



MDS Workshop  
for the  
Seasoned

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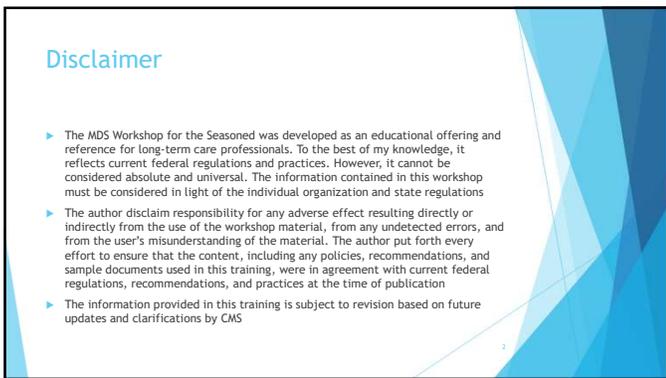
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Disclaimer

- ▶ The MDS Workshop for the Seasoned was developed as an educational offering and reference for long-term care professionals. To the best of my knowledge, it reflects current federal regulations and practices. However, it cannot be considered absolute and universal. The information contained in this workshop must be considered in light of the individual organization and state regulations
- ▶ The author disclaim responsibility for any adverse effect resulting directly or indirectly from the use of the workshop material, from any undetected errors, and from the user's misunderstanding of the material. The author put forth every effort to ensure that the content, including any policies, recommendations, and sample documents used in this training, were in agreement with current federal regulations, recommendations, and practices at the time of publication
- ▶ The information provided in this training is subject to revision based on future updates and clarifications by CMS

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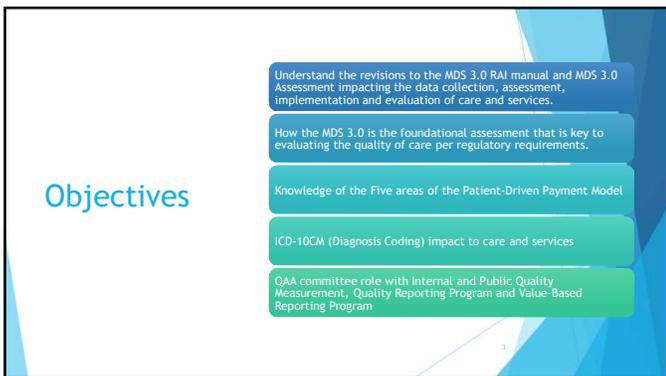
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Objectives

- Understand the revisions to the MDS 3.0 RAI manual and MDS 3.0 Assessment impacting the data collection, assessment, implementation and evaluation of care and services.
- How the MDS 3.0 is the foundational assessment that is key to evaluating the quality of care per regulatory requirements.
- Knowledge of the Five areas of the Patient-Driven Payment Model
- ICD-10CM (Diagnosis Coding) impact to care and services
- QAA committee role with Internal and Public Quality Measurement, Quality Reporting Program and Value-Based Reporting Program

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**Section A**  
**Identification Information**

Obtain key information to uniquely identify each resident, nursing home, type of record, and reasons for assessment.

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**Section A**  
**A0300: Optional State Assessment**

**Item Rationale**

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

**Coding Instructions for A0300, Optional State Assessment**

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

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

- Enter the value indicating whether your state requires this assessment for payment.
- 0. No
- 1. Yes

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**Section A**  
**A0300: Optional State Assessment**

**Coding Tips and Special Populations**

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

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**Section A**  
A0300: Optional State Assessment

**Coding Instructions for A0300B, Assessment Type**

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

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**Section A**  
A0310B, PPS Assessment

PPS Scheduled Assessment for Medicare Part A Stay	• 01. 5-day scheduled assessment
PPS Unscheduled Assessment for Medicare Part A Stay	• 08. IPA-Interim Payment Assessment
Not PPS Assessment	• 99. None of the above

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**A0310G1,**  
Is this a SNF Part A Interrupted Stay?

<b>Code 0, no:</b>	• If the resident was discharged from SNF care (i.e., from a Medicare Part A-covered stay) but did not resume SNF care in the same SNF within the interruption window.
<b>Code 1, yes:</b>	• If the resident was discharged from SNF care (i.e., from a Medicare Part A-covered stay) but did resume SNF care in the same SNF within the interruption window.
<b>Coding Tips</b>	• The interrupted stay policy applies to residents who either leave the SNF, then return to the same SNF within the interruption window, or to residents who are discharged from Part A-covered services and remain in the SNF, but then resume a Part A-covered stay within the interruption window.

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**Section A  
Interrupted  
Stay**

## Interrupted Stay

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

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**Section A  
Interruption  
Window**

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

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**Section A  
Interrupted Stay**

- ▶ Examples of an interrupted stay when the resident leaves the SNF and then returns to the same SNF to resume Part A-covered services
- ▶ Examples include, but are not limited to, the following:
  - ▶ Resident transfers to an acute care setting for evaluation or treatment due to a change in condition and returns to the same SNF within the interruption window.
  - ▶ Resident transfers to a psychiatric facility for evaluation or treatment and returns to the same SNF within the interruption window.
  - ▶ Resident transfers to an outpatient facility for a procedure or treatment and returns to the same SNF within the interruption window.
  - ▶ Resident transfers to an assisted living facility or a private residence with home health services and returns to the same SNF within the interruption window.
  - ▶ Resident leaves against medical advice and returns to the same SNF within the interruption window.

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### Section A Interrupted Stay

Examples of an interrupted stay when the resident under a Part A-covered stay remains in the facility but the stay stops being covered under the Part A PPS benefit, and then resumes Part A-covered services in the SNF within the interruption window. Examples include, but are not limited to, the following:

- ▶ Resident elects the hospice benefit, thereby declining the SNF benefit, and then revokes the hospice benefit and resumes SNF-level care within the interruption window.
- ▶ Resident refuses to participate in rehabilitation and has no other daily skilled need; this ends the Part A coverage. Within the interruption window, the resident decides to engage in the planned rehabilitation regime and Part A coverage resumes.
- ▶ Resident changes payer sources from Medicare Part A to an alternate payer source (i.e., hospice, private pay or private insurance) and then wishes to resume their Medicare Part A stay, at the same SNF, within the interruption window.

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### Section A Interrupted Stay

- ▶ If a resident is discharged from SNF care, remains in the SNF, and resumes a Part A-covered stay in the SNF within the interruption window, this is an interrupted stay. No discharge assessment (OBRA or Part A PPS) is required, nor is an Entry Tracking Record or 5-Day required on resumption.
- ▶ If a resident leaves the SNF and returns to resume Part A-covered services in the same SNF within the interruption window, this is an interrupted stay.
- ▶ Although this situation does not end the resident's Part A PPS stay, the resident left the SNF, and therefore an OBRA Discharge assessment is required.
- ▶ On return to the SNF, no 5-Day would be required. An OBRA Admission would be required if the resident was discharged return not anticipated.
- ▶ If the resident was discharged return anticipated, no new OBRA Admission would be required.

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### Section A Interrupted Stay

When an interrupted stay occurs, a 5-Day PPS assessment is not required upon reentry or resumption of SNF care in the same SNF, because an interrupted stay does not end the resident's Part A PPS stay.

- ▶ If a resident is discharged from SNF care, remains in the SNF and does not resume Part A-covered services within the interruption window, an interrupted stay did not occur.
- ▶ In this situation, a Part A PPS Discharge is required.
- ▶ If the resident qualifies and there is a resumption of Part A services within the 30-day window allowed by Medicare, a 5-Day would be required as this would be considered a new Part A stay.
- ▶ The OBRA schedule would continue from the resident's original date of admission (item A1900).

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### Section A Interrupted Stay

When an interrupted stay occurs, a 5-Day PPS assessment is not required upon reentry or resumption of SNF care in the same SNF, because an interrupted stay does not end the resident's Part A PPS stay.

- ▶ If a resident leaves the SNF and does not return to resume Part A-covered services in the same SNF within the interruption window, an interrupted stay did not occur.
  - ▶ In this situation, both the Part A PPS and OBRA Discharge assessments are required (and may be combined).
- ▶ If the resident returns to the same SNF, this would be considered a new Part A stay.
  - ▶ An Entry Tracking record and 5-Day would be required on return.
  - ▶ An OBRA Admission would be required if the resident was discharged return not anticipated.
- ▶ If the resident was discharged return anticipated, no new OBRA Admission would be required.
- ▶ The OBRA assessment schedule is unaffected by the interrupted stay policy. Please refer to Chapter 2 for guidance on OBRA assessment scheduling requirements.

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### Section A Interrupted Stay

#### ▶ A2400: Medicare Stay

- ▶ When a resident on Medicare Part A has an interrupted stay (i.e., is discharged from SNF care and subsequently readmitted to the same SNF within the interruption window after the discharge), this is a continuation of the Medicare Part A stay, not a new Medicare Part A stay.

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### Section A Interrupted Stay

#### ▶ Example

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

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

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

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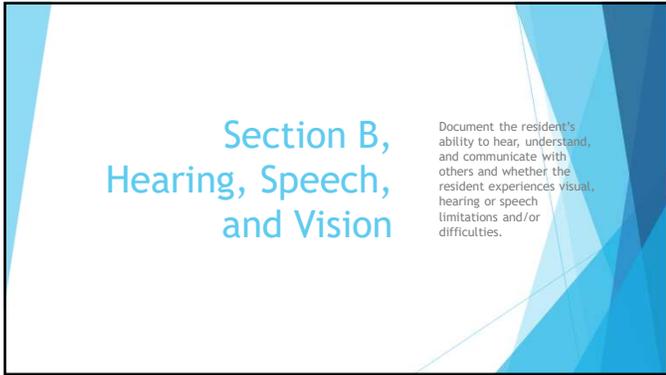
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**Section B,  
Hearing, Speech,  
and Vision**

Document the resident's ability to hear, understand, and communicate with others and whether the resident experiences visual, hearing or speech limitations and/or difficulties.

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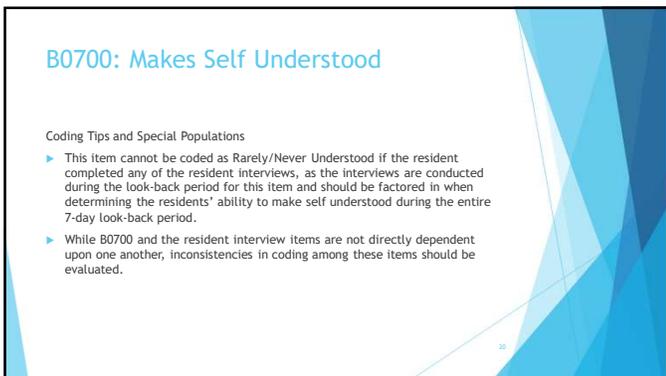
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**B0700: Makes Self Understood**

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.

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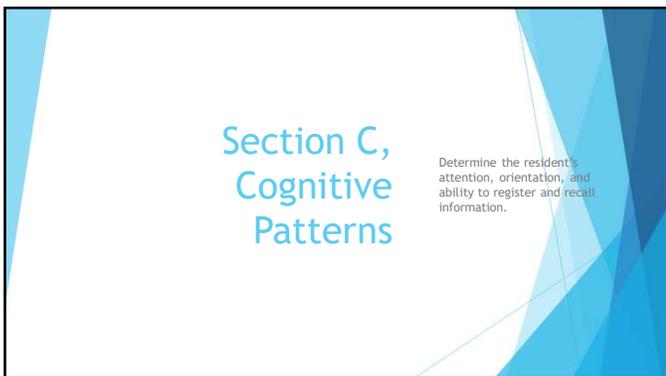
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**Section C,  
Cognitive  
Patterns**

Determine the resident's attention, orientation, and ability to register and recall information.

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### Section C, Cognitive Patterns

Coding Tips

- ▶ Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.
- ▶ If the resident needs an interpreter, every effort should be made to have an interpreter present for the BIMS. If it is not possible for a needed interpreter to participate on the day of the interview, code C0100 = 0 to indicate interview not attempted and complete C0700-C1000, Staff Assessment of Mental Status, instead of C0200-C0500, Brief Interview for Mental Status.
- ▶ If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item C0100 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items.

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### Section C, Cognitive Patterns

Coding Tips cont.

- ▶ Because a PDPM cognitive level is utilized in the speech language pathology (SLP) payment component of PDPM, only in the case of PPS assessments, staff may complete the Staff Assessment for Mental Status for an interviewable resident when the resident is unexpectedly discharged from a Part A stay prior to the completion of the BIMS.
- ▶ In this case, the assessor should enter 0, No in C0100: Should Brief Interview for Mental Status Be Conducted? and proceed to the Staff Assessment for Mental Status.

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### C1000: Cognitive Skills for Daily Decision Making

DAILY DECISION MAKING

- ▶ Includes: choosing clothing; knowing when to go to meals; using environmental cues to organize and plan (e.g., clocks, calendars, posted event notices);
- ▶ In the absence of environmental cues, seeking information appropriately (i.e. not repetitively) from others in order to plan the day;
- ▶ Using awareness of one's own strengths and limitations to regulate the day's events (e.g., asks for help when necessary);
- ▶ Acknowledging need to use appropriate assistive equipment such as a walker.

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Section D, Mood

Identify signs and symptoms of mood distress.

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Section D, Mood  
9-ITEM PATIENT HEALTH QUESTIONNAIRE (PHQ-9©)

PHQ-9 - A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder.

- ▶ Health-related Quality of Life
- ▶ Depression can be associated with:
  - psychological and physical distress,
  - decreased participation in therapy and activities,
  - decreased functional status, and
  - poorer outcomes.

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Section D, Mood

Coding Tips and Special Populations

- ▶ For question D02001, Thoughts That You Would Be Better Off Dead or of Hurting Yourself in Some Way:
  - ▶ Beginning interviewers may feel uncomfortable asking this item because they may fear upsetting the resident or may feel that the question is too personal. Others may worry that it will give the resident inappropriate ideas. However,
  - ▶ Experienced interviewers have found that most residents who are having this feeling appreciate the opportunity to express it.
  - ▶ Asking about thoughts of self-harm does not give the person the idea. It does let the provider better understand what the resident is already feeling.
  - ▶ The best interviewing approach is to ask the question openly and without hesitation.

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### Section D, Mood

Coding Tips and Special Populations cont.

- ▶ Responses to PHQ-9© can indicate possible depression. Responses can be interpreted as follows:
- ▶ Major Depressive Syndrome is suggested if—of the 9 items—
  - ▶ 5 or more items are identified at a frequency of half or more of the days (7-11 days) during the look-back period and at least one of these,
  - ▶ (1) little interest or pleasure in doing things, or
  - ▶ (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days) during the look-back period.

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### Section D, Mood

Coding Tips and Special Populations cont.

- ▶ Minor Depressive Syndrome is suggested if, of the 9 items,
  - ▶ (1) feeling down, depressed or hopeless,
  - ▶ (2) trouble falling or staying asleep, or sleeping too much, or
  - ▶ (3) feeling tired or having little energy are identified at a frequency of half or more of the days (7-11 days) during the look-back period and
  - ▶ At least one of these,
    - ▶ (1) little interest or pleasure in doing things, or
    - ▶ (2) feeling down, depressed, or hopeless is identified at a frequency of half or more of the days (7-11 days).

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### Section D, Mood

Coding Tips and Special Populations cont.

- ▶ In addition, PHQ-9© Total Severity Score can be used to track changes in severity over time. Total Severity Score can be interpreted as follows:
- 1-4: minimal depression
- 5-9: mild depression
- 10-14: moderate depression
- 15-19: moderately severe depression
- 20-27: severe depression

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**Section E, Behavior**

Identify behavioral symptoms that may cause distress or are potentially harmful to the resident, or may be distressing or disruptive to facility residents, staff members or the environment.

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**Section E, Behavior**

**HALLUCINATION**

- ▶ The perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch.

**DELUSION**

- ▶ A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary.

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**Section E, Behavior**

Health-related Quality of Life

Psychotic symptoms may be associated with

- ▶ – delirium,
- ▶ – dementia,
- ▶ – adverse drug effects,
- ▶ – psychiatric disorders, and
- ▶ – hearing or vision impairment.

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### Section E, Behavior

Health-related Quality of Life cont.

Hallucinations and delusions may

- ▶ – be distressing to residents and families,
- ▶ – cause disability,
- ▶ – interfere with delivery of medical, nursing, rehabilitative and personal care, and
- ▶ – lead to dangerous behavior or possible harm.

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### Section E, Behavior

Planning for Care

- ▶ Reversible and treatable causes should be identified and addressed promptly. When the cause is not reversible, the focus of management strategies should be to minimize the amount of disability and distress.

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### E0200: Behavioral Symptom—Presence & Frequency

E0200. Behavioral Symptom—Presence & Frequency	
Note presence of symptoms and their frequency	
	Enter Codes in Boxes
Coding: 0. Behavior not exhibited 1. Behavior of this type occurred 1 to 3 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily	<input type="checkbox"/> A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) <input type="checkbox"/> B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) <input type="checkbox"/> C. Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, drooling in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

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### E0200: Behavioral Symptom—Presence & Frequency

Examples

- ▶ Every morning, a nursing assistant tries to help a resident who is unable to dress himself. On the last 4 out of 6 mornings, the resident has hit or scratched the nursing assistant during attempts to dress him.
- ▶ Coding: E0200A would be coded 2, behavior of this type occurred 4-6 days, but less than daily.
- ▶ Rationale: Scratching the nursing assistant was a physical behavior directed toward others.

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### E0500: Impact on Resident

E0500: Impact on Resident	
Did any of the identified symptoms(s):	
Enter Code	A. Put the resident at significant risk for physical illness or injury?
<input type="checkbox"/>	0. No
	1. Yes
Enter Code	B. Significantly interfere with the resident's care?
<input type="checkbox"/>	0. No
	1. Yes
Enter Code	C. Significantly interfere with the resident's participation in activities or social interactions?
<input type="checkbox"/>	0. No
	1. Yes

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### E0500: Impact on Resident

Examples

- ▶ A resident frequently grabs and scratches staff when they attempt to change her soiled brief, digging her nails into their skin. This makes it difficult to complete the care task.
- ▶ Coding: E0500B would be coded 1, yes.
- ▶ Rationale: This behavior interfered with delivery of essential personal care.

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### E0600: Impact on Others

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

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### E0600: Impact on Others

Example

- ▶ A resident, when sitting in the hallway outside the community activity room, continually yells, repeating the same phrase. The yelling can be heard by other residents in hallways and activity/recreational areas but not in their private rooms.
- ▶ Coding: E0600A would be coded 0, no; E0600B and E0600C would be coded 1, yes.
- ▶ Rationale: The behavior does not put others at risk for significant injury. The behavior does create a climate of excessive noise, disrupting the living environment and the activity of others.

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### E0800: Rejection of Care—Presence & Frequency

REJECTION OF CARE

- ▶ Behavior that interrupts or interferes with the delivery or receipt of care. Care rejection may be manifested by verbally declining or statements of refusal or through physical behaviors that convey aversion to or result in avoidance of or interfere with the receipt of care.

INTERFERENCE WITH CARE

- ▶ Hindering the delivery or receipt of care by disrupting the usual routines or processes by which care is given, or by exceeding the level or intensity of resources that are usually available for the provision of care.

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## Section F, Preferences for Customary Routine and Activities

Obtain information regarding the resident's preferences for his or her daily routine and activities.

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### F0400: Interview for Daily Preferences

**F0400. Interview for Daily Preferences**  
Show resident the response options and say, "While you are in this facility..."

Enter Codes in Boxes

<input type="checkbox"/>	A. How important is it to you to choose what clothes to wear?
<input type="checkbox"/>	B. How important is it to you to take care of your personal belongings or things?
<input type="checkbox"/>	C. How important is it to you to choose between a tub-bath, shower, bed bath, or sponge bath?
<input type="checkbox"/>	D. How important is it to you to have snacks available between meals?
<input type="checkbox"/>	E. How important is it to you to choose your own bedtime?
<input type="checkbox"/>	F. How important is it to you to have your family or a close friend involved in discussions about your care?
<input type="checkbox"/>	G. How important is it to you to be able to use the phone in private?
<input type="checkbox"/>	H. How important is it to you to have a place to lock your things to keep them safe?

**Coding:**  
 1. Very important  
 2. Somewhat important  
 3. Not very important  
 4. Not important at all  
 5. Important, but can't do or no choice  
 9. No response or non-responsive

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### F0500: Interview for Activity Preferences

**F0500. Interview for Activity Preferences**  
Show resident the response options and say, "While you are in this facility..."

Enter Codes in Boxes

<input type="checkbox"/>	A. How important is it to you to have books, newspapers, and magazines to read?
<input type="checkbox"/>	B. How important is it to you to have a pet to make you like?
<input type="checkbox"/>	C. How important is it to you to be around animals such as pets?
<input type="checkbox"/>	D. How important is it to you to keep up with the news?
<input type="checkbox"/>	E. How important is it to you to do things with groups of people?
<input type="checkbox"/>	F. How important is it to you to do your favorite activities?
<input type="checkbox"/>	G. How important is it to you to go outside to get fresh air when the weather is good?
<input type="checkbox"/>	H. How important is it to you to participate in religious services or practices?

**Coding:**  
 1. Very important  
 2. Somewhat important  
 3. Not very important  
 4. Not important at all  
 5. Important, but can't do or no choice  
 9. No response or non-responsive

**F0600. Daily and Activity Preferences Primary Respondent**  
 Indicate primary respondent for Daily and Activity Preferences (F0400 and F0500)

Enter Code  **1. Resident**  
**2. Family or significant other** (close friend or other representative)  
 9. Interview could not be completed by resident or family/significant other ("No response" to 3 or more items)

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## Section G, Functional Status

Assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion.

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## Section G, Functional Status

- ▶ ADL - Tasks related to personal care; any of the tasks listed in items G0110A-J and G0120.

**ADL ASPECTS**

- ▶ Components of an ADL activity. These are listed next to the activity in the item set. For example, the components of G0110H (Eating) are eating, drinking, and intake of nourishment or hydration by other means, including tube feeding, total parenteral nutrition and IV fluids for hydration.

**ADL SELF- PERFORMANCE**

- ▶ Measures what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last 7 days according to a performance-based scale.

**ADL SUPPORT PROVIDED**

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

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

- ▶ Code 0, independent:
  - ▶ If resident completed activity with no help or oversight every time during the 7-day look-back period and the activity occurred at least three times.
- ▶ Code 1, supervision:
  - ▶ If oversight, encouragement, or cueing was provided three or more times during the last 7 days.
- ▶ Code 2, limited assistance:
  - ▶ If resident was highly involved in activity and received physical help in guided maneuvering of limb(s) or other non-weight-bearing assistance on three or more times during the last 7 days.

1.  
**Self-Performance**

↓ Enter Cod

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

- ▶ Code 3, extensive assistance:
  - ▶ If resident performed part of the activity over the last 7 days and help of the following type(s) was provided three or more times:
    - ▶ – Weight-bearing support provided three or more times, OR
    - ▶ – Full staff performance of activity three or more times during part but not all of the last 7 days.

1.  
Self-Performance  
↓ Enter Cod

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

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

1.  
Self-Performance  
↓ Enter Cod

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### Coding Instructions for G0110, Column 1, ADL Self-Performance The Rule of 3

- ▶ The following ADL Self-Performance coding levels are exceptions to the Rule of 3:
  - ▶ Code 0, Independent - Coded only if the resident completed the ADL activity with no help or oversight every time the ADL activity occurred during the 7-day look-back period and the activity occurred at least three times.
  - ▶ Code 4, Total dependence - Coded only if the resident required full staff performance of the ADL activity every time the ADL activity occurred during the 7-day look-back period and the activity occurred three or more times.
  - ▶ Code 7, Activity occurred only once or twice - Coded if the ADL activity occurred fewer than three times in the 7-day look back period.
  - ▶ Code 8, Activity did not occur - Coded only if the ADL activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day look-back period.

1.  
Self-Performance  
↓ Enter Cod

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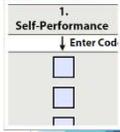
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### Instructions for the Rule of 3

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




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### Instructions for the Rule of 3 cont.

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




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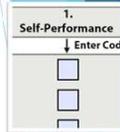
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### Instructions for the Rule of 3 cont.

3. When an activity occurs three or more times and at multiple levels, but not three times at any one level, apply the following cont.:
  - b. When there is a combination of full staff performance and weight-bearing assistance that total three or more times—code extensive assistance (3).
  - c. When there is a combination of full staff performance /weight-bearing assistance, and/or non-weight-bearing assistance that total three or more times—code limited assistance (2).
 If none of the above are met, code supervision.




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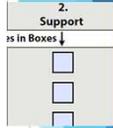
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### Coding Instructions for G0110, Column 2, ADL Support

Code for the most support provided over all shifts.

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



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### Section G, Functional Status Coding Tips and Special Populations

- ▶ Do NOT include the emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag in G0110 1.
- ▶ Do NOT record the staff's assessment of the resident's potential capability to perform the ADL activity. The assessment of potential capability is covered in ADL Functional Rehabilitation Potential Item (G0900).
- ▶ Do NOT record the type and level of assistance that the resident "should" be receiving according to the written plan of care. The level of assistance actually provided might be very different from what is indicated in the plan. Record what actually happened.
- ▶ Do NOT include assistance provided by family or other visitors

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### Section G, Functional Status Coding Tips and Special Populations

- ▶ Some residents sleep on furniture other than a bed (for example, a recliner). Consider assistance received in this alternative bed when coding bed mobility.
- ▶ Differentiating between guided maneuvering and weight-bearing assistance: determine who is supporting the weight of the resident's extremity or body. For example, if the staff member supports some of the weight of the resident's hand while helping the resident to eat (e.g., lifting a spoon or a cup to mouth), or performs part of the activity for the resident, this is "weight-bearing" assistance for this activity. If the resident can lift the utensil or cup, but staff assistance is needed to guide the resident's hand to his or her mouth, this is guided maneuvering.

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### Section G, Functional Status Coding Tips and Special Populations

- ▶ Some residents are transferred between surfaces, including to and from the bed, chair, and wheelchair, by staff, using a full-body mechanical lift. Whether or not the resident holds onto a bar, strap, or other device during the full-body mechanical lift transfer is not part of the transfer activity and should not be considered as resident participation in a transfer.
- ▶ Transfers via lifts that require the resident to bear weight during the transfer, such as a stand-up lift, should be coded as Extensive Assistance, as the resident participated in the transfer and the lift provided weight-bearing support.

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### Section G, Functional Status Example

- ▶ Mr. Q. is a wheelchair-bound and is able to self-propel on the unit. On two occasions during the 7-day look-back period, he self-propelled off the unit into the courtyard.
- ▶ Coding: G0110F1 would be coded 7, activity occurred only once or twice. G0110F2 would be coded 0, no setup or physical help from staff.
- ▶ Rationale: The activity of going off the unit happened only twice during the look-back period with no help or oversight from staff.

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### Section G, Functional Status Example

- ▶ Staff must assist Mr. P. to zip his pants, hand him a washcloth, and remind him to wash his hands after using the toilet daily. This occurred multiple times each day during the 7-day look-back period.
- ▶ Coding: G0110I1 would be coded 2, limited assistance. G0110I2 would be coded 2, one person physical assist.
- ▶ Rationale: Resident required staff to perform non-weight-bearing activities to complete the task multiple times each day during the 7-day look-back period.

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### Examples for G0110J, Personal Hygiene

- ▶ Mrs. J. normally completes all hygiene tasks independently. Three mornings during the 7-day look-back period, however, she was unable to brush and style her hair because of elbow pain, so a staff member did it for her.
- ▶ Coding: G0110J1 would be coded 3, extensive assistance. G0110J2 would be coded 2, one person physical assist.
- ▶ Rationale: A staff member had to complete part of the activity of personal hygiene for the resident 3 out of 7 days during the look-back period. The assistance, although non-weight-bearing, is considered full staff performance of the personal hygiene sub-task of brushing and styling her hair. Because this ADL sub-task was completed for the resident 3 times, but not every time during the last 7 days, it qualifies under the second criterion of the extensive assistance definition.

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### G0120: Bathing

**G0120. Bathing**  
How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (excludes washing of back and hair). Code for most dependent in self-performance and support.

Enter Code	<b>A. Self-performance</b>
<input type="checkbox"/>	0. Independent - no help provided
	1. Supervision - oversight help only
	2. Physical help limited to transfer only
	3. Physical help in part of bathing activity
	4. Total dependence
	8. Activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period
Enter Code	<b>B. Support provided</b>
<input type="checkbox"/>	(Bathing support codes are as defined in item G0110 column 2, ADL Support Provided, above)

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### G0300: Balance During Transitions and Walking

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

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### G0300: Balance During Transitions and Walking

#### UNSTEADY

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

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### Coding for G0300D, Moving on and off Toilet

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

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### G0400: Functional Limitation in Range of Motion

#### 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.

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### G0400: Functional Limitation in Range of Motion

**Coding Tips**

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

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### Section GG, Functional Abilities and Goals

Assess the need for assistance with self-care and mobility activities.

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**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:**

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

**Enter Codes in Boxes**

- |                          |  |
|--------------------------|--|
| <input type="checkbox"/> | <b>A. Self-Care:</b> Code the resident's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.  |
| <input type="checkbox"/> | <b>B. Indoor Mobility (Ambulation):</b> 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. |
| <input type="checkbox"/> | <b>C. Stairs:</b> 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.                     |
| <input type="checkbox"/> | <b>D. Functional Cognition:</b> 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.                   |

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

**Section GG Functional Abilities and Goals - Admission (Start of SNF PPS Stay)**

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

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

1. Admission Performance	2. Discharge Goal
Enter Codes in Boxes	Enter Codes in Boxes
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

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**GG0130: Self-Care & GG0170: Mobility, 3-day assessment period**

For the 5-Day PPS assessment, code the resident's functional status based on a clinical assessment of the resident's performance that occurs soon after the resident's admission.

- ▶ This functional assessment must be completed within the first three days (3 calendar days) of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, and the following two days, ending at 11:59 PM on day 3.
- ▶ The admission function scores are to reflect the resident's admission baseline status and are to be based on an assessment. The scores should reflect the resident's status prior to any benefit from interventions.
- ▶ The assessment should occur, when possible, prior to the resident benefiting from treatment interventions in order to determine the resident's true admission baseline status. Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted.
- ▶ Treatment should not be withheld in order to conduct the functional assessment.

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

**Section GG Functional Abilities and Goals - Interim Payment Assessment**

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

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

5. Interim Performance
Enter Codes in Boxes
<input type="text"/>
<input type="text"/>
<input type="text"/>

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### GG0130: Self-Care & GG0170: Mobility, 3-day assessment period

- Interim Performance (Optional): The Interim Payment Assessment (IPA) is an optional assessment that may be completed by providers in order to report a change in the resident's PDPM classification.
- ▶ For Section GG on the IPA, providers will use the same 6-point scale and activity not attempted codes to complete the column "Interim Performance," which will capture the interim functional performance of the resident.
  - ▶ The ARD for the IPA is determined by the provider, and the assessment period is the last 3 days (i.e., the ARD and the 2 calendar days prior).
  - ▶ It is important to note that the IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed.
  - ▶ The IPA does not affect the variable per diem schedule.

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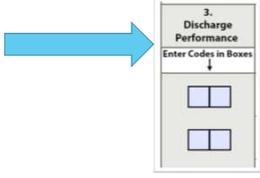
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### GG0130: Self-Care (3-day assessment period) Discharge (End of Medicare Part A Stay)

**Section GG Functional Abilities and Goals - Discharge (End of SNF PPS Stay)**  
 GG0130: Self-Care (Assessment period is the last 3 days of the SNF PPS Stay ending on A2400C)  
 Complete only if A03100 is not = 2 and A03101 = 1 and A2400C minus A2400B is greater than 2 and A2100 is not = 03  
 Code the resident's usual performance at the end of the SNF PPS stay for each activity using the 6-point scale. If an activity was not attempted at the end of the SNF PPS stay, code the reason.



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### GG0130: Self-Care & GG0170: Mobility, 3-day assessment period

- Discharge: The Part A PPS Discharge assessment is required to be completed when the resident's Medicare Part A Stay ends (as documented in A2400C, End of Most Recent Medicare Stay),
- ▶ Either as a standalone assessment when the resident's Medicare Part A stay ends, but the resident remains in the facility; or
  - ▶ May be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or one day before the resident's Discharge Date (A2000).

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### Section GG

#### 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.

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### GG0130: Self-Care & GG0170: Mobility, 3-day assessment period

Admission, Interim, or Discharge Performance Coding Instructions  
 When coding the resident's usual performance and discharge goal(s), use the six-point scale, or use one of the four "activity was not attempted" codes to specify the reason why an activity was not attempted.

- ▶ Code 06, Independent: if the resident completes the activity by him/herself with no assistance from a helper.
- ▶ Code 05, Setup or clean-up assistance: if the helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity, but not during the activity. For example, the resident requires assistance cutting up food or opening container or requires setup of hygiene item(s) or assistive device(s).

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### GG0130: Self-Care & GG0170: Mobility, 3-day assessment period

Admission, Interim, or Discharge Performance Coding Instructions cont.

- ▶ Code 04, Supervision or touching assistance:
- ▶ If the helper provides verbal cues or touching/steadying/contact guard assistance as resident completes activity.
- ▶ Assistance may be provided throughout the activity or intermittently.
- ▶ For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete activity; or resident may require only incidental help such as contact guard or steadying assist during the activity.

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### GG0130: Self-Care & GG0170: Mobility, 3-day assessment period

Admission, Interim, or Discharge Performance Coding Instructions cont.

- ▶ Code 03, Partial/moderate assistance: if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.
- ▶ Code 02, Substantial/maximal assistance: if the helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
- ▶ Code 01, Dependent: if the helper does ALL of the effort. Resident does none of the effort to complete the activity; or the assistance of two or more helpers is required for the resident to complete the activity.

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### GG0130: Self-Care & GG0170: Mobility, 3-day assessment period

Admission, Interim, or Discharge Performance Coding Instructions cont.

- ▶ 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.

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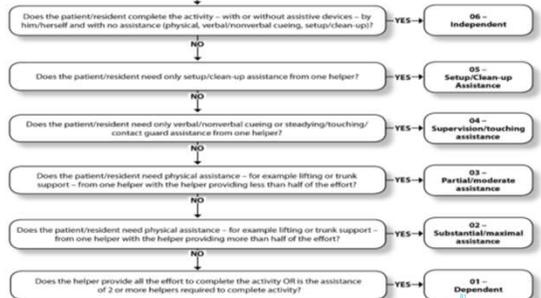
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START DECISION TREE HERE



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### Section GG Coding Tips: Admission, Interim, or Discharge Performance

- ▶ If the resident does not attempt the activity and a helper does not complete the activity for the resident during the entire assessment period, code the reason the activity was not attempted.
- ▶ For example, code as 07 if the resident refused to attempt the activity;
- ▶ Code as 09 if the activity is not applicable for the resident (the activity did not occur at the time of the assessment and prior to the current illness, injury, or exacerbation);
- ▶ Code as 10 if the resident was not able to attempt the activity due to environmental limitations; or
- ▶ Code as 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.

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### Section GG Coding Tips: Admission, Interim, or Discharge Performance

- ▶ If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent.
- ▶ A dash (“-”) indicates “No information.” CMS expects dash use to be a rare occurrence.
- ▶ Documentation in the medical record is used to support assessment coding of Section GG. Data entered should be consistent with the clinical assessment documentation in the resident’s medical record.
- ▶ This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with State and Federal regulations.

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### Section GG: Tips for Coding the Resident’s Usual Performance

- ▶ When coding the resident’s usual performance, “effort” refers to the type and amount of assistance a helper provides in order for the activity to be completed.
- ▶ The six-point rating scale definitions include the following types of assistance:
  - ▶ Setup/cleanup
  - ▶ Touching assistance
  - ▶ Verbal cueing
  - ▶ Lifting assistance

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### Section GG: Tips for Coding the Resident's Usual Performance

- ▶ If the resident performs the activity more than once during the assessment period and the resident's performance varies, coding in Section GG should be based on the resident's "usual performance," which is identified as the resident's usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period.
- ▶ Therefore, if the resident's Self-Care performance varies during the assessment period, report the resident's usual performance, not the resident's most independent performance and not the resident's most dependent performance.
- ▶ A provider may need to use the entire three-day assessment period to obtain the resident's usual performance.

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### Coding Tips for GG0130A, Eating

GG0130A, Eating involves bringing food and liquids to the mouth and swallowing food.

- ▶ The administration of tube feedings and parenteral nutrition is not considered when coding this activity.
- ▶ If the resident does not eat or drink by mouth and relies solely on nutrition and liquids through tube feedings or total parenteral nutrition (TPN) because of a new (recent-onset) medical condition,
  - ▶ Code GG0130A as 88, Not attempted due to medical condition or safety concerns.

Assistance with tube feedings or TPN is not considered when coding Eating.

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### Coding Tips for GG0130C, Toileting Hygiene

Toileting hygiene includes managing undergarments, clothing, and incontinence products and performing perineal cleansing before and after voiding or having a bowel movement. If the resident does not usually use undergarments, then assess the resident's need for assistance to manage lower body clothing and perineal hygiene.

- ▶ Toileting hygiene takes place before and after use of the toilet, commode, bedpan, or urinal. If the resident completes a bowel toileting program in bed, code Toileting hygiene based on the resident's need for assistance in managing clothing and perineal cleansing.
- ▶ If the resident has an indwelling urinary catheter and has bowel movements, code the Toileting hygiene item based on the amount of assistance needed by the resident before and after moving his or her bowels.

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### Examples for GG0130C, Toileting hygiene

- ▶ Toileting hygiene: Mrs. P has urinary urgency. As soon as she gets in the bathroom, she asks the certified nursing assistant to lift her gown and pull down her underwear due to her balance problems. After voiding, Mrs. P wipes herself, pulls her underwear back up, and adjusts her gown.
- ▶ Coding: GG0130C would be coded 03, Partial/moderate assistance.
- ▶ Rationale: The helper provides more than touching assistance. The resident performs more than half the effort; the helper does less than half the effort. The resident completes two of the three toileting hygiene tasks.

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### GG0130H Putting on/taking off footwear

- ▶ Mrs. F was admitted to the SNF for a neurologic condition and experiences visual impairment and fine motor coordination and endurance issues. She requires setup for retrieving her socks and shoes, which she prefers to keep in the closet. Mrs. F often drops her shoes and socks as she attempts to put them onto her feet or as she takes them off. Often a certified nursing assistant must first thread her socks or shoes over her toes, and then Mrs. F can complete the task. Mrs. F needs the certified nursing assistant to initiate taking off her socks and unstrapping the Velcro used for fastening her shoes.
- ▶ Coding: GG0130H would be coded 02, Substantial/maximal assistance.
- ▶ Rationale: A helper provides Mrs. F with assistance in initiating putting on and taking off her footwear because of her limitations regarding fine motor coordination when putting on/taking off footwear. The helper completes more than half of the effort with this activity.

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### Discharge Goals: Coding Tips

- ▶ Discharge goals are coded with each Admission (Start of SNF PPS Stay) assessment.
- ▶ For the SNF Quality Reporting Program (QRP), a minimum of one self-care or mobility discharge goal must be coded.
- ▶ However, facilities may choose to complete more than one self-care or mobility discharge goal.
- ▶ Code the resident's discharge goal(s) using the six-point scale.
- ▶ Use of the "activity was not attempted" codes (07, 09, 10, and 88) is permissible to code discharge goal(s).
- ▶ Use of a dash is permissible for any remaining self-care or mobility goals that were not coded.
- ▶ Of note, at least one Discharge Goal must be indicated for either Self-Care or Mobility. Using the dash in this allowed instance after the coding of at least one goal does not affect Annual Payment Update (APU) determination.

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### Discharge Goals: Coding Tips

- ▶ Licensed, qualified clinicians can establish a resident's Discharge Goal(s) at the time of admission based on the resident's prior medical condition, admission assessment self-care and mobility status, discussions with the resident and family, professional judgment, the professional's standard of practice, expected treatments, the resident's motivation to improve, anticipated length of stay, and the resident's discharge plan.
- ▶ Goals should be established as part of the resident's care plan.
- ▶ If the admission performance of an activity was coded 88, Not attempted due to medical condition or safety concern during the admission assessment, a Discharge Goal may be entered using the 6-point scale if the resident is expected to be able to perform the activity by discharge.

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### Discharge Goal: Coding Examples

1. Discharge Goal Code Is Higher than 5-Day PPS Assessment Admission Performance Code
  - ▶ If the qualified clinician determines that the resident is expected to make gains in function by discharge, the code reported for Discharge Goal will be higher than the admission performance code.
2. Discharge Goal Code Is the Same as 5-Day PPS Assessment Admission Performance Code
  - ▶ The qualified clinician determines that a medically complex resident is not expected to progress to a higher level of functioning during the SNF Medicare Part A stay; however, the qualified clinician determines that the resident would be able to maintain her admission functional performance level. The qualified clinician discusses functional status goals with the resident and her family and they agree that maintaining functioning is a reasonable goal. In this example, the Discharge Goal is coded at the same level as the resident's admission performance code.
3. Discharge Goal Code Is Lower than 5-Day PPS Assessment Admission Performance Code
  - ▶ The qualified clinician determines that a resident with a progressive neurologic condition is expected to rapidly decline and that skilled therapy services may slow the decline of function. In this scenario, the Discharge Goal code is lower than the resident's 5-Day PPS assessment admission performance code.

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### GG0170: Mobility: 3-day assessment period, Coding Tips for GG0170G, Car transfer

- Admission, Interim, and Discharge Performance Coding Tips
- ▶ Use of an indoor car can be used to simulate outdoor car transfers. These half or full cars would need to have similar physical features of a real car for the purpose of simulating a car transfer, that is, a car seat within a car cabin.
  - ▶ The Car transfer item does not include transfers into the driver's seat, opening/closing the car door, fastening/unfastening the seat belt. The Car transfer item includes the resident's ability to transfer in and out of the passenger seat of a car or car simulator.
  - ▶ In the event of inclement weather or if an indoor car simulator or outdoor car is not available during the entire 3-day assessment period, then use code 10, Not attempted due to environmental limitations.
  - ▶ If at the time of the assessment the resident is unable to attempt car transfers, and could not perform the car transfers prior to the current illness, exacerbation or injury, code 09, Not applicable.

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**Coding Tips for GG0170I-G0170L Walking Items**

- ▶ Walking activities do not need to occur during one session. Allowing a resident to rest between activities or completing activities at different times during the day or on different days may facilitate completion of the activities.
- ▶ Do not consider the resident's mobility performance when using parallel bars. Parallel bars are not a portable assistive device. If safe, assess and code walking using a portable walking device.

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**Coding Tips for GG0170I-G0170L Walking Items Example**

Walk 50 feet with two turns: Mr. T walks 50 feet with the therapist providing trunk support. He also requires a second helper, the rehabilitation aide, who provides supervision and follows closely behind with a wheelchair for safety. Mr. T walks the 50 feet with two turns with the assistance of two helpers.

- ▶ Coding: GG0170J would be coded 01, Dependent.
- ▶ Rationale: Mr. T requires two helpers to complete the activity.

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**Section H: Bladder and Bowel**

- ▶ Gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.

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Section H		Bladder and Bowel
H0100. Appliances		
↓ Check all that apply		
<input type="checkbox"/>	A.	Indwelling catheter (including suprapubic catheter and nephrostomy tube)
<input type="checkbox"/>	B.	External catheter
<input type="checkbox"/>	C.	Ostomy (including urostomy, ileostomy, and colostomy)
<input type="checkbox"/>	D.	Intermittent catheterization
<input type="checkbox"/>	Z.	None of the above

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**Section H: B&B, H0100. Appliances Coding Tips and Special Populations**

- ▶ Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter (H0100A) only and not as an ostomy (H0100C).
- ▶ Condom catheters (males) and external urinary pouches (females) are often used intermittently or at night only; these should be coded as external catheters.
- ▶ Do not code gastrostomies or other feeding ostomies in this section. Only appliances used for elimination are coded here.
- ▶ Do not include one-time catheterization for urine specimen during look-back period as intermittent catheterization.
- ▶ Self-catheterizations that are performed by the resident in the facility should be coded as intermittent catheterization (H0100D). This includes self-catheterizations using clean technique.

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<b>H0200. Urinary Toileting Program</b>	
Enter Code <input type="checkbox"/>	<b>A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility?</b> 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
Enter Code <input type="checkbox"/>	<b>B. Response - What was the resident's response to the trial program?</b> 0. No improvement 1. Decreased wetness 2. Completely dry (continent) 9. Unable to determine or trial in progress
Enter Code <input type="checkbox"/>	<b>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?</b> 0. No 1. Yes

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**H0200. Urinary Toileting Program**

Health-related Quality of Life

- ▶ An individualized, resident-centered toileting program may decrease or prevent urinary incontinence, minimizing or avoiding the negative consequences of incontinence.
- ▶ Determining the type of urinary incontinence can allow staff to provide more individualized programming or interventions to enhance the resident's quality of life and functional status.
- ▶ Many incontinent residents (including those with dementia) respond to a toileting program, especially during the day.

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**H0200. Urinary Toileting Program**

Planning for Care

- ▶ The steps toward ensuring that the resident receives appropriate treatment and services to restore as much bladder function as possible are
  - ▶ Determining if the resident is currently experiencing some level of incontinence or is at risk of developing urinary incontinence;
  - ▶ Completing an accurate, thorough assessment of factors that may predispose the resident to having urinary incontinence; and
  - ▶ Implementing appropriate, individualized interventions and modifying them as appropriate.

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**Steps for Assessment: H0200A, Trial of a Toileting Program**

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

**BLADDER REHABILITATION/ BLADDER RETRAINING**

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

**PROMPTED VOIDING**

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

**HABIT TRAINING/ SCHEDULED VOIDING**

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

**CHECK AND CHANGE**

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

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### Steps for Assessment: H0200B, Response to Trial Toileting Program

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

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### Steps for Assessment: H0200C, Current Toileting Program or Trial

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

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### Section I: Active Diagnoses



- ▶ Code diseases that have a relationship to the resident’s current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death.

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**I0020. Indicate the resident's primary medical condition category**  
Complete only if A0310B = 01 or 08

Enter Code:

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

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

I0020B. ICD Code

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**I0020: Indicate the resident's primary medical condition category**

Planning for Care

- ▶ Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay.

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**I0020: Indicate the resident's primary medical condition category**

Coding Instructions

- ▶ Complete only if A0310B = 01 or 08
- ▶ Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay; then proceed to I0020B and enter the International Classification of Diseases (ICD) code for that condition, including the decimal.
- ▶ While certain conditions described below represent acute diagnoses, SNFs should not use acute diagnosis codes in I0020B. Sequelae and other such codes should be used instead.
- ▶ Include the primary medical condition coded in this item in Section I: Active Diagnoses in the last 7 days.

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### I0020: Indicate the resident's primary medical condition category

- ▶ Code 09, Hip and Knee Replacement, if the resident's primary medical condition category is due to a hip or knee replacement. An example is total knee replacement. If hip replacement is secondary to hip fracture, code as fracture.
- ▶ Code 10, Fractures and Other Multiple Trauma, if the resident's primary medical condition category is fractures and other multiple trauma. Examples include hip fracture, pelvic fracture, and fracture of tibia and fibula.
- ▶ Code 11, Other Orthopedic Conditions, if the resident's primary medical condition category is other orthopedic condition. An example is unspecified disorders of joint.

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### I0020: Indicate the resident's primary medical condition category, Example

- ▶ Mrs. E is an 82-year-old female who was hospitalized for a hip fracture with subsequent total hip replacement and is admitted for rehabilitation. The admitting physician documents Mrs. E's primary medical condition as total hip replacement (THR) in her medical record. The hip fracture resulting in the total hip replacement is also documented in the medical record in the discharge summary from the acute care hospital.
- ▶ Coding: I0020 would be coded 10, Fractures and Other Multiple Trauma. I0020B would be coded as S72.062D (Displaced articular fracture of the head of the left femur).

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### I0020: Indicate the resident's primary medical condition category, Example cont.

- ▶ 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.

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**Section I Active Diagnoses**

**Active Diagnoses in the last 7 days - Check all that apply**  
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

- Cancer**
  - 0100. Cancer** (with or without metastasis)
- Heart/Circulation**
  - 0200. Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle-cell)
  - 0205. Atrial Fibrillation or Other Dysrhythmias** (e.g., bradycardia and tachycardia)
  - 0400. Coronary Artery Disease (CAD)** (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
  - 0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)**
  - 0600. Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
  - 0700. Hypertension**
  - 0800. Orthostatic Hypotension**
  - 0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**
- Gastrointestinal**
  - 1100. Cirrhosis**
  - 1200. Gastroesophageal Reflux Disease (GERD) or Ulcer** (e.g., esophageal, gastric, and peptic ulcers)
  - 1300. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease**
- Genitourinary**
  - 1400. Benign Prostatic Hyperplasia (BPH)**

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**I: Active Diagnoses in the Last 7 Days**

- ▶ **Health-related Quality of Life**
  - ▶ Disease processes can have a significant adverse effect on an individual's health status and quality of life.
- ▶ **Planning for Care**
  - ▶ This section identifies active diseases and infections that drive the current plan of care.

**Steps for Assessment**

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

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**I: Active Diagnoses in the Last 7 Days**

**ACTIVE DIAGNOSES**

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

**FUNCTIONAL LIMITATIONS**

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

**NURSING MONITORING**

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

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### I: Active Diagnoses in the Last 7 Days

- ▶ If a disease or condition is not specifically listed, enter the diagnosis and ICD code in item I8000, Additional active diagnosis.
- ▶ If an individual is receiving aftercare following a hospitalization, a Z code may be assigned. Z codes cover situations where a patient requires continued care for healing, recovery, or long-term consequences of a disease when initial treatment for that disease has already been performed.
- ▶ When Z codes are used, another diagnosis for the related primary medical condition should be checked in items I0100-I7900 or entered in I8000. ICD-10-CM coding guidance with links to appendices can be found here: <https://www.cms.gov/Medicare/Coding/ICD10/index.html>.

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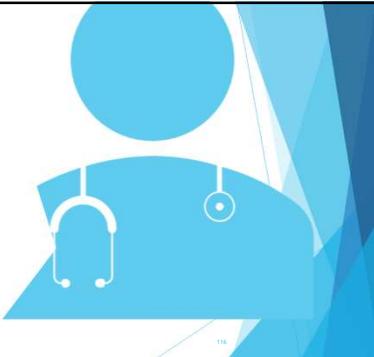
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### Section J: Health Conditions

Document health conditions that impact the resident's functional status and quality of life.



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### J0100: Pain Management 5-Day Look Back

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

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

Enter Code	<input type="checkbox"/>	A. Received scheduled pain medication regimen?
	0.	No
	1.	Yes
Enter Code	<input type="checkbox"/>	B. Received PRN pain medications OR was offered and declined?
	0.	No
	1.	Yes
Enter Code	<input type="checkbox"/>	C. Received non-medication intervention for pain?
	0.	No
	1.	Yes

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**J0100: Pain Management  
5-Day Look Back**

**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.

**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."

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**J0100: Pain Management  
5-Day Look Back**

**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, biofeedback, 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.

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**J0200: Should Pain Assessment Interview  
Be Conducted?**

**Coding Tips and Special Populations**

- ▶ If the resident interview should have been conducted, but was not done within the look-back period of the ARD (except when an interpreter is needed/requested and unavailable), item J0200 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items J0300-J0600. Item J0700, Should the Staff Assessment for Pain be Conducted, is coded 0, No.
- ▶ Do not complete the Staff Assessment for Pain Items (J0800-J0850) if the resident interview should have been conducted, but was not done.
- ▶ If it is not possible for an interpreter to be present during the look-back period, code J0200 = 0 to indicate interview not attempted and complete Staff Assessment of Pain item (J0800), instead of the Pain Interview items (J0300-J0600).

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### J0200: Should Pain Assessment Interview Be Conducted?

#### Health-related Quality of Life

- ▶ The effects of unrelieved pain impact the individual in terms of functional decline, complications of immobility, skin breakdown and infections.
- ▶ Pain significantly adversely affects a person's quality of life and is tightly linked to depression, diminished self-confidence and self-esteem, as well as an increase in behavior problems, particularly for cognitively-impaired residents.
- ▶ Some older adults limit their activities in order to avoid having pain. Their report of lower pain frequency may reflect their avoidance of activity more than it reflects adequate pain management.

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### Steps for Assessment: Basic Interview Instructions for Pain Assessment Interview (J0300-J0600)

- ▶ 1. Interview any resident not screened out by the Should Pain Assessment Interview be Conducted? item (J0200).
- ▶ 2. The Pain Assessment Interview for residents consists of four items:
  - ▶ The primary question Pain Presence item (J0300), and
  - ▶ Three follow-up questions Pain Frequency item (J0400);
  - ▶ Pain Effect on Function item (J0500); and
  - ▶ Pain Intensity item (J0600).
- ▶ If the resident is unable to answer the primary question on Pain Presence item J0300, skip to the Staff Assessment for Pain beginning with Indicators of Pain or Possible Pain item (J0800).
- ▶ 3. The look-back period on these items is 5 days. Because this item asks the resident to recall pain during the past 5 days, this assessment should be conducted close to the end of the 5- day look-back period; preferably on the day before, or the day of the ARD. This should more accurately capture pain episodes that occur during the 5-day look-back period.

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### Steps for Assessment: Basic Interview Instructions for Pain Assessment Interview (J0300-J0600)

#### 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 he or she says it does.

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### J1400: Prognosis

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.

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### J1400: Prognosis

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.

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.

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### J1550: Problem Conditions Coding Tips

Fever:

- ▶ Fever is defined as a temperature 2.4 degrees F higher than baseline. The resident's baseline temperature should be established prior to the Assessment Reference Date.
- ▶ Fever assessment prior to establishing base line temperature: A temperature of 100.4 degrees F (38 degrees C) on admission (i.e., prior to the establishment of the baseline temperature) would be considered a fever.

Internal Bleeding:

- ▶ Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools). Clinical indicators include black, tarry stools, vomiting "coffee grounds," hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed) that requires packing.
- ▶ However, 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.

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### J1550: Problem Conditions Coding Tips

Dehydrated:

Check this item if the resident presents with two or more of the following potential indicators for dehydration:

- ▶ 1. Resident takes in less than the recommended 1,500 ml of fluids daily (water or liquids in beverages and water in foods with high fluid content, such as gelatin and soups). Note: The recommended intake level has been changed from 2,500 ml to 1,500 ml to reflect current practice standards.
- ▶ 2. Resident has one or more potential clinical signs (indicators) of dehydration, including but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, or abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium, albumin, blood urea nitrogen, or urine specific gravity).
- ▶ 3. Resident's fluid loss exceeds the amount of fluids he or she takes in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement).

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### Fall, J1700 - J1900 Definitions

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). 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. Falls are not a result of an overwhelming external force (e.g., a resident pushes another resident).
- ▶ An intercepted fall occurs when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person - this is still considered a fall.
- ▶ CMS understands that challenging a resident's balance and training him/her 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.

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### Fall, J1700 - J1900 Definitions

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.

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

Planning for Care

- ▶ Identification of residents who are at high risk of falling is a top priority for care planning. A previous fall is the most important predictor of risk for future falls.
- ▶ Falls may be an indicator of functional decline and development of other serious conditions such as delirium, adverse drug reactions, dehydration, and infections.
- ▶ External risk factors include medication side effects, use of appliances and restraints, and environmental conditions.
- ▶ A fall should stimulate evaluation of the resident's need for rehabilitation, ambulation aids, modification of the physical environment, or additional monitoring (e.g., toileting, to avoid incontinence).

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

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 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 bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.

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

Coding Tip

- ▶ If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system, the assessment must be modified to update the level of injury that occurred with that fall.

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### J2000: Prior Surgery

#### 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.

**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

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### J2100: Recent Surgery Requiring Active SNF Care

#### Health-related Quality of Life

▶ A recent history of major surgery during the inpatient stay that preceded the resident's Part A admission can affect a resident's recovery.

#### Planning for Care

▶ This item identifies whether the resident had major surgery during the inpatient stay that immediately preceded the resident's Part A admission. A recent history of major surgery can affect a resident's recovery.

**J2100. Recent Surgery Requiring Active SNF Care** - 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

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### J2100: Recent Surgery Requiring Active SNF Care

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

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

**Procedure Codes** - Complete only if J2100 = 1

**Joint Replacement**

300. Knee Replacement - partial or total

310. Hip Replacement - partial or total

320. Ankle Replacement - partial or total

330. Shoulder Replacement - partial or total

**Spinal Surgery**

J2400. Involving the spinal cord or major spinal

J2410. Involving fusion of spinal bones

J2420. Involving lamina, discs, or facets

J2499. Other major spinal surgery

**Other Orthopedic Surgery**

J2500. Repair fractures of the shoulder (includes

J2510. Repair fractures of the pelvis, hip, leg

J2520. Repair but not replace joints

J2530. Repair other bones (such as hand, foot

J2599. Other major orthopedic surgery

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### J2100: Surgical Procedures

In the rare circumstance of the absence of specific documentation that a surgery requires active SNF care, the following indicators may be used to confirm that the surgery requires active SNF care:

- ▶ The inherent complexity of the services prescribed for a resident is such that they can be performed safely and/or effectively only by or under the general supervision of skilled nursing. For example:
  - The management of a surgical wound that requires skilled care (e.g., managing potential infection or drainage).
  - Daily skilled therapy to restore functional loss after surgical procedures.
  - Administration of medication and monitoring that requires skilled nursing.

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### Section K: Swallowing/Nutritional Status

- ▶ Assess conditions that could affect the resident's ability to maintain adequate nutrition and hydration.

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Section K	Swallowing/Nutritional Status
<b>K0100. Swallowing Disorder</b>	
Signs and symptoms of possible swallowing disorder	
↓ Check all that apply	
<input type="checkbox"/>	A. Loss of liquids/solids from mouth when eating or drinking
<input type="checkbox"/>	B. Holding food in mouth/cheeks or residual food in mouth after meals
<input type="checkbox"/>	C. Coughing or choking during meals or when swallowing medications
<input type="checkbox"/>	D. Complaints of difficulty or pain with swallowing
<input type="checkbox"/>	Z. None of the above

**K0100: Swallowing Disorder**

**Coding Tips**

- ▶ Do not code a swallowing problem when interventions have been successful in treating the problem and therefore the signs/symptoms of the problem (K0100A through K0100D) did not occur during the 7-day look-back period.
- ▶ Code even if the symptom occurred only once in the 7-day look-back period.

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### Coding Tips for K0510A

The following items are NOT to be coded in K0510A:

- ▶ IV Medications—Code these when appropriate in O0100H, IV Medications.
- ▶ IV fluids used to reconstitute and/or dilute medications for IV administration.
- ▶ IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay.
- ▶ IV fluids administered solely as flushes.
- ▶ Parenteral/IV fluids administered in conjunction with chemotherapy or dialysis.

Enteral feeding formulas:

- ▶ Should not be coded as a mechanically altered diet.
- ▶ Should only be coded as K0510D, Therapeutic Diet when the enteral formula is altered to manage problematic health conditions, e.g. enteral formulas specific to diabetics.

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### Section M: Skin Conditions



- ▶ Document the risk, presence, appearance, and change of pressure ulcers as well as other skin ulcers, wounds or lesions.
- ▶ Also includes treatment categories related to skin injury or avoiding injury.

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### M0100: Determination of Pressure Ulcer/Injury Risk

Planning for Care

- ▶ Throughout this section, terminology referring to “healed” versus “unhealed” ulcers refers to whether or not the ulcer is “closed” versus “open.” When considering this, recognize that Stage 1, Deep Tissue Injury (DTI), and unstageable pressure ulcers although “closed” (i.e., may be covered with tissue, eschar, slough, etc.) would not be considered “healed.”
- ▶ Facilities should be aware that the resident is at higher risk of having the area of a closed pressure ulcer open up due to damage, injury, or pressure, because of the loss of tensile strength of the overlying tissue.
- ▶ Tensile strength of the skin overlying a closed pressure ulcer is 80% of normal skin tensile strength. Facilities should put preventative measures in place that will

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### M0100: Determination of Pressure Ulcer/Injury Risk

**HEALED PRESSURE ULCER**

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

**PRESSURE ULCER/ INJURY RISK FACTOR**

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

**PRESSURE ULCER/ INJURY RISK TOOLS**

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

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### M0210: Unhealed Pressure Ulcers/Injuries

**PRESSURE ULCER/INJURY**

- ▶ A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.
- ▶ 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.

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### M0210: Unhealed Pressure Ulcers/Injuries, Coding Tips

- ▶ If an ulcer/injury arises from a combination of factors that are primarily caused by pressure, then the area should be included in this section as a pressure ulcer/injury.
- ▶ Oral Mucosal ulcers caused by pressure should not be coded in Section M. These ulcers are captured in item L0200C, Abnormal mouth tissue.
- ▶ 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.

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### M0210: Unhealed Pressure Ulcers/Injuries, Coding Tips

- ▶ If a pressure ulcer is surgically closed with a flap or graft, it should be coded as a surgical wound and not as a pressure ulcer. If the flap or graft fails, continue to code it as a surgical wound until healed.
- ▶ Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether a resident with DM has an ulcer/injury that is caused by pressure or other factors.
- ▶ If a resident with DM has a heel ulcer/injury from pressure and the ulcer/injury is present in the 7-day look-back period, code 1 and proceed to code items in M0300 as appropriate for the pressure ulcer/injury.
- ▶ If a resident with DM has an ulcer on the plantar (bottom) surface of the foot closer to the metatarsals and the ulcer is present in the 7-day look-back period, code 0 and proceed to M1040 to code the ulcer as a diabetic foot ulcer. It is not likely that pressure is the primary cause of the resident's ulcer when the ulcer is in this location.

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### M0210: Unhealed Pressure Ulcers/Injuries, 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.
- ▶ Eschar characteristics and the level of damage it causes to tissues is what makes it easy to distinguish from a scab.
- ▶ It is extremely important to have staff who are trained in wound assessment and who are able to distinguish scabs from eschar.

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### M0210: Unhealed Pressure Ulcers/Injuries, 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. Stage and measure each pressure ulcer/injury separately.
- ▶ 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.

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

Step 1: Determine Deepest Anatomical Stage

- ▶ For each pressure ulcer, determine the deepest anatomical stage. Do not reverse or back stage. Consider current and historical levels of tissue involvement.
- ▶ If the pressure ulcer has ever been classified at a higher numerical stage than what is observed now, it should continue to be classified at the higher numerical stage.
- ▶ Pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development before they re-epithelialize.
- ▶ Stage 3 and 4 pressure ulcers fill with granulation tissue. This replacement tissue is never as strong as the tissue that was lost and hence is more prone to future breakdown.
- ▶ Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage—in this example, a healed Stage 4 pressure ulcer. For care planning purposes, this healed Stage 4 pressure ulcer would remain at increased risk for future breakdown or injury and would require continued monitoring and preventative care.

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

- ▶ DEFINITIONS
- ▶ EPITHELIAL TISSUE
- ▶ New skin that is light pink and shiny (even in persons with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and at the edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound.
- ▶ GRANULATION TISSUE
- ▶ Red tissue with “cobblestone” or bumpy appearance; bleeds easily when injured.

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

Step 2: Identify Unstageable Pressure Ulcers

- ▶ 1. Visualization of the wound bed is necessary for accurate staging.
- ▶ 2. If, after careful cleansing of the pressure ulcer/injury, a pressure ulcer's/injury's anatomical tissues remain obscured such that the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer/injury is considered unstageable.
- ▶ 3. Pressure ulcers that have eschar (tan, black, or brown) or slough (yellow, tan, gray, green or brown) tissue present such that the anatomic depth of soft tissue damage cannot be visualized or palpated in the wound bed, should be classified as unstageable.
- ▶ 4. 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.
- ▶ 5. 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.
- ▶ 6. 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.

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

Step 3: Determine "Present on Admission"

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

DEFINITION

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

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

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.



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

- ▶ 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.



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**M0300 current Number if Unhealed Pressure Ulcers/Injuries at Each Stage**

▶ **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.
- ▶ **NON-BLANCHABLE**
- ▶ Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device.

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**M0300 current Number if Unhealed Pressure Ulcers/Injuries at Each Stage**

**STAGE 2 PRESSURE ULCER**

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

**Planning for Care**

- Most Stage 2 pressure ulcers should heal in a reasonable time frame (e.g., 60 days).
- If a pressure ulcer fails to show some evidence toward healing within 14 days, the pressure ulcer (including potential complications) and the patient's overall clinical condition should be reassessed.
- The care plan should include individualized interventions and evidence that the interventions have been monitored and modified as appropriate.

**Coding Tips**

- Stage 2 pressure ulcers by definition have partial thickness loss of the dermis. Granulation tissue, slough, and eschar are not present in Stage 2 pressure ulcers.
- Do not code skin tears, tape burns, moisture associated skin damage, or excoriation here.
- When a pressure ulcer presents as an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury is determined, do not code as a Stage 2.

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**M0300 current Number if Unhealed Pressure Ulcers/Injuries at Each Stage**

**STAGE 3 PRESSURE ULCER**

- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling (see definition of undermining and tunneling on page M-19).

**Coding Tips**

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

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**M0300 current Number if Unhealed Pressure Ulcers/Injuries at Each Stage**

**STAGE 4 PRESSURE ULCER**

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

**TUNNELING**

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

**UNDERMINING**

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

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**M0300 current Number if Unhealed Pressure Ulcers/Injuries at Each Stage**

**Coding Tips for a Stage 4 pressure ulcer**

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

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**M0300 current Number if Unhealed Pressure Ulcers/Injuries at Each Stage**

**Unstageable Pressure Ulcers/Injuries Related to Non-removable Dressing/Device**

**NON-REMOVABLE DRESSING/ DEVICE**

- Includes, for example, a primary surgical dressing that cannot be removed, an orthopedic device, or cast.

**Planning for Care**

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

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**M0300 current Number if Unhealed Pressure Ulcers/Injuries at Each Stage**

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

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**M0300 current Number if Unhealed Pressure Ulcers/Injuries at Each Stage**

**Coding Tips for Unstageable Pressure Ulcers Related to Slough and/or Eschar**

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

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**M0300 current Number if Unhealed Pressure Ulcers/Injuries at Each Stage**

**Unstageable Pressure Injuries Related to Deep Tissue Injury**

**DEEP TISSUE INJURY**

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

**Health-related Quality of Life**

- Deep tissue injury may precede the development of a Stage 3 or 4 pressure ulcer even with optimal treatment.

**Planning for Care**

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

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### M0300 current Number if Unhealed Pressure Ulcers/Injuries at Each Stage

#### Coding Tips for Unstageable Pressure Injuries Related to Deep Tissue Injury

- Once deep tissue injury has opened to an ulcer, reclassify the ulcer into the appropriate stage. Then code the ulcer for the reclassified stage.
- Deep tissue injury may be difficult to detect in individuals with dark skin tones.
- Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.
- When a lesion due to pressure presents with an intact blister AND the surrounding or adjacent soft tissue does NOT have the characteristics of deep tissue injury, do not code here (see definition of Stage 2 pressure ulcer on page M-12).

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### M1030: Number of Venous and Arterial Ulcers

#### VENOUS ULCERS

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

#### ARTERIAL ULCERS

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

#### HEMOSIDERIN

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

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### M1030: Number of Venous and Arterial Ulcers, Coding Tips

#### Arterial Ulcers

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

#### Venous Ulcers

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

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### M1200: Skin and Ulcer/Injury Treatments

#### TURNING/ REPOSITIONING PROGRAM

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

#### NUTRITION OR HYDRATION INTERVENTION TO MANAGE SKIN PROBLEMS

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

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### Scenarios for Pressure Ulcer Coding

Example M0100-M1200

- ▶ 1. Mrs. P was admitted to the nursing home on 10/23/2019 for a Medicare stay. In completing the PPS 5-day assessment (ARD of 10/28/2019), it was noted that the resident had a head-to-toe skin assessment and her skin was intact, but upon assessment using the Braden scale, was found to be at risk for skin breakdown.
- ▶ The resident was noted to have a Stage 2 pressure ulcer that was identified on her coccyx on 11/1/2019.

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### Scenarios for Pressure Ulcer Coding cont.

- ▶ This Stage 2 pressure ulcer was noted to have pink tissue with some epithelialization present in the wound bed.
- ▶ Dimensions of the ulcer were length 01.1 cm, width 00.5 cm, and no measurable depth. Mrs. P does not have any arterial or venous ulcers, wounds, or skin problems. She is receiving ulcer care with application of a dressing applied to the coccygeal ulcer.
- ▶ Mrs. P. also has pressure reducing devices on both her bed and chair and has been placed on a 1½ hour turning and repositioning schedule per tissue tolerance. In order to stay closer to her family, Mrs. P was discharged to another nursing home on 11/5/2019.
- ▶ This was a planned discharge (A0310G = 2), and her OBRA Discharge assessment was coded at A0310F as 10, Discharge assessment - return not anticipated.

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**Scenarios for Pressure Ulcer Coding cont.**

**5-Day PPS:**

**Coding:**

- M0100B (Formal assessment instrument), Check box.
- M0100C (Clinical assessment), Check box.
- M0150 (Risk of Pressure Ulcers/Injuries), Code 1.
- M0210 (One or more unhealed pressure ulcers/injuries), Code 0 and skip to M1030 (Number of Venous and Arterial Ulcers).
- M1030 (Number of Venous and Arterial Ulcers), Code 0.
- M1040 (Other ulcers, wounds and skin problems), Check Z (None of the above).
- M1200 (Skin and Ulcer Treatments), Check Z (None of the above were provided).

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**Scenarios for Pressure Ulcer Coding**

**Rationale:**

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

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**Section N:  
Medications**



- ▶ Record the number of days that any type of injection, insulin, and/or select medications was received by the resident.

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### Coding Tips and Special Populations (N0450B and N0450C)

- ▶ Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication,
- ▶ The 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 in Appendix PP of the State Operations Manual).

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### Coding Tips and Special Populations (N0450B and N0450C)

- ▶ 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.
- ▶ Do not include gradual dose reductions 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 the resident was admitted to the 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.

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### Coding Tips and Special Populations (N0450B and N0450C)

- ▶ Do not count as a GDR an antipsychotic medication reduction performed for the purpose of switching the resident from one antipsychotic medication 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 medication.

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### Coding Tips and Special Populations (N0450B and N0450C)

- ▶ In 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.
- ▶ Federal requirements regarding GDRs are found at 42 CFR 483.45(d) Unnecessary drugs and 483.45(e) Psychotropic drugs.

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### N2001: Drug Regimen Review

- ▶ Intent: The intent of the drug regimen review items is to document whether a drug regimen review was conducted upon the resident's admission (start of Skilled Nursing Facility [SNF] Prospective Payment System [PPS] stay) and throughout the resident's stay (through Part A PPS discharge) and whether any clinically significant medication issues identified were addressed in a timely manner.

<b>N2001. Drug Regimen Review - Complete only if A0310B = 01</b>	
Enter Code	<b>Did a complete drug regimen review identify potential clinically significant medication issues?</b>
<input type="checkbox"/>	0. No - No issues found during review
	1. Yes - Issues found during review
	9. NA - Resident is not taking any medications

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### N2001: Drug Regimen Review

- ▶ **DRUG REGIMEN REVIEW**
  - ▶ A drug regimen review includes medication reconciliation, a review of all medications a resident is currently using, and a review of the drug regimen to identify, and if possible, prevent potential clinically significant medication adverse consequences.
  - ▶ The drug regimen review includes all medications, prescribed and over the counter (OTC), nutritional supplements, vitamins, and homeopathic and herbal products, administered by any route. It also includes total parenteral nutrition (TPN) and oxygen.

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**N2001: Drug Regimen Review**

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.

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**N2001: Drug Regimen Review**

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.

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**N2001: 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.

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**N2003: Medication Follow-up**

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.

**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

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**N2003: Medication Follow-up**

Steps for Assessment

- ▶ This item is completed if one or more potential or actual clinically significant medication issues were identified during the admission drug regimen review (N2001 = 1).
- ▶ 1. Review the resident's medical record to determine whether the following criteria were met for any potential or actual clinically significant medication issues that were identified upon admission:
  - ▶ • Two-way communication between the clinician(s) and the physician was completed by midnight of the next calendar day, AND
  - ▶ • All physician-prescribed/-recommended actions were completed by midnight of the next calendar day.

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**N2003: Medication Follow-up**

Coding Instructions

- ▶ • Code 0, No: if the facility did not contact the physician and complete prescribed/recommended actions in response to each identified potential or actual clinically significant medication issue by midnight of the next calendar day.
- ▶ • Code 1, Yes: if the facility contacted the physician AND completed the prescribed/recommended actions by midnight of the next calendar day after each potential or actual clinically significant medication issue was identified.

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**N2005: Medication Intervention**

- ▶ The observation period for this item is from the date of admission (start of SNF PPS stay) through discharge (Part A PPS discharge).

**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

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**N2005: Medication Intervention**

Coding Instructions

- ▶ Code 0, No: if the facility did not contact the physician and complete prescribed/ recommended actions by midnight of the next calendar day each time a potential or actual clinically significant medication issue was identified since admission (start of SNF PPS stay).
- ▶ Code 1, Yes: if the facility contacted the physician and completed prescribed/ recommended actions by midnight of the next calendar day each time a potential or actual clinically significant medication issue was identified since admission (start of SNF PPS stay).
- ▶ Code 9, NA: if there were no potential or actual clinically significant medication issues identified at admission or throughout the resident's stay or the resident was not taking any medications at admission or at any time throughout the stay.

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**Section O:  
Special  
Treatments,  
Procedures,  
and Programs**

- ▶ Identify any special treatments, procedures, and programs that the resident received during the specified time periods.

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### 00100: Special Treatments, Procedures, and Programs

**Coding Instructions for Column 1**

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

**Coding Instructions for Column 2**

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

00100: Special Treatments, Procedures, and Programs		
Check all of the following treatments, procedures, and programs that were performed during the last 14 days.		
	1. While NOT a Resident Performance while NOT a resident of this facility and within the last 14 days. Only check column 1 if resident entered admission or reentry IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank.	2. While a Resident Performance while a resident of this facility and within the last 14 days.
	1. While NOT a Resident	2. While a Resident
	Check all that apply	
<b>Cancer Treatments</b>		
A. Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
B. Radiation	<input type="checkbox"/>	<input type="checkbox"/>
<b>Respiratory Treatments</b>		
C. Oxygen therapy	<input type="checkbox"/>	<input type="checkbox"/>
D. Suctioning	<input type="checkbox"/>	<input type="checkbox"/>
E. Tracheostomy care	<input type="checkbox"/>	<input type="checkbox"/>
F. Invasive Mechanical Ventilator (invasive or noninvasive)	<input type="checkbox"/>	<input type="checkbox"/>
G. Non Invasive Mechanical Ventilator (BIPAP/CPAP)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other</b>		
H. IV medications	<input type="checkbox"/>	<input type="checkbox"/>
I. Transfusions	<input type="checkbox"/>	<input type="checkbox"/>
J. Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
K. Hospice care	<input type="checkbox"/>	<input type="checkbox"/>
L. Isolation or quarantine for active infectious disease (does not include standard body fluid precautions)	<input type="checkbox"/>	<input type="checkbox"/>
M. Name of the Above	<input type="checkbox"/>	<input type="checkbox"/>
Z. None of the above	<input type="checkbox"/>	<input type="checkbox"/>

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### 00100: Special Treatments, Procedures, and Programs

**Coding Tips**

- ▶ 00100A, Chemotherapy
- ▶ Code any type of chemotherapy agent administered as an antineoplastic given by any route in this item. Each medication should be evaluated to determine its reason for use before coding it here. Medications coded here are those actually used for cancer treatment

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### 00100: Special Treatments, Procedures, and Programs

**Coding Tips for 00100M, Isolation for active infectious disease (does not include standard precautions)**

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

- The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.
- Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
- 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.
- The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

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### 00250: Influenza Vaccine

#### Health-related Quality of Life

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

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### 00300: Pneumococcal Vaccine

#### Health-related Quality of Life

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

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### 00300: Pneumococcal Vaccine

#### Coding Tips

- ▶ Specific guidance about pneumococcal vaccine recommendations and timing for adults can be found at <https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf>.
- ▶ "Up to date" in item 00300A 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/schedules/hcp/index.html>
  - ▶ <http://www.cdc.gov/vaccines/hcp/acip-recs/index.html>
  - ▶ <https://www.cdc.gov/pneumococcal/vaccination.html>
- ▶ 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, 00300A is coded 1, yes, indicating the resident's pneumococcal vaccination is up to date.

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**00400: Therapies**

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

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**00400: Therapies**

**Individual minutes**

- Enter the total number of minutes of therapy that were provided on an individual basis in the last 7 days.

**Concurrent minutes**

- Enter the total number of minutes of therapy that were provided on a concurrent basis in the last 7 days.
- Concurrent therapy is defined as the treatment of 2 residents at the same time, when the residents are not performing the same or similar activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant for Medicare Part A.
- When a Part A resident receives therapy that meets this definition, it is defined as concurrent therapy for the Part A resident regardless of the payer source for the second resident.
- For Part B, residents may not be treated concurrently;
- For all other payers, follow Medicare Part A instructions.

**Group minutes**

- Enter the total number of minutes of therapy that were provided in a group in the last 7 days.
- Group therapy is defined for Part A as the treatment of two to six residents, regardless of payer source, who are performing the same or similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals.
- For Medicare Part B, treatment of two patients (or more), regardless of payer source, at the same time is documented as group treatment.
- For all other payers, follow Medicare Part A instructions.

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**00400: Therapies**

Coding Instructions for Respiratory, Psychological, and Recreational Therapies

- ▶ Total Minutes—Enter the actual number of minutes therapy services were provided in the last 7 days. Enter 0 if none were provided.
- ▶ Days—Enter the number of days therapy services were provided in the last 7 days.
- ▶ A day of therapy is defined as treatment for 15 minutes or more in the day. Enter 0 if therapy was provided but for less than 15 minutes every day for the last 7 days.
- ▶ If the total number of minutes during the last 7 days is 0, skip this item and leave blank.

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For Speech-Language Pathology Services (SLP) and Physical (PT) and Occupational Therapies (OT) include only skilled therapy services. Skilled therapy services must meet all of the following conditions (Refer to Medicare Benefit Policy Manual, Chapters 8 and 15, for detailed requirements and policies):

Part A, services must be ordered by a physician.  
For Part B the plan of care must be certified by a physician following the therapy evaluation;

- Services must be directly and specifically related to an active written treatment plan that is approved by the physician after any needed consultation with the qualified therapist and is based on an initial evaluation performed by a qualified therapist prior to the start of therapy services in the facility;
- Services must be of a level of complexity and sophistication, or the condition of the resident must be of a nature that requires the judgment, knowledge, and skills of a therapist;
- Services must be provided with the expectation, based on the assessment of the resident's restoration potential made by the physician, that the condition of the patient will improve materially in a reasonable and generally predictable period of time; or, the services must be necessary for the establishment of a safe and effective maintenance program; or, the services must require the skills of a qualified therapist for the performance of a safe and effective maintenance program.
- Services must be considered under accepted standards of medical practice to be specific and effective treatment for the resident's condition; and,
- Services must be reasonable and necessary for the treatment of the resident's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable, and they must be furnished by qualified personnel.

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### 00425: Part A Therapies

**00425. Part A Therapies**  
Complete only if A0310H = 1

**A. Speech-Language Pathology and Audiology Services**

**B. Occupational Therapy**

**C. Physical Therapy**

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)

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)

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 00430, Distinct Calendar Days of Part A Therapy**

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)

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)

**00430. Distinct Calendar Days of Part A Therapy**  
Complete only if A0310H = 1

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)

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### 00425: Part A Therapies

#### Planning for Care

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

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### 00425: Part A Therapies, Steps for Assessment

NOTE: The look back for these items is the entire SNF Part A stay, starting at Day 1 of the Part A stay and finishing on the last day of the Part A stay.

Once reported on the MDS, CMS grouping software will calculate the percentage of group and concurrent therapy, combined, provided to each resident as a percentage of all therapies provided to that resident, by discipline.

- If the combined amount of group and concurrent therapy provided, by discipline, exceeds 25 percent, then this would be deemed as non-compliance and a warning message would be received on the Final Validation Report.

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

- Step 1: Total Therapy Minutes, by discipline (00425X1 + 00425X2 + 00425X3)
- Step 2: Total Concurrent and Group Therapy Minutes, by discipline (00425X2+00425X3)
- Step 3: Concurrent/Group Ratio (Step 2 result/Step 1 result)
- Step 4: If Step 3 result is greater than 0.25, then the provider is non-compliant.

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### 00430: Distinct Calendar Days of Part A Therapy

Item Rationale

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

**00430. 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 (A2400E)

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### 00450: Resumption of Therapy

- ▶ CMS does not require completion of this item; however, some States continue to require its completion. It is important to know your State's requirements for completing this item.

**00450. Resumption of Therapy**

Enter Code

**A. Has a previous rehabilitation therapy regimen (speech, occupational, and/or physical therapy) ended, as reported on this End of Therapy OMRA, and has this regimen now resumed at exactly the same level for each discipline?**

0. No  
1. Yes

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### O0500: Restorative Nursing Programs

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

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

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### O0500: Restorative Nursing Programs

- ▶ Health-related Quality of Life
- ▶ Maintaining independence in activities of daily living and mobility is critically important to most people.
- ▶ Functional decline can lead to depression, withdrawal, social isolation, and complications of immobility, such as incontinence and pressure ulcers/injuries.

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### O0500: Restorative Nursing Programs, Steps for Assessment

- ▶ 1. Review the restorative nursing program notes and/or flow sheets in the medical record.
- ▶ 2. For the 7-day look-back period, enter the number of days on which the technique, training or skill practice was performed for a total of at least 15 minutes during the 24-hour period.

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**O0500: Restorative Nursing Programs, Steps for Assessment**

- ▶ 3. The following criteria for restorative nursing programs must be met in order to code O0500:
  - ▶ • Measureable objective and interventions must be documented in the care plan and in the medical record. If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this reassessment should be documented in the resident's medical record.

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**O0500: Restorative Nursing Programs**

- ▶ 3. The following criteria for restorative nursing programs must be met in order to code O0500 cont:
  - ▶ • Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record. When not contraindicated by state practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established.

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**O0500: Restorative Nursing Programs**

- ▶ 3. The following criteria for restorative nursing programs must be met in order to code O0500 cont.:
  - ▶ • Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity.
  - ▶ • This category does not include groups with more than four residents per supervising helper or caregiver.

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### O0500: Restorative Nursing Programs, Steps for Assessment

3. The following criteria for restorative nursing programs must be met in order to code O0500 cont:

- A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a restorative nursing program.
- Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents.
- Restorative nursing does not require a physician's order.
- Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services.
- In situations where such services do not actually require the involvement of a qualified therapist, the services may not be coded as therapy in item O0400, Therapies or O0425, Part A Therapies, because the specific interventions are considered restorative nursing services (see item O0400, Therapies and O0425, Part A Therapies).
- The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes.
- Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.

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### O0500: Restorative Nursing Programs, Technique

O0500A, Range of Motion (Passive)

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

O0500B, Range of Motion (Active)

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

O0500C, Splint or Brace Assistance

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

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### O0500: Restorative Nursing Programs, Training and Skill Practice

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

O0500D, Bed Mobility

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

O0500E, Transfer

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

O0500F, Walking

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

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### O0500: Restorative Nursing Programs, Training and Skill Practice

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

#### O0500G, Dressing and/or Grooming

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

#### O0500H, Eating and/or Swallowing

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

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### O0500: Restorative Nursing Programs, Training and Skill Practice

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

#### O0500I, Amputation/ Prosthesis Care

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

#### O0500J, Communication

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

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### Section P: Restraints and Alarms

- ▶ Record the frequency that the resident was restrained by any of the listed devices at any time during the day or night; record the frequency that any of the listed alarms were used.



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### SECTION P: RESTRAINTS AND ALARMS

▶ Intent: The intent of this section is to record the frequency that the resident was restrained by any of the listed devices or an alarm was used, at any time during the day or night, during the 7-day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definitions in the appropriate categories.

#### Are Restraints Prohibited by CMS?

▶ Federal regulations and CMS guidelines do not prohibit use of physical restraints in nursing homes, except when they are imposed for discipline or convenience and are not required to treat the resident's medical symptoms. The regulation specifically states, "The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms" (42 CFR 483.10(e)(1) and 483.12).

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### SECTION P: RESTRAINTS AND ALARMS

#### ▶ PHYSICAL RESTRAINTS

▶ Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body (State Operations Manual, Appendix PP).

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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.	
Enter Codes in Boxes	
Used in Bed	
<input type="checkbox"/>	A. Bed rail
<input type="checkbox"/>	B. Trunk restraint
<input type="checkbox"/>	C. Limb restraint
<input type="checkbox"/>	D. Other
Used in Chair or Out of Bed	
<input type="checkbox"/>	E. Trunk restraint
<input type="checkbox"/>	F. Limb restraint
<input type="checkbox"/>	G. Chair prevents rising
<input type="checkbox"/>	H. Other

### SECTION P: RESTRAINTS AND ALARMS

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**SECTION P: RESTRAINTS AND ALARMS**

- ▶ 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.

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**SECTION P: RESTRAINTS AND ALARMS**

- ▶ Clarifications
- ▶ • “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.

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**SECTION P: RESTRAINTS AND ALARMS**

- ▶ Additional Information
- ▶ • Restraint reduction/elimination. It is further expected, for residents whose care plan indicates the need for physical restraints, that the nursing home engages in a systematic and gradual process towards reducing (or eliminating, if possible) the restraints (e.g., gradually increasing the time for ambulation and strengthening activities).
- ▶ This systematic process also applies to recently-admitted residents for whom physical restraints were used in the previous setting.

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SECTION P: RESTRAINTS AND ALARMS

- ▶ Additional Information
- ▶ Restraints as a fall prevention approach. Although physical restraints have been traditionally used as a fall prevention approach, they have major drawbacks and can contribute to serious injuries.
- ▶ Falls do not constitute self-injurious behavior nor a medical symptom supporting the use of physical restraints.
- ▶ There is no evidence that the use of physical restraints, including but not limited to side rails, will prevent, reduce, or eliminate falls. In fact, in some instances, reducing the use of physical restraints may actually decrease the risk of falling.
- ▶ Additionally, falls that occur while a person is physically restrained often result in more severe injuries.

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SECTION P: RESTRAINTS AND ALARMS

- ▶ 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.
- ▶ According to 42 CFR 483.10(e)(1) and 483.12, "The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms." CMS expects that no resident will be physically restrained for discipline or convenience. Prior to employing any physical restraint, the nursing home must perform a prescribed resident assessment to properly identify the resident's needs and the medical symptom the physical restraint is being employed to address. The guidelines in the State Operations Manual (SOM) state,

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SECTION P: RESTRAINTS AND ALARMS

- ▶ Additional Information
- ▶ "...the legal surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms.
- ▶ That is, the facility may not use restraints in violation of regulation solely based on a resident, legal surrogate or representative's request or approval."
- ▶ The SOM goes on to state, "While Federal regulations affirm the resident's right to participate in care planning and to refuse treatment, the regulations do not create the right for a resident, legal surrogate or representative to demand that the facility use specific medical interventions or treatment that the facility deems inappropriate.
- ▶ Statutory requirements hold the facility ultimately accountable for the resident's care and safety, including clinical decisions."

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### Q0490: Resident's Preference to Avoid Being Asked Question Q0500B

► For Quarterly, Correction to Quarterly, and Not-OBRA Assessments.  
(A0310A=02, 06, 99)

**Q0490. Resident's Preference to Avoid Being Asked Question Q0500B**  
Complete only if A0310A = 02, 06, or 99

Enter Code:  **Does the resident's clinical record document a request that this question be asked only on comprehensive assessments?**

0. No  
1. Yes → Skip to Q0600, Referral

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

**Q0550. Resident's Preference to Avoid Being Asked Question Q0500B Again**

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

0. No: then document in resident's clinical record and ask again only on the next comprehensive assessment

1. Yes

8. Information not available

**B. Indicate information source for Q0550A**

1. Resident

2. If not resident, then family or significant other

3. If not resident, family or significant other, then guardian or legally authorized representative

9. None of the above

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

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

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

Coding Instructions for Q0550B, Indicate information source for Q0550A

- Code 1, Resident: If resident responded to Q0550A.
- Code 2, If not resident, then family or significant other.
- Code 3, If not resident, family or significant other, then guardian or legally authorized representative.
- Code 9, None of the above.

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### Q0600: Referral

- ▶ DESIGNATED LOCAL CONTACT AGENCY (LCA)
- ▶ Each state has community contact agencies that can provide individuals with information about community living options and available supports and services. These local contact agencies may be a single entry point agency, an Aging and Disability Resource Center (ADRC), an Area Agency on Aging (AAA), a Center for Independent Living (CIL), or other state designated entities.

**Q0600. Referral**

Enter Code  Has a referral been made to the Local Contact Agency? (Document reasons in resident's clinical record)

0. No - referral not needed  
 1. No - referral is or may be needed (For more information see Appendix C, Care Area Assessment Resources #20)  
 2. Yes - referral made

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### Section V: Care Area Assessment (CAA) Summary

- ▶ Document triggered care areas, whether or not a care plan has been developed for each triggered area, and the location of care area assessment documentation.

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### V0100: Items From the Most Recent Prior OBRA or PPS Assessment

**V0100. Items From the Most Recent Prior OBRA or PPS Assessment**

Complete only if A0310E = 0 and if the following is true for the prior assessment: A0310A = 01, 06 or A0310B = 01

**A. Prior Assessment Referral (OBRA) Reason for Assessment (A0310A value from prior assessment)**

01. Abandonment or neglect (documented by day 16)

02. Change in care recipient

03. Referral assessment

04. Significant change in status assessment

05. Significant connection to prior comprehensive assessment

06. Significant connection to prior specific assessment

07. None of the above

**B. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment)**

01. 3-day checked assessment

02. 90-day assessment assessment

03. None of the above

**C. Prior Assessment Reference Date (A0310C value from prior assessment)**

MM/YY

**D. Prior Assessment Staff Interview for Mental Status (MMS) Summary Score (C0000 value from prior assessment)**

01

02

03

**E. Prior Assessment Resident Mood Interview (PMQ-R) Total Severity Score (C0000 value from prior assessment)**

01

02

03

**F. Prior Assessment Staff Assessment of Resident Mood (PMQ-S-CV) Total Severity Score (C0000 value from prior assessment)**

01

02

03

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**Section X:  
Correction  
Request**

- ▶ Request to modify or inactivate a record already present in the QIES ASAP database.

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**SECTION X: CORRECTION REQUEST**

A modification request is used to correct a QIES ASAP record containing incorrect MDS item values due to:

- ▶ • transcription errors,
- ▶ • data entry errors,
- ▶ • software product errors,
- ▶ • item coding errors, and/or
- ▶ • other error requiring modification

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**SECTION Z:  
ASSESSMENT  
ADMINISTRATION**

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### SECTION Z: ASSESSMENT ADMINISTRATION

Z0100: Medicare Part A Billing

- Used to capture the Patient Driven Payment Model (PDPM) case mix version code followed by Health Insurance Prospective Payment System (HIPPS) modifier based on type of assessment.

MEDICARE-COVERED STAY

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

HIPPS CODE

- Health Insurance Prospective Payment System code is comprised of the PDPM case mix code, which is calculated from the assessment data. The first four positions of the HIPPS code contain the PDPM classification codes for each PDPM component to be billed for Medicare reimbursement, followed by an indicator of the type of assessment that was completed.

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### Section Z: Assessment Administration

- Provide billing information and signatures of persons completing the assessment

**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

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### Z0500: Signature of RN Assessment Coordinator Verifying Assessment Completion

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

**Coding Instructions**

- For Z0500B, use the actual date that the MDS was completed, reviewed, and signed as complete by the RN assessment coordinator. This date must be equal to the latest date at Z0400 or later than the date(s) at Z0400, which documents when portions of the assessment information were completed by assessment team members.
- If for some reason the MDS cannot be signed by the RN assessment coordinator on the date it is completed, the RN assessment coordinator should use the actual date that it is signed.

**Coding Tips**

- The RN assessment coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals.

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**CHAPTER 6:  
MEDICARE SKILLED  
NURSING FACILITY  
PROSPECTIVE  
PAYMENT SYSTEM  
(SNF PPS)**

6.2 Using the MDS in the Medicare Prospective Payment System

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**Patient Driven Payment Model (PDPM)**

- ▶ The MDS assessment data is used to calculate the resident's Patient Driven Payment Model (PDPM) classification necessary for payment.
- ▶ The MDS contains extensive information on the resident's nursing and therapy needs, ADL status, cognitive status, behavioral problems, and medical diagnoses.
- ▶ This information is used to define PDPM case-mix adjusted groups, within which a hierarchy exists that assigns case-mix weights that capture differences in the relative resources used for treating different types of residents.

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**6.3 Patient Driven Payment Model (PDPM)**

- ▶ PDPM adjusts payment for each major element of a resident's SNF care,
- ▶ Physical therapy (PT),
- ▶ Occupational therapy (OT),
- ▶ Speech-language pathology (SLP),
- ▶ Nursing, and
- ▶ Non-therapy ancillaries (NTA).

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### Patient Driven Payment Model (PDPM)

#### 6.4 Relationship between the Assessment and the Claim

- ▶ The SNF PPS establishes a schedule of PPS assessments.
- ▶ The 5-Day assessment is the only required PPS assessment that is used to support PPS reimbursement.
- ▶ Interim Payment Assessment (IPA), may be used to reclassify the resident into a new PDPM classification, and would also affect the associated payment rate.
- ▶ See Chapter 2 of this manual for greater detail on assessment types and requirements.

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### 6.4 Relationship between the Assessment and the Claim

The SNF claim must include two data items derived from the MDS assessment:

- ▶ Assessment Reference Date (ARD)
  - ▶ The ARD must be reported on the SNF claim. CMS has developed internal mechanisms to link the MDS assessment and the claims processing system.
- ▶ Health Insurance Prospective Payment System (HIPPS) Code
  - ▶ Each SNF claim contains a five-position HIPPS code for the purpose of billing Part A covered days to the Medicare Administrative Contractor (MAC).
  - ▶ The HIPPS code consists of a series of codes representing the resident's PDPM classification and the Assessment Indicator (AI) as described below. CMS provides standard