate information source for Q0550A** 1. **Resident** 2. If not resident, then **family or significant other** 3. If not resident, family or significant other, then **guardian or legally authorized representative** 8. **No information source available**
3	Q0550	Q-18	**Coding Instructions for Q0550A, Does the resident, (or family or significant other or guardian or legally authorized representative~~,~~ if resident is unable to respond) want to be asked about returning to the community on all assessments? (r~~R~~ather than ~~being asked yearly~~ only on comprehensive assessments.)~~?~~** • **Code ~~9~~8, Information not available:**

Track Changes
from Chapter 3, Section Z V1.10
to Chapter 3, Section Z V1.11

Chapter	Section	Page	Change
3	Z0400	Z-7	**Coding Tips and Special Populations** • 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.
3	Z0500	Z-8	Page length change.

Track Changes
from Chapter 5 V1.10
to Chapter 5 V1.11

Chapter	Section	Page	Change
5	5.2	5-2	• **Completion Timing:** — 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 MDS Completion Date (Z0500B) must be no later than 13 days after the Assessment Reference Date (ARD) (A2300).~~ — For the Admission assessment, the Care Area Assessment (CAA) Completion Date (V0200B2) must be no later more than 13 days after the Entry Date (A1600).~~For the Admission assessment, the Care Area Assessment (CAA) Completion Date (V0200B2) must be no more than 13 days after the Entry Date (A1600).~~
5	5.2	5-2	— 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).

Track Changes
from Chapter 6 V1.09
to Chapter 6 V1.11

Chapter	Section	Page	Change
6	6.5	6-22	The attending physician or a physician on the staff of the skilled nursing home who has knowledge of the case—or a nurse practitioner (NP), physician assistant (PA), ~~-~~or clinical nurse
6	6.6	6-32	At least 5 distinct calendar days of any combination of the three disciplines
6	6.6	6-33	At least 3 distinct calendar days of any combination of the 3 disciplines
6	6.6	6-35	At least 5 distinct calendar days of any combination of the three disciplines At least 3 distinct calendar days of any combination of the three disciplines
6	6.6	6-38	(1) ~~K0700A~~ K0710A3 is 51% or more of total calories OR (2) ~~K0700A~~K0710A3 is 26% to 50% of total calories and ~~K0700B~~K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.
6	6.6	6-40	(1) ~~K0700A~~ K0710A3 is 51% or more of total calories OR (2) ~~K0700A~~ K0710A3 is 26% to 50% of total calories and ~~K0700B~~K0710B3 is 501 cc or more per day fluid enteral intake in the last 7 days.
6	6.6	6-49	**Situation 2** If the Z0100A classification for an SOT OMRA (Item A0310C = 1), ***not combined*** with an OBRA assessment or other PPS assessment, ***is not*** in a Rehabilitation Plus Extensive Services group or a Rehabilitation group, then the following adjustment applies:
6	6.6	6-55	**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 scheduled 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/her SNF benefit period. The SNF must set the ARD for the PPS assessment on December 11, 12, or 13 to bill for the RUG category associated with the assessment. A SNF may use a date outside the SNF Part A Medicare Benefit (i.e., 100 days) as the ARD for an unscheduled PPS assessment, but only in the case where the ARD for the unscheduled assessment falls on a day that is not counted among the beneficiary's 100 days due to a leave of absence (LOA), as defined in Chapter 2, sections 2.4 and 2.13, and the resident returns to the facility from the LOA on Medicare Part A. For example, Day 7 of the COT observation period occurs 7 days following the ARD of the most recent PPS assessment used for

Chapter	Section	Page	Change
			payment, regardless if a LOA occurs at any point during the COT observation period. If the ARD for a resident's 30-day assessment were set for November 7 and the resident went to the emergency room at 11:00pm on November 14, returning on November 15, Day 7 of the COT observation period would remain November 14 for purposes of coding the COT OMRA.

Track Changes
from Appendix A V1.09
to Appendix A V1.11

Chapter	Section	Page	Change
Appendix A		A-5	~~Any void into a commode, urinal, or bedpan that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting.~~ Any void that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting.