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MDS Basics Workshop 2026
Intro to RAI and line by line coding

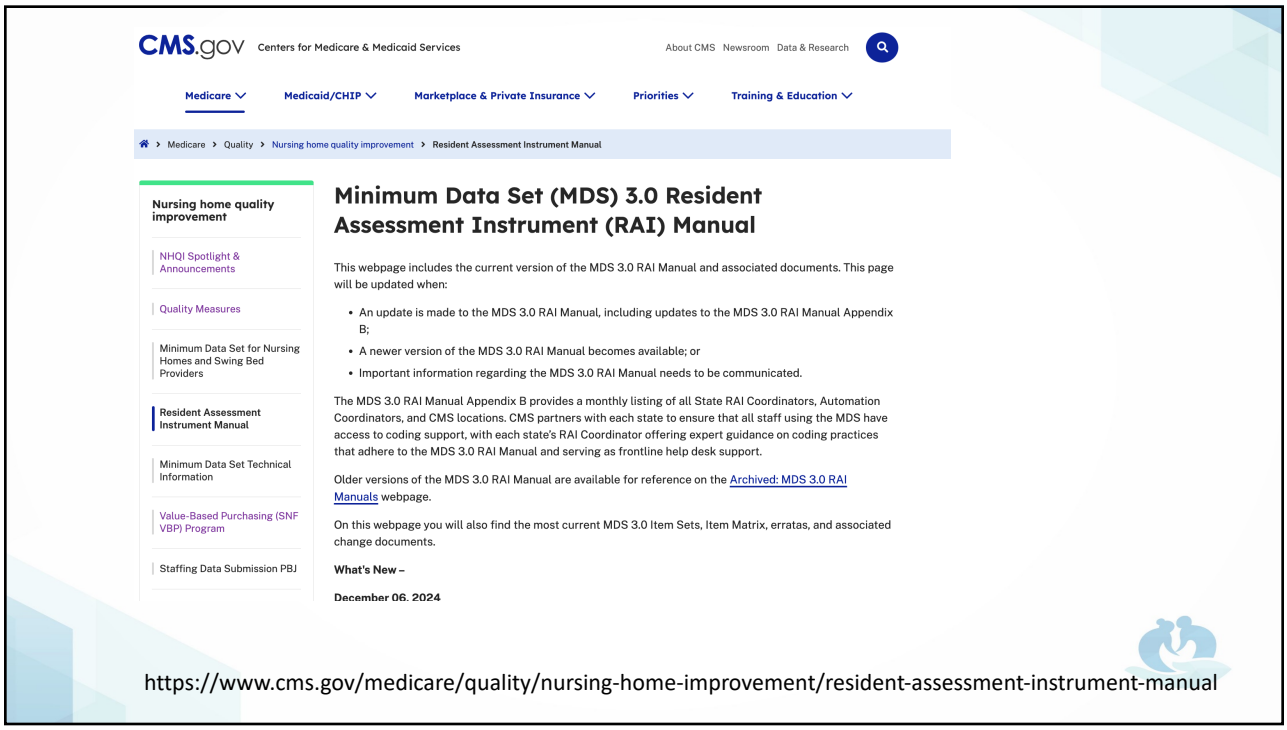
WilhideConsulting
Respect the Aged

1

Objectives

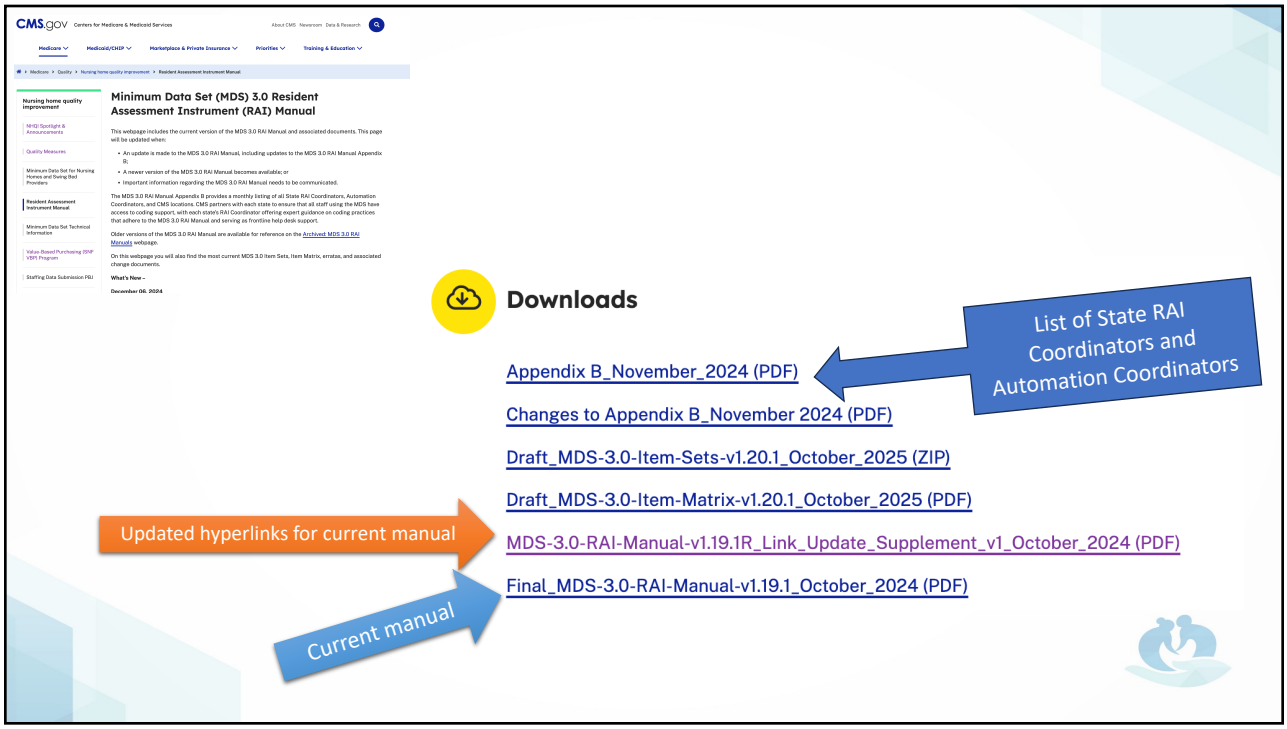
- Introduce the Resident Assessment Instrument
- Explain F641, MDS Accuracy and F642, Coordination of assessments
- List the uses of the MDS
- Understand the layout of the RAI manual and how to use it
- Explain key terms: Assessment Reference Date, Look back period, Assessment completion
- Understand what the signatures mean in Z0400, Z0500, V0200B, V0200C
- Introduce the Casper Reporting User's Guide and the MDS Provider User's Guide at QTSO.CMS.Gov
- Explain the Final Validation Report
- Explain tracking records and OBRA Discharge Assessments
- Learn to use the RAI manual by reviewing line by line coding instructions for major sections of the MDS:
  - B: Hearing, speech, vision
  - GG Functional Abilities and Goals
  - H: Bladder and Bowel
  - I: Active Diagnoses
  - J: Health Conditions
  - M: Skin Conditions
  - N: Medications
  - O: Special Treatments, Procedures and Programs
  - P: Restraints and Alarms

2



https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual

3



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RAI: Resident Assessment Instrument = Comprehensive MDS

RAI Process:

1. MDS: Comprehensive Minimum Data Set
2. CAA: Care Area Assessment Process
3. Utilization Guidelines (Content of RAI Manual & Survey regulations)

5

Survey Regulations

- Federal regulations for long term care facilities
- Guidance to surveyors to assist in determining deficient practices

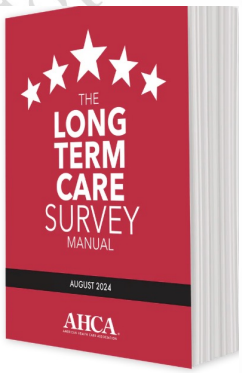
Other names:

- Conditions of Participation (or revised conditions of participation
- Survey Book

Appendix PP: https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/policy-memos-states/revised-long-term-care-ltc-surveyor-guidance-significant-revisions-enhance-quality-and-oversight-ltc

State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities

Table of Contents



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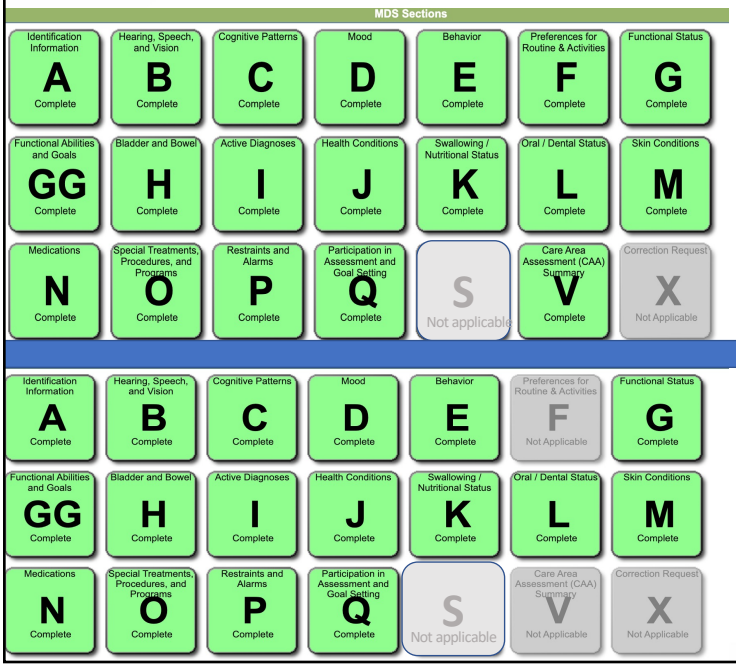
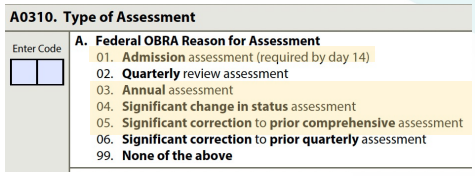
What's a comprehensive MDS assessment?

Comprehensive = Resident Assessment Instrument





The Quarterly & Significant correction to prior quarterly are not comprehensive assessments. Section F and V are missing entirely, some other sections are shorter.

Kansas

7

OBRA MDS: Designated by Omnibus Reconciliation Act (OBRA) of 1987

- Core set of
  - screening,
  - clinical, and
  - functional status elements
- Primary purpose of OBRA assessment is to identify resident care problems that are addressed in a written, resident-centered comprehensive plan of care

<u>Forms the foundation</u> of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid.

Page 1 - 6

8

Care Area Assessment (CAA) Process

- Assists to systematically interpret information recorded on the **comprehensive MDS**.
  - Admission, Annual, Significant Change
- If care area has been triggered, we conduct an assessment of the potential problem and ***determine whether or not to care plan for it.***
- Helps focus on key issues so that decisions as to whether and how to intervene can be explored with the resident.

9

F641 §483.20(g) Accuracy of Assessment

- The assessment must accurately reflect the resident's status.
- Coordination: A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.
  - Certification.
  - (1) A registered nurse must sign and certify that the assessment is completed.
  - (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.
  - Penalty for Falsification.
    - Under Medicare and Medicaid, an individual who willfully and knowingly—
      - Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or
      - (Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.
    - Clinical disagreement does not constitute a material and false statement.

10

GUIDANCE §483.20(g)

- *"Accuracy of Assessment"* means appropriate, qualified health professionals correctly document the resident's medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (RAI) (i.e. comprehensive, quarterly, significant change in status).
- *Facilities are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.*

11

F641: Accuracy of Assessment: ***GUIDANCE*** continued

- The assessment must represent an accurate picture of the resident's status during the observation period of the MDS.
  - The Observation Period (also known as the Look-back period) is the time period over which the resident's condition or status is captured by the MDS assessment and ends at 11:59 p.m. on the day of the Assessment Reference Date (ARD). Be aware that different items on the MDS have different Observation Periods.
- When the MDS is completed, only those occurrences during the observation period will be captured on the assessment. In other words, if it did not occur during the observation period, it is not coded on the MDS.

12

Guidance Continued: Inaccurate MDS Diagnosis Coding

CMS is aware of situations where residents are given a diagnosis of schizophrenia without sufficient supporting documentation that meets the criteria in the current version of the DSM for diagnosing schizophrenia. For these situations, determine if non-compliance exists for the facility's completion of an accurate assessment. This practice may also require referrals by the facility and/or the survey team to State Medical Boards or Boards of Nursing.

Surveyors should investigate this concern through record review and interviews with staff who completed the assessment. Surveyors are not questioning the physician's medical judgement, but rather, they are evaluating whether the medical record contains supporting documentation for the diagnosis to verify the accuracy of the resident assessment.

13

Inaccurate MDS Diagnosis Coding

If the facility is unable to provide documentation which supports the MDS coding of the new diagnosis in question, then noncompliance exists at F641. Supporting documentation should include, but is not limited to, evaluation(s) of the resident's physical, behavioral, mental, psychosocial status, and comorbid conditions, ruling out physiological effects of a substance (e.g., medication or drugs) or other medical conditions, indications of distress, changes in functional status, resident complaints, behaviors, symptoms, and/or state Preadmission Screening and Resident Review (PASARR) evaluation.

14

Inaccurate MDS Diagnosis Coding

One or two assessments with *inaccurate MDS diagnosis coding* should be cited as isolated. If the surveyor identifies a *pattern (i.e., three or more)* of inaccurate coding for *any new diagnosis (such as schizophrenia) with no supporting documentation by a physician*, the surveyor should cite the scope of the non-compliance at a minimum of pattern or widespread as appropriate, make a referral to the State Board of Nursing, and see the *guidance below* in Investigative Procedures for making a referral to the Office of the Inspector General.

15

Inaccurate MDS Diagnosis Coding

Surveyors are expected to focus on MDS coding accuracy but are not expected to investigate possible falsification of the resident assessment instrument. If the surveyor identifies a pattern (i.e., three or more residents) of inaccurate MDS coding by staff who completed, signed, and certified to the accuracy of the portion of the assessment they completed, and *there are indications or concerns that the individual who completed the section(s) in question knew the coding was inaccurate*, a referral should be made to the Office of Inspector General for investigation of falsification per §483.20(j). See the Submit a Hotline Complaint section, under the Fraud tab, on the Department of Health & Human Services Office of the Inspector General's Office webpage at https://oig.hhs.gov/fraud/report-fraud/index.asp.

16

PROBES §483.20(g): Questions for surveyors to answer about their investigation of MDS Accuracy

- Based on your total review of the resident, observations, interviews and record reviews, does each portion of the MDS assessment accurately reflect the resident's status as of the Assessment Reference Date?
- Is there evidence that the health professionals who assessed the resident had the skills and qualifications to conduct the assessment? For example, has the resident's nutritional status been assessed by someone who is knowledgeable in nutrition and capable of correctly assessing a resident?

17

Guidance continued:

- Each resident's assessment will be coordinated by and certified as complete by a registered nurse, and all individuals who complete a portion of the assessment will sign and certify to the accuracy of the portion of the assessment he or she completed.
- Guidance: …each individual assessor is responsible for certifying the accuracy of responses relative to the resident's condition and discharge or entry status…

18

F641 *GUIDANCE §483.20(h)-(j)*

- **Backdating Completion Dates** is not acceptable – note that recording the actual date of completion is not considered backdating.
  - For example, if an MDS was completed electronically and a hard copy was printed two days later, writing the date the MDS was completed on the hard copy is not considered backdating.
- Patterns of MDS Assessment and Submissions: MDS information serves as the clinical basis for care planning and care delivery and provides information for Medicare and Medicaid payment systems, quality monitoring and public reporting. MDS information as it is reported impacts a nursing home's payment rate and standing in terms of the quality monitoring process. ***A willfully and knowingly-provided false assessment may be indicative of payment fraud or attempts to avoid reporting negative quality measures***.
- All information recorded within the MDS Assessment must reflect the resident's status at the time of the Assessment Reference Date (ARD).

19

Guidance:

- A pattern of clinical documentation or of MDS assessment/reporting practices that result in:
  - Higher Resource Utilization Group (RUG) scores
  - Untriggering Care Area Assessments (CAAs)
  - Unflagging Quality Measures (QMs)

  where the information **does not accurately reflect the resident's status**, may be indicative of payment fraud or attempts to avoid reporting negative quality measures.

20

Guidance

- Such practices may include, but are not limited to, a pattern or high prevalence of the following:
  - Submitting inaccurate MDS Assessments
  - Submitting correction(s) to previously submitted MDS data , where corrected information is inaccurate per medical record
  - Submitting Significant Correction Assessments where the assessment it claims to correct does not appear to have been in error
  - Submitting Significant Change in Status Assessments where the criteria for significant change in the resident's status do not appear to be met
  - Delaying or withholding MDS Assessments from the QIES ASAP (iQIES) system.
    - *Quality Improvement Evaluation System Assessment Submission and Processing (QIES ASAP): MDS national repository*

21

Additional Uses of the MDS

Medicare and Medicaid Payment Systems: Certain items on certain types of MDS assessments are used to determine resident acuity. Dollar amounts are tied to different acuity levels

- Medicare: Skilled Nursing Facility Prospective Payment System (SNF PPS) Medicare reimbursement system:
  - Patient Driven Payment Model (PDPM): PPS Assessments are completed to set payment rates for Medicare Part A skilled residents.
    - PPS 5 day (A0310B = 01)
    - Interim Payment Assessment (A0310B = 08
- Some State Medicaid systems use an MDS or an OSA (optional state assessment) in their state payment systems.

Page 1-7

22

Other MDS uses: Quality Measurement

MDS-based QMs

- Care Compare Public Website at Medicare.gov
- SNF Quality Reporting Program (QRP)
- Five Star Rating System
- Facility QM Reports (iQIES)

Claims-Based QMs

- Medicare claims data
- Use selected MDS items for risk-adjustment
- Care Compare Public Website at Medicare.gov
- Five Star Rating System
- SNF Quality Reporting Program (QRP)
- SNF Value Based Purchasing (VBP)

National Health Safety Network reported QMs

- Staff Influenza and Covid Vaccine data submitted directly to NHSN
- No MDS data used to calculate these measures

23

RAI Manual

Chapter 1: General overview, background

Chapter 2:

- Assessment types and definitions
- OBRA and PPS scheduling
- Tracking forms & Discharge assessments
- Timing requirements
- Imperative to understand this chapter for OBRA and PPS scheduling, combinations, etc.

Chapter 3: Line by line coding instructions: Required to complete the MDS

Chapter 4: CAAs and Care Planning: Instructions for working CAAs and completing care plans

Chapter 5: Modifications, Inactivations, Transmittal rules and links to the qtso.cms.gov website

Chapter 6:

- PDPM grouper
- Medicare rules
- PPS payment rules
- Rules for non-compliance with PPS schedule

24

RAI Manual

- Appendix A: Glossary
- Appendix B: State Agency and CMS Regional Office RAI/MDS Contacts
- Appendix C: Care Area Assessment (CAA) Resources
- Appendix D: Interviewing to Increase Resident Voice in MDS Assessments
- Appendix E: PHQ-9 Scoring Rules and Instruction for BIMS (When Administered In Writing)
- Appendix F: Item Matrix
- Appendix G: References
- Appendix H: MDS 3.0 Item Sets

25

How to Use the RAI manual for accurate coding

- Chapter 3: Line by line coding instructions by MDS section

Chapter 3: Overview to the Item-by-Item Guide to the MDS 3.0

26

Coding instructions for each MDS section have the same format:

- Intent
- Screenshot of each item in the section
  - Rationale for that item

Go to Section M Chapter 3

SECTION M: SKIN CONDITIONS

Intent: The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure. A complete assessment of skin is essential to an effective pressure ulcer prevention and skin treatment program. Be certain to include in the assessment process, a holistic approach. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.

CMS is aware of the array of terms used to describe alterations in skin integrity due to pressure. Some of these terms include: pressure ulcer, pressure injury, pressure sore, decubitus ulcer, and bed sore. Acknowledging that clinicians may use and documentation may reflect any of these terms, it is acceptable to code pressure-related skin conditions in Section M if different terminology is recorded in the clinical record, as long as the primary cause of the skin alteration is related to pressure. For example, if the medical record reflects the presence of a Stage 2 pressure injury, it should be coded on the MDS as a Stage 2 pressure ulcer.

M0100: Determination of Pressure Ulcer/Injury Risk

M0100. Determination of Pressure Ulcer/Injury Risk	
↓ Check all that apply	
☐	A. Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device
☐	B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)
☐	C. Clinical assessment
☐	Z. None of the above

Item Rationale

Health-related Quality of Life

- Pressure ulcers/injuries occur when tissue is compressed between a bony prominence and an external surface. In addition to pressure, shear force, and friction are important contributors to pressure ulcer/injury development.
- The underlying health of a resident's soft tissue affects how much pressure, shear force, or friction is needed to damage tissue. Skin and soft tissue changes associated with aging, illness, small blood vessel disease, and malnutrition increase vulnerability to pressure ulcers/injuries.
- Additional external factors, such as excess moisture, microclimate, and tissue exposure to urine or feces, can increase risk.

Planning for Care

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

27

Examples: Some items have examples after the Coding Tips or Coding Instructions: These also can change what the coding instructions seemed to be saying.

Summary:

- Steps for Assessment
- Coding Instructions
- Coding Tips
- Examples

All must be read and understood to achieve MDS accuracy.

Examples

1. Ms. K is admitted to the facility without a pressure ulcer/injury. During the stay, she develops a stage 2 pressure ulcer. This is a **facility acquired** pressure ulcer and was **not "present on admission."** Ms. K is hospitalized and returns to the facility with the same stage 2 pressure ulcer. This pressure ulcer was **originally acquired in the nursing home** and **should not be considered as "present on admission"** when she returns from the hospital.

2. Mr. J is a new admission to the facility and is admitted with a stage 2 pressure ulcer. This pressure ulcer is considered as "**present on admission**" as it was **not acquired in the facility**. Mr. J is hospitalized and returns with the same stage 2 pressure ulcer, unchanged from the prior admission/entry. This pressure ulcer is **still considered "present on admission"** because it was **originally acquired outside the facility** and has not changed.

28

Assessment Reference Date (ARD): The last day of the observation (or "look back") period that the assessment covers for the resident. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period.

- The facility is required to set the ARD on the MDS Item Set or in the facility software within the required timeframe of the assessment type being completed. This concept of setting the ARD is used for all assessment types (OBRA and Medicare-required PPS) and varies by assessment type and facility determination.
- Most items have a 7 day look back period. If a resident has an ARD of July 1, 2011 then all pertinent information starting at 12 AM on June 25th and ending on July 1st at 11:59PM should be included for MDS 3.0 coding Page 2-9

Observation (Look Back) Period: Time period over which resident's condition or status is captured by the MDS assessment. When the resident is first admitted to the nursing home, the RN assessment coordinator and the IDT will set the ARD. For subsequent assessments, the observation period for a particular assessment for a particular resident will be chosen based upon the regulatory requirements concerning timing and the ARDs of previous assessments. Most MDS items themselves require an observation period, such as 7 or 14 days, depending on the item. Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the observation period must also cover this time period. When completing the MDS, only those occurrences during the look back period will be captured. In other words, if it did not occur during the look back period, it is not coded on the MDS. Page 2-14

29

Assessment Reference Date (ARD) A2300

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21 ARD
22	23	24	25	26	27	28

When completing the MDS, only those occurrences during the look back period will be captured. In other words, if it did not occur during the look back period, it is not coded on the MDS. 2-14

30

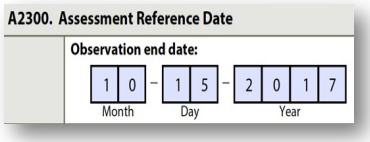
Assessment Completion refers to the date that all information needed has been collected and recorded for a particular assessment type and staff have signed and dated that the assessment is complete.

- For Comprehensive assessments, "completion" is completion of the CAA process in addition to the MDS items, meaning that the RN assessment coordinator has signed and dated both the MDS (Item Z0500) and CAA(s) (Item V0200B) completion attestations.
- For non-comprehensive and Discharge assessments, assessment completion is defined as completion of the MDS only, meaning that the RN assessment coordinator has signed and dated the MDS (Item Z0500) completion attestation.
- Completion requirements are dependent on the assessment type and timing requirements. Scheduling requirements are in Chapter 2 of the RAI Manual.

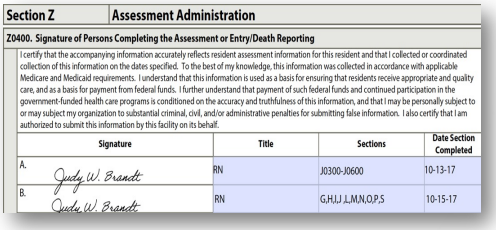
31

Timeframes for Completion Non-comprehensive

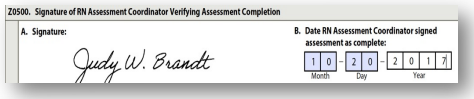
End-point for look-back



Signature attesting to accuracy



RN attesting to completion



32

Section Z Assessment Administration

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

	Signature	Title	Sections	Date Section Completed
A.	*Judy Wilhide Brandt*	*Dietitian*	K	August 7, 2015
B.				

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.

Z-6

33

Item Rationale

- To obtain the signature of all persons who completed any part of the MDS. ***Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response***. Each person completing a section or portion of a section of the MDS *is required* to sign the Attestation Statement.

The importance of accurately completing and submitting the MDS cannot be over-emphasized.

Z-6

34

Key Point

- When you transmit an MDS you are submitting to the federal and state governments (survey and case mix):
  - Payment data
  - Quality measurement data
  - Survey data
  - Resident characteristic data
- The legal assumption is that it's accurately coded by someone who knew how to do it.
- The stakes are very high.
- Don't let anyone push you to sacrifice accuracy for speed or anything else.

35

Z0500 MDS Completion Z-8

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion

A. Signature: Judy Brandt, RN

B. Date RN Assessment Coordinator signed assessment as complete: 01 – 06 – 2015 (Month – Day – Year)

Item Rationale: Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete.

Steps for Assessment

1. Verify that all items on this assessment are complete.
2. Verify that Item Z0400 (Signature of Persons Completing the Assessment) contains attestation for all MDS sections.

Coding Instructions

- For Z0500B, use the actual date that the MDS was completed, reviewed, and signed as complete by the RN assessment coordinator. This date 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.

36

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.***

37

CAA & Care Plan Completion

A. CAA Results

Care Area	A. Care Area Triggered	B. Care Planning Decision	Location and Date of CAA documentation
	↓ Check all that apply ↓		
01. Delirium	☒	☒	See CAA Summary on Review of Indicators 1/2/15
02. Cognitive Loss/Dementia	☒	☒	See nursing notes by J. Brandt 1/3/15
03. Visual Function	☒	☐	See MD progress note 1/3/15, Nsg note 1/4/15
04. Communication	☐	☐	
05. ADL Fu[illegible]habilitation			

B. Signature of RN Coordinator for CAA Process and Date Signed

1. Signature: Judy W. Brandt, RN
2. Date: 01 (Month) – 17 (Day) – 2015 (Year)

C. Signature of Person Completing Care Plan Decision and Date Signed

1. Signature: Sally Smith, LPN
2. Date: 01 (Month) – 20 (Day) – 2015 (Year)

38

Coding Instructions for V0200A, CAAs

- Use the CAA process to assess each triggered care area and document the resident's status. *Refer to Chapter 4 for detailed instructions on the CAA process, care planning, and documentation.*
- **Complete the Care Planning Decision column within 7 days after finishing the RAI, as noted by the date in V0200C2, marking when the care planning decision(s) and the resident's care plan were finalized.**
- For each triggered care area, record the date and location of CAA documentation in the appropriate column. *See Chapter 4 for more information on the CAA process, care planning, and documentation.*

V-5

39

Coding Instructions for V0200B, Signature of RN Coordinator for CAA Process and Date Signed

V0200B1, Signature

- Signature of the RN coordinating the CAA process.

V0200B2, Date

- Date that the RN coordinating the CAA process certifies that the CAAs have been completed. The CAA review must be completed no later than the 14th day of admission (admission date + 13 calendar days) for an Admission assessment and within 14 days of the Assessment Reference Date (A2300) for an Annual assessment, Significant Change in Status Assessment, or a Significant Correction to Prior Comprehensive Assessment. This date is considered the date of completion for the RAI.

V-5

40

Coding Instructions for V0200C, Signature of Person Completing Care Plan Decision and Date Signed

V0200C1, Signature

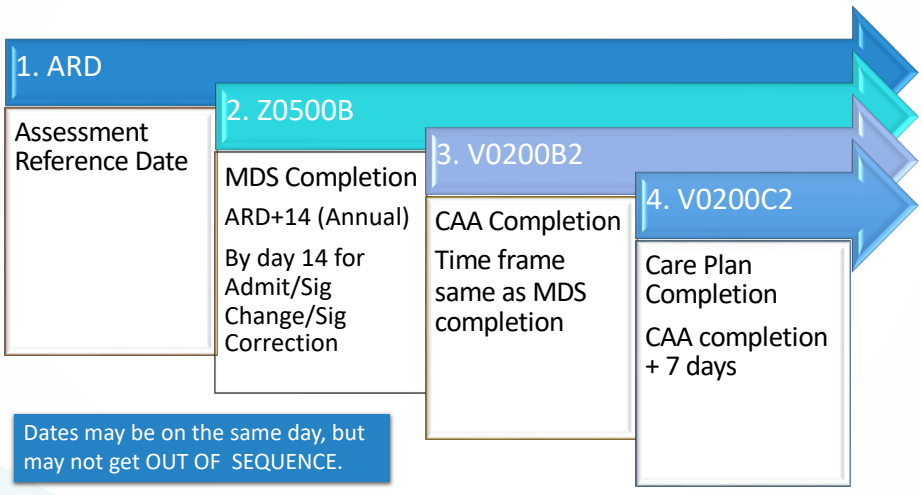
- Signature of the staff person facilitating the care planning decision-making. Person signing does not have to be an RN.

V0200C2, Date

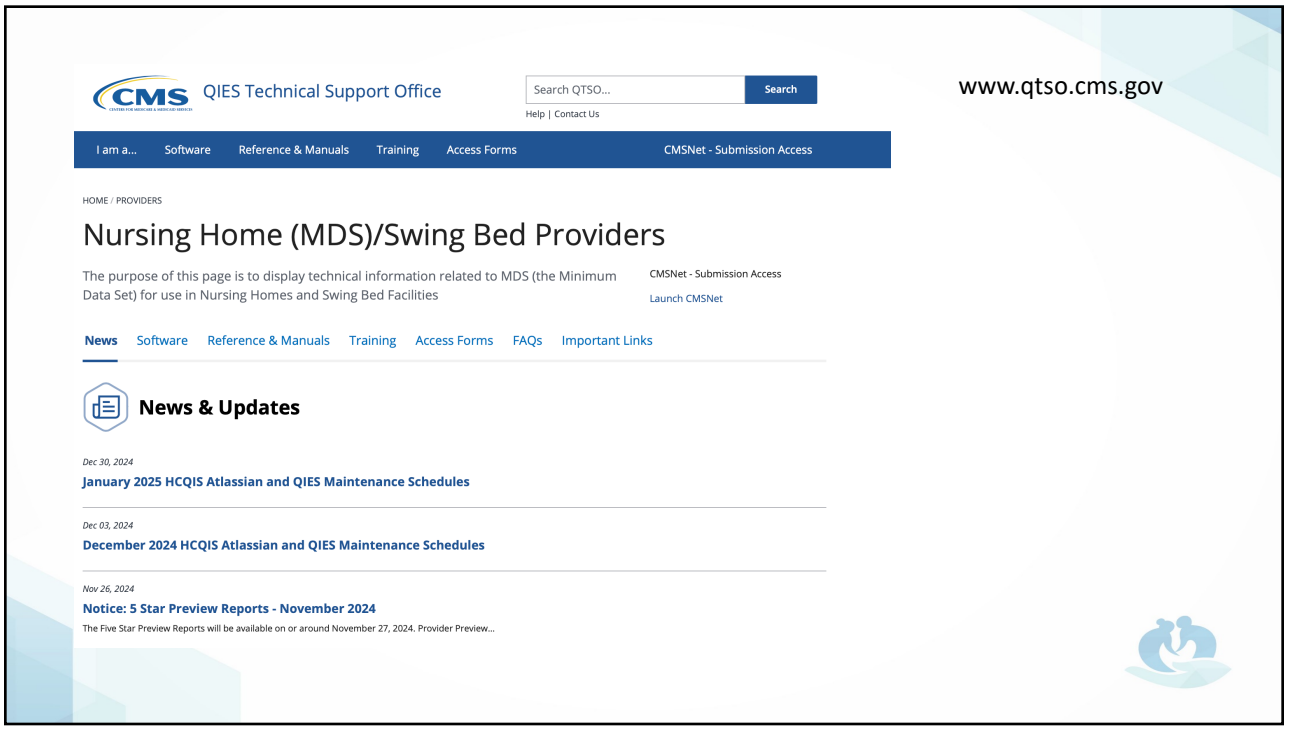
- The date on which a staff member completes the Care Planning Decision column (V0200A, Column B), which is done *after the care plan is completed*. The care plan must be completed within 7 days of the completion of the comprehensive assessment (MDS and CAAs), as indicated by the date in V0200B2.

41

Timeframes for Comprehensive



42



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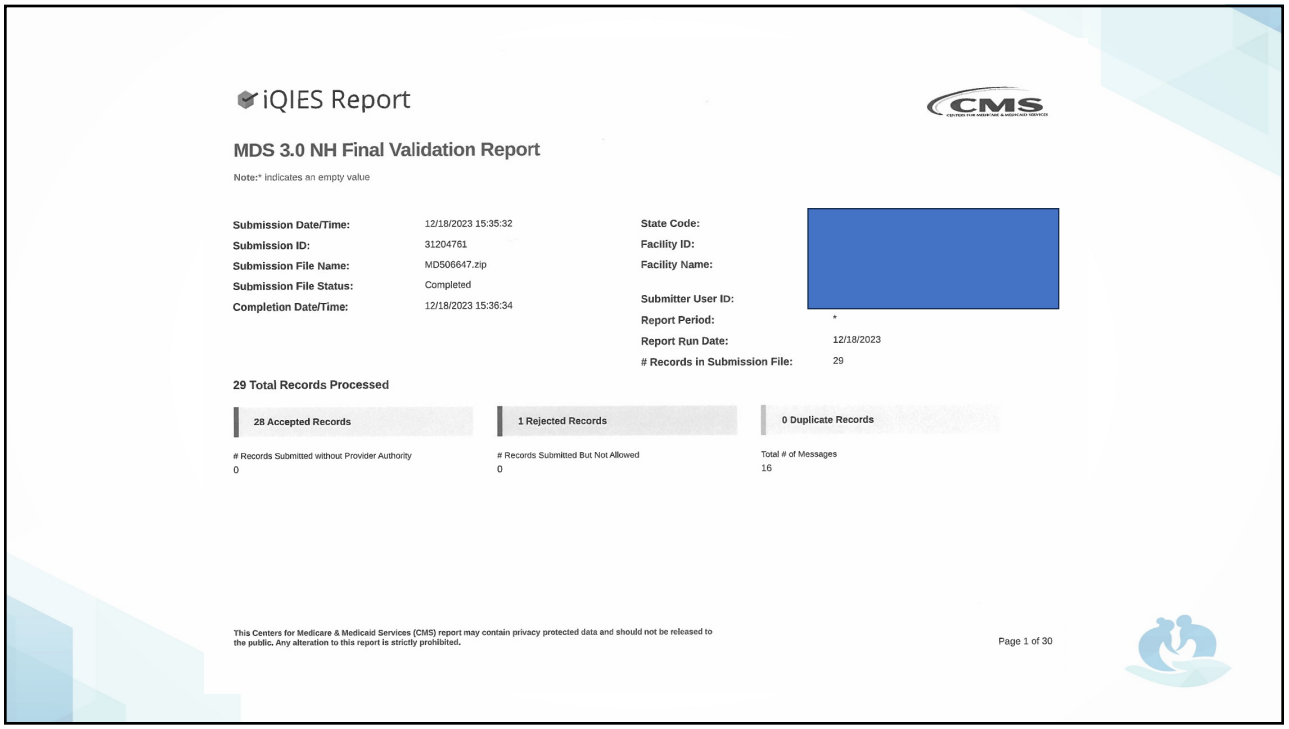
43



44

MDS 3.0 NH Final Validation Report

iQIES Report

Record	Status	Name	XML File Name
2	Accepted		506647_2.xml

Asmt_ID:	312497255			**Name:**	
Res_Int_ID:	6050724			**SSN:**	
A0200:	1	**A0300B:**	*	**Medicare Num:**	5FW8YF0EH62
A0300A:	0	**A0310B:**	01	**A0050:**	NEW RECORD
A0310A:	01	**A0310D:**	*	**Target Date:**	12/10/2023
A0310C:	*	**A0310F:**	99	**Attestation Date (X1100E):**	^
A0310E:	1	**A0310H:**	0	**Data Specs Version #:**	3.01
A0310G:	^				
Item Subset Code:	NC				

MDS 3.0 Item(s):	A1005X
Item Values:	Old: 0 New: 1
Message Number:	-1031
Message Type:	Warning
Message:	Resident Information Mismatch: Submitted value(s) for the item(s) listed do not match the values in the iQIES database. If the record was accepted, the resident information in the database was updated. Verify that the new information is correct.

45

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Centers for Medicare & Medicaid Services

Internet Quality Improvement and Evaluation System (iQIES)

Reports User Manual

Version 2.3

April 17, 2023

MDS			
MDS 3.0 QM Package	Package Reports	Quality Measure	Allows users to run one or multiple MDS 3.0 Quality Measure reports using the same report criteria selections for one or more providers in a single report request. All data for the selected reports will be returned in files separated by provider.
MDS 3.0 Activity	Provider	Submission	Displays a list of accepted assessments, tracking records and inactivation requests that were submitted by the requested facility(ies) for the time frame selected.

46

Centers for Medicare & Medicaid Services

Internet Quality Improvement Evaluation System (iQIES)

Minimum Data Set (MDS)
Error Message
User Guide

Version 1.0
April 17, 2023

Error ID	Error Message	Severity	Type	Potential Cause	Tips /Action
-3810a	Record Submitted Late: The submission date is more than 14 days after A1600 on this new (A0050 equals 1) entry tracking record (A0310F equals 01).	Warning	**Consistency**	Based upon the values submitted in items A0310A (Federal OBRA Reason for Assessment), A0310F (Entry/discharge reporting), A0050 (Type of Record) and one or more date items, the assessment was not completed within CMS timing guidelines.	**Tips:** IF A0310F is 01 and A0050 is 1 and the submission date is more than 14 days after A1600 (Entry Date), THEN this record was submitted late.
-3810b	Record Submitted Late: The submission date is more than 14 days after A2000 on this new (A0050 equals 1) death in facility tracking record (A0310F equals 12).	Warning	**Consistency**	Based upon the values submitted in items A0310A (Federal OBRA Reason for Assessment), A0310F (Entry/discharge reporting), A0050 (Type of Record) and one or more date items, the assessment was not completed within CMS timing guidelines.	**Tips:** IF A0310F is 12 and A0050 is 1 and the submission date is more than 14 days after A2000 (Discharge Date), THEN this record was submitted late.

47

Coding Major Sections of the MDS

Chapter 3 RAI Manual

48

A2300: Assessment Reference Date

- Designates the end of the look-back period.
- Serves as the reference point for determining what care and services are captured on the MDS assessment.
- Look-back period includes observations and events through midnight of the ARD,
  - including LOA if specific MDS item instructions permit.
- When resident dies/is discharged prior to the end of the look-back period for a required assessment, the ARD must be adjusted to equal the discharge date.

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

49

ARD Example

1	2	3	4	5	6	7
8	9	10	11 **ARD**	12	13	14
15	16	17	18	19	20	21

Anything that happens
- After the ARD, or
- Before the lookback period

Will not be captured on the MDS.

Preadmission Data is not captured unless the specific MDS item allows it.

Lookback is 7 days unless specific MDS item instructions designate different timeframe.

50

Most Recent Admission/Entry or Reentry into this Facility

A1600. Entry Date

Month – Day – Year

A1700. Type of Entry

Enter Code

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

A1800. Entered From

Enter Code

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

Very important to code all this info correctly!

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

Month – Day – Year

First, we need to explain tracking records and discharge assessment

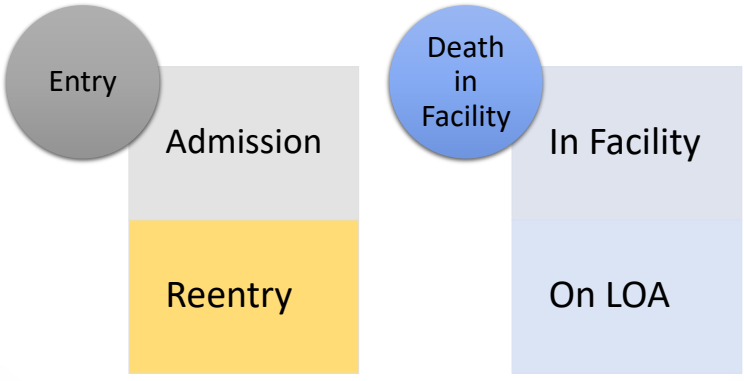
51

Tracking Records

Enter Code: 0 1 or 1 2

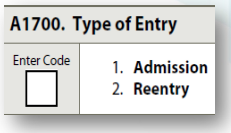
F. Entry/discharge reporting

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



52

Tracking Records



Entry

- Admission
- Reentry

- Contains:
  - Demographic information
  - Date entered
  - "Entered From"
  - Medicare Part A stay dates
- Must be:
  - Completed NLT 7 days from entry
  - Transmitted NLT 14 days from entry

53

OBRA Discharge assessment: Used to Track Quality, shorter than Quarterly

Return Anticipated

- Completed when resident is discharged and expected to return in 30 days.
  - Hospital
  - Respite

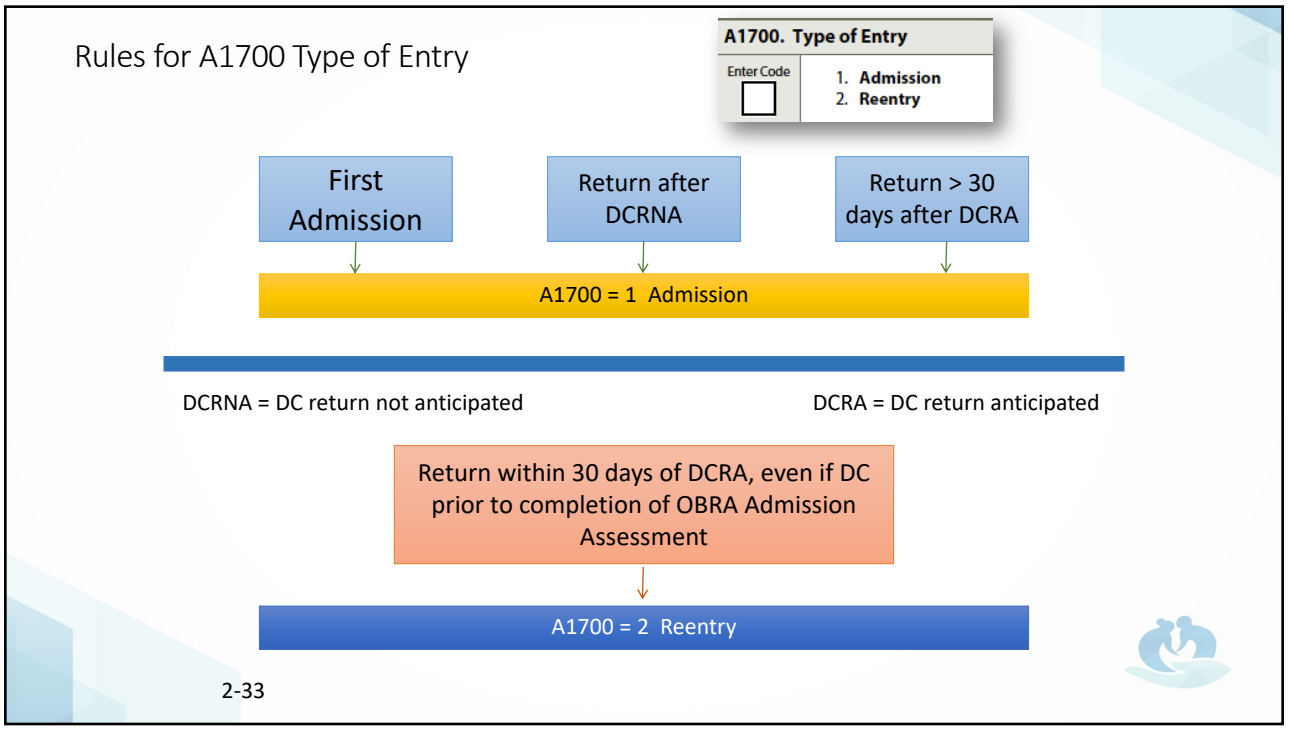
Return Not Anticipated

- Completed when resident is discharged and not expected to return in 30 days.

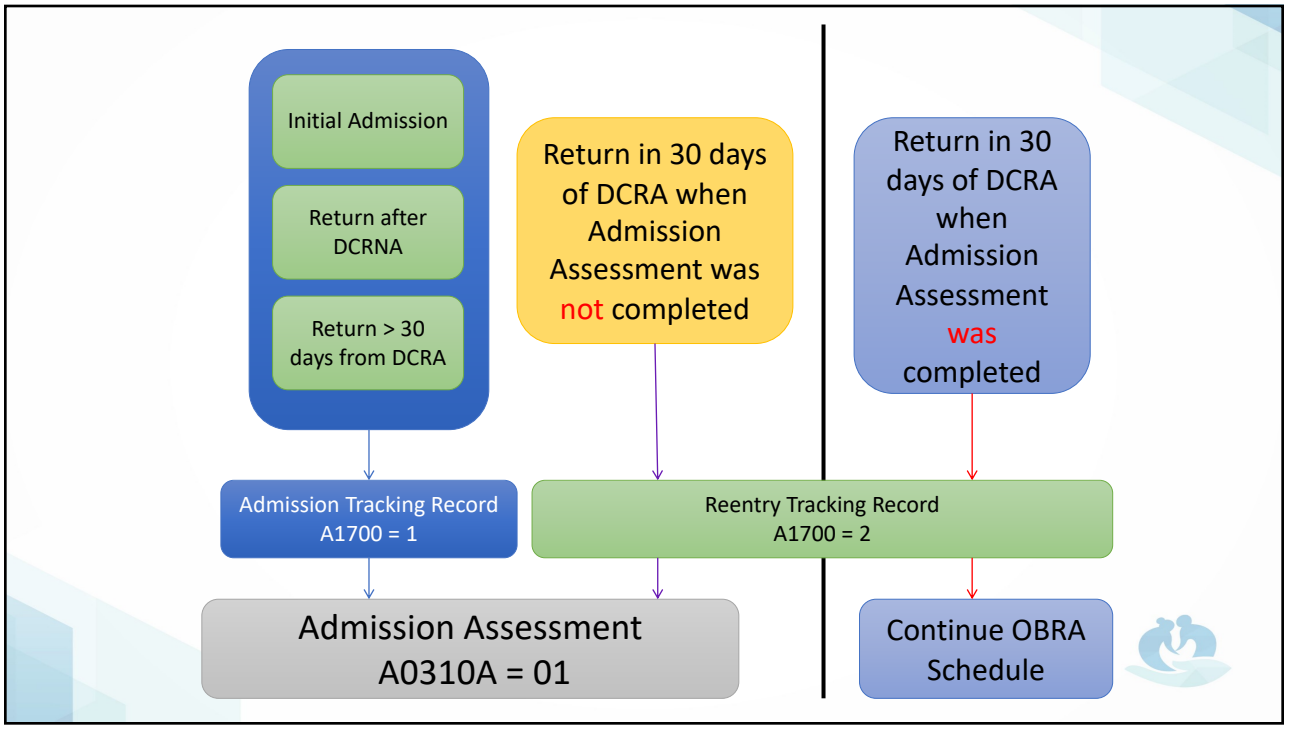
Must be competed (Z0500b) within 14 days of discharge date.
Must be submitted within 14 days of completion.

2-37

54

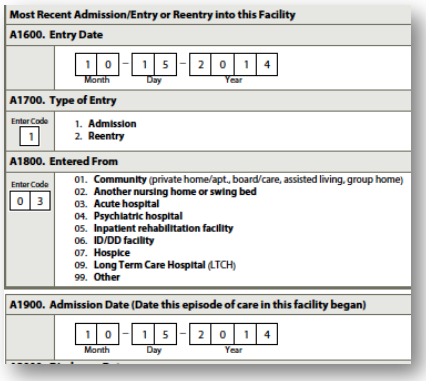

Rules for A1700 Type of Entry
A1700. Type of Entry
Enter Code
1. Admission
2. Reentry
First Admission
Return after DCRNA
Return > 30 days after DCRA
A1700 = 1 Admission
DCRNA = DC return not anticipated
DCRA = DC return anticipated
Return within 30 days of DCRA, even if DC prior to completion of OBRA Admission Assessment
A1700 = 2 Reentry
2-33

55


Initial Admission
Return after DCRNA
Return > 30 days from DCRA
Return in 30 days of DCRA when Admission Assessment was not completed
Return in 30 days of DCRA when Admission Assessment was completed
Admission Tracking Record A1700 = 1
Reentry Tracking Record A1700 = 2
Admission Assessment A0310A = 01
Continue OBRA Schedule

56

New Episode starts with entry tracking record coded as "Admission A1700 = 1"



Most Recent Admission/Entry or Reentry into this Facility

A1600. Entry Date

10 – 15 – 2014
Month Day Year

A1700. Type of Entry

Enter Code: 1

1. Admission
2. Reentry

A1800. Entered From

Enter Code: 03

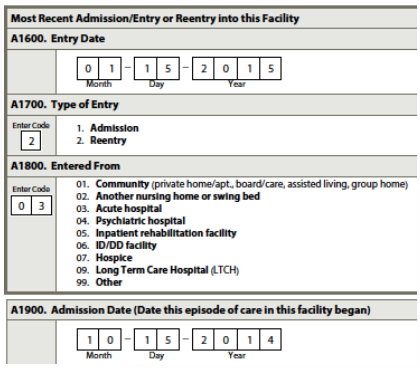
01. Community (private home/apt., board/care, assisted living, group home)
02. Another nursing home or swing bed
03. Acute hospital
04. Psychiatric hospital
05. Inpatient rehabilitation facility
06. ID/DD facility
07. Hospice
09. Long Term Care Hospital (LTCH)
99. Other

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

10 – 15 – 2014
Month Day Year

New Episode

Episode continues after DCRA out ≤ 30 days



Most Recent Admission/Entry or Reentry into this Facility

A1600. Entry Date

01 – 15 – 2015
Month Day Year

A1700. Type of Entry

Enter Code: 2

1. Admission
2. Reentry

A1800. Entered From

Enter Code: 03

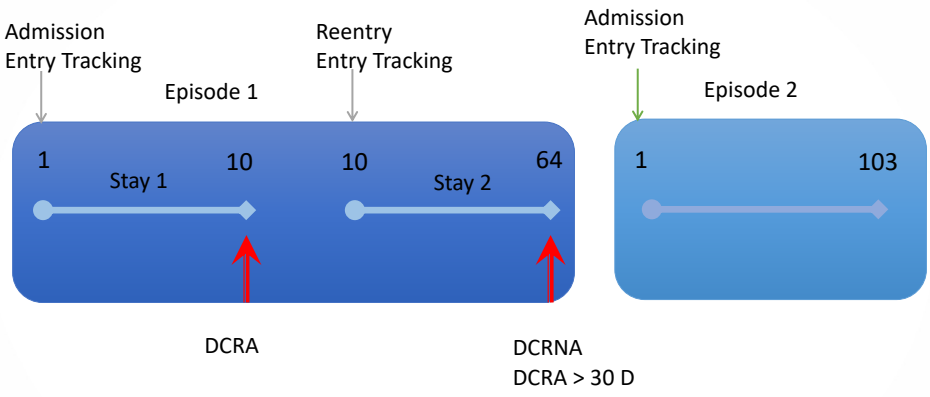
01. Community (private home/apt., board/care, assisted living, group home)
02. Another nursing home or swing bed
03. Acute hospital
04. Psychiatric hospital
05. Inpatient rehabilitation facility
06. ID/DD facility
07. Hospice
09. Long Term Care Hospital (LTCH)
99. Other

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

10 – 15 – 2014
Month Day Year

57

Quality Measures (Why A1700 matters)



Cumulative Days in Facility:
≤ 100 = Short Stay
> 100 = Long Stay

58

Definitions

CMS's RAI Version 3.0 Manual — Appendix A: Glossary and Common Acronyms

Term	Abbreviation	Definition
Respiratory Therapy		Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function. Respiratory therapy services include coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse. A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws.
Respite		Short-term, temporary care provided to residents to allow family members to take a break from the daily routine of care giving.
Significant Error		An error in an assessment where the resident's clinical status is not accurately represented (i.e. miscoded) on the erroneous assessment and the error has not been corrected via submission of a more recent assessment.
Skilled Nursing Facility	**SNF**	A facility that is primarily engaged in providing skilled nursing care and related services to individuals who require medical or nursing care or rehabilitation services of injured, disabled, or sick persons.
Sleep Hygiene		Practices, habits, and environmental factors that promote and/or improve sleep patterns.
Social Isolation		An actual or perceived lack of contact with other people, such as living alone or residing in a remote area.
Social Security Number		A tracking number assigned to an individual by the U.S. Federal government for taxation, benefits, and identification purposes.

2.5 Assessment Types and Definitions

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

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

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

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

Upon return of the resident to the facility, providers should make appropriate documentation in the medical record regarding any changes in the resident's status. If significant changes in status are noted after an LOA, a Significant Change in Status Assessment (SCSA) may be necessary (see Section 2.6).

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

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

59

Definitions

Within the coding instructions of Chapter 3

DEFINITION

PAIN
Any type of physical pain or discomfort in any part of the body. It may be localized to one area or may be more generalized. It may be acute or chronic, continuous or intermittent, or occur at rest or with movement. Pain is very subjective; pain is whatever the experiencing person says it is and exists whenever they say it does.

DEFINITION

PAIN MEDICATION REGIMEN
Pharmacological agent(s) prescribed to relieve or prevent the recurrence of pain. Include all medications used for pain management by any route and any frequency during the look-back period. Include oral, transcutaneous, subcutaneous, intramuscular, rectal, intravenous injections or intraspinal delivery. This item does not include medications that primarily target treatment of the underlying condition, such as chemotherapy or steroids, although such treatments may lead to pain reduction.

DEFINITIONS

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

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

PRIOR TO THE BENEFIT OF SERVICES means prior to provision of any care by facility staff that would result in more independent coding.

DEFINITIONS

INDICATION
The identified, documented clinical rationale for administering a medication that is based upon a physician's (or prescriber's) assessment of the resident's condition and therapeutic goals.

DOSE
The total amount/strength/concentration of a medication given at one time or over a period of time. The individual dose is the amount/strength/concentration received at each administration. The amount received over a 24-hour period may be referred to as the "daily dose."

MONITORING
The ongoing collection and analysis of information (such as observations and diagnostic test results) and comparison to baseline and current data in order to ascertain the individual's response to treatment and care, including progress or lack of progress toward a goal. Monitoring can detect any improvements, complications, or adverse consequences of the condition or the treatments and support decisions about adding, modifying, continuing, or discontinuing any interventions.

60

Some useful definitions:

- **Leave of Absence (LOA)**, which does not require completion of either a Discharge assessment or an Entry tracking record, occurs when a resident has a:
  - Temporary home visit of at least one night; or
  - Therapeutic leave of at least one night; or
  - Hospital observation stay less than 24 hours and the hospital does not admit the resident.
- Providers should refer to Chapter 6 [Medicare ramifications] and their State [Medicaid] LOA policy for further information, if applicable.

61

- **Discharge** refers to the date a resident leaves the facility, or the date the resident's Medicare Part A stay ends but the resident remains in the facility. A day begins at 12:00 a.m. and ends at 11:59 p.m.
- There are three types of discharges: two are OBRA required—return anticipated and return not anticipated; the third is Medicare required—Part A PPS Discharge. A Discharge assessment is required with all three types of discharges. Any of the following situations warrant a Discharge assessment, regardless of facility policies regarding opening and closing clinical records and bed holds:
  - Resident is discharged from the facility to a private residence (as opposed to going on an LOA);
  - Resident is admitted to a hospital or other care setting (regardless of whether the nursing home discharges or formally closes the record);
  - Resident has a hospital observation stay greater than 24 hours, regardless of whether the hospital admits the resident.
  - Resident is transferred from a Medicare- and/or Medicaid-certified bed to a non-certified bed.
  - Resident's Medicare Part A stay ends, but the resident remains in the facility.

62

Section A: Entered from and discharged to:

01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
02. **Nursing Home** (long-term care facility)
03. **Skilled Nursing Facility** (SNF, swing beds)
04. **Short-Term General Hospital** (acute hospital, IPPS)
05. **Long-Term Care Hospital** (LTCH)
06. **Inpatient Rehabilitation Facility** (IRF, free standing facility or unit)
07. **Inpatient Psychiatric Facility** (psychiatric hospital or unit)
08. **Intermediate Care Facility** (ID/DD facility)
09. **Hospice** (home/non-institutional)
10. **Hospice** (institutional facility)
11. **Critical Access Hospital** (CAH)
12. **Home under care of organized home health service organization**
99. **Not listed**

Critical to code accurately. This is used in different ways in some quality measures

63

SECTION B: HEARING, SPEECH, AND VISION

- **Intent:** to document whether the resident is comatose, the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others, and the resident's ability to see objects nearby in their environment.

B0100. Comatose	
Enter Code ☐	**Persistent vegetative state/no discernible consciousness** 0. **No** → Continue to B0200, Hearing 1. **Yes** → Skip to G0110, Activities of Daily Living (ADL) Assistance

Code 1, yes: if physician, nurse practitioner or clinical nurse specialist has documented a diagnosis of coma or persistent vegetative state that **is applicable** during the 7-day look-back period. Skip to Section GG, Functional Abilities and Goals.

- Note: *The diagnosis does not have to be made in the 7 day lookback period.*

64

64

B0200 Hearing

- Conduct assessment with hearing appliance in place.

B0200. Hearing	
Enter Code ☐	**Ability to hear** (with hearing aid or hearing appliances if normally used) 0. **Adequate** - no difficulty in normal conversation, social interaction, listening to TV 1. **Minimal difficulty** - difficulty in some environments (e.g., when person speaks softly or setting is noisy) 2. **Moderate difficulty** - speaker has to increase volume and speak distinctly 3. **Highly impaired** - absence of useful hearing

- 0. No difficulty in normal conversation, social interaction, or listening to TV. The resident hears all normal conversational speech and telephone or group conversation.
- 1. Hearing is adequate after environmental adjustments are made, e.g., reducing background noise
- 2. Speaker has to increase volume and speak distinctly.
- 3. Absence of useful hearing.

B0300. Hearing Aid	
Enter Code ☐	**Hearing aid or other hearing appliance used** in completing B0200, Hearing 0. **No** 1. **Yes**

65

B0600. Speech Clarity	
Enter Code ☐	**Select best description of speech pattern** 0. **Clear speech** - distinct intelligible words 1. **Unclear speech** - slurred or mumbled words 2. **No speech** - absence of spoken words

- Determine the **quality** of the resident's speech, not **content or appropriateness**.
- **Code 0, clear speech:** if the resident ***usually*** utters distinct, intelligible words.
- **Code 1, unclear speech:** if the resident ***usually*** utters slurred or mumbled words.
- **Code 2, no speech:** if there is an absence of spoken words.

66

Makes Self Understood: B0700

DEFINITION

- Able to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language, whether in speech, writing, sign language, gestures, or a combination of these. Deficits in the ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and/or gesturing.

Unaddressed communication problems can be inappropriately mistaken for confusion or cognitive impairment.

67

67

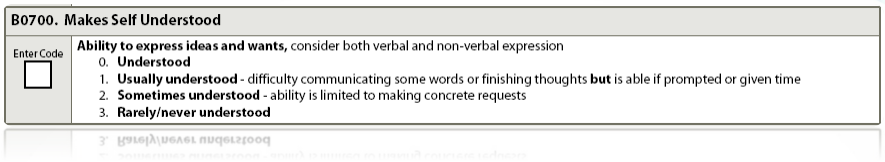
B0700: Makes Self Understood

Steps for Assessment

- Assess using the resident's preferred language or method of communication.
- Interact with the resident. Be sure he or she can hear you or have access to his or her preferred method for communication. If the resident seems unable to communicate, offer alternatives such as writing, pointing, sign language, or using cue cards.
- Observe his or her interactions with others in different settings and circumstances.
- Consult with the primary nurse assistants (over all shifts) and the resident's family and speech-language pathologist.

68

68



B0700. Makes Self Understood	
Enter Code ☐	**Ability to express ideas and wants,** consider both verbal and non-verbal expression 0. **Understood** 1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time 2. **Sometimes understood** - ability is limited to making concrete requests 3. **Rarely/never understood**

0. **Understood: E**xpresses requests and ideas clearly.
1. **Usually understood: H**as difficulty communicating some words or finishing thoughts **but** is able if prompted or given time. He or she may have delayed responses or may require some prompting to make self understood.
2. **Sometimes understood: H**as limited ability but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, toilet).
3. **Rarely or never understood:** if, at best, the resident's understanding is limited to staff interpretation of highly individual, resident-specific sounds or body language (e.g., indicated presence of pain or need to toilet).

69

Coding Tips and Special Populations

- This item cannot be coded as Rarely/Never Understood if the resident completed any of the resident interviews, as the interviews are conducted during the look-back period for this item and should be factored in when determining the residents' ability to make self understood during the entire 7-day look-back period.
- While B0700 and the resident interview items are not directly dependent upon one another, inconsistencies in coding among these items should be evaluated.
  - Resident Interview Items:
    - Section C: Brief Interview for Mental Status (BIMS)
    - Section D: Mood Interview (PHQ 2-9)
    - Section F: Preferences for Customary Routine and Activities
    - Section J: Pain

70

B0800. Ability To Understand Others	
Enter Code ☐	**Understanding verbal content, however able** (with hearing aid or device if used) 0. **Understands** - clear comprehension 1. **Usually understands** - misses some part/intent of message **but** comprehends most conversation 2. **Sometimes understands** - responds adequately to simple, direct communication only 3. **Rarely/never understands**

- **Code 0, understands:** Clear comprehension demonstrated by words or actions/behaviors.
- **Code 1, usually understands:** May have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions.
- **Code 2, sometimes understands:** Demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or instructions. When staff rephrase or simplify the message(s) and/or use gestures, the resident's comprehension is enhanced.
- **Code 3, rarely/never understands:** Demonstrates very limited ability to understand communication. Or, if staff have difficulty determining whether or not the resident comprehends messages, based on verbal and nonverbal responses. Or, the resident can hear sounds but does not understand messages.

71

B1000. Vision	
Enter Code ☐	**Ability to see in adequate light** (with glasses or other visual appliances) 0. **Adequate** - sees fine detail, including regular print in newspapers/books 1. **Impaired** - sees large print, but not regular print in newspapers/books 2. **Moderately impaired** - limited vision; not able to see newspaper headlines but can identify objects 3. **Highly impaired** - object identification in question, but eyes appear to follow objects 4. **Severely impaired** - no vision or sees only light, colors or shapes; eyes do not appear to follow objects
B1200. Corrective Lenses	
Enter Code ☐	**Corrective lenses (contacts, glasses, or magnifying glass) used** in completing B1000, Vision 0. **No** 1. **Yes**

- Ask resident to look at regular-size print in a book or newspaper and read aloud, starting with larger headlines and ending with the finest, smallest print. If unable to read a newspaper, provide material with larger print, such as a flyer or large textbook.
- When the resident is unable to read out loud (e.g. aphasia, illiteracy), test by another means such as, but not limited to:
  - Substituting numbers or pictures for words that are displayed in the appropriate print size (regular-size print in a book or newspaper)
- If the resident is unable to communicate or follow your directions for testing vision, observe the resident's eye movements to see if his or her eyes seem to follow movement of objects or people. For residents who appear to do this, **code 3, highly impaired.**

72

B1300. Health Literacy

Complete only if A0310B = 01 **or** A0310G = 1 and A0310H = 1

Enter Code ☐

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
7. **Resident declines to respond**
8. **Resident unable to respond**

This item is intended to be a resident self-report item. No other source should be used to identify the response.

- Ask the resident, "How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?"

73

SECTION GG: FUNCTIONAL ABILITIES

Intent: This section includes items about functional abilities. It includes items focused on prior function, admission and discharge performance, performance throughout a resident's stay, mobility device use, and range of motion. Functional status is assessed based on the need for assistance when performing self-care and mobility activities.

74

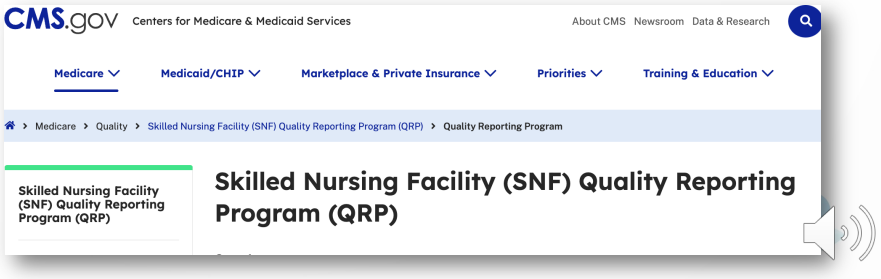
GG0130 Self Care and GG0170 Mobility Uses:

- PT/OT and Nursing Function Score for PDPM payment
- MDS-based Quality Measures:
  - ADL Decline: Four Late-loss ADLs
    - GG0130A Eating
    - GG0170B Sit to Lying
    - GG0170D: Sit to Stand
    - GG0170F: Toilet Transfer
  - Worsened Ability to Walk
    - GG0710I: Walk 10 feet
    - Covariate risk adjustments
      - GG0130A Eating
      - GG0170F: Toilet Transfer
      - GG0170D: Sit to Stand
- Pressure Ulcers Long Stay: Covariate risk adjustment
  - GG0170C: Lying to sitting on side of bed
- New/worsened incontinence: Covariate risk adjustment
  - GG0170B: Sit to lying
  - GG0170D: Sit to Stand
  - Walk 10 Feet or Wheel 50 Feet with Two Turns
  - GG0170R: Wheel 50” w/2 turns

75

GG0130 Self Care and GG0170 Mobility Uses:

- SNF Quality Reporting Program (SNF-QRP) Unique set of quality measures for Original Medicare Part A stays only
  - Discharge Self-Care
  - Discharge Mobility
  - Discharge Function Score
  - Changes in Skin Integrity (covariates)



76

GG0100 & GG0110: Prior Functioning Everyday Activities

Section GG - Functional Abilities and Goals

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

Coding:

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

Enter Codes in Boxes

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

Used to risk adjust SNF QRP QMs: If resident was less than independent in these items, it' important to capture it.

77

77

GG0100. Prior Functioning: Everyday Activities

Item Rationale

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

Steps for Assessment

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

78

78

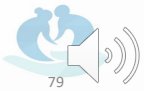
GG0100. Prior Functioning: Everyday Activities

A. Self-Care: Need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation or injury.

B. Indoor Mobility (Ambulation): Need for assistance walking from room to room (with or without a device such as a cane, crutch, or walker) prior to the current illness, exacerbation or injury.

C. Stairs: Need for assistance with internal or external stairs (with or without a device such as a cane, crutch or walker) prior to the current illness, exacerbation or injury.

D. Functional Cognition: Need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.



79

Rating Scale: Prior Functioning – Everyday Activities

03 Independent

02 Needed some help: resident needed partial assistance from another person to complete the activities.

01 Dependent: Helper does all effort or at least 2 helpers required

08 Unknown: usual ability prior to the current illness, exacerbation, or injury is unknown

09 Not applicable: Activities were not applicable to the resident prior to current illness, exacerbation, or injury

80

GG0110: Prior Device Use:

Check all used immediately prior to the current illness, exacerbation, or injury.

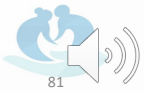
GG0110. Prior Device Use. Indicate devices and ai
Complete only if A0310B = 01

Check all that apply	
☐	A. Manual wheelchair
☐	B. Motorized wheelchair and/or scooter
☐	C. Mechanical lift
☐	D. Walker
☐	E. Orthotics/Prosthetics
☐	Z. None of the above

Coding Tips

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

Used to risk adjust QRP QMs. Important to capture any prior device use.



81

GG0115: Functional Limitation in ROM

GG0115. Functional Limitation in Range of Motion

Code for limitation that interfered with daily functions or placed resident at risk of injury in the last 7 days

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)

DEFINITION

FUNCTIONAL LIMITATION IN RANGE OF MOTION

Limited ability to move a joint that interferes with daily functioning (particularly with activities of daily living) or places the resident at risk of injury.

- Review medical record, talk with staff, family/SO about any impairment in function ROM in the 7 day lookback period.
- Test upper and lower extremity ROM via thorough, comprehensive assessment, following standards of practice for evaluating ROM impairment.
- If impairment exists, determine if it interferes with function or places resident at risk of injury. If not, do not code impairment.

82

GG0120: Mobility Devices

GG0120. Mobility Devices

Check all that were normally used in the last 7 days

☐	A.	Cane/crutch
☐	B.	Walker
☐	C.	Wheelchair (manual or electric)
☐	D.	Limb prosthesis
☐	Z.	None of the above were used

- **GG0120B: Walker: walker, hemi-walker, enclosed frame-wheeled walker, also check if resident uses pushing a WC as a walker**
- **Check G0120C, wheelchair (manual or electric):** if the resident normally sits in wheelchair when moving about. Include hand-propelled, motorized, or pushed by another person. Do not include geri-chairs, reclining chairs with wheels, positioning chairs, scooters, and other types of specialty chairs.

83

GG0130 Self Care & GG0170 Mobility Overview

- GG0130 and GG0170: Functional Abilities: Clinical assessment during a ***specific 3-day lookback, not always tied to the ARD.***
  - Not all ADLs are on stand-alone OBRA assessments
- Lookback:
  - PPS assessments (combined with OBRA or stand alone)
    - If PPS combined with OBRA, follow PPS rules
      - PPS 5 day: First 3 days of Part A stay (A2400B: Medicare Start Date)
      - PPS Discharge: Last 3 days of Part A stay (A2400C: Medicare End Date)
      - PPS IPA: 3 days ending in ARD.
  - Stand Alone OBRA:
    - Admission: First three days of stay: A1600 entry date
    - Discharge: Last three days of stay: A2000 Discharge date
    - All other OBRA
      - Quarterly, Significant Change, Annual, Significant Correction
        - 3 days ending in ARD

84

ADL Definitions

GG0130: Self-Care (cont.)

Coding Tips for GG0130A, Eating

- *The intent of GG0130A, Eating is to assess the resident's ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.*
- The administration of tube feedings and parenteral nutrition is not considered when coding this activity.

Note: ADL Definitions are and the form and under "coding tips" for each section (GG0130 and GG0170)

85

GG0130A: Eating

- **The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.**
- Assesses eating and drinking by mouth only
  - Assistance with tube feedings or TPN is not considered when coding the Eating item.
  - If NPO with tube feeding/TPN because of a new (recent-onset) medical condition, code GG0130A as 88, Not attempted due to medical condition or safety concerns.
  - If NPO with tube feeding/TPN and they did not eat or drink by mouth prior to the current illness, injury, or exacerbation, code GG0130A as 09, Not applicable - Not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
  - If both PO and tube/TPN, count PO only.
  - If a resident requires assistance (e.g., supervision or cueing) to **swallow safely**, code based on the type and amount of assistance required for feeding and safe swallowing.
  - If a resident **swallows safely without assistance, exclude swallowing** from consideration when coding GG0130A, Eating.
  - If the resident eats finger foods using their hands, then 'hands' are 'suitable utensil."

86

GG0130B: Oral hygiene

- **The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth and manage denture soaking and rinsing with use of equipment.**
- If a resident does not perform oral hygiene during therapy, determine the resident's abilities based on performance on the nursing care unit.
- For a resident who is edentulous, code Oral hygiene based on the type and amount of assistance required from a helper to clean the resident's gums.

87

GG0130C: Toileting Hygiene

- **The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment**
- Toileting hygiene (managing clothing and perineal cleansing) takes place before and after use of the toilet, commode, bedpan, or urinal. If the resident completes a bowel toileting program in bed, code the item Toileting hygiene based on the resident's need for assistance managing clothing and perineal cleansing.
- Includes:
  - Performing perineal hygiene.
  - Managing clothing (including undergarments and incontinence products, such as incontinence briefs or pads) before and after voiding or having a bowel movement.
  - Adjusting clothing relevant to the individual resident.
- If a resident has an indwelling catheter, toileting hygiene includes perineal hygiene to the indwelling catheter site, but not management of the equipment.

88

GG0130E. Shower/Bathe Self

- **The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.**
- Assessment of Shower/bathe self can take place in any location including a shower or bath or at a sink or in bed (i.e., full body sponge bath). Bathing can be assessed with the resident seated on a tub bench.

89

GG0130F: Upper body dressing
GG0130G: Lower body dressing
GG0130H. Putting on/taking off footwear

- **The ability to dress and undress [*above/below]* the waist; including fasteners, if applicable**
- **The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable**
- If using elastic bandage, elastic stockings, or an orthosis or prosthesis, count them as a piece of [clothing/footwear] for appropriate category. (F,G,H)

90

GG0130I: Personal Hygiene

- The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, and washing and drying face and hands (excludes baths, showers, and oral hygiene).

91

GG0170A,B,C: Bed Mobility items

If resident does not sleep in a bed, clinicians should assess bed mobility activities using the alternative sleep furniture (e.g, a recliner).

GG0170A: Roll left to right: **The ability to roll from lying on back to left and right side and return to lying on back on the bed.**

GG0170B: Sit to lying: **Ability to move from sitting on side of bed to lying flat on the bed**

GG0170C: Lying to sitting on side of bed: Ability to move from lying on the back to sitting on side of bed, no back support

92

GG0170D,E,F,FF,G: Transfers

- GG0170D Sit to Stand: **Ability to come to a standing position from sitting in a chair, wheelchair or side of bed**. Includes coming to a standing position from any sitting surface.

- GG0170E Chair/bed to chair transfer: **Ability to transfer to and from a bed to a chair or wheelchair,** once seated at edge of bed [or chair]. This transfer does not include sitting or lying or lying to sitting, assessed in GG0170B&C.

- GG0170F Toilet Transfer: **Ability to get on or off a toilet or bedside commode.** Bedpan not included.

93

GG0170D,E,F,FF,G: Transfers

- GG0170FF Tub/shower transfer: **Ability to get in and out of a tub/shower.**

- GG017G Car transfer: **The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.**
  - Does not include getting to or from the vehicle
  - If the resident is transferred into a vehicle in a wheelchair, then use appropriate "activity not attempted" code.
  - The setup and/or clean-up of an assistive device that is used for walking to and from the car, but not used for the transfer in and out of the car seat, would not be considered when coding the Car transfer activity.

94

GG0170I, J, K, L Walking

- Assessment starts with resident standing.
- A helper cannot complete a walking activity for a resident. Resident must be able to complete entire distance. May take brief standing rest break. If resident sits prior to completing distance, use appropriate activity not attempted code.
- If a clinician chooses to combine the assessment of multiple walking activities, use clinical judgment to determine type/amount of assistance needed for each individual activity when they overlap or occur sequentially.
- Walking activities do not need to occur during one session. Allowing a resident to rest between activities or completing them at different times during the day or on different days may facilitate completion of the activities.
- Do not consider walking in parallel bars.
- When coding GG0170K, Walk 150 feet, if the resident's environment does not accommodate a walk of 150 feet without turns, but they can walk the distance with turns, code using the 6-point scale.
- For GG0170L, Walking 10 feet on uneven surfaces. Examples of uneven surfaces, inside or outside, include uneven or sloping surfaces, turf, and gravel.

95

GG0170I, J, K, L Walking

- GG0170I Walk 10 feet**: Once standing, the ability to walk at least ten feet in a room, corridor or similar space**.{If unable to attempt, J,K and L are skipped}

•GG0170J **Walk 50 feet with two turns.**

•GG0170K **Walk 150 feet.**

•GG0170L **Walk 10 feet on uneven or sloping surfaces.**

96

GG0170M, N, O: Steps (1, 4 or 12 steps)

- Getting to and from the stairs not included
- Ascending and descending M, N & O does not have to occur sequentially or during one session. Resident may take standing or seated rest break between ascending/descending the 4 steps or 12 steps.
- A resident who uses a wheelchair may be assessed going up and down stairs (including one step or curb) in a wheelchair.
- If a resident requires a helper to provide total assist (for example, the resident requires total assist from a helper to move up and down over a curb in their wheelchair), code as 01, Dependent.

97

GG0170M, N, O: Steps

- GG0170M: The ability to go up and down a curb and/or up and down one step.{if not attempted, skip N&O}
- GG0170N: The ability to go up and down four steps with or without a rail
- GG0170O: The ability to go up and down 12 steps with or without a rail.

98

GG0170P: Picking up object

- **The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.**
- Picking up the object must be assessed while the resident is in a standing position. If the resident is not able to stand, the activity did not occur, and the appropriate "not attempted" code would be used.
- If a standing resident is unable to pick up a small object from the floor, therefore requiring the helper to assist in picking up the object, code appropriate assistance, depending on whether the helper is providing all the effort, more than half of the effort, or less than half of the effort, respectively.
- Assistive devices and adaptive equipment may be used, for example, a cane to support standing balance and/or a reacher to pick up the object.

99

GG0170Q: Does the resident use a wheelchair or scooter?

- If the resident used a wheelchair for self-mobilization prior to admission to the facility, indicate 1, Yes, to the gateway wheelchair items on the initial assessment in GG0170Q1. (PPS 5 day or OBRA Admission)
  - The responses for gateway wheelchair items (GG0170Q1, GG0170Q3, and/or GG0170Q5) do not have to be the same on subsequent assessments. For example, the Admission assessment may indicate that the resident does not use a wheelchair but the subsequent assessment may indicate that the resident uses a wheelchair.
    - Wheelchair items:
      - GG0170Q1: PPS 5 day or OBRA Admission
      - GG0170Q3: PPS DC or OBRA DC
      - GG0170Q5: Any other OBRA or IPA

100

GG0170Q: Does the resident use a wheelchair or scooter?

- If a wheelchair is used for transport purposes only, then GG0170Q1, GG0170Q3, and/or GG0170Q5, Does the resident use a wheelchair or scooter? is coded as 0, No; then follow the skip pattern to continue coding the assessment.
  - Example of using a wheelchair for transport convenience: A resident is transported in a wheelchair by staff between their room and the therapy gym or by family to the facility cafeteria, but the resident is not expected to use a wheelchair after discharge.

101

R. **Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

RR3. Indicate the type of wheelchair or scooter used.

☐ 1. **Manual**
☐ 2. **Motorized**

S. **Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.

SS3. Indicate the type of wheelchair or scooter used.

☐ 1. **Manual**
☐ 2. **Motorized**

- If environment does not accommodate wheelchair or scooter use for 150 feet without turns, but the resident can mobilize a wheelchair/scooter with/without assistance for 150 feet with turns, you can count that.
- For the wheeling items, a helper can assist a resident in completing the required distance in the wheelchair or in making turns if required. When a resident is unable to wheel the entire distance themself, the activity can still be completed, and a performance code can be determined based on the type and amount of assistance required from the helper to complete the entire activity.

102

Determining level of assistance for GG0130 & GG0170

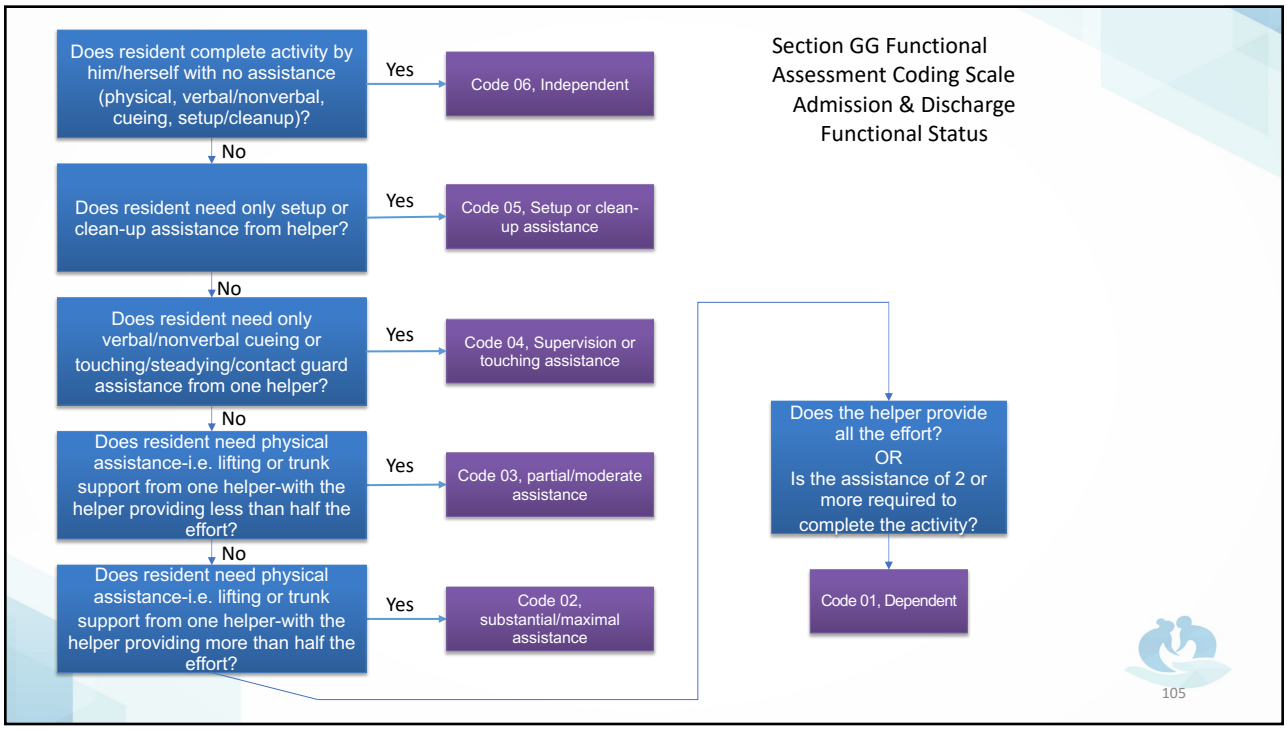
- We must code the "usual performance" also called "baseline performance" for the 3 day lookback period.
  - **"A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance."**

103

Determining level of assistance for GG0130 & GG0170

- Assess the resident's self-care and mobility performance based on direct observation, incorporating resident self-reports and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the assessment period. CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the assessment period.
- For the PPS 5 day: Assessment should be conducted prior to the benefit of services to reflect true admission baseline functional status. If tx has started, determine what baseline was prior to benefit of services.
  - PRIOR TO THE BENEFIT OF SERVICES means prior to provision of any care by facility staff that would result in more independent coding.

104



105

Determining level of assistance for GG0130 & GG0170
4 codes for "activity not attempted":

- Code 07, Resident refused: if the resident refused to complete the activity.
- Code 09, Not applicable: if the activity was not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury.
- Code 10, Not attempted due to environmental limitations: if the resident did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.
- Code 88, Not attempted due to medical condition or safety concerns: if the activity was not attempted due to medical condition or safety concerns.

106

GG Q&A SNF QRP Training

Question

- Can you provide more guidance on the amount of documentation needed; who is to provide this documentation for scoring Section GG on the MDS? Is it necessary to document every shift over the 3-day look-back period?

Answer

- CMS does not impose specific documentation procedures on nursing homes in completing the RAI. While this is the case, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, nursing home teams can determine the documentation that they feel is necessary to support coding items on the MDS 3.0, including coding the items in GG0130. Self-Care and GG0170. Mobility, according to their facility policy and procedure and in compliance with any Federal and State requirements. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS. Please see Chapter 1, 1.3. for further details.

https://www.cms.gov/files/document/2023septembersnfguidancetrainingprogramqa.pdf

107

GG Q&A SNF QRP Training

Question

- Are we allowed to establish and document the final "usual" functional performance AFTER the 3 days documentation?

Answer

- Completion of Section GG of the MDS (i.e., coding determination) does not need to occur within the 3-day assessment window, but it is expected to be based on assessment(s) completed within the 3-day assessment window. The Interdisciplinary Team (IDT) can assimilate the data to determine "usual performance" after day 3 as long as they only utilize data/information from the 3-day assessment window.

https://www.cms.gov/files/document/2023septembersnfguidancetrainingprogramqa.pdf

108

GG Q&A SNF QRP Training

Question	Answer
• What should be coded if the resident didn't receive a bath/shower the first 3 days or in any 3 day lookback period?	• If the resident did not receive a bath/shower because the resident did not attempt the activity and a helper did not complete the activity for the resident during the entire assessment period, GG0130E. Shower/bathe self would be coded with one of the "activity not attempted" codes (07, 09, 10, or 88). • If the resident did not receive a bath/shower because they were not scheduled for one during the entire assessment period, the assessment did not occur and GG0130E. Shower/bathe self would be coded with a dash (-). A dash value indicates that the data element was not assessed and therefore no information is available.

https://www.cms.gov/files/document/2023septembersnfguidancetrainingprogramqa.pdf

109

CMS Training Aides for staff to document GG ADLs

Job Aids

Companion job aids assist providers in the assessment and coding of assessment items and provide clinically relevant information to assist providers in understanding specific guidelines and clinical considerations that should be applied to coding these items. The job aids are provided in multiple file types designed for printing, viewing, or sharing electronically. An explanation of the file types is provided in the ZIP file.

Job Aids – GG0130A. Eating, GG0130B. Oral Hygiene, GG0130C. Toileting Hygiene, GG0130E. Shower/Bathe Self, GG0130F. Upper Body Dressing, GG0130G. Lower Body Dressing, and GG0130H. Putting On/Taking Off Footwear

- 2021_November.10_SNF_GG0130 Job Aides (ZIP)

Pocket Guides / Badge Buddies

Pocket Guides are intended to assist providers in the assessment and coding of assessment items and provide a quick reference for important terms and definitions that promote coding accuracy. These pocket guides are approximately 2 x 3.5 inches in size and are designed to be worn behind a provider identification badge.

- Pocket Guide #1: Coding for Self-Care and Mobility Items (PDF).
- Pocket Guide #2: Definitions for Coding Section J Fall Items (PDF).
- Pocket Guide #3: Pressure Ulcers/Injuries Stages and Definitions (PDF)

https://www.cms.gov/medicare/quality/snf-quality-reporting-program/training

110

CMS Training Aides for staff to document GG ADLs

Skilled Nursing Facility: Section GG Job Aid

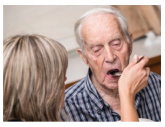
GG0130A. Eating

A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.

Assessment Timing

Admission:
- Admission performance.
- Discharge goal.

Discharge:
- Discharge performance.



Eating Inclusions and Exclusions for Coding

Included:	Excluded:
• All food and liquids. • All diets taken by mouth, including mechanically altered. • Setup and clean-up of the meal.	• Assistance with or administration of tube feedings, parenteral nutrition, or total parenteral nutrition (TPN).

Coding Tips

The activity of eating involves bringing food and liquids to the mouth using suitable utensils, and swallowing food and/or liquids once the meal is placed before the resident.

CMS QRP POCKET GUIDE

GG Self-Care and Mobility Performance Coding Instructions

06. Independent: The patient/resident completes the activity by themselves with **no assistance** from a helper.

05. Setup or clean-up assistance: The helper sets up or cleans up; patient/resident completes activity. The helper assists **only prior to or following** the activity, but not during the activity.

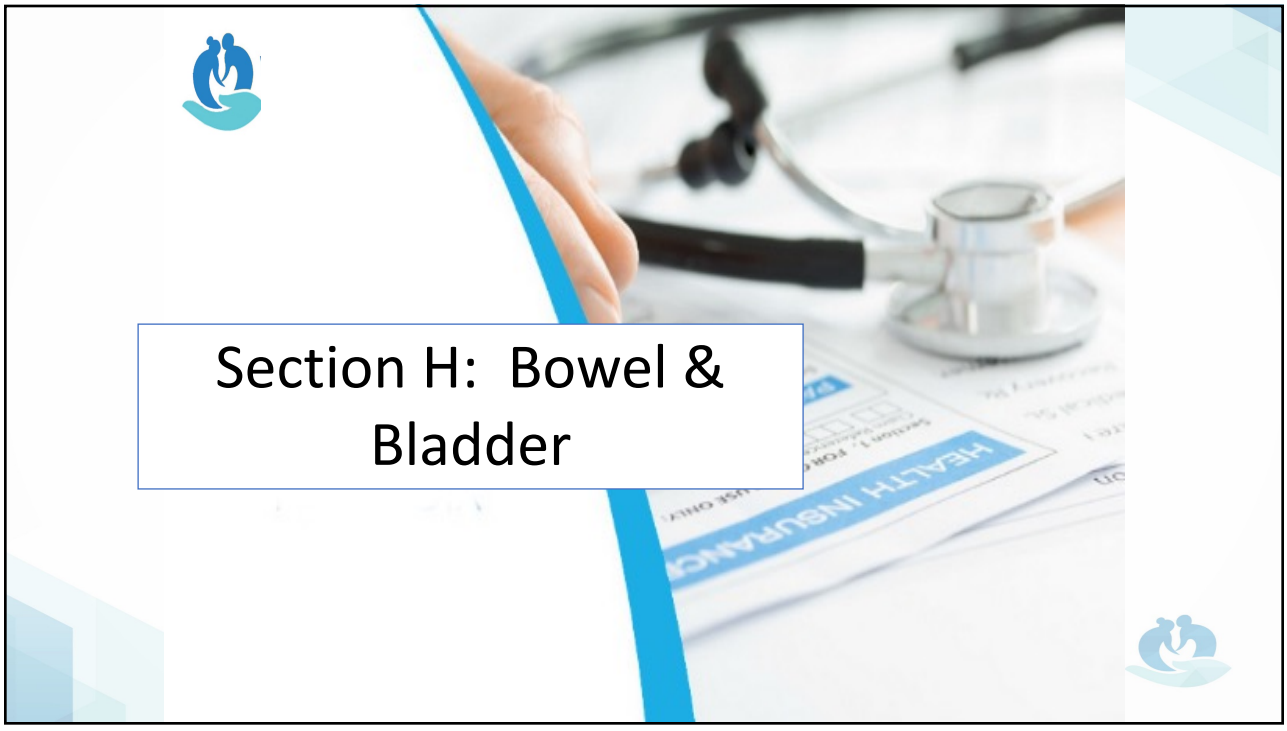
04. Supervision or touching assistance: The helper provides verbal cues and/or touching/steadying and/or contact guard assistance as the patient/resident completes the activity. Assistance may be provided **throughout** the activity **or intermittently.**

03. Partial/moderate assistance: The helper does **LESS THAN HALF** the effort. The helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.

02. Substantial/maximal assistance: The helper does **MORE THAN HALF** the effort. The helper lifts or holds trunk or limbs and provides more than half the effort.

01. Dependent: The helper does **ALL of the effort.** The patient/resident does none of the effort to complete the activity, or the assistance of two or more helpers is required for the patient/resident to complete the activity.

111



112

H0100 Appliances

7 day lookback or since the last entry

A. Indwelling Catheter

Includes suprapubic catheter and nephrostomy tubes

B. External Catheter

Includes condom catheters and external urinary pouches

C. Ostomy

Includes urostomy, ileostomy, and colostomy. **Does not include feeding tube ostomies, includes excretory ostomies only**

D. Intermittent catheterization

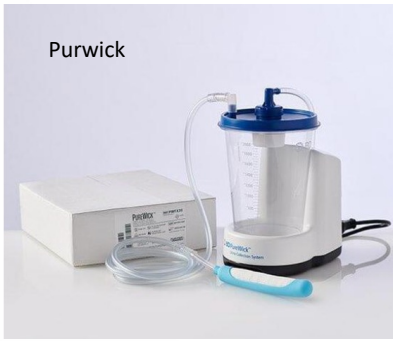
Do not include one time catheterization for urine specimen. Does include clean technique self-cath

113

113

Section H: H0100B: External catheter

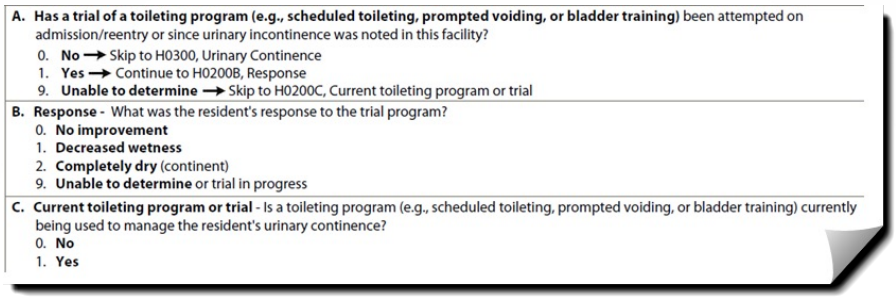
- Female external catheters and other **non-invasive urine output management devices** or systems should be coded as external catheters (H0100B).



Pouch: Many brands

114

H0200 Urinary Toileting Program



A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/reentry or since urinary incontinence was noted in this facility?

0. **No** → Skip to H0300, Urinary Continence
1. **Yes** → Continue to H0200B, Response
9. **Unable to determine** → Skip to H0200C, Current toileting program or trial

B. Response - What was the resident's response to the trial program?

0. **No improvement**
1. **Decreased wetness**
2. **Completely dry** (continent)
9. **Unable to determine** or trial in progress

C. Current toileting program or trial - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?

0. **No**
1. **Yes**

- Captures 3 aspects of a toileting program:
  - A. Whether a toileting program has been attempted
  - B. Resident's response to any trial program
  - C. Whether a toileting program is being used now to manage incontinence

115

Urinary Toileting: Defined

- Toileting program refers to a specific approach:
  - Organized, planned, documented, monitored, and evaluated.
  - Consistent with nursing home policies and procedures and current standards of practice.
- Toileting program does not refer to:
  - Simply tracking continence status.
  - Changing pads or wet garments.
  - Random assistance with toileting or hygiene.

116

H0200A: Urinary Toileting Trial Attempted

- Review record for evidence of a trial of an individualized, resident-centered toileting program.
  - Should include observations of at least 3 days of toileting patterns with **prompting to toilet** and of recording results in a bladder record or voiding diary.
  - Simply tracking continence status using a bladder record or voiding diary **should not be** considered a trial of an individualized, resident-centered toileting program.

Lookback:
- If incontinent upon admission, since admission
- If continent upon admission, since resident became incontinent

H-4

117

Urinary Toileting Programs

Prompted Voiding includes:
- regular monitoring with encouragement to report continence status,
- Using a schedule and prompting to toilet, and
- Praise & positive feedback when resident is continent & attempts to toilet.

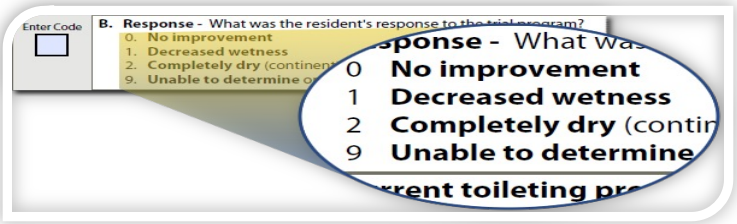
Bladder rehab/retraining: behavioral technique that requires the resident to resist or inhibit the sensation of urgency, to postpone or delay voiding, and to urinate according to a timetable rather than to the urge to void.

Habit training/scheduled voiding: Behavior technique that calls for scheduled toileting at regular intervals on a planned basis to match resident's voiding habits/needs

118

H0200B Response to Trial

- Code **0.** if incontinence did not decrease.
- Code **1.** if frequency decreased but still incontinent.
- Code **2.** if resident becomes completely continent of urine.
- Code **9.** if no information or trial is in progress.



No quantitative definition of improvement. However, the improvement should be clinically meaningful.

119

H0200C: Current urinary toileting program

- **Code 1, yes:** for residents who are being managed, during 4 or more days of the 7-day look-back period, with some type of systematic toileting program
  - bladder rehabilitation/bladder retraining
  - prompted voiding,
  - habit training/scheduled voiding
- Some residents prefer to not be awakened to toilet. If that resident, however, is on a toileting program during the day, code "yes."

120

H0300 Urinary Continence: Definition

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

121

H0300 Urinary Continence

- Code 0, always continent: No episodes of incontinence
- Code 1, occasionally incontinent: Incontinent less than 7 episodes.
- Code 2, frequently incontinent: Incontinent during ≥ 7 episodes but had at least 1 continent void.
- Code 3, always incontinent: No continent voids.
- Code 9, not rated: if the resident had an indwelling bladder catheter, condom catheter, ostomy, or no urine output for the entire 7 days.
  - If intermittent cath is used to drain the bladder, code continence level based on continence **between catheterizations.**

122

H0400: Bowel Continence

- Code 0, always continent: No episodes of incontinence.
- Code 1, occasionally incontinent: Incontinent of stool once.
- Code 2, frequently incontinent: Incontinent of bowel more than once, but had at least one continent BM
- Code 3, always incontinent: No continent BMs
- Code 9, not rated: Resident had an ostomy or did not have BM for the entire 7 days

123

H0500: Bowel Toileting Program

H0500. Bowel Toileting Program	
Enter Code ☐	Is a toileting program currently being used to manage the resident's bowel continence? 0. No 1. Yes

- Look for documentation showing:
  - Implementation of an individualized, resident-specific bowel toileting program based on an assessment of the resident's unique bowel pattern;
  - Evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, verbal and a written report; and
  - Notations of the resident's response to the toileting program and subsequent evaluations, as needed.

124

H0600. Bowel Patterns	
Enter Code ☐	**Constipation present?** 0. **No** 1. **Yes**

- Constipation:
  - ≤ 2 BMs during 7-day look-back period or
  - if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements).
- If unaddressed, constipation can lead to fecal impaction.

125

GG Q&A SNF QRP Training

Question

- Can you provide more guidance on the amount of documentation needed; who is to provide this documentation for scoring Section GG on the MDS? Is it necessary to document every shift over the 3-day look-back period?

Answer

- CMS does not impose specific documentation procedures on nursing homes in completing the RAI. While this is the case, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, nursing home teams can determine the documentation that they feel is necessary to support coding items on the MDS 3.0, including coding the items in GG0130. Self-Care and GG0170. Mobility, according to their facility policy and procedure and in compliance with any Federal and State requirements. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS. Please see Chapter 1, 1.3. for further details.

https://www.cms.gov/files/document/2023septembersnfguidancetrainingprogramqa.pdf

126

GG Q&A SNF QRP Training

Question	Answer
• Are we allowed to establish and document the final "usual" functional performance AFTER the 3 days documentation?	• Completion of Section GG of the MDS (i.e., coding determination) does not need to occur within the 3-day assessment window, but it is expected to be based on assessment(s) completed within the 3-day assessment window. The Interdisciplinary Team (IDT) can assimilate the data to determine “usual performance” after day 3 as long as they only utilize data/information from the 3-day assessment window.

https://www.cms.gov/files/document/2023septembersnfguidancetrainingprogramqa.pdf

127

GG Q&A SNF QRP Training

Question	Answer
• What should be coded if the resident didn’t receive a bath/shower the first 3 days or in any 3 day lookback period?	• If the resident did not receive a bath/shower because the resident did not attempt the activity and a helper did not complete the activity for the resident during the entire assessment period, GG0130E. Shower/bathe self would be coded with one of the "activity not attempted" codes (07, 09, 10, or 88). • If the resident did not receive a bath/shower because they were not scheduled for one during the entire assessment period, the assessment did not occur and GG0130E. Shower/bathe self would be coded with a dash (-). A dash value indicates that the data element was not assessed and therefore no information is available.

https://www.cms.gov/files/document/2023septembersnfguidancetrainingprogramqa.pdf

128

Let's talk about GG documentation support

- Federally required documentation:
  - 3 day lookback: Possible sources
    - Nursing
    - CNA
    - Therapy
  - Final Determination based on lookback documentation: Possible ways to document
    - Final determination note:

Based on direct observation, reports from qualified clinicians, and as documented in the Resident's medical record during the 3-day look back period for the ARD on 12/25/2024, there were conflicting reports of functional status for some activities. The IDT discussed these discrepancies and using the coding guidance in the current RAI manual determined true performance for this look back period. This note affirms an IDT of qualified clinicians has determined the admission functional status as coded on this MDS in section GG0130 and GG0170.

129

Other ways to document final determination

4/4/2025 10:11 MDS Note

Note Text: MDS and therapy reconciled nursing GG's (Day 1-3 of admission) for ARD of 4/5/25.
Self care:
Eating-P
Oral Hygiene-P
Toileting hygiene-M
Shower/bathe self-M
Upper body dressing-M
Lower body dressing-M
Putting on/taking off footwear-M
Personal Hygiene-P
Mobility:
Roll left and right-M
Sit to lying-M
Lying to sitting on side of bed-M
Sit to stand-M
Chair/bed to chair transfer-M
Toilet Transfer-M
Tub/shower transfer-M
Car Transfer-88
Walk 10 ft-88
Walk 50 ft with 2 turns-88
Walk 150 ft-88
Walking 10 ft on uneven surfaces-88
1 step (curb)-09
4 steps-09
12 steps-09
Picking up object-88
Does the resident use a w/c and/or scooter –NO
Wheel 50 ft with 2 turns-
Type of w/c or scooter used-
Manual-
Motorized-
Wheel 150 ft-
Manual-
Motorized-

130

Other ways to document final determination: UDA with all GG items
Can do one form or separate forms for different GG items on different assessments

MDS Reason for Evaluation

1. MDS Reason for Evaluation
   - ○ a. Admission (stand-alone or combination)
   - ○ b. PPS 5-Day (stand-alone) (Information provided should reflect USUAL status during THIS window)
   - ◉ c. Admission/5-Day (combined) (Information provided should reflect USUAL status during THIS window)

2. Dates for 3-Day Window:
   5/1, 5/2, 5/3

Usual performance was based on direct observation, the residents self-report, family reports and direct-care staff reports of resident's self-care status

3A. IDT Collaboration included the Following:

☑ a. Director of Rehab ☑ b. MDS Nurse ☑ c. Licensed Nurse ☐ d. Therapist ☑ e. Other

3B. Additional Information

130. Self-Care

A1. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. - Admission Performance

131

CNA Documentation discussion

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

Suggestion: List all GG0130 items in CNA task list

132

5. OBRA/ Interim Performance	Enter Codes in Boxes
☐☐	A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
☐☐	B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
☐☐	C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed and with no back support.
☐☐	D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
☐☐	F. **Toilet transfer:** The ability to get on and off a toilet or commode.
☐☐	FF. **Tub/shower transfer:** The ability to get in and out of a tub/shower.
☐☐	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If performance in the last 7 days is coded 07, 09, 10, or 88 → Skip to GG0170Q5, Does the resident use a wheelchair and/or scooter?
☐☐	J. **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
☐☐	K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

Q5. Does the resident use a wheelchair and/or scooter?
0. **No** → Skip to H0100, Appliances
1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns

R. **Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

RR5. Indicate the type of wheelchair or scooter used.
1. **Manual**
2. **Motorized**

S. **Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.

SS5. Indicate the type of wheelchair or scooter used.
1. **Manual**
2. **Motorized**

CNA documentation suggestion: Only the OBRA GG0170 items

May not be appropriate to have CNAs document on:

- Car transfer
- Walk 10 ft uneven surfaces
- Steps
- Pick up object

133

GG final thoughts

- The GG functional status assessment is meant to be an actual assessment by qualified clinicians of the resident's ability to do the ADLs on a specific type of assessment. It's not passively counting occurrences and documenting what happened.
- Nursing and/or therapy should perform this assessment during the lookback period. Example: If shower isn't scheduled for the 3 days, schedule one and assess performance.

134

Section I: Active Diagnoses

- **Intent:** The items in this section are intended to code diseases that have a ***direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death.***
- One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status.

Definition of "Active Diagnosis" for Section I

135

Section I: Diagnoses

- There are two look-back periods for this section:
  1. Provider documented diagnosis must be in 60-day look-back period including prior to admission.
  2. Diagnosis must be active in 7-day look-back period including prior to admission
- Check the following information sources in the medical record for the last 7 days to identify "active" diagnoses: transfer documents, physician progress notes, recent history and physical, recent discharge summaries, nursing assessments, nursing care plans, medication sheets, doctor's orders, consults and official diagnostic reports, and other sources as available.

Exception: UTI has unique coding rules that apply only to UTI diagnosis

136

Section I: Subsections:

- I0020: Primary Medical Condition Category
- I0100 – I8000: Active Diagnoses in the Last 7 Days :
  - Some portion of this sub-section is on every type of assessment
    - Some diagnosis checkboxes used in Medicare and many state Medicaid systems
    - Some diagnoses are used in calculating quality measurements
    - Always a survey focus

137

Section I - Active Diagnoses

I0020. Indicate the resident's primary medical condition category

Complete only if A0310B = 01 or if state requires completion with an OBRA assessment

Indicate the resident's primary medical condition category that best describes the primary reason for admission

Enter Code

01. Stroke
02. Non-Traumatic Brain Dysfunction
03. Traumatic Brain Dysfunction
04. Non-Traumatic Spinal Cord Dysfunction
05. Traumatic Spinal Cord Dysfunction
06. Progressive Neurological Conditions
07. Other Neurological Conditions
08. Amputation
09. Hip and Knee Replacement
10. Fractures and Other Multiple Trauma
11. Other Orthopedic Conditions
12. Debility, Cardiorespiratory Conditions
13. Medically Complex Conditions

I0020B. ICD Code

Used for SNF QRP Quality Measures Risk Adjustments only on PPS assessments

Used for PDPM classification system for Medicare and many state case mix systems.

Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay. Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.

138

Section I - Active Diagnoses

I0020. Indicate the resident's primary medical condition category

Complete only if A0310B = 01 or if state requires completion with an OBRA assessment

In fact, I0020 is active on all OBRA & PPS Assessments

Indicate the resident's primary medical condition category that best describes the primary reason for admission

Enter Code

01. Stroke
02. Non-Traumatic Brain Dysfunction
03. Traumatic Brain Dysfunction
04. Non-Traumatic Spinal Cord Dysfunction
05. Traumatic Spinal Cord Dysfunction
06. Progressive Neurological Conditions
07. Other Neurological Conditions
08. Amputation
09. Hip and Knee Replacement
10. Fractures and Other Multiple Trauma
11. Other Orthopedic Conditions
12. Debility, Cardiorespiratory Conditions
13. Medically Complex Conditions

I0020B. ICD Code

There is no guidance in the RAI manual for when the resident is not in a Medicare Part A stay. CMS says to get that guidance from your State.
If your State has no guidance, here's my opinion:

- The primary reason for a LTC stay is the reason they must be there and not a lower level of care. I recommend having the provider document "primary reason for LTC diagnosis" in their 60 day certifications for LTC.
- If your state is now using PDPM for Medicaid payment, refer to any documentation guidelines the state produces, if such guidance exists

- Indicate the resident's primary medical condition category that best describes the primary reason for the ***Medicare Part A stay***. Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.

139

Coding Instructions, continued:

- When an acute condition represents the primary reason for the resident's SNF stay, it can be coded in I0020B. However, it is more common that a resident presents to the SNF for care related to an aftereffect of a disease, condition, or injury. Therefore, subsequent encounter or sequelae codes should be used.
  - *From Judy: But a significant portion of SNF admissions are for active diagnosis: Infection, unstable chronic conditions, etc. Determine the primary reason, then just use the correct ICD-10 code for the provider documented diagnosis and it will be accurate.*
- Include the primary medical condition coded in this item in Section I: Active Diagnoses in the last 7 days.

140

Coding Instructions: I0020

- **Code 01, Stroke**
  - Examples include ischemic stroke, subarachnoid hemorrhage, cerebral vascular accident (CVA), and other cerebrovascular disease
- **Code 02, Non - traumatic Brain Dysfunction**
  - Examples include Alzheimer's disease, dementia with or without behavioral disturbance, malignant neoplasm of brain, and anoxic brain damage
- **Code 03, Traumatic Brain Dysfunction**
  - Examples include traumatic brain injury, severe concussion, and cerebral laceration and contusion

141

Coding Instructions: I0020

Code 04, Non-traumatic Spinal Cord Dysfunction

Examples include spondylosis with myelopathy, transverse myelitis, spinal cord lesion due to spinal stenosis, and spinal cord lesion due to dissection of aorta

Code 05, Traumatic Spinal Cord Dysfunction

Examples include paraplegia and quadriplegia following trauma

Code 06, Progressive Neurological Conditions

Examples include Multiple Sclerosis and Parkinson's disease

142

Coding Instructions: I0020

- **Code 07, Other Neurological Conditions**
  - Examples include cerebral palsy, polyneuropathy, and myasthenia gravis
- **Code 08, Amputation**
  - For example, acquired absence of limb
- **Code 09, Hip and Knee Replacement**
  - For example, total knee replacement
  - If hip replacement is secondary to hip fracture, code as 10, fracture
- **Code 10, Fractures and Other Multiple Trauma**
  - Examples include hip fracture, pelvic fracture, and fracture of tibia and fibula

143

Coding Instructions:
I0020

- **Code 11, Other Orthopedic Conditions**
  - For example, unspecified disorders of joint
- **Code 12, Debility, Cardiorespiratory Conditions**
  - Use if primary medical condition category is debility or a cardiorespiratory condition: Examples include chronic obstructive pulmonary disease (COPD), asthma, and other malaise and fatigue
  - Also includes primary cardiac conditions, with or without a respiratory condition
- **Code 13, Medically Complex Conditions**
  - Examples include diabetes, **pneumonia**, chronic kidney disease, open wounds, pressure ulcer/injury, infection, and disorders of fluid, electrolyte, and acid-base balance

144

Example of Primary Medical Condition: Page I-3

- Mrs. E is an 82-year-old female who was hospitalized for a hip fracture with total hip replacement and is admitted for rehabilitation. The admitting MD documents her primary medical condition as total hip replacement (THR) in her medical record. The hip fracture resulting in the total hip replacement is also documented in the discharge summary.
- **Coding:** I0020 would be coded **10, Fractures and Other Multiple Trauma.** *I0020B would be coded as S72.062D (Displaced articular fracture of the head of the left femur).*
- **Rationale:** Medical record documentation demonstrates that Mrs. E had a total hip replacement due to a hip fracture and required rehabilitation. Because she was admitted for rehabilitation as a result of the hip fracture and total hip replacement, Mrs. E's primary medical condition category is **10, Fractures and Other Multiple Trauma.** *The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.*

145

Example

- Resident H is 78 w/ hx HTN and hip replacement 2 years ago. Qualifying hospitalization primary was idiopathic pancreatitis.
- Central line placed for TPN (total parenteral nutrition).
- Received regular blood glucose monitoring and treatment with insulin when they became hyperglycemic.
- During SNF stay he's receiving TPN and SLP is working to transition to PO
- Hospital discharge diagnoses of idiopathic pancreatitis, hypertension, and malnutrition were incorporated into his SNF medical record. Coding: I0020 would be coded 13, Medically Complex Conditions. I0020B would be coded as K85.00 (Idiopathic acute pancreatitis without necrosis or infection).
- Rationale: Resident H had hospital care for pancreatitis immediately prior to their SNF stay. Their principal diagnosis of pancreatitis was included in the summary from the hospital. The surgical placement of their central line does not change their care to a surgical category because it is not considered to be a major surgery. The ICD-10 code provided in I0020B above is only an example of an appropriate code for this condition category.

146

ICD-10-CM Official Guidelines for Coding and Reporting FY 2026

(October 1, 2025 - September 30, 2026)

- ICD-10/CM code set book ***required to code accurately, contains:***
  - Official Guidelines for Coding and Reporting for current fiscal year.
  - Official CMS Code Set
- Correct ICD-10 coding, per the ICD 10 coding guidelines, is required for I0020B and I8000.

147

Steps for Assessment. Diagnoses

1. **Identify diagnoses:** The disease conditions in this section require a physician* documented diagnosis in the **last 60 days.** Medical record sources:
   - progress notes,
   - most recent history and physical
   - transfer documents
   - discharge summaries
   - diagnosis/ problem list
   - other resources as available.
- If a diagnosis/problem list is used, only diagnoses confirmed by the physician should be entered.

*Physician includes: Physician, nurse practitioner, clinical nurse specialist, physician's assistant, as State allows

148

Steps for Assessment

- Diagnoses communicated verbally ***must be documented in the medical record by the physician*** to ensure follow-up.
- Diagnostic information, including past history obtained from family members and close contacts, ***must also be documented in the medical record by the physician*** to ensure validity and follow-up.

149

Steps for Assessment

Examples of diseases are included for some disease categories.

- Diseases to be coded in these categories are not meant to be limited to only those listed in the examples
- For example, **I0200, Anemia,** includes anemia of any etiology, including those listed (e.g., aplastic, iron deficiency, pernicious, sickle cell)
- Check off each active disease. Check all that apply
- If a disease or condition is **not** specifically listed, enter the diagnosis and ICD code in item I8000, Additional active diagnosis

In fact, due to PDPM, you must list the dx code in I8000 if it's a payment code, to avoid improper reimbursement, unless your state case mix guidelines are more stringent.

150

Indicators of Active Diagnosis:

- Specific Documentation of Active Diagnosis in medical record by MD/NPP
- May be found in progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc.
- In the absence of specific documentation:
  - Recent onset or acute exacerbation indicated by a positive study, test, or procedure, hospitalization for acute S/S, and/or recent changes in therapy.
  - Symptoms and abnormal signs indicating ongoing or decompensated disease.
    - Must be specifically attributable to a disease
  - Ongoing therapy w/meds or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor potential adverse effects.

151

Signs and Symptoms that indicate active disease

- Symptoms and abnormal signs indicating ongoing or decompensated disease in the last 7 days.
- For example, intermittent claudication (lower extremity pain on exertion) in conjunction with a diagnosis of peripheral vascular disease would indicate active disease.
- Sometimes signs and symptoms can be nonspecific and could be caused by several disease processes. Therefore, a symptom must be specifically attributed to the disease.
  - For example, a productive cough would confirm a diagnosis of pneumonia if specifically noted as such by a physician. Sources may include radiological reports, nursing assessments and care plans, progress notes, etc.

152

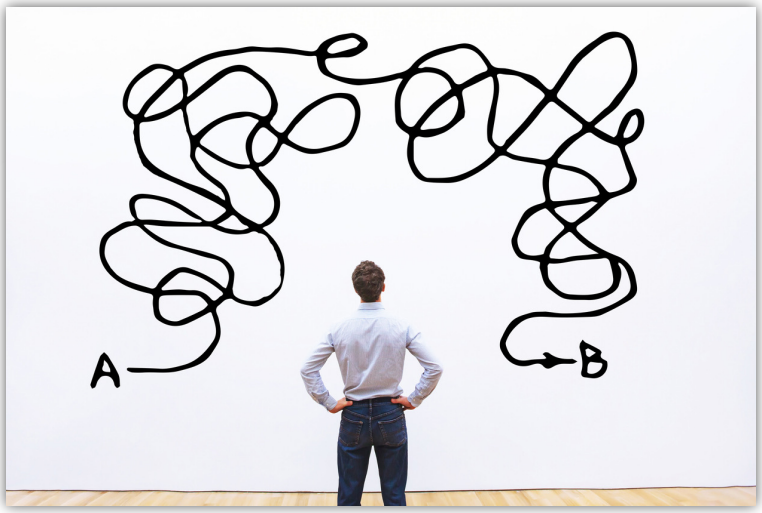
- Listing a disease/diagnosis (e.g., arthritis) on the resident's medical record problem list is not sufficient for determining active or inactive status.
- To determine if arthritis, for example, is an "active" diagnosis, the reviewer would check progress notes (including the history and physical) during the 7-day look-back period for notation of treatment of symptoms of arthritis, doctor's orders for medications for arthritis, and documentation of physical or other therapy for functional limitations caused by arthritis.

153

In situations where practitioners have potentially misdiagnosed residents with a condition for which *there is a lack of appropriate diagnostic information* in the medical record, such as for a mental disorder, the corresponding diagnosis in Section I should not be coded, and a referral by the facility and/or the survey team to the State Medical Boards or Boards of Nursing may be necessary.

Diagnosis is a complex multi-step process by a physician, which is difficult to accomplish with a single set of criteria. -NIH

154



This will take a while, but you need to know

155

If I'm not a provider, it's beyond my scope of practice to evaluate a provider's diagnostic criteria.

ICD-10 CM Coding criteria

Code assignment and Clinical Criteria

The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis. If there is conflicting medical record documentation, query the provider.

So, where did this strange guidance come from?

156

History

CMS became concerned that LTC providers were diagnosing schizophrenia when antipsychotics were ordered, so that antipsychotic would not trigger antipsychotic quality measures.

From Survey Book: F641 MDS Accuracy, F658 Comprehensive Care Plan, F757 Unnecessary drugs, F758 psychotropic drugs (repeated this paragraph for all 4 F-tags)

***Note**: CMS is aware of situations where practitioners have potentially misdiagnosed residents with a condition for which antipsychotics are an approved use (e.g., new diagnosis of schizophrenia) which would then exclude the resident from the long-stay antipsychotic quality measure. For these situations, determine if non-compliance exists for the facility's completion of an accurate assessment. This practice may also require referrals by the facility and/or the survey team to State Medical Boards or Boards of Nursing.*

157

F740: Behavioral health services:

Schizophrenia

Schizophrenia is a serious mental disorder that may interfere with a person's ability to think clearly, manage emotions, make decisions and relate to others. It is uncommon for schizophrenia to be diagnosed in a person younger than 12 or older than 40. Schizophrenia must be diagnosed by a qualified practitioner, using evidence-based criteria and professional standards, such as the Diagnostic and Statistical Manual of Mental Disorders - Fifth edition (DSM-5), and documented in the resident's medical record. Symptoms of Schizophrenia include delusions, hallucinations, disorganized speech (e.g., frequent derailment or incoherence), grossly disorganized or catatonic behavior, and diminished expression or initiative. Delusions refer to false beliefs that don't change even when the person who holds them is presented with new ideas or facts. Hallucinations include a person hearing voices, seeing things, or smelling things others can't perceive.

158

DSM-5 Diagnosis: Schizophrenia

- Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be delusions, hallucinations or disorganized speech:
  - Delusions
  - Hallucinations
  - Disorganized speech (e.g., frequent derailment or incoherence)
  - Grossly disorganized or catatonic behavior
  - Negative symptoms (i.e., diminished emotional expression or avolition)
- Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet the above criteria (i.e., active phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested only be negative symptoms or by two or more symptoms listed above present in an attenuated form.
- For a significant portion of time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is a failure to achieve expected level of interpersonal, academic, or occupational functioning).
- Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out.
- The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated).

The focus for CMS is on residents who were given the **new diagnosis after admission,** without going through the steps on this list.

- A person developing schizophrenia after 40 years old is very unlikely.

159

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-23-05-NH

DATE: January 18, 2023

TO: State Survey Agency Directors

FROM: Director, Quality, Safety & Oversight Group (QSOG)

SUBJECT: **Updates to the Nursing Home Care Compare Website and Five Star Quality Rating System: Adjusting Quality Measure Ratings Based on Erroneous Schizophrenia Coding, and Posting Citations Under Dispute**

Memorandum Summary

- **Adjusting Quality Measure Ratings:** CMS will be conducting audits of schizophrenia coding in the Minimum Data Set data and, based upon the results, adjust the Nursing Home Care Compare quality measure star ratings for facilities whose audits reveal inaccurate coding.
- **Posting Citations Under Dispute:** To be more transparent, CMS will now display citations under informal dispute on the Nursing Home Care Compare website.

CMS is concerned that some nursing homes have erroneously coded residents as having schizophrenia, which can mask the facilities' true rate of antipsychotic medication use. Therefore, CMS will conduct offsite audits of schizophrenia coding and based upon the results, adjust the quality measure star ratings for facilities whose audit reveals inaccurate coding.

CMS conducts focused schizophrenia audits to specifically address the issue of erroneous MDS coding of schizophrenia in nursing homes. Audits examine facility's evidence for appropriately documenting, assessing, and coding a diagnosis of schizophrenia in the MDS.

In pilot audits we found several issues.

- absence of comprehensive psychiatric evaluations and behavior documentation
- many residents had only sporadic behaviors noted in their medical records, and these behaviors were related to dementia, rather than schizophrenia.

In handouts

160

Schizophrenia audit results

each of the sampled residents. We found that the documentation provided did not support MDS coding for the diagnosis of schizophrenia. Our findings were based on the following:

☒ **Diagnosis: I6000. Schizophrenia (e.g., schizoaffective and schizophreniform disorders)**

- ☒ The diagnosis of schizophrenia was not noted anywhere in the medical record(s); however, it was listed on the electronic health record diagnosis list and subsequently inaccurately coded on the MDS. This issue pertains to resident number 2.
- ☐ The diagnosis was present upon admission per the facility-submitted documentation; however, the diagnosis was not coded on the admission MDS assessment(s).
- ☒ The Resident Assessment Instrument Manual was not followed regarding the requirement for the diagnosis to be coded on the MDS, including a progress note signed by the physician in the last 60 days, and documentation of an active problem in the last seven days of the assessment reference date. This issue pertains to resident numbers 2, 3, 4, 7, 8, 9, 10, 12, 14, 17

☒ **Diagnostic Process:**

- ☐ The reviewed medical record(s) lacked sufficient documentation of behaviors indicative of a schizophrenia diagnosis, in the six months prior to the diagnosis. This issue pertains to resident numbers 2, 3, 4, 7, 8, 9, 10, 12, 14, 17
- ☒ The reviewed medical record(s) did not contain documentation of a comprehensive medical and psychiatric evaluation, completed by a physician that meets professional standards of practice, at the time of the initial diagnosis of schizophrenia. This issue pertains to resident numbers 2, 3, 4, 7, 8, 9, 10, 12, 14, 17

In handouts

161

Schizophrenia audit results

☐ **Antipsychotic Medication Use – Clinical Indications, Monitoring, and Gradual Dose Reductions (GDR):**

- ☐ Clinical indications for the use of antipsychotic medications were lacking in the medical record(s) of the sampled resident(s).
- ☒ Documentation of monitoring for adverse drug reactions was lacking in the reviewed medical record(s). This issue pertains to resident numbers 4, 7, 8, 10, 12, 14
- ☒ The reviewed medical record(s) lacked documentation to indicate that GDRs were recommended and attempted, as appropriate. This issue pertains to resident number 10
- ☐ The sampled resident(s) were receiving antipsychotic medications; however, these medications were not appropriately coded on the MDS.
- ☒ Documentation of monitoring for target behaviors was lacking in the reviewed medical record(s). This issue pertains to resident numbers 8, 10, 12, 14, 17

CMS expects that all issues identified during this audit be corrected immediately. This pertains to all sampled residents, other residents within the facility currently impacted by the identified issues, and residents that may be impacted in the future.

162

In Summary:

In situations where practitioners have potentially misdiagnosed residents with a condition for which there is a lack of appropriate diagnostic information in the medical record, such as for a mental disorder, the corresponding diagnosis in Section I should not be coded, and a referral by the facility and/or the survey team to the State Medical Boards or Boards of Nursing may be necessary.

Coding tip doesn't specify schizophrenia. Example does. My opinion: If you think you have a diagnosis that doesn't meet any diagnostic criteria, discuss it with your boss & follow their guidance. They may need a "sit down" with the provider, But let's all be on the same page before we transmit that MDS.

The resident was admitted without a diagnosis of schizophrenia. After admission, the resident is prescribed an antipsychotic medication for schizophrenia by the primary care physician. However, the resident's medical record includes no documentation of a detailed evaluation by an appropriate practitioner of the resident's mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for six months prior to the start of the antipsychotic medication in accordance with professional standards.

Coding: Schizophrenia item (I6000), would **not be checked.**

Rationale: Although the resident has a physician diagnosis of schizophrenia and is receiving antipsychotic medications, coding the schizophrenia diagnosis would not be appropriate because of the lack of documentation of a detailed evaluation, in accordance with professional standards (§483.21(b)(3)(i)), of the resident's mental, physical, psychosocial, and functional status (§483.45(e)) and persistent behaviors for the time period required.

163

Diagnoses Checkboxes

Orange comments are from Judy, not the manual, source: CDC or NIH

Cancer {uncontrolled abnormal growth of cells, not all neoplasms are cancer}

- **I0100,** cancer (with or without metastasis)

Heart/Circulation

- **I0200,** anemia (e.g., aplastic, iron deficiency, pernicious, sickle cell)
  - Other types: Anemia due to B12 deficiency, due to folate deficiency, hemolytic anemia, idiopathic aplastic anemia, megaloblastic anemia, thalassemia
- **I0300,** atrial fibrillation or other dysrhythmias (e.g., bradycardias, tachycardias)
  - Other types: Atrial flutter, heart block, V fibrillation, Long QT syndrome, premature ventricular contractions, cardiac arrest, Torsade's de Pointes
- **I0400,** coronary artery disease (CAD) (e.g., angina, myocardial infarction, atherosclerotic heart disease [ASHD])
- **I0500,** deep venous thrombosis (DVT), pulmonary embolus (PE), or pulmonary thrombo-embolism (PTE)

164

- **I0600,** heart failure (e.g., congestive heart failure [CHF] and pulmonary edema)
  - While heart failure is a leading cause of pulmonary edema, the cause can be noncardiogenic

Noncardiogenic

Noncardiogenic pulmonary edema occurs when other diseases cause fluid to accumulate in your lungs. It isn't caused by increased blood flow in your lungs due to a backup from heart problems. Instead, the blood vessels in your lungs become inflamed or injured. The blood vessels then become leaky, and fluid goes into your air sacs.

Adult respiratory distress syndrome (ARDS) is another common name for noncardiogenic pulmonary edema. In ARDS, inflammation is the main problem, with causes that include:

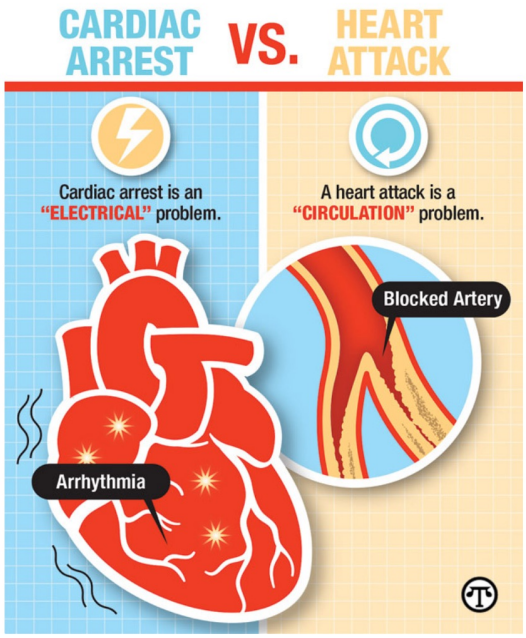
- Pneumonia.
- Sepsis (severe infection).
- Trauma.
- Pancreatitis.
- Liver disease.
- Drugs.
- Bleeding or swelling in your brain (neurogenic pulmonary edema).

If Pulmonary edema is not cardiogenic, you can use I8000 for more specific diagnosis

Cleveland Clinic

165

Cardiac arrest = I0300 dysrhythmias
Heart Attack = I0400 CAD



A heart attack is a "plumbing" problem whereas a cardiac arrest is an "electrical" problem.

166

Diagnoses Checkboxes

- **I0700,** hypertension
- **I0800,** orthostatic hypotension
- **I0900,** peripheral vascular disease or peripheral arterial disease

Gastrointestinal

- **I1100,** cirrhosis
- **I1200,** gastroesophageal reflux disease (GERD) or ulcer (e.g., esophageal, gastric, and peptic ulcers)
- **I1300,** ulcerative colitis or Crohn's disease or inflammatory bowel disease
  - Not inflammatory bowel syndrome

Genitourinary

- **I1400,** benign prostatic hyperplasia (BPH)
- **I1500,** renal insufficiency, renal failure, or end-stage renal disease (ESRD)
- **I1550,** neurogenic bladder
- **I1650,** obstructive uropathy

167

Diagnoses Checkboxes

Infections

- **I1700,** multidrug resistant organism (MDRO)
  - For epidemiologic purposes, MDROs are defined as microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents. Although the names of certain MDROs describe resistance to only one agent (e.g., MRSA, VRE), these pathogens are frequently resistant to most available antimicrobial agents. - CDC
- **I2000,** pneumonia
- **I2100,** septicemia* see next slide
- **I2200,** tuberculosis
- **I2300,** urinary tract infection (UTI) (last 30 days)
- **I2400,** **<u>viral</u>** hepatitis (e.g., hepatitis A, B, C, D, and E)
  - Non-viral hepatitis does not go here: 1. toxic 2. alcoholic 3. autoimmune
- **I2500,** wound infection <u>(other than foot)</u>

168

Section I: I2100: Septicemia

- For sepsis to be considered septicemia, there needs to be inflammation due to sepsis and evidence of a microbial process. If the medical record reflects inflammation due to sepsis and evidence of a microbial process, code I2100, Septicemia. If the medical record does not reflect inflammation due to sepsis and evidence of a microbial process, enter the sepsis diagnosis and ICD code in item I8000, Additional Active Diagnoses.

169

- Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs.
- This response is characterized by widespread inflammation throughout the body. Here's how it happens and an example:
- **How Sepsis Causes Inflammation**
  1. **Infection:** It starts with an infection somewhere in the body, which could be bacterial, viral, or fungal.
  2. **Immune Response:** The body's immune system kicks in to fight the infection. This involves releasing various chemicals and cells into the bloodstream.
  3. **Overreaction:** In sepsis, the immune system overreacts, and this response becomes dysregulated. Instead of just targeting the infection, it triggers a widespread inflammatory response throughout the body.
  4. **Inflammation:** This inflammation can damage tissues and organs, leading to a cascade of problems like blood clots, leaky blood vessels, and organ failure.

-Yale Medicine

170

Diagnoses Checkboxes

Metabolic

- **I2900,** diabetes mellitus (DM) (e.g., diabetic retinopathy, nephropathy, neuropathy)
- **I3100,** hyponatremia
- **I3200,** hyperkalemia
- **I3300,** hyperlipidemia (e.g., hypercholesterolemia)
- **I3400,** thyroid disorder (e.g., hypothyroidism, hyperthyroidism, Hashimoto's thyroiditis)

171

Diagnoses Checkboxes

Musculoskeletal

- **I3700,** arthritis (e.g., degenerative joint disease [DJD], osteoarthritis, rheumatoid arthritis [RA])
- **I3800,** osteoporosis
- **I3900,** hip fracture (any hip fracture that has a relationship to current status, treatments, monitoring (e.g., subcapital fractures and fractures of the trochanter and femoral neck)
- **I4000,** other fracture

172

Neurological

- **I4200,** Alzheimer's disease
- **I4300,** aphasia: from any cause
- **I4400,** cerebral palsy
- **I4500,** cerebrovascular accident (CVA), transient ischemic attack (TIA), or stroke
- **I4800,** dementia (e.g., Lewy-Body dementia; vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia, such as Pick's disease; and dementia related to stroke, Parkinson's disease or Creutzfeldt-Jakob diseases)
- **I4900,** hemiplegia or hemiparesis: from any cause
- **I5000,** paraplegia: from any cause
- **I5100,** quadriplegia* see next slide
- **I5200,** multiple sclerosis (MS)
- **I5250,** Huntington's disease
- **I5300,** Parkinson's disease
- **I5350,** Tourette's syndrome
- **I5400,** seizure disorder or epilepsy
- **I5500,** traumatic brain injury (TBI)

173

Section I5100: Quadriplegia

Quadriplegia primarily refers to the paralysis of all four limbs, arms and legs, caused by spinal cord injury.

Coding I5100 Quadriplegia is limited to spinal cord injuries and must be a primary diagnosis and not the result of another condition.

Functional quadriplegia refers to complete immobility due to severe physical disability or frailty, E.g. cerebral palsy, stroke, contractures, brain disease, advanced dementia, etc. For these, the primary physician-documented diagnosis should be coded on the MDS and not the resulting paralysis or paresis from that condition. For example, an individual with cerebral palsy with spastic quadriplegia should be coded in I4400 Cerebral Palsy, and not in I5100, Quadriplegia.

174

174

Diagnoses Checkboxes

Nutritional

- **I5600,** malnutrition (protein or calorie) or ***at risk for malnutrition***

Psychiatric/Mood Disorder

- **I5700,** anxiety disorder
- **I5800,** depression (other than bipolar)
- **I5900,** bipolar disorder
- **I5950,** psychotic disorder (other than schizophrenia)
- **I6000,** schizophrenia (e.g., schizoaffective and schizophreniform disorders)
- **I6100,** post-traumatic stress disorder (PTSD)

175

I6000, schizophrenia (e.g., schizoaffective and schizophreniform disorders)

- Schizoaffective disorder is much like schizophrenia with a mood component. In addition to delusions, hallucinations, or disorganized thoughts the patient suffers from major mood episodes (depressive or manic). This means they cannot be treated for a psychotic disorder alone; the mood disorder must also be addressed. [7]
- **Schizophreniform disorder** has identical features to schizophrenia but the duration of symptoms is less. The patient has experienced symptoms for longer than one week but less than six months. This diagnosis is often considered the first step towards an eventual schizophrenia diagnosis, which requires continuous signs of disturbance for at least six months.[8] Psycom.net

Note: Schizoaffective disorder and schizophreniform disorder are different from psychosis, but we check the same box for all three. Know this when talking to surveyors or Schizophrenia auditors.

176

Diagnoses Checkboxes

Pulmonary

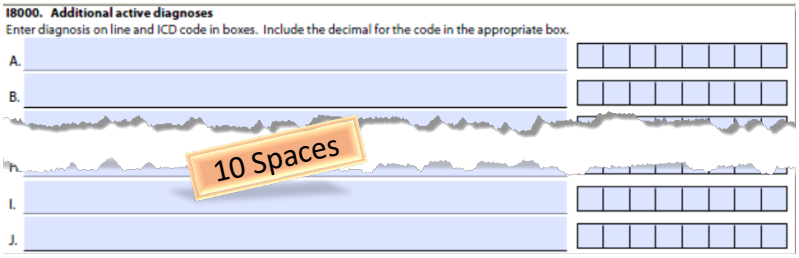
- **I6200,** asthma, chronic obstructive pulmonary disease (COPD), or chronic lung disease (e.g., chronic bronchitis and restrictive lung diseases, such as asbestosis)
- **I6300,** respiratory failure
  - For PDPM you must check this box and list dx code in I8000.
    - I6300 + O2 while resident = Special Care Low
    - Dx code for respiratory failure in I8000 is 1 NTA point

Vision

- **I6500,** cataracts, glaucoma, or macular degeneration
- **None of Above**
- **I7900,** none of the above active diagnoses within the past 7 days

177

I8000 Additional Active Diagnoses



178

Section I: UTI Definition

Item I2300 Urinary tract infection (UTI): The UTI has a look-back period of 30 days for active disease instead of 7 days.

- **Code only if both of the following are met in the last 30 days:**

1. It was determined that the resident had a UTI using evidence-based criteria such as McGeer, NHSN, or Loeb in the last 30 days,

AND

2. A physician documented UTI diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days.

179

Section I: UTI Definition

- Facilities are expected to use the same nationally recognized criteria chosen for use in their Infection Prevention and Control Program to determine the presence of a UTI in a resident.
- Example: if a facility chooses to use the Surveillance Definitions of Infections (updated McGeer criteria) as part of the facility's Infection Prevention and Control Program, then the facility should also use the same criteria to determine whether or not a resident has a UTI.
- **Resources for evidence-based UTI criteria:**
  - Loeb criteria: https://www.researchgate.net/publication/12098745_Development_of_Minimum_Criteria_for_the_Initiation_of_Antibiotics_in_Residents_of_Long-Term-Care_Facilities_Results_of_a_Consensus_Conference
  - Surveillance Definitions of Infections in LTC (updated McGeer criteria): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538836/
  - National Healthcare Safety Network (NHSN):
  - https://www.cdc.gov/nhsn/ltc/uti/index.html

180

UTI: Coding Tips

- If the diagnosis of UTI was made prior to the resident's admission, entry, or reentry into the facility, it is **not** necessary to obtain or evaluate the evidence-based criteria used to make the diagnosis in the prior setting. A documented physician diagnosis of UTI prior to admission is acceptable. This information may be included in the hospital transfer summary or other paperwork.
- When the resident is transferred, but not admitted, to a hospital (e.g., emergency room visit, observation stay) the facility must use evidence-based criteria to evaluate the resident and determine if the criteria for UTI are met AND verify that there is a physician-documented UTI diagnosis when completing I2300 Urinary Tract Infection (UTI).

181

Examples I-9

- The resident had a stroke 4 months ago and continues to have left-sided weakness, visual problems, and inappropriate behavior. The resident is on aspirin and has physical therapy and occupational therapy three times a week. The physician's note 25 days ago lists stroke.
- **Coding: Cerebrovascular Vascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke** item (I4500), would be **checked**.
- **Rationale:** The physician note within the last 30 days indicates stroke, and the resident is receiving medication and therapies to manage continued symptoms from stroke.

182

Examples:

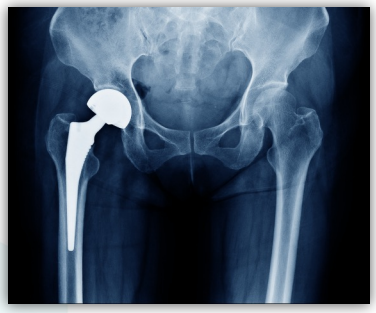
- Mr. J fell and fractured his hip 2 years ago. At the time of the injury, the fracture was surgically repaired. Following the surgery, the resident received several weeks of physical therapy in an attempt to restore him to his previous ambulation status, which had been independent without any devices. Although he received therapy services at that time, he now requires assistance to stand from the chair and uses a walker. He also needs help with lower body dressing because of difficulties standing and leaning over.
- **Coding: Hip Fracture** item (I3900), would **not be checked.**
- **Rationale:** Although the resident has mobility and self-care limitations in ambulation and ADLs due to the hip fracture, he has not received therapy services during the 7-day look-back period; thus, Hip Fracture would be considered inactive.

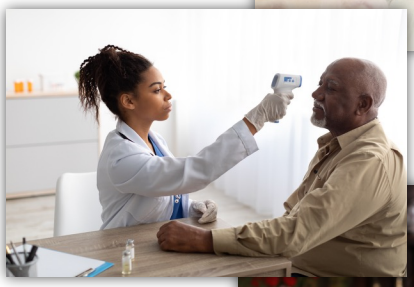
183

- A resident with a past history of healed peptic ulcer is prescribed a non-steroidal anti-inflammatory (NSAID) medication for arthritis. The physician also prescribes a proton-pump inhibitor to decrease the risk of peptic ulcer disease (PUD) from NSAID treatment. Coding: Arthritis item (I3700), would be checked.
- Rationale: Arthritis would be considered an active diagnosis because of the need for medical therapy. Given that the resident has a history of a healed peptic ulcer without current symptoms, the proton-pump inhibitor prescribed is preventive and therefore PUD would not be coded as an active disease.

184

Section J: Health Status





185

J0100: Pain Management: 5 days or since most recent entry

J0100. Pain Management - Complete for all residents, regardless of current pain level

At any time in the last **5** days, has the resident:

Enter Code ☐ **A. Received scheduled pain medication regimen?**
0. No
1. Yes

Enter Code ☐ **B. Received PRN pain medications OR was offered and declined?**
0. No
1. Yes

Enter Code ☐ **C. Received non-medication intervention for pain?**
0. No
1. Yes

- Received PRN
  - Yes if PRN med was either received OR ***was offered & declined.***
- Non-med intervention
  - Yes if scheduled as part of the care plan and documented that intervention was actually received and assessed for efficacy.

186

J0100 Pain Management

PAIN MEDICATION REGIMEN: Pharmacological agent(s) prescribed to relieve or prevent the recurrence of pain. Include all medications used for pain management by any route and any frequency during the look-back period. Include oral, transcutaneous, subcutaneous, intramuscular, rectal, intravenous injections or intraspinal delivery. This item does not include medications that primarily target treatment of the underlying condition, such as chemotherapy or steroids, although such treatments may lead to pain reduction.

J-1

187

J0100 Instructions

SCHEDULED PAIN MEDICATION REGIMEN: Pain medication order that defines dose and specific time interval for pain medication administration. For example, once a day, every 12 hours.

PRN PAIN MEDICATIONS
Pain medication order that specifies dose and indicates that pain medication may be given on an as needed basis, including a time interval, such as every 4 hours as needed for pain or every 6 hours as needed for pain.

NON-MEDICATION PAIN INTERVENTION: Scheduled and implemented non-pharmacological interventions include, but are not limited to: bio-feedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electrical stimulation, radiotherapy, ultrasound and acupuncture. Herbal or alternative medicine products are not included in this category.

J-2

188

Pain interview

7 Day Lookback

J0200 – J0600

- Standardized, structured, scripted
- Not chats
- May be done verbally, in writing or both
- Cue cards recommended
- Appendix D Review

189

Coding Instructions J0200: Should Interview be conducted? (Gateway question)

- *Attempt to complete the interview if the resident is at least sometimes understood and an **interpreter is present** or not required.*

J0200. Should Pain Assessment Interview be Conducted?

Attempt to conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea)

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete J0800, Indicators of Pain or Possible Pain
1. **Yes** → Continue to J0300, Pain Presence

190

Interview Instructions

- Conduct the interview in a private setting.
- Interact in preferred language. If resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.
- Be sure the resident can hear you and they have access to their preferred method of communication.
- Minimize background noise.
- Sit so that the resident can see your face. Minimize glare by directing light sources away from the resident's face.
- Give an introduction before starting the interview. Suggested language: "I'd like to ask you some questions about pain. The reason I am asking these questions is to understand how often you have pain, how severe it is, and how pain affects your daily activities. This will help us to develop the best plan of care to help manage your pain."

191

Coding Tips and Special Populations

- Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.
- If the resident interview should have been conducted, but was not done within the look-back period of the ARD item J0200 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items J0300–J0600. Item J0700, Should the Staff Assessment for Pain be Conducted, is coded 0, No.

192

Interview Instructions

- Directly ask the resident each item in J0300 through J0600 in the order provided.
  - Use other terms for pain or follow-up discussion if the resident seems unsure or hesitant.
- If the resident chooses not to answer a particular item, accept his/her refusal, **code 9**, and move on to the next item.
- If the resident is unsure about whether the pain occurred in the 5-day time interval, prompt the resident to think about the most recent episode of pain and try to determine whether it occurred within the look-back period.

193

Pain Interview Instructions

J0300. Pain Presence

Enter Code ☐

Ask resident: ***"Have you had pain or hurting at any time** in the last 5 days?"*

0. **No** → Skip to J1100, Shortness of Breath
1. **Yes** → Continue to J0410, Pain Frequency
9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

J0410. Pain Frequency

Enter Code ☐

Ask resident: ***"How much of the time have you experienced pain or hurting** over the last 5 days?"*

1. **Rarely or not at all**
2. **Occasionally**
3. **Frequently**
4. **Almost constantly**
9. **Unable to answer**

9 = unable, unwilling or nonsensical response

194

J0510. Pain Effect on Sleep

Enter Code ☐

Ask resident: *"Over the past 5 days,* ***how much of the time has pain made it hard for you to sleep at night?"***

1. Rarely or not at all
2. Occasionally
3. Frequently
4. Almost constantly
8. Unable to answer

J0520. Pain Interference with Therapy Activities

Enter Code ☐

Ask resident: *"Over the past 5 days,* ***how often have you limited your participation in rehabilitation therapy sessions due to pain?"***

0. Does not apply - I have not received rehabilitation therapy in the past 5 days
1. Rarely or not at all
2. Occasionally
3. Frequently
4. Almost constantly
8. Unable to answer

J0530. Pain Interference with Day-to-Day Activities

Enter Code ☐

Ask resident: *"Over the past 5 days,* ***how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?"***

1. Rarely or not at all
2. Occasionally
3. Frequently
4. Almost constantly
8. Unable to answer

DEFINITION

REHABILITATION THERAPY

Special healthcare services or programs that help a person regain physical, mental, and/or cognitive (thinking and learning) abilities that have been lost or impaired as a result of disease, injury, or treatment. Can include, for example, physical therapy, occupational therapy, speech therapy, and cardiac and pulmonary therapies.

195

195

J0600. Pain Intensity - Administer **ONLY ONE** of the following pain intensity questions (A or B)

Enter Rating ☐☐

A. Numeric Rating Scale (00-10)

Ask resident: *"Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine."* (Show resident 00 -10 pain scale)

Enter two-digit response. Enter 99 if unable to answer.

Enter Code ☐

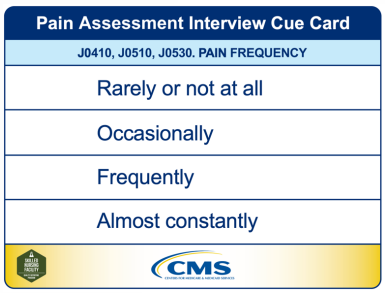
B. Verbal Descriptor Scale

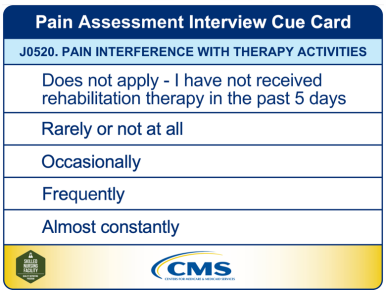
Ask resident: *"Please rate the intensity of your worst pain over the last 5 days."* (Show resident verbal scale)

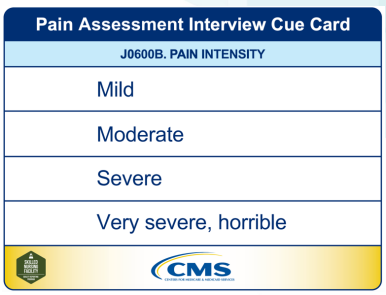
1. Mild
2. Moderate
3. Severe
4. Very severe, horrible
9. Unable to answer

1. You may use either the Numeric Rating Scale item (J0600A) or the Verbal Descriptor Scale item (J0600B) to interview the resident about pain intensity. For each resident, try to use the same scale used on prior assessments.
2. If the resident is unable to answer using one scale, the other scale should be attempted.

196







Available here:

https://www.cms.gov/files/document/2023septembersnfpainassessmentinterviewcuecards.pdf

197

J0700. Should the Staff Assessment for Pain be Conducted?

Enter Code ☐

0. **No** (J0410 = 1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea)
1. **Yes** (J0410 = 9) → Continue to J0800, Indicators of Pain or Possible Pain

The Staff Assessment for Pain should only be completed if the Pain Assessment Interview (J0300–J0600) was not completed.

DEFINITION

COMPLETED *PAIN ASSESSMENT* INTERVIEW

The *P*ain *Assessment* *I*nterview is successfully completed if the resident reported no pain (J0300 = *0. No*), or if the resident reported pain (J0300 = *1. Y*es) and the follow-up question J04*1*0 is answered.

198

J0800: Indicators of Pain or Possible Pain: 5 day lookback

Staff Assessment for Pain.

J0800. Indicators of Pain or Possible Pain in the last 5 days

↓ Check all that apply

- ☐ A. **Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)
- ☐ B. **Vocal complaints of pain** (e.g., that hurts, ouch, stop)
- ☐ C. **Facial expressions** (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
- ☐ D. **Protective body movements or postures** (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
- ☐ Z. **None of these signs observed or documented** → If checked, skip to J1100, Shortness of Breath (dyspnea)

J0850. Frequency of Indicator of Pain or Possible Pain in the last 5 days

Enter Code ☐

Frequency with which resident complains or shows evidence of pain or possible pain

1. **Indicators of pain** or possible pain observed **1 to 2 days**
2. **Indicators of pain** or possible pain observed **3 to 4 days**
3. **Indicators of pain** or possible pain observed **daily**

Check all that apply in the past 5 days based on staff observation of pain indicators. If any indicators, code frequency in J0850

199

J1100 & J1300

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

↓ Check all that apply

- ☐ A. **Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
- ☐ B. **Shortness of breath** or trouble breathing **when sitting at rest**
- ☐ C. **Shortness of breath** or trouble breathing **when lying flat**
- ☐ Z. **None of the above**

J1300. Current Tobacco Use

Enter Code ☐

0. **No**
1. **Yes**

Vape pens do not contain tobacco

DEFINITION

TOBACCO USE
Includes tobacco used in any form.

200

Shortness of Breath

Steps for Assessment

- Interview resident. Many residents may be able to provide feedback about their own symptoms.
- If the resident is not experiencing SOB during interview, ask if SOB occurs when he or she engages in certain activities.
- Review the medical record….Interview staff, family/significant other regarding resident history of shortness of breath, allergies or other environmental triggers of shortness of breath.
- Observe for SOB or trouble breathing. If observed, note whether it occurs with certain positions or activities.

201

Shortness of Breath

- For SOB with exertion:
  - If the resident avoids activity or is unable to engage in activity because of shortness of breath, then code this as present.
- For SOB lying flat:
  - Also code this as present if the resident avoids lying flat because of shortness of breath.

SOB does not have to actually happen during the lookback in these cases.

202

J1400 Prognosis

Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months (Requires physician documentation)

0. No
1. Yes

Code 1, yes: if the medical record includes physician documentation:

1) that the resident is terminally ill; or
2) the resident is receiving hospice services.

J-24

203

J1400

Steps for Assessment

1. Review the medical record for documentation by the physician that the resident's condition or chronic disease may result in a life expectancy of less than 6 months, or that they have a terminal illness.
2. If the physician states that the resident's life expectancy may be less than 6 months, request that he or she document this in the medical record. Do not code until there is documentation in the medical record.
3. Review the medical record to determine whether the resident is receiving hospice services.

204

TERMINALLY ILL
Terminally ill means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

HOSPICE SERVICES
A program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider. Under the hospice program benefit regulations, a physician is required to document in the medical record a life expectancy of less than 6 months, so if a resident is on hospice the expectation is that the documentation is in the medical record.

205

DEFINITION
CONDITION OR CHRONIC DISEASE THAT MAY RESULT IN A LIFE EXPECTANCY OF LESS THAN 6 MONTHS
In the physician's judgment, the resident has a diagnosis or combination of clinical conditions that have advanced (or will continue to deteriorate) to a point that the average resident with that level of illness would not be expected to survive more than 6 months.

This judgment should be substantiated by a physician note. It can be difficult to pinpoint the exact life expectancy for a single resident. Physician judgment should be based on typical or average life expectancy of residents with similar level of disease burden as this resident.

206

J1550. Problem Conditions	
↓ Check all that apply	
☐	A. Fever
☐	B. Vomiting
☐	C. Dehydrated
☐	D. Internal bleeding
☐	Z. None of the above

Fever: 2.4 above baseline, or **100.4 upon admission** (prior to baseline establishment)

Internal Bleeding: Nose bleeds that are easily controlled, **menses, or a urinalysis that shows a small amount of red blood cells** should not be coded as internal bleeding.

207

Dehydration

- Dehydration requires at least two of the following indicators:
  1. Takes in less than 1,500 ml of fluids daily.
  2. Has one or more clinical signs of dehydration.
  3. Fluid loss exceeds amount of fluids residents takes in.

208

J1700/1800/1900: Falls & Injury

J1700. Fall History on Admission/Entry or Reentry
Complete only if A0310A = 01 or A0310E = 1

Admission or 1st assessment since entry

Do not count PPS assessment not transmitted (Not original Med A)

Enter Code ☐

A. Did the resident have a fall any time in the **last month** prior to admission/entry or reentry?
- **0. No**
- **1. Yes**
- **9. Unable to determine**

Enter Code ☐

B. Did the resident have a fall any time in the **last 2–6 months** prior to admission/entry or reentry?
- **0. No**
- **1. Yes**
- **9. Unable to determine**

Enter Code ☐

C. Did the resident have any **fracture related to a fall in the 6 months** prior to admission/entry or reentry?
- **0. No**
- **1. Yes**
- **9. Unable to determine**

J1800. Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

Enter Code ☐

Has the resident **had any falls since admission/entry or reentry or the prior assessment** (OBRA or Scheduled PPS), whichever is more recent?
- **0. No** → Skip to J2000, Prior Surgery
- **1. Yes** → Continue to J1900, Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS)

J1900. Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent

Coding:	↓	Enter Codes in Boxes
0. None 1. One 2. Two or more	☐	**A. No injury** - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall
	☐	**B. Injury (except major)** - as described in the CMS LTCF RAI User's Manual
	☐	**C. Major injury** - as described in the CMS LTCF RAI User's Manual

209

Definition of a Fall

DEFINITION

FALL

Unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., onto a bed, chair, or bedside mat) *or the result of an overwhelming external force (e.g., a resident pushes another resident)*.

An intercepted fall occurs when the resident would have fallen if they had not caught themself or had not been intercepted by another person – this is still considered a fall.

210

Falls Definitions

DEFINITION

FRACTURE RELATED TO A FALL
Any documented bone fracture (in a problem list from a medical record, an x-ray report, or by history of the resident or caregiver) that occurred as a direct result of a fall or was recognized and later attributed to the fall. Do not include fractures caused by trauma related to car crashes or pedestrian versus car accidents or impact of another person or object against the resident.

DEFINITIONS

INJURY RELATED TO A FALL
Any documented injury that occurred as a result of, or was recognized within a short period of time (e.g., hours to a few days) after the fall and attributed to the fall.

INJURY (EXCEPT MAJOR)
Includes, *but is not limited to,* skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain.

MAJOR INJURY
Includes, *but is not limited to, traumatic* bone fractures, joint dislocations/ *subluxations, internal organ injuries, amputations, spinal cord injuries*, head injuries, *and crush injuries*.

211

211

Steps for Assessment – J1900

J1900.	Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS), whichever is more recent		
Coding:		↓	Enter Codes in Boxes
0. None 1. One 2. Two or more		☐	A. **No injury** - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall
		☐	B. **Injury (except major)** - as described in the CMS LTCF RAI User's Manual
		☐	C. **Major injury** - as described in the CMS LTCF RAI User's Manual

1. If this is the first assessment/entry or reentry (A0310E = 1), review medical record for time period from the admission date to the ARD.
2. If this is not the first assessment/entry or reentry (A0310E = 0), the review period is from the day after the ARD of the last OBRA or scheduled PPS MDS assessment to the ARD of the current assessment.
3. Review all available sources for any fall since the last assessment, no matter whether it occurred while out in the community, in an acute hospital, or in the nursing home. Include medical records generated in any health care setting since last assessment.

212

Steps for Assessment – J1900

4. Review nursing home incident reports, fall logs and the medical record (physician, nursing, therapy, and nursing assistant notes).
5. Ask the resident and family about falls during the look-back period. Resident and family reports of falls should be captured here whether or not these incidents are documented in the medical record.
6. Review any follow-up medical information received pertaining to the fall, even if this information is received after the ARD (e.g., emergency room x-ray, MRI, CT scan results), and ensure that this information is used to code the assessment.

213

Coding Tips

- The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground.
- Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or a nursing home.
- CMS understands that challenging a resident's balance and training them to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls. *However, if there is a loss of balance during supervised therapeutic interventions and the resident comes to rest on the ground, floor or next lower surface despite the clinician's effort to intercept the loss of balance, it is considered a fall.*

214

Coding Tips

- If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to the Internet Quality Improvement and Evaluation System (iQIES), the assessment must be modified to update the level of injury that occurred with that fall.
- *Fractures confirmed to be pathologic (vs. traumatic) are not considered a major injury resulting from a fall.*

215

Differentiating from Traumatic vs. Pathological Fractures

- Resident A, who has osteoporosis, falls, resulting in a right hip fracture. The Emergency Department physician confirms that the fracture is a result of the resident's bone disease and not a result of the fall.
  - Coding: J1800 would be coded 1, yes and J1900C would be coded 0, none. Rationale: The physician determined that the fracture was a pathological fracture due to osteoporosis. Because the fracture was determined to be pathological, it is not coded as a fall with major injury.
- Resident L, who has osteoporosis, falls, resulting in a right hip fracture. The physician in the acute care hospital confirms that the fracture is a result of the resident's fall and not the resident's history of osteoporosis.
  - Coding: J1800 would be coded 1, yes and J1900C would be coded 1, one. Rationale: Because the physician determined that the fracture was a result of the fall, it is a traumatic fracture and, therefore, is a fall with major injury.

216

J2000. Prior Surgery - Complete only if A0310B = 01

Enter Code	Did the resident have major surgery during the **100 days prior to admission**?
☐	0. **No** 1. **Yes** 8. **Unknown**

Used for SNF QRP Risk Adjustments

Coding Tips

Generally, major surgery for item J2000 refers to a procedure that meets the following criteria:

1. the resident was an inpatient in an acute care hospital for at least one day in the 100 days prior to admission to the skilled nursing facility (SNF), ***and***
2. the surgery carried some degree of risk to the resident's life or the potential for severe disability

217

J2100. Recent Surgery Requiring Active SNF Care - Complete only if A0310B = 01 or 08

Enter Code	Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay?
☐	0. **No** 1. **Yes** 8. **Unknown**

Used in PDPM payment system

Coding Instructions

• Code 0, No: if the resident did not have major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.

• Code 1, Yes: if the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.

• Code 8, Unknown: if it is unknown or cannot be determined whether the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission.

Coding Tips

• Generally, major surgery for item J2100 refers to a procedure that meets the following criteria:

1. the resident was an inpatient in an acute care hospital for **at least one day in the 30 days prior to admission to the skilled nursing facility (SN**F), and
2. the surgery carried some degree of risk to the resident's life or the potential for severe disability.

218

Patient Surgical Categories

Item	Surgical Procedure Category	Item	Surgical Procedure Category
J2100	Recent Surgery Requiring Active SNF Care	J2610	Neuro surgery - peripheral and autonomic nervous system - open and percutaneous
J2300	Knee Replacement - partial or total	J2620	Neuro surgery - insertion or removal of spinal and brain neurostimulators, electrodes, catheters, and CSF drainage devices
J2310	Hip Replacement - partial or total	J2699	Neuro surgery - other
J2320	Ankle Replacement - partial or total	J2700	Cardiopulmonary surgery - heart or major blood vessels - open and percutaneous procedures
J2330	Shoulder Replacement - partial or total	J2710	Cardiopulmonary surgery - respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords - open and endoscopic
J2400	Spinal surgery - spinal cord or major spinal nerves	J2799	Cardiopulmonary surgery - other
J2410	Spinal surgery - fusion of spinal bones	J2800	Genitourinary surgery - male or female organs
J2420	Spinal surgery - lamina, discs, or facets	J2810	Genitourinary surgery - kidneys, ureter, adrenals, and bladder - open, laparoscopic
J2499	Spinal surgery - other	J2899	Genitourinary surgery - other
J2500	Ortho surgery - repair fractures of shoulder or arm	J2900	Major surgery - tendons, ligament, or muscles
J2510	Ortho surgery - repair fractures of pelvis, hip, leg, knee, or ankle	J2910	Major surgery - GI tract and abdominal contents from esophagus to anus, biliary tree, gall bladder, liver, pancreas, spleen - open, laparoscopic
J2520	Ortho surgery - repair but not replace joints	J2920	Major surgery - endocrine organs (such as thyroid, parathyroid), neck, lymph nodes, and thymus - open
J2530	Ortho surgery - repair other bones	J2930	Major surgery - breast
J2599	Ortho surgery - other	J2940	Major surgery - deep ulcers, internal brachytherapy, bone marrow, stem cell harvest/transplant
J2600	Neuro surgery - brain, surrounding tissue/blood vessels	J5000	Major surgery - other not listed above

219

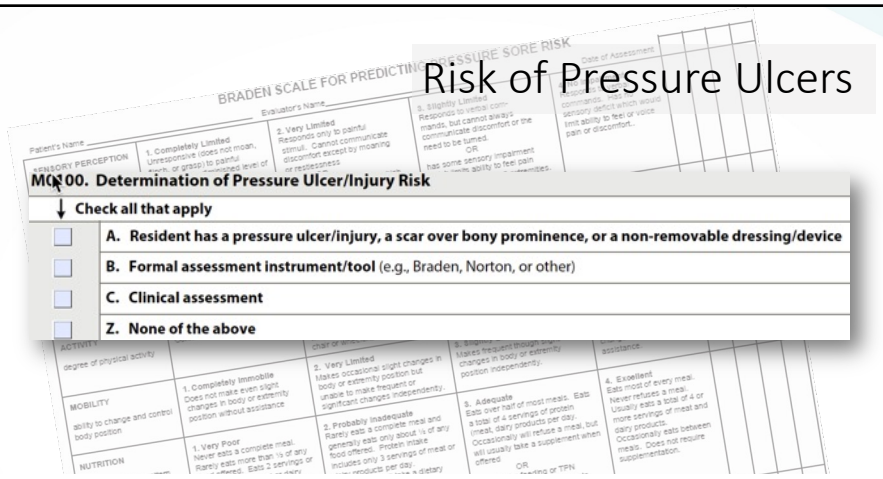
J2300 – J5000: Recent surgeries requiring active SNF care

Steps for Assessment

- Identify recent surgeries: The surgeries in this section must have been documented by a physician (NPP) **in the last 30 days and must have occurred during the inpatient stay that immediately preceded the resident's Part A admission.**
- Determine whether the surgeries require active care during the SNF stay: Once a recent surgery is identified, it must be determined if the surgery requires active care during the SNF stay. Surgeries requiring active care during the SNF stay are surgeries that have a direct relationship to the resident's primary SNF diagnosis, as coded in I0020B.
- Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered surgeries that do not require active care during the SNF stay.

220

Risk of Pressure Ulcers



M0100. Determination of Pressure Ulcer/Injury Risk

Check all that apply

- A. Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device
- B. Formal assessment instrument/tool (e.g., Braden, Norton, or other)
- C. Clinical assessment
- Z. None of the above

RAI Page 3-3: Check all that have occurred **in the 7 day lookback period or since most recent entry**

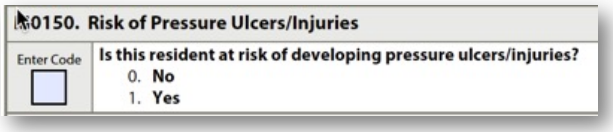
RAI Page 2-2: If it did not occur during the look back period, it is not coded on the MDS.

221

M0100: Steps for Assessment

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

222

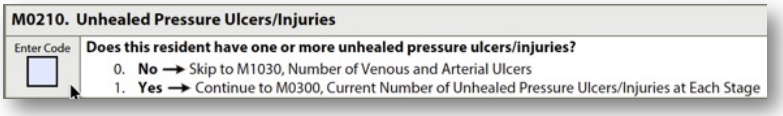


Steps for Assessment:

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

223

M0210: Unhealed Pressure Ulcers/Injuries: 7- day lookback or since last entry



Planning for Care

- The pressure ulcer/injury definitions used in the RAI Manual have been adapted from those recommended by NPUAP (National Pressure Ulcer Advisory Panel).
- For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or DTI 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 must code the MDS according to the instructions in this manual.**

224

M0210: Unhealed Pressure Ulcers/Injuries: 7 day lookback or since last entry

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code	Does this resident have one or more unhealed pressure ulcers/injuries?
☐	0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers 1. **Yes** → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Coding Tips

- if an ulcer arises from a combination of factors which are primarily caused by pressure, then the ulcer should be included in this section as a pressure ulcer/injury.
- Mucosal pressure ulcers are not staged using the skin pressure ulcer staging system because anatomical tissue comparisons cannot be made. Therefore, mucosal ulcers (for example, those related to nasogastric tubes, nasal oxygen tubing, endotracheal tubes, urinary catheters, etc.) should not be coded here. Oral mucosal ulcers are captured in item L0200C, Abnormal mouth tissue.
- If a pressure ulcer is surgically closed with a flap or graft, it should be coded as a surgical wound and not as a pressure ulcer. If the flap or graft fails, continue to code it as a surgical wound until healed.

225

M0210: Unhealed Pressure Ulcers/Injuries: 7 day lookback or since last entry

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code	Does this resident have one or more unhealed pressure ulcers/injuries?
☐	0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers 1. **Yes** → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Coding Tips

- Scabs and eschar are different both physically and chemically.
  - Eschar is a collection of dead tissue within the wound that is flush with the surface of the wound.
  - A scab is made up of dried blood cells and serum, sits on the top of the skin, and forms over exposed wounds such as wounds with granulating surfaces (like pressure ulcers, lacerations, evulsions, etc.).
  - A scab is evidence of wound healing. A pressure ulcer that was staged as a 2 and now has a scab indicates it is a healing stage 2, and therefore, staging should not change.

226

M0210: Unhealed Pressure Ulcers/Injuries: 7 day lookback or since last entry

M0210. Unhealed Pressure Ulcers/Injuries

Enter Code	Does this resident have one or more unhealed pressure ulcers/injuries?
☐	0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers 1. **Yes** → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Coding Tips

- If two pressure ulcers/injuries occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate pressure ulcers/injuries.
- If a resident had a pressure ulcer/injury that healed during the look-back period of the current assessment, **do not code the ulcer/injury on the assessment.**
- Skin changes at the end of life (SCALE), also referred to as Kennedy Terminal Ulcers (KTUs) and skin failure, are not primarily caused by pressure and are not coded in Section M.

227

M0300: Current Number of Unhealed pressure ulcers/injuries at each stage

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

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

Enter Number ☐ 1. **Number of Stage 1 pressure injuries**

B. **Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

Enter Number ☐ 1. **Number of Stage 2 pressure ulcers** - If 0 → Skip to M0300C, Stage 3

Enter Number ☐ 2. **Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

C. **Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling

Enter Number ☐ 1. **Number of Stage 3 pressure ulcers** - If 0 → Skip to M0300D, Sta

Enter Number ☐ 2. **Number of these Stage 3 pressure ulcers that were present up** noted at the time of admission/entry or reentry

D. **Stage 4:** Full thickness tissue loss with exposed bone, tendon or muscle. wound bed. Often includes undermining and tunneling

Enter Number ☐ 1. **Number of Stage 4 pressure ulcers** - If 0 → Skip to M0300E, Ur

Enter Number ☐ 2. **Number of these Stage 4 pressure ulcers that were present up** noted at the time of admission/entry or reentry

E. **Unstageable - Non-removable dressing/device:** Known but not stageable due to non-removable dressing/device

Enter Number ☐ 1. **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable - Slough and/or eschar

Enter Number ☐ 2. **Number of these unstageable pressure ulcers/injuries that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

F. **Unstageable - Slough and/or eschar:** Known but not stageable due to coverage of wound bed by slough and/or eschar

Enter Number ☐ 1. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** - If 0 → Skip to M0300G, Unstageable - Deep tissue injury

Enter Number ☐ 2. **Number of these unstageable pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

G. **Unstageable - Deep tissue injury:**

Enter Number ☐ 1. **Number of unstageable pressure injuries presenting as deep tissue injury** - If 0 → Skip to M1030, Number of Venous and Arterial Ulcers

Enter Number ☐ 2. **Number of these unstageable pressure injuries that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

228

Steps for completing M0300A-G

Step 1: Determine Deepest Anatomical Stage

- For each pressure ulcer, determine the deepest anatomical stage. At admission, code based on findings from the first skin assessment that is conducted on or after and as close to the admission as possible. Do not reverse or back stage. Consider current and historical levels of tissue involvement.
- Ulcer staging should be based on the ulcer's deepest anatomic soft tissue damage that is visible or palpable. If a pressure ulcer's tissues are obscured such that the depth of soft tissue damage cannot be observed, it is considered to be unstageable
- If the stageable pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage until healed unless it becomes unstageable.

229

Step 1: Continued

- Pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue that were lost during pressure ulcer development before they re-epithelialize. Stage 3 and 4 pressure ulcers fill with *granulation tissue*.
  - *Red tissue with "cobblestone" or bumpy appearance; bleeds easily when injured.*
- A previously closed pressure ulcer that opens again should be reported at its worst stage, unless currently presenting at a higher stage or unstageable.

230

Steps for completing M0300A-G

Step 2: Identify Unstageable Pressure Ulcers

- If, **after careful cleansing** of the pressure ulcer/injury, anatomical tissues remain obscured it is considered unstageable.
- If the wound bed is only *partially* covered by eschar or slough, and the anatomical depth of tissue damage can be visualized or palpated, numerically stage the ulcer, and do not code this as unstageable.
- A pressure injury with intact skin that is a deep tissue injury (DTI) should not be coded as a Stage 1 pressure injury. It should be coded as unstageable.
- Known pressure ulcers/injuries covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable. "Known" refers to when documentation is available that says a pressure ulcer/injury exists under the non-removable dressing/device.

231

Steps for completing M0300A-G

Step 3: Determine "Present on Admission"

- For each pressure ulcer/injury, determine if it was present at the time of admission/entry or reentry and not acquired while the resident was in the care of the nursing home.
- If it was present on admission/entry or reentry and subsequently increased in numerical stage during the resident's stay, it is coded at that higher stage, and is not considered "present on admission."

232

Steps for completing M0300A-G

- If it was present on admission/entry or reentry and becomes unstageable due to slough or eschar, during the resident's stay, it is not coded "present on admission."
- If it was unstageable on admission/entry or reentry, then 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 coded as "present on admission."

233

Step 3: Determine "Present on Admission"

- If a pressure ulcer/injury was **originally acquired in the facility** & resident is hospitalized and returns with that pressure ulcer/injury at the same numerical stage, the pressure ulcer/injury **should not be coded as "present on admission**"

234

Step 3: Determine "Present on Admission"

- If a resident who has a pressure ulcer/injury that was **"present on admission"** (not acquired in the facility) is hospitalized and returns with that pressure ulcer/injury at the same numerical stage, the pressure ulcer is **still coded as "present on admission"** because it was **originally acquired outside the facility** and has not changed in stage.
- If a resident who has a pressure ulcer/injury is hospitalized and the ulcer/injury increases in numerical stage or becomes unstageable due to slough or eschar during the hospitalization, it **should be coded as "present on admission"** upon reentry.

235

Step 3: Determine "Present on Admission"

- If a pressure ulcer was numerically staged, then became unstageable, and is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the numerical stage has increased, code this pressure ulcer as **not present on admission.**
- If a resident has a pressure ulcer/injury that was documented on admission that closed then reopens at the same stage (i.e., not a higher stage), the ulcer/injury is coded as "present on admission."

236

Step 3: Determine "Present on Admission"

- If two pressure ulcers merge, that were both "present on admission," continue to code the merged pressure ulcer as "present on admission." Although two merged pressure ulcers might increase the overall surface area of the ulcer, there needs to be an increase in numerical stage or a change to unstageable due to slough or eschar in order for it to be considered not "present on admission."

237

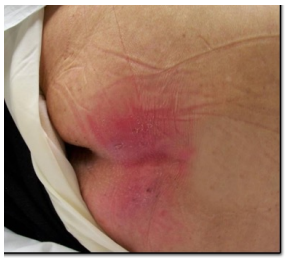
Step 3: Determine "Present on Admission"

- If a pressure ulcer/injury was unstageable on admission/entry or reentry and then becomes unstageable for another reason, it should be considered "present on admission" at the new unstageable status. For example, if a resident is admitted with a deep tissue injury, but later the injury opens, the wound bed is covered with slough, and the wound is still unstageable, this wound would still be considered "present on admission."

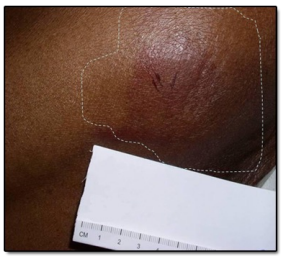
238

Stage 1 Pressure Injury

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



Reddened areas of tissue that do not lose skin color when firmly pressed with a finger.

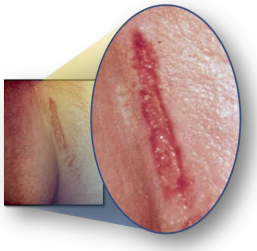


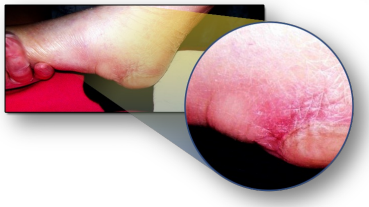
Darkly pigmented skin may not have a visible blanching; may appear with persistent blue or purple hues.

M-11

239

Stage 2 Pressure Ulcers:





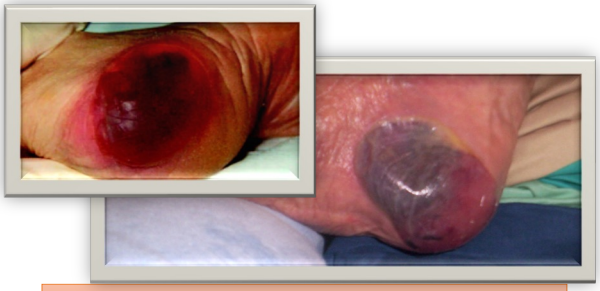
Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured blister.

240

Blister caused by pressure: Stage 2 Pressure Ulcer or DTI

Examine the area adjacent to or surrounding an intact blister for evidence of tissue damage. If other conditions are ruled out and the tissue adjacent to, or surrounding the blister demonstrates signs of tissue damage, (e.g., color change, tenderness, bogginess or firmness, warmth or coolness) these characteristics suggest a deep tissue injury (DTI) rather than a Stage 2 Pressure Ulcer.

Color Change
Bogginess
Firmness
Tenderness
Warmth
Coolness



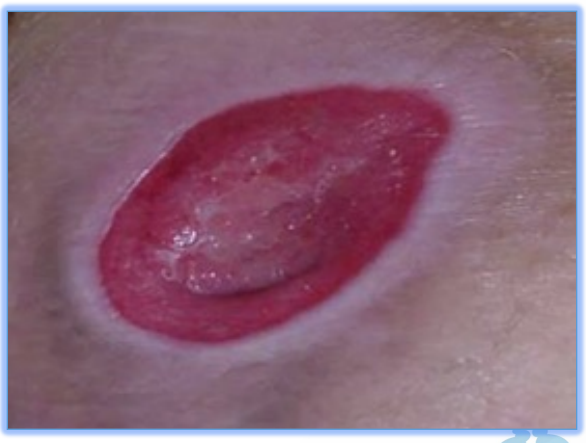
These are Deep Tissue Injuries, not St 2 PrU!

M-10

241

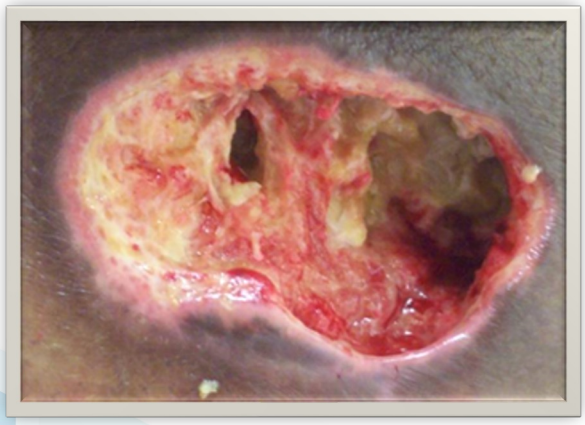
Stage 3 Pressure Ulcers

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



242

Stage 4 Pressure Ulcers

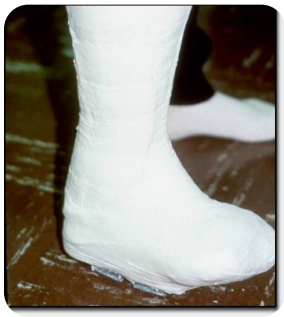


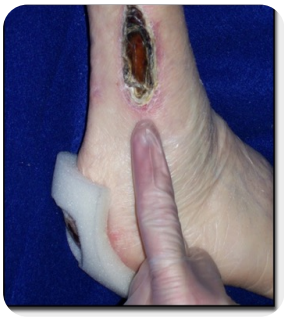
- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. M-13
- Cartilage serves the same anatomical function as bone. Therefore, pressure ulcers that have exposed cartilage should be classified as a Stage 4. M-14

243

Unstageable:

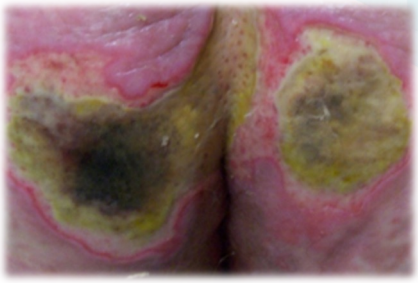
1. Non-removable dressing/device is covering a known pressure ulcer.





244

2. Unstageable due to slough or eschar



SLOUGH TISSUE

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

ESCHAR TISSUE

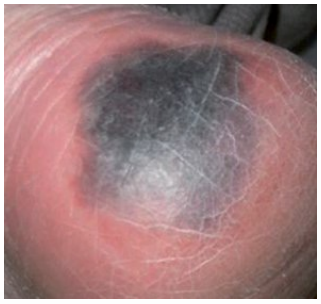
Dead or devitalized issue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound.

245

3. Unstageable Deep Tissue Injury

- Purple or maroon localized area of discolored intact skin due to underlying soft tissue damage. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler than adjacent tissue.

In dark-skinned individuals, the area of injury is probably not purple/maroon, but rather darker than the surrounding tissue.



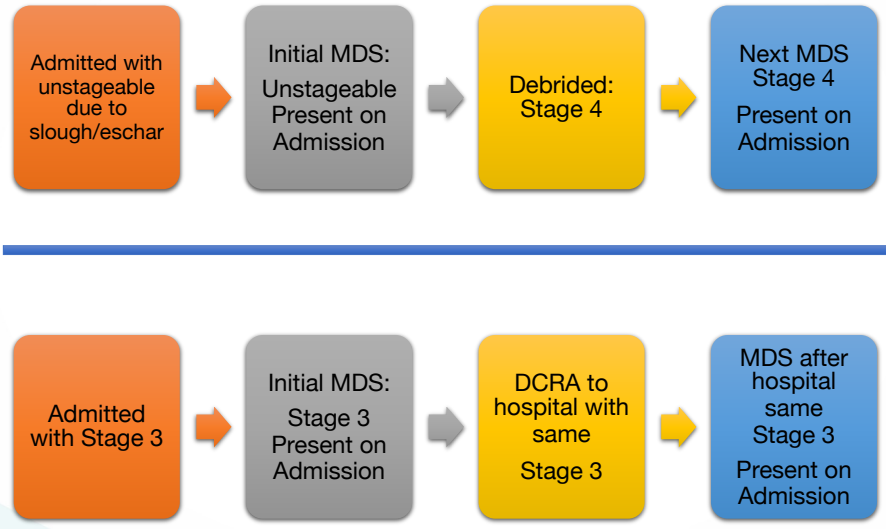
246

Coding Tips: DTI

- Once DTI has opened, reclassify the ulcer into the appropriate stage. Then code the ulcer for the reclassified stage.
- 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.

247

Examples:



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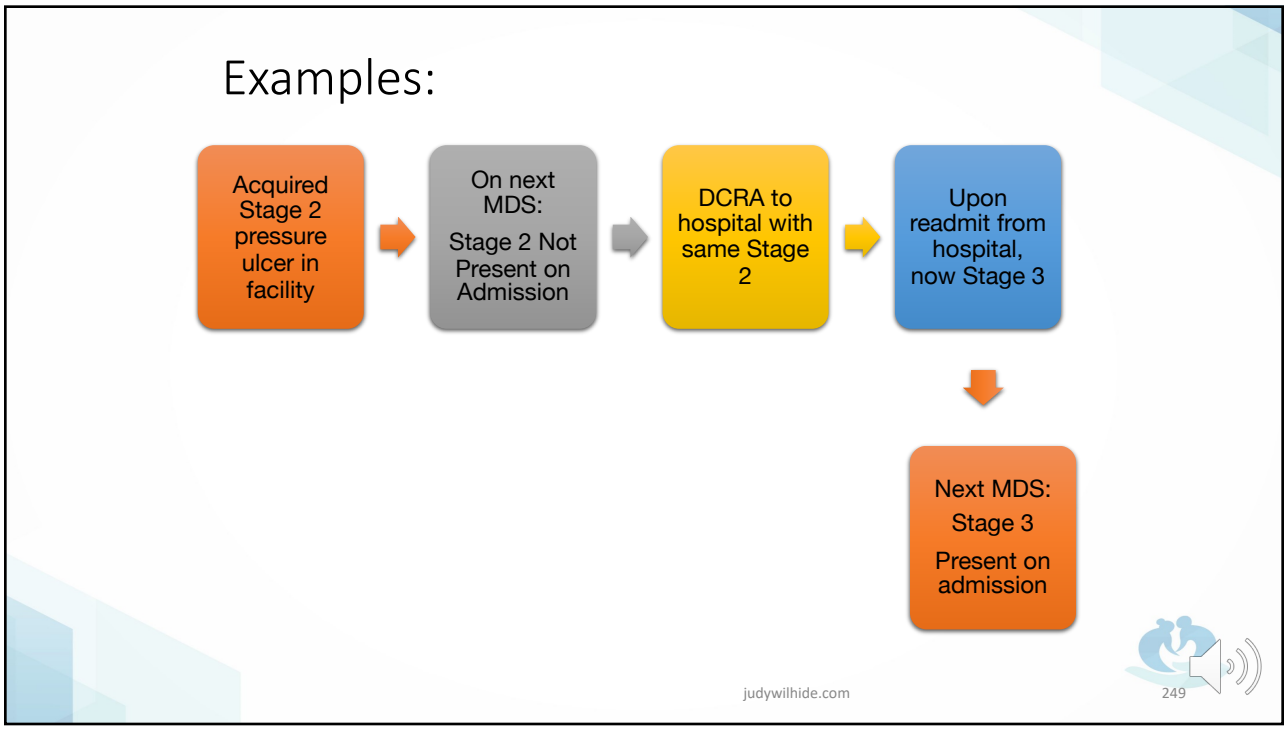
248

248


Examples:
Acquired Stage 2 pressure ulcer in facility
On next MDS:
Stage 2 Not Present on Admission
DCRA to hospital with same Stage 2
Upon readmit from hospital, now Stage 3
Next MDS:
Stage 3
Present on admission
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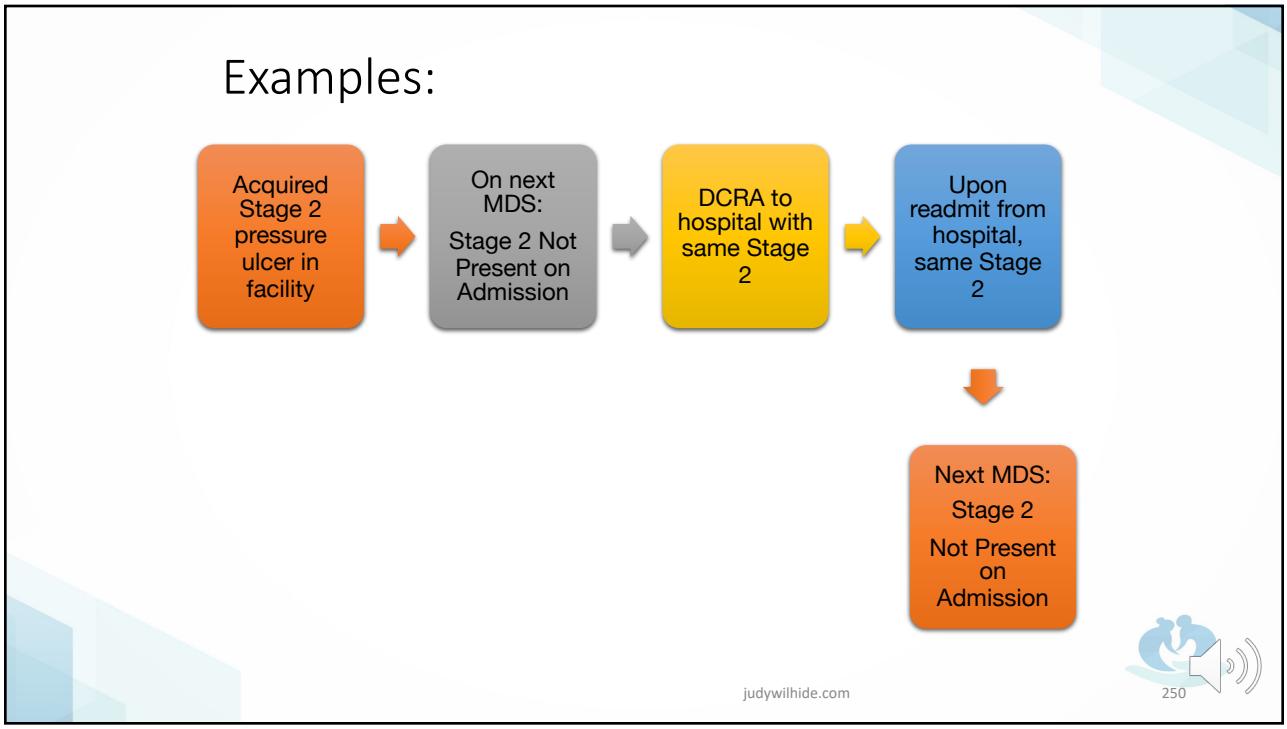
249

249


Examples:
Acquired Stage 2 pressure ulcer in facility
On next MDS:
Stage 2 Not Present on Admission
DCRA to hospital with same Stage 2
Upon readmit from hospital, same Stage 2
Next MDS:
Stage 2
Not Present on Admission
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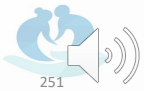
250

250

Examples:

Stage 2 pressure ulcer Present on Admission → On next MDS: Unstageable to due slough/eschar Not Present on Admission



251

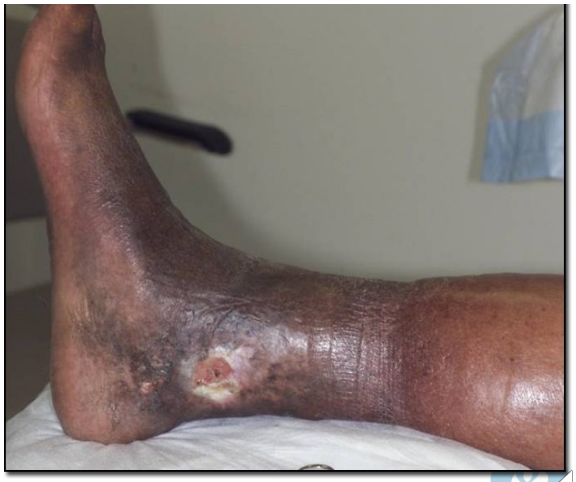
M1030. Number of Venous and Arterial Ulcers	
Enter Number ☐	Enter the total number of venous and arterial ulcers present

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

252

M1030: Venous Ulcers

- Ulcers caused by peripheral venous disease, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg.
- Wound may start due to minor trauma.
- Usual location is lower leg area or medial or lateral malleolus.
- Characterized by:
  - Irregular wound edges
- Hemosiderin staining (dark yellow-brown)
- Leg edema

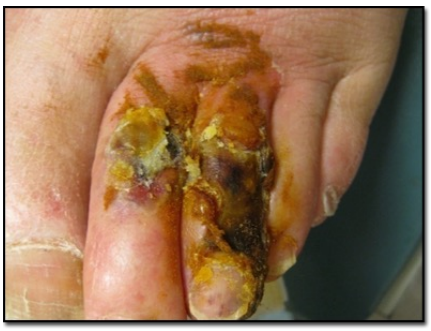


253

M-31

M1030: ARTERIAL ULCERS

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



254

M1040A: Infection of the foot (e.g., cellulitis, purulent drainage)

Example: M-32:
Mrs. F. complained of discomfort of her right great toe and when her stocking and shoe was removed, it was noted that her toe was red, inflamed and had pus draining from the edge of her nail bed. The podiatrist determined that Mrs. F. has an infected ingrown toenail.

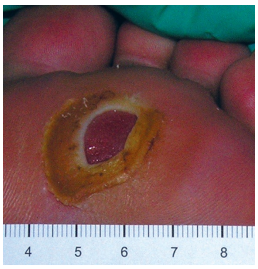
Coding: Check M1040A, Infection of the foot.

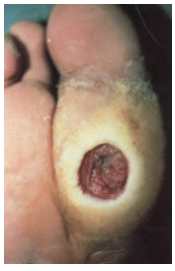
Rationale: Mrs. F. has an infected right great toe due to an ingrown toenail.

255

M1040B: Diabetic Foot Ulcer

- Ulcers caused by the neuropathic and small blood vessel complications of diabetes.
  - Typically occur over the plantar (bottom) surface of the foot on load-bearing areas such as the ball of the foot.
  - Usually deep, with necrotic tissue, moderate amounts of exudate, and calloused wound edges.
  - Very regular in shape, wound edges are even with a punched-out appearance.
  - Typically not painful.





256

M1040C: Other open lesions **on the foot**, e.g. cuts, fissures

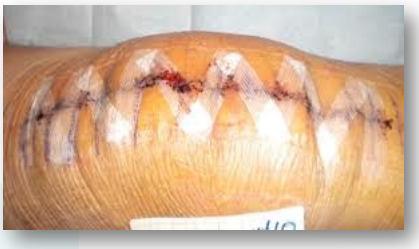
M1040D Open Lesion(s) Other than Ulcers, Rashes, Cuts

- Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and vesicles, should be coded in this item.
- Do not code rashes, abrasions, or cuts/lacerations here.
- Do not code pressure ulcers/injuries, venous or arterial ulcers, diabetic foot ulcers, or skin tears here. These conditions are coded in other items on the MDS.

257

M1040E Surgical Wounds

- Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites.
- This category does not include healed surgical sites and healed stomas or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.
- A pressure ulcer that has been surgically debrided should continue to be coded as a pressure ulcer.
- Once a pressure ulcer is excised and a graft and/or flap is applied, it is no longer considered a pressure ulcer, but a surgical wound.



258

Other Skin Problems

M1040F Burns (Second or Third Degree)

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

M1040G Skin Tear(s)

- Skin tears are a result of shearing, friction or trauma to the skin that causes a separation of the skin layers. They can be partial or full thickness. Code all skin tears in this item, even if already coded in Item J1900B.
- Do not code cuts/lacerations or abrasions here. Although not recorded on the MDS, these skin conditions should be considered in the plan of care.

259

M1040H: Moisture Associated Skin Damage

- Caused by moisture rather than pressure. It is superficial skin damage caused by sustained exposure to moisture such as incontinence, wound exudate, or perspiration.

- If pressure and moisture are both present, code the skin damage as a pressure ulcer/injury in M0300.
- If there is tissue damage extending into the subcutaneous tissue or deeper and/or necrosis is present, code the skin damage as a pressure ulcer in M0300.

260

M1200: Skin and Ulcer Treatments

- M1200A/M1200B Pressure Reducing Devices
  - Do not include egg crate cushions of any type or doughnut/ring devices in this category.
- M1200C Turning/Repositioning Program
  - Must be specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours).
  - Progress notes, assessments, and other documentation should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.

261

TURNING/REPOSITIONING PROGRAM

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

NUTRITION OR HYDRATION INTERVENTION TO MANAGE SKIN PROBLEMS (M1200D)

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

262

- **M1200E Pressure Ulcer Care**
  - Pressure ulcer care includes **any** intervention for treating pressure ulcers coded in **Current Number of Unhealed Pressure Ulcers at Each Stage (M0300A-G)**. Examples may include the use of topical dressings, enzymatic, mechanical or surgical debridement, wound irrigations, negative pressure wound therapy (NPWT), and/or hydrotherapy.

263

M1200F Surgical Wound Care

- Does not include post-operative care following eye or oral surgery.
- Surgical debridement of a pressure ulcer does not create a surgical wound. Any wound care associated with pressure ulcer debridement would be coded in **M1200E, Pressure Ulcer Care**.
- Surgical wound care may include any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application.

264

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

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

265

M1200H Application of Ointments/Medications Other than to Feet

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

266

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

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

267

Section N: Medications

Section N	Medications	Lookback: 7 days or since last entry
N0300. Injections		
Enter Days ☐	**Record the number of days that injections of any type** were received during the last 7 days or since admission/entry or reentry if less than 7 days. If 0 → Skip to N0410, Medications Received	
N0350. Insulin		
Enter Days ☐	**A. Insulin injections - Record the number of days that insulin injections** were received during the last 7 days or since admission/entry or reentry if less than 7 days	
Enter Days ☐	**B. Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders** during the last 7 days or since admission/entry or reentry if less than 7 days	

N0300: Count the number of days that **the resident received any type of injection while a resident of the nursing home.**

- For subcutaneous pumps, code only the number of days that the resident actually required a subcutaneous injection to restart the pump.
- Antigens and vaccines count
- Count any injections given on leave of absence or out at MD visit, etc. Since last entry

N0350: Count the number of days insulin injections were received and/or insulin orders changed

268

N0415. High-Risk Drug Classes: Use and Indication

1. **Is taking**
   Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days
2. **Indication noted**
   If Column 1 is checked, check if there is an indication noted for all medications in the drug class

		1. Is taking	2. Indication noted
		↓ Check all that apply ↓	
A.	**Antipsychotic**	☐	☐
B.	**Antianxiety**	☐	☐
C.	**Antidepressant**	☐	☐
D.	**Hypnotic**	☐	☐
E.	**Anticoagulant** (e.g., warfarin, heparin, or low-molecular weight heparin)	☐	☐
F.	**Antibiotic**	☐	☐
G.	**Diuretic**	☐	☐
H.	**Opioid**	☐	☐
I.	**Antiplatelet**	☐	☐
J.	**Hypoglycemic** (including insulin)	☐	☐
K.	**Anticonvulsant**	☐	☐
Z.	**None of the above**	☐	[redacted]

INDICATION

The identified, documented clinical rationale for administering a medication that is based upon a physician's (or prescriber's) assessment of the resident's condition and therapeutic goals.

269

Coding instructions

- Code "indication for use" if all medications given in a class have an indication.
  - If any do not, you may not check "indication" for that drug class

270

Coding Tips:

- Facilities may wish to identify a resource that their staff consistently use to identify pharmacological classification as assessors should be able to identify the source(s) used to support coding the MDS 3.0.
- Assessors should consult the manufacturer's package insert, which may contain the medication's pharmacological classification. They can also work with the resident's pharmacist to confirm the medication classification(s) for a resident's medication(s).

271

N0415: Coding tips

- Code based on therapeutic category and/or pharmacological classification, not how it is used. For example, although oxazepam may be prescribed for use as a hypnotic, it is categorized as an antianxiety.
- Medications that have more than one therapeutic category and/or pharmacological classification should be coded in **all** categories/classifications assigned to the medication, regardless of how it is being used. For example, prochlorperazine [Compazine] is dually classified as an antipsychotic and an antiemetic. Therefore, in this section, it would be coded as an antipsychotic, regardless of how it is used.

N-7

272

N0415: Coding tips

- Include any route in any setting while a resident.
  - Even if given only once during lookback.
- Count long-acting medications, such as fluphenazine decanoate or haloperidol decanoate, that are given every few weeks or monthly **only** if they are given during the 7-day look-back period (or since admission/entry or reentry if less than 7 days)
- Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as N0415E, Anticoagulant.

N-7

273

Coding tips

- Transdermal patches are generally worn for and release medication over a period of several days. To code N0415, only capture the medication if the transdermal patch was applied to the resident's skin during the observation period. For example, if, during the 7-day look-back period, a fentanyl patch was applied on days 1, 4, and 7, N0415H Opioid would be checked, because the application occurred during the look-back period
- Combination medications should be coded in all categories/pharmacologic classes that constitute the combination. For example, if the resident receives a single tablet that combines an antipsychotic and an antidepressant, then **both** antipsychotic and antidepressant categories should be coded.

N-8

274

Coding tips

- Anticoagulants such as Target Specific Oral Anticoagulants (TSOACs), which may or may not require laboratory monitoring, should be coded in N0415E, Anticoagulant.
- Do not code flushes to keep an IV access port patent.
- Over-the-counter sleeping medications are not coded as hypnotics, as they are not categorized as hypnotic medications.

N-8

275

Coding Tips:

- Herbal and alternative medicine products are considered to be dietary supplements by the
- Food and Drug Administration (FDA). These products are not regulated by the FDA (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). Therefore, they should not be counted as medications (e.g., melatonin, chamomile, valerian root).

276

N0450: Antipsychotic Medication Review:

N0450. Antipsychotic Medication Review

Enter Code ☐

A. Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent?

0. **No** - Antipsychotics were not received → Skip to O0100, Special Treatments, Procedures, and Programs
1. **Yes** - Antipsychotics were received on a routine basis only → Continue to N0450B, Has a GDR been attempted?
2. **Yes** - Antipsychotics were received on a PRN basis only → Continue to N0450B, Has a GDR been attempted?
3. **Yes** - Antipsychotics were received on a routine and PRN basis → Continue to N0450B, Has a GDR been attempted?

Enter Code ☐

B. Has a gradual dose reduction (GDR) been attempted?

0. **No** → Skip to N0450D, Physician documented GDR as clinically contraindicated
1. **Yes** → Continue to N0450C, Date of last attempted GDR

C. Date of last attempted GDR:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

D. Physician documented GDR as clinically contraindicated

0. **No** - GDR has not been documented by a physician as clinically contraindicated → Skip to O0100, Special Treatments, Procedures, and Programs
1. **Yes** - GDR has been documented by a physician as clinically contraindicated → Continue to N0450E, Date physician documented GDR as clinically contraindicated

E. Date physician documented GDR as clinically contraindicated:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Item sets: NC, NQ

277

N0450B: Has a gradual dose reduction (GDR) been attempted?

Gradual Dose Reduction (GDR) Step-wise tapering of a dose to determine whether or not symptoms, conditions, or risks can be managed by a lower dose or whether or not the dose or medication can be discontinued. N-8

- **Code 0, no:** if a GDR has not been attempted. Skip to N0450D, Physician documented GDR as clinically contraindicated.
- **Code 1, yes:** if a GDR has been attempted. Continue to N0450C, Date of last attempted GDR.

N0450C:
- Enter the date of the last attempted Gradual Dose Reduction.

278

N0450B&C (GDR & Date) Coding Tips

- Within 1st year
  - when admitted on antipsychotic medication or
  - after the facility has initiated an antipsychotic medication

  facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless physician documentation is present in the medical record indicating that a GDR is clinically contraindicated. After the first year, a GDR must be attempted at least annually, unless clinically contraindicated. See F758 for more.
- In N0450B and N0450C, include GDR attempts conducted since the resident was admitted to the facility, if the resident was receiving an antipsychotic medication at the time of admission, **OR** since the resident was started on the antipsychotic medication, if the medication was started after the resident was admitted.

N-13

279

N0450B&C (GDR & Date) Coding Tips

- Do not include GDRs that occurred prior to **admission** to the facility (e.g., GDRs attempted during the resident's acute care stay prior to admission to the facility).
- If resident admitted to facility with a documented GDR attempt in progress and the resident received the last dose(s) of the antipsychotic medication of the GDR in the facility, then the GDR would be coded in N0450B and N0450C.
- If the resident received a dose or doses of an antipsychotic medication that was not part of a documented GDR attempt, such as if the resident received a dose or doses of the medication PRN or one or two doses were ordered for the resident for a specific day or procedure, these are **not coded as a GDR attempt** in N0450B and N0450C.

N-13

280

N0450B&C (GDR & Date) Coding Tips

- Discontinuation of antipsychotic, even without a GDR process, should be coded in N0450B and N0450C as GDR. When antipsychotic is discontinued without a GDR, the date of the GDR in N0450C is **the first day the resident did not receive the discontinued antipsychotic medication**. N-13
- Do not count as a GDR an antipsychotic medication reduction performed for the purpose of switching from one antipsychotic to another.
- The start date of the last attempted GDR should be entered in N0450C, Date of last attempted GDR. The GDR start date is the **first day the resident received the reduced dose** of the antipsychotic.

N-13 & N-14

281

N0450B&C (GDR & Date) Coding Tips

- **I**n cases in which a resident is or was receiving multiple antipsychotic medications on a routine basis and one medication was reduced or discontinued, record the date of the reduction attempt or discontinuation in N0450C.
- If multiple dose reductions have been attempted since admission OR since initiation of the antipsychotic medication, record the date of the most recent reduction attempt in N0450C.

282

N0450E (date MD documented GDR contraindicated): Coding TIps

- In N0450D and N0450E, include physician documentation that GDR attempt is clinically contraindicated since the resident was admitted to the facility, if the resident was receiving an antipsychotic medication at the time of admission, **OR** since the resident was started on the antipsychotic medication, if the medication was started after the resident was admitted to the facility.
- Physician documentation indicating dose reduction attempts are clinically contraindicated **must include the clinical rationale for why an attempted dose reduction is inadvisable**. This decision should be based on the fact that tapering of the medication would not achieve the desired therapeutic effects and the current dose is necessary to maintain or improve the resident's function, well-being, safety, and quality of life.

283

N2001. Drug Regimen Review - Complete only if A0310B = 01

Enter Code ☐

Did a complete drug regimen review identify potential clinically significant medication issues?
0. **No** - No issues found during review
1. **Yes** - Issues found during review
9. **NA** - Resident is not taking any medications

N2003. Medication Follow-up - Complete only if N2001 =1

Enter Code ☐

Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescri recommended actions in response to the identified potential clinically significant medication issues?
0. **No**
1. **Yes**

N2005. Medication Intervention - Complete only if A0310H = 1

Enter Code ☐

Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnigh calendar day each time potential clinically significant medication issues were identified since the admission?
0. **No**
1. **Yes**
9. **NA** - There were no potential clinically significant medication issues identified since admission or resident is not taking medications

Drug Regimen Review: PPS 5 day and PPS Part A Discharge

For calculation of SNF QRP QM

284

284

Steps for Assessment

Complete if A0310B = 01

1. Complete a drug regimen review upon admission (start of SNF PPS stay) or as close to the actual time of admission as possible to identify any potential or actual clinically significant medication issues.

Medical record sources include medical records received from facilities where the resident received health care, the resident's most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available.

285

Steps for Assessment

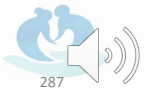
Complete if A0310B = 01

Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, the resident, and the resident's family/significant other) may supplement and/or clarify the information gleaned from the resident's medical records.

286

Clinically significant medication issues include, but are not limited to:

- Medication prescribed despite documented medication allergy or prior adverse reaction
- Excessive or inadequate dose
- Adverse reactions to medication
- Ineffective drug therapy
- Drug interactions
- Duplicate therapy
- Wrong resident, drug, dose, route, and time errors
- Medication dose, frequency, route, or duration not consistent with resident's condition, manufacturer's instructions, or applicable standards of practice
- Use of a medication without evidence of adequate indication for use
- Presence of a medical condition that may warrant medication therapy (e.g., a resident with primary hypertension does not have an antihypertensive medication prescribed)
- Omissions (medications missing from a prescribed regimen)
- Nonadherence (purposeful or accidental)



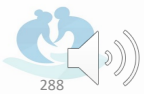
287

Coding Instructions:

- **Code 0, No:** if no clinically significant medication issues were identified during the drug regimen review.
- **Code 1, Yes:** if one or more clinically significant medication issues were identified during the drug regimen review.
- **Code 9, NA:** if the resident was not taking any medications at the time of the drug regimen review.

Coding Tips

- A dash (–) value is a valid response for this item; however, CMS expects dash use to be a rare occurrence.
- The drug regimen review includes all medications, prescribed and over the counter (OTC), including nutritional supplements, vitamins, and homeopathic and herbal products, administered by any route. The drug regimen review also includes total parenteral nutrition (TPN) and oxygen.



288

Potential or Actual Clinically Significant Medication Issue

A clinically significant medication issue is a potential or actual issue that, in the clinician's professional judgment, warrants physician (or physician-designee) communication and completion of prescribed/recommended actions by midnight of the next calendar day at the latest.

"Clinically significant" means effects, results, or consequences that materially affect or are likely to affect an individual's mental, physical, or psychosocial well-being, either positively, by preventing a condition or reducing a risk, or negatively, by exacerbating, causing, or contributing to a symptom, illness, or decline in status.
Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the purpose of the drug regimen review items.

289

289

N2003. Medication Follow-up - Complete only if N2001 =1	
Enter Code ☐	**Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescri recommended actions in response to the identified potential clinically significant medication issues?** 0. **No** 1. **Yes**

Medication Follow-Up

The process of contacting a physician to communicate an identified medication issue and completing all physician-prescribed/recommended actions by midnight of the next calendar day at the latest.

290

290

Communication to MD/Non-physician practitioner (NPP) to convey an identified potential or actual clinically significant medication issue AND

A response from the physician to convey prescribed/recommended actions in response to the medication issue

Medical record must show the following criteria were met :

1. Two-way communication between the clinician(s) and the physician was completed by midnight of the next calendar day, AND
2. All physician-prescribed/-recommended actions were completed by midnight of the next calendar day.

Contact with Physician/designee

291

N2003:

Communication may be:

In person	Telephone	Voice Mail	Electronically	Fax

Or any other means that is two way communication between MD/NPP and SNF that appropriately conveys resident status

292

N2001. Drug Regimen Review - Complete only if A0310B = 01

Enter Code [-]

Did a complete drug regimen review identify potential clinically significant medication issues?
0. **No** - No issues found during review
1. **Yes** - Issues found during review
9. **NA** - Resident is not taking any medications

N2003. Medication Follow-up - Complete only if N2001 =1

Enter Code [-]

Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?
0. **No**
1. **Yes**

If no DRR completed

- N2001 and N2003 coded with dash (-).
- CMS expects dash use to be rare

293

293

N2005. Medication Intervention - Complete only if A0310H = 1

Enter Code [ ]

Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?
0. **No**
1. **Yes**
9. **NA** - There were no potential clinically significant medication issues identified since admission or resident is not taking any medications

Look-back: SNF admission to SNF discharge

294

294

Coding Tips

If MD prescribes action that will take longer than midnight of the next calendar day to complete, then **code 1, Yes,** should still be entered, if by midnight of the next calendar day, the clinician has taken the appropriate steps to comply with the recommended action.

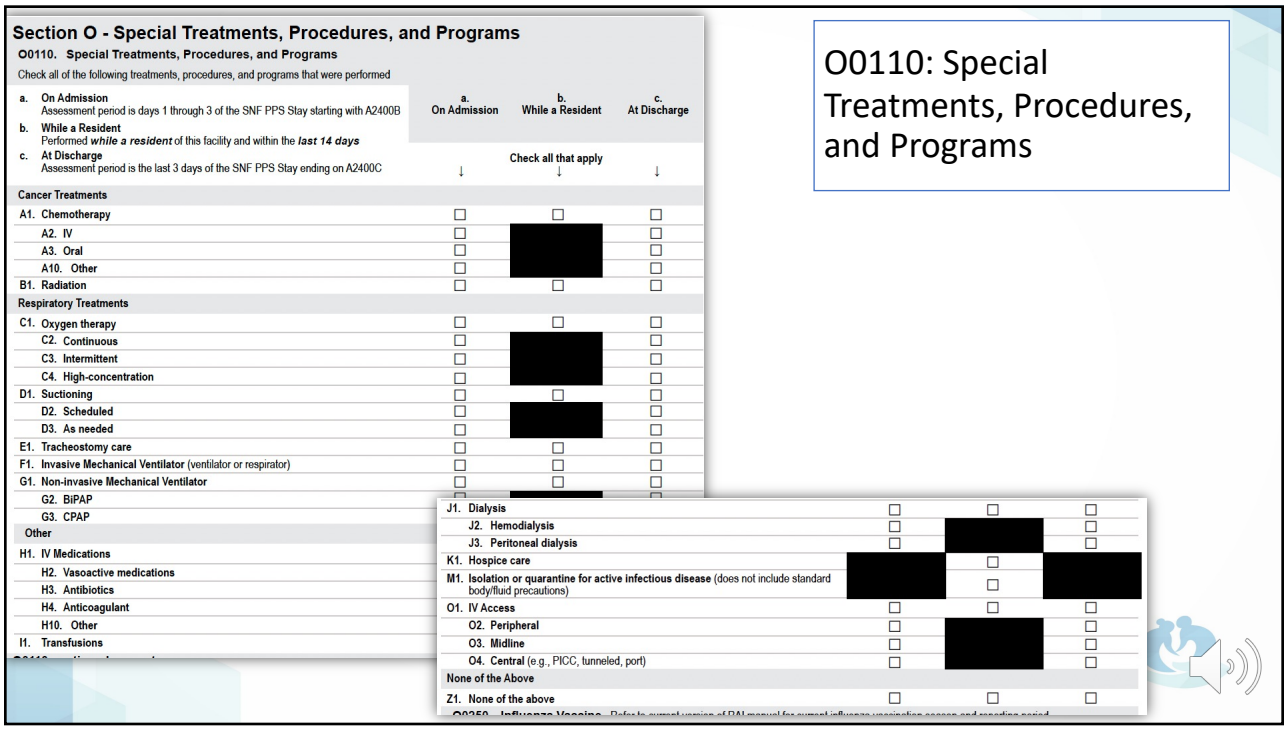
- Example of a **physician-recommended action that would take longer than midnight of the next calendar day to complete**:
  - The physician writes an order instructing the clinician to monitor the medication issue over the next three days & call if the problem persists.
- A dash (–) value is a valid response for this item; however, CMS expects dash use to be a rare occurrence.

295

295

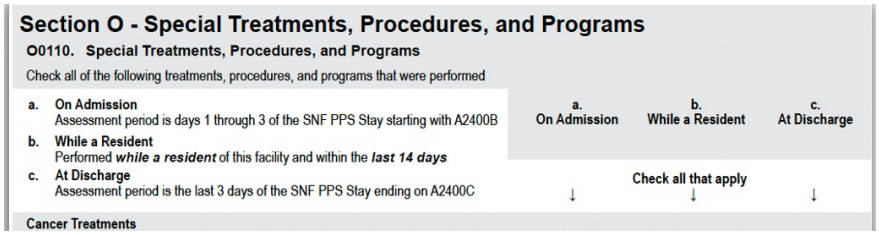
Section O: Special Treatments, Procedures, and Programs

296



297

Lookback periods



A = first 3 days of PPS Stay (SPADE for SNF QRP*) on PPS 5 Day
B = While a resident in 14 day lookback, on OBRA and PPS assessments
C= Last 3 days of PPS stay (SPADE for SNFQRP*) on PPS DC

*Standardized Patient Assessment Data Element for Skilled Nursing Facility Quality Reporting Program

298

O0110: Coding Tips

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

299

Cancer Treatments
A1. Chemotherapy
A2. IV
A3. Oral
A10. Other
B1. Radiation

O0110B1 Radiation: Code intermittent radiation therapy, as well as radiation administered via radiation implant in this item.

- O0110A1 Chemotherapy: Code any type of chemotherapy agent administered as an antineoplastic for cancer treatment. If antineoplastic but not for cancer (Megace) do not code.
- Hormonal and other agents administered to prevent recurrence of slow growth of cancer should not be coded in this item.
- IVs, IV medication, and blood transfusions administered during chemotherapy are not record d under items K0520A (Parenteral/IV), O0110H (IV Medications), or O0110I (Transfusions).

300

Respiratory Treatments
C1. Oxygen therapy
C2. Continuous
C3. Intermittent
C4. High-concentration
D1. Suctioning
D2. Scheduled
D3. As needed

- Oxygen:
  - Continuous: Delivered continuously for at least 14 hours per day
  - Intermittent: Less than 14 hours continuously per day
  - High-Concentration: FiO2 > 40%
- Suctioning: Nose or trach only, not oral.

301

E1. Tracheostomy care
F1. Invasive Mechanical Ventilator (ventilator or respirator)
G1. Non-invasive Mechanical Ventilator
G2. BiPAP
G3. CPAP

- E1: Tracheostomy care: Code cleansing of the tracheostomy and/or cannula in this item. This item may be coded if the resident performs their own tracheostomy care. Includes laryngectomy tube care.
- F1: Invasive Mechanical Ventilator: An electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become (such as during weaning attempts) unable to support their own respiration.
- G2: BiPAP: Bilevel positive airway pressure, use a higher pressure for the inhalation phase and a lower pressure for the exhalation phase
- G3: CPAP: Continuous positive airway pressure

302

H1.	IV Medications
H2.	Vasoactive medications
H3.	Antibiotics
H4.	Anticoagulant
H10.	Other

H2: can increase or decrease blood pressure and heart rate through vascular activity
H3: Does not include antifungals
H4: Does not include flushes to keep a port patent

- H1: Any drug or biological given IV push, epidural pump, or drip through a central or peripheral port in this item.
- Do not code flushes to keep an IV access port patent, or IV fluids without medication here.
- Epidural, intrathecal, and baclofen pumps may be coded here, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance.
- Subcutaneous pumps are not coded in this item.
- Do not include IV medications of any kind that were administered during dialysis or chemotherapy.
- Lactated Ringers given IV is not considered a medication and should not be coded here.

303

I1.	Transfusions
J1.	Dialysis
J2.	Hemodialysis
J3.	Peritoneal dialysis
K1.	Hospice care

- I1. Transfusions: Code transfusions of blood or any blood products (e.g., platelets, synthetic blood products), that are administered directly into the bloodstream in this item. Do not include transfusions that were administered during dialysis or chemotherapy.
- J1 Dialysis: Code dialysis which occurs at the nursing home or at another facility, record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item.
- IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are not to be coded under items K0520A (Parenteral/IV), O0110H (IV medications), or O0110I (transfusions).
- This item may be coded if the resident performs their own dialysis.

304

I1.	Transfusions
J1.	Dialysis
J2.	Hemodialysis
J3.	Peritoneal dialysis
K1.	Hospice care

K1: Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.

- J2: In hemodialysis the patient's blood is circulated directly through a dialysis machine that uses special filters to remove waste products and excess fluid from the blood.
- J3: In peritoneal dialysis, dialysate is infused into the peritoneal cavity and the peritoneum (the membrane that surrounds many of the internal organs of the abdominal cavity) serves as a filter to remove the waste products and excess fluid from the blood.

305

M1. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)

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

306

M1. **Isolation or quarantine for active infectious disease** (does not include standard body/fluid precautions)

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

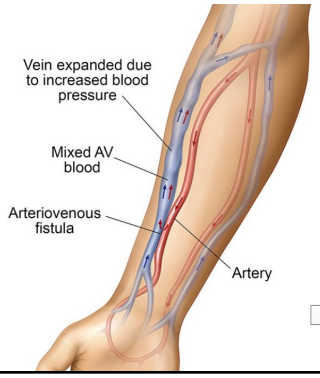
1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet,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

307

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

O1. **IV Access**
- O2. **Peripheral**
- O3. **Midline**
- O4. **Central** (e.g., PICC, tunneled, port)

An AV fistula is a surgical connection made between an artery and a vein, created by a vascular specialist



308

O0250. Influenza Vaccine - Refer to current version of RAI manual for current influenza vaccination season and reporting period

Enter Code ☐

A. Did the **resident receive the influenza vaccine *in this facility*** for this year's influenza vaccination season?
0. **No** → Skip to O0250C, If influenza vaccine not received, state reason
1. **Yes** → Continue to O0250B, Date influenza vaccine received

B. Date influenza vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

C. If influenza vaccine not received, state reason:
1. **Resident not in this facility** during this year's influenza vaccination season
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain influenza vaccine** due to a declared shortage
9. **None of the above**

O-7

Steps for Assessment

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

309

Coding Tips and Special Populations

- Once the influenza vaccination has been administered to a resident for the current influenza season, this value is carried forward until the new influenza season begins.

More information about when facilities must offer residents the influenza vaccine is available in 42 CFR 483.80(d), Influenza and pneumococcal immunizations, which can be found in Appendix PP of the State Operations Manual: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf#page=708.

310

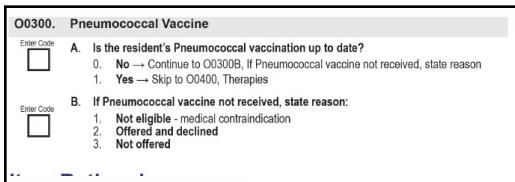
F883

- §483.80(d) Influenza and pneumococcal immunizations
- §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-
  - (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
  - (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
  - (iii) The resident or the resident's representative has the opportunity to refuse immunization; and
  - (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
    - (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
    - (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

311

- §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
  - (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
  - (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
  - (iii) The resident or the resident's representative has the opportunity to refuse immunization; and
  - (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
    - (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
    - (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

312



O0300. Pneumococcal Vaccine

Enter Code ☐ A. Is the resident's Pneumococcal vaccination up to date?
0. No → Continue to O0300B, If Pneumococcal vaccine not received, state reason
1. Yes → Skip to O0400, Therapies

Enter Code ☐ B. If Pneumococcal vaccine not received, state reason:
1. Not eligible - medical contraindication
2. Offered and declined
3. Not offered

Steps for Assessment

1. Review the resident's medical record to determine whether *any* pneumococcal vaccine*s* ha*ve* been received. If vaccination status is unknown, proceed to the next step.
2. Ask the resident if he *or* she received *any* pneumococcal vaccine*s* *outside of the facility*. If vaccination status is still unknown, proceed to the next step.
3. If the resident is unable to answer, ask the same question of *the* responsible party/legal guardian and/or primary care physician. If vaccination status is still unknown, proceed to the next step.

313

313

O0300: Pneumococcal vaccine

4. If pneumococcal vaccination status cannot be determined, administer the recommended vaccine(s) to the resident, according to the standards of clinical practice.
   - If the resident has had a severe allergic reaction to a pneumococcal vaccine or its components, the vaccine should not be administered.
   - If the resident has a moderate to severe acute illness, the vaccine should be administered after the illness.
   - If the resident has a minor illness (e.g., a cold) check with the resident's physician before administering the vaccine.

314

314

Coding Tips

These recommendations change! Ensure your vaccine program has all the latest information.

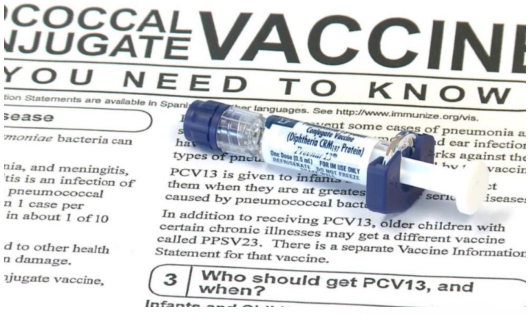
- Specific guidance about pneumococcal vaccine recommendations and timing for adults
- can be found at *https://www.cdc.gov/pneumococcal/downloads/vaccine-timing-adults- jobaid.pdf*.
- "Up to date" in item O0300A means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations.
- For up-to-date information on timing and intervals between vaccines, please refer to ACIP vaccine recommendations available at
  - https://www.cdc.gov/vaccines/hcp/imz-schedules/
  - https://www.cdc.gov/acip-recs/hcp/vaccine-specific/
- https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/

315

315

Coding Tips

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



316

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

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

Enter Code ☐

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

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

317

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

- Code 0, No, resident is not up to date if the resident does not meet the CDC's definition of up to date. This includes residents who have not received one or more recommended COVID-19 vaccine doses for any reason including medical, religious, or other qualified exemptions.
- This includes residents for whom vaccination status cannot be determined.
- For the definition of "up to date" providers should refer to the CDC webpage "staying up to date with COVID-19 vaccines."

318

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

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

319

Coding Instructions

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

320

Minutes of therapy

- When a resident returns from the hospital, an initial evaluation is required, and only therapies after this evaluation count, except for interrupted stays.
- O0390 therapy items don't require 15 minutes of a single therapy mode; minutes from different modes in the same discipline can be combined.
- Documentation and initial evaluation time are excluded.
- Time spent on follow-up reevaluations during treatment should be counted.
- Family education with the resident present must be documented and counted.

321

Respiratory & PsychologicalTherapy Criteria for Coding on MDS:

- MD order must include frequency, duration, and scope of treatment.
- Must be directly and specifically related to an active written treatment plan based on an initial evaluation performed by qualified personnel.
- Required and provided by qualified personnel.
- Must be reasonable and necessary for treatment of the resident's condition.

322

Respiratory Therapy Definition: Appendix A

- Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function. Respiratory therapy services include coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse.
- A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws.

323

O0400D: Respiratory Therapy minutes

- Only minutes that the respiratory therapist or respiratory nurse spends with the resident shall be recorded on the MDS. This time includes resident evaluation/assessment, treatment administration and monitoring, and setup and removal of treatment equipment. Time that a resident self-administers a nebulizer treatment without supervision of the respiratory therapist or respiratory nurse is not included in the minutes recorded on the MDS. Do not include administration of metered-dose and/or dry powder inhalers in respiratory minutes.

O0400. Therapies
Complete only if O0390D is checked

D. Respiratory Therapy

Enter Number of Days ☐

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

324

O0425 Part A Therapies & O0430 Distinct Calendar days of Part A therapy: Only on PPS Discharge

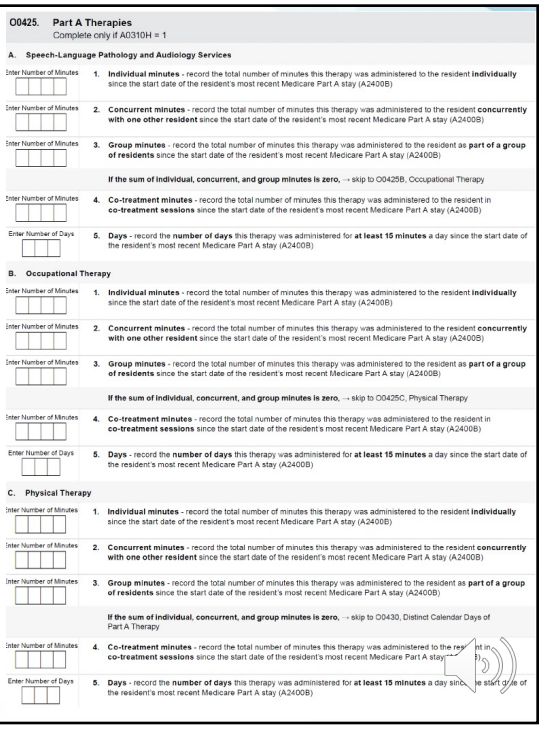
Detailed instructions in RAI manual with requirements for each mode of therapy.

The look-back period covers the entire SNF Part A stay. CMS software calculates the percentage of group and concurrent therapy per resident by discipline. If combined group and concurrent therapy exceeds 25%, it triggers non-compliance and a warning in the Final Validation Report.

O0430. Distinct Calendar Days of Part A Therapy
Complete only if A0310H = 1

Enter Number of Days

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



O0425. Part A Therapies
Complete only if A0310H = 1

A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes — 1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Minutes — 2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Minutes — 3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** since the start date of the resident's most recent Medicare Part A stay (A2400B)

If the sum of individual, concurrent, and group minutes is zero, → skip to O0425B, Occupational Therapy

Enter Number of Minutes — 4. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Days — 5. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

B. Occupational Therapy

Enter Number of Minutes — 1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Minutes — 2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Minutes — 3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** since the start date of the resident's most recent Medicare Part A stay (A2400B)

If the sum of individual, concurrent, and group minutes is zero, → skip to O0425C, Physical Therapy

Enter Number of Minutes — 4. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Days — 5. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

C. Physical Therapy

Enter Number of Minutes — 1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Minutes — 2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Minutes — 3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** since the start date of the resident's most recent Medicare Part A stay (A2400B)

If the sum of individual, concurrent, and group minutes is zero, → skip to O0430, Distinct Calendar Days of Part A Therapy

Enter Number of Minutes — 4. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in **co-treatment sessions** since the start date of the resident's most recent Medicare Part A stay (A2400B)

Enter Number of Days — 5. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day since the start date of the resident's most recent Medicare Part A stay (A2400B)

325

O0500 Restorative Nursing,

- Restorative care must meet the following criteria:
  - Measurable objective(s) and intervention(s) documented in the care plan and medical record.
  - Evidence of periodic evaluation by the licensed nurse must be present in the medical record.
  - Nursing assistants/ aides must be trained in techniques that promote resident involvement in the activity.
  - A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a nursing restorative program.

326

O0500 Assessment Guidelines

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

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

- Technique, training or skill practice must take place at least 15 minutes during the 24-hour period.
  - Code each type of restorative care separately.
  - Total minutes of care provided across the 24-hour period.
  - Cannot combine time across item categories.
- Does not include groups with **more than four residents** per supervising helper or caregiver.
- Detailed descriptions of each restorative program found in coding instructions

327

Criteria

- Measurable goals and interventions must be documented in the care plan and medical record.
- Licensed nurses should periodically evaluate and document progress, with restorative aides' notes countersigned when allowed by state practice act
- Nursing assistants or other restorative caregivers must be trained in the techniques, and a licensed nurse must supervise restorative activities.
- Groups should not exceed four residents per caregiver.

328

Section P: Restraints and Alarms

Section P	Restraints and Alarms
P0100. Physical Restraints	
Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body	
Coding: 0. Not used 1. Used less than daily 2. Used daily	↓ Enter Codes in Boxes
	Used in Bed
	☐ A. Bed rail
	☐ B. Trunk restraint
	☐ C. Limb restraint
	☐ D. Other
	Used in Chair or Out of Bed
	☐ E. Trunk restraint
	☐ F. Limb restraint
	☐ G. Chair prevents rising
	☐ H. Other
P0200. Alarms	
An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected	
Coding: 0. Not used 1. Used less than daily 2. Used daily	↓ Enter Codes in Boxes
	☐ A. Bed alarm
	☐ B. Chair alarm
	☐ C. Floor mat alarm
	☐ D. Motion sensor alarm
	☐ E. Wander/elopement alarm
	☐ F. Other alarm

329

P0100: Restraints: Planning for care

- When the interdisciplinary team determines that the use of physical restraints is the appropriate course of action, and there is a signed physician order that gives the medical symptom supporting the use of the restraint, the least restrictive manual method or physical or mechanical device, material or equipment that will meet the resident's needs must be selected.

330

P0100: Restraints

- Observe resident to determine the effect the restraint has on the resident's normal function. Do not focus on the type, intent, or reason behind its use.
- Evaluate whether the resident can easily and voluntarily remove any manual method or physical or mechanical device, material, or equipment attached or adjacent to his or her body. If the resident cannot easily and voluntarily do this, continue with the assessment to determine whether or not the manual method or physical or mechanical device, material or equipment restrict freedom of movement or restrict the resident's access to his or her own body.

P-3

331

Clarifications

- **"Remove easily"** means that the manual method or physical or mechanical device, material, or equipment can be removed intentionally by the resident in the same manner as it was applied by the staff (e.g., side rails are put down or not climbed over, buckles are intentionally unbuckled, ties or knots are intentionally untied), considering the resident's physical condition and ability to accomplish his or her objective (e.g., transfer to a chair, get to the bathroom in time).
- **"Freedom of movement"** means any change in place or position for the body or any part of the body that the person is physically able to control or access.

P-3

332

- "Medical symptoms/diagnoses" are defined as an indication or characteristic of a physical or psychological condition.
- Objective findings derived from clinical evaluation of the resident's subjective symptoms and medical diagnoses should be considered when determining the presence of medical symptom(s) that might support restraint use.
- The resident's subjective symptoms may not be used as the sole basis for using a restraint. In addition, the resident's medical symptoms/diagnoses should not be viewed in isolation; rather, the medical symptoms identified should become the context in which to determine the most appropriate method of treatment related to the resident's condition, circumstances, and environment, and not a way to justify restraint use.

333

Steps for Assessment

Any manual method or physical or mechanical device, material, or equipment that meets the definition of a physical restraint must have:

- Physician documentation of a medical symptom that supports the use of the restraint,
- Physician's order for the type of restraint and parameters of use, and
- Care plan and a process in place for systematic and gradual restraint reduction (and/or elimination, if possible), as appropriate.

P-3

334

Selected Coding Tips

- Exclude from this section items that are typically used in the provision of medical care, such as catheters, drainage tubes, casts, traction, leg, arm, neck, or back braces, abdominal binders, and bandages that are serving in their usual capacity to meet medical need(s).
- When coding this section, do not consider as a restraint a locked/secured unit or building in which the resident has the freedom to move about the locked/secured unit or building. Additional guidance regarding locked/secured units is provided in the section "Considerations Involving Secured/Locked Areas" of F603 in Appendix PP of the State Operations Manual.

335

- **Bed rails** any combination of partial or full rails (e.g., one-side half-rail, one-side full rail, two-sided half-rails or quarter-rails, rails along the side of the bed that block three-quarters to the whole length of the mattress from top to bottom, etc.). Include in this category enclosed bed systems.
  - *Bed rails used as positioning devices.* If the use of bed rails meet the definition of a physical restraint even though they may improve the resident's mobility in bed, the nursing home must code their use as a restraint at P0100A.
  - *Bed rails used with residents who are immobile.* If the resident is immobile and cannot voluntarily get out of bed because of a physical limitation or because proper assistive devices were not present, the bed rails do not meet the definition of a physical restraint.

336

- **Trunk restraints** include any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the resident cannot easily remove such as, but not limited to, vest or waist restraints or belts used in a wheelchair that either restricts freedom of movement or access to his or her body.
- **Limb restraints** include any manual method or physical or mechanical device, material or equipment that the resident cannot easily remove, that restricts movement of any part of an upper extremity (i.e., hand, arm, wrist) or lower extremity (i.e., foot, leg) that either restricts freedom of movement or access to his or her own body. Hand mitts/mittens are included in this category.
  - **Trunk or limb restraints**, if used in both bed and chair, should be marked in both sections.

337

- **Chairs that prevent rising** include any type of chair with a locked lap board, that places the resident in a recumbent position that restricts rising, chairs that are soft and low to the floor, chairs that have a cushion placed in the seat that prohibit the resident from rising, geriatric chairs, and enclosed-frame wheeled walkers.
  - For residents who have the ability to transfer from other chairs, but cannot transfer from a geriatric chair, the geriatric chair would be considered a restraint to that individual, and should be coded as P0100G–Chair Prevents Rising.
  - For residents who have no ability to transfer independently, the geriatric chair does not meet the definition of a restraint, and should not be coded at P0100G–Chair Prevents Rising.

338

- Geriatric chairs used for residents who are immobile: For residents who have no voluntary or involuntary movement, the geriatric chair does not meet the definition of a restraint.
- Enclosed-frame wheeled walkers, with or without a posterior seat, and other devices like it should not automatically be classified as a physical restraint. These types of walkers are only classified as a physical restraint if the resident cannot exit the walker via opening a gate, bar, strap, latch, removing a tray, etc. When deemed a physical restraint, these walkers should be coded at P0100G–Chair Prevents Rising.

339

Restraints used in emergency situations

- If resident needs emergency care, physical restraints may be used for brief periods to permit medical treatment to proceed, unless the resident or legal representative has previously made a valid refusal of the treatment in question. The use of physical restraints in this instance should be limited to preventing the resident from interfering with life-sustaining procedures only and not for routine care.
  - A resident who is injuring himself/herself or is threatening physical harm to others may be physically restrained in an emergency to safeguard the resident and others.
  - A resident whose unanticipated violent or aggressive behavior places him/her or others in imminent danger does not have the right to refuse the use of physical restraints, as long as those restraints are used as a last resort to protect the safety of the resident or others and use is limited to the immediate episode.

340

Additional Information

- **Restraint reduction/elimination**. The nursing home must engage in a systematic and gradual process towards reducing (or eliminating, if possible) the restraints.
- **Restraints as a fall prevention approach**. Falls do not constitute self-injurious behavior nor a medical symptom supporting the use of physical restraints. There is no evidence that the use of physical restraints, including but not limited to side rails, will prevent, reduce, or eliminate falls.

341

Additional Information

- **Request for restraints**. While a resident, family member, legal representative, or surrogate may request use of a physical restraint, the nursing home is responsible for evaluating the appropriateness of that request, just as they would for any medical treatment. As with other medical treatments, such as the use of prescription drugs, a resident, family member, legal representative, or surrogate has the right to refuse treatment, but not to demand its use when it is not deemed medically necessary.

342

An alarm is any physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected, and may include bed, chair and floor sensor pads, cords that clip to the resident's clothing, motion sensors, door alarms, or elopement/wandering devices.

Code any type of alarm, ***audible or inaudible***, used during the look-back period in this section.

Coding:
0. **Not used**
1. **Used less than daily**
2. **Used daily**

- ☐ **A. Bed alarm**
- ☐ **B. Chair alarm**
- ☐ **C. Floor mat alarm**
- ☐ **D. Motion sensor alarm**
- ☐ **E. Wander/elopement alarm**
- ☐ **F. Other alarm**

P-8

343

- **Bed alarm** includes devices such as a sensor pad placed on the bed or a device that clips to the resident's clothing.
- **Chair alarm** includes devices such as a sensor pad placed on the chair or wheelchair or a device that clips to the resident's clothing.
- **Floor mat alarm** includes devices such as a sensor pad placed on the floor beside the bed.
- **Motion sensor alarm** includes infrared beam motion detectors.
- **Wander/elopement alarm** includes devices such as bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exit sensors worn/attached to the resident that alert the staff when the resident nears or exits an area or building. This includes devices that are attached to the resident's assistive device (e.g., walker, wheelchair, cane) or other belongings.
- **Other alarm** includes devices such as alarms on the resident's bathroom and/or bedroom door, toilet seat alarms, or seatbelt alarms.

344

- If an alarm meets the criteria as a restraint, code the alarm use in both P0100, Physical Restraints, and P0200, Alarms.
- Motion sensors and wrist sensors worn by the resident to track the resident's sleep patterns should not be coded in this section.
- Bracelets or devices worn or attached to the resident and/or his or her belongings that signal a door to lock when the resident approaches should be coded in P0200E Wander/elopement alarm, whether or not the device activates a sound.
- Do not code a universal building exit alarm applied to an exit door that is intended to alert staff when *anyone* (including visitors or staff members) exits the door.
- When determining whether the use of an alarm also meets the criteria of a restraint, refer to the section "Determination of the Use of Position Change Alarms as Restraints" of F604 in Appendix PP of the State Operations Manual.

345

F604:
Restraints

- Examples of facility practices that meet the definition of a physical restraint include, but are not limited to:
- Using a position change alarm to monitor resident movement, and the resident is afraid to move to avoid setting off the alarm.
- **"Position change alarms"** are alerting devices intended to monitor a resident's movement. The devices emit an audible signal when the resident moves in a certain way.
  - Types of position change alarms include chair and bed sensor pads, bedside alarmed mats, alarms clipped to a resident's clothing, seatbelt alarms, and infrared beam motion detectors.
  - Position change alarms do not include alarms intended to monitor for unsafe wandering such as door or elevator alarms.

346

Determination of the Use of Position Change Alarms as Restraints

- While position change alarms may be implemented to monitor a resident's movements, for some residents, the use of position change alarms that are audible to the resident(s) may have the unintended consequence of inhibiting freedom of movement.
- For example, a resident may be afraid to move to avoid setting off the alarm and creating noise that is a nuisance to the resident(s) and staff, or is embarrassing to the resident. For this resident, a position change alarm may have the potential effect of a physical restraint.

347

Questions/Discussion

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348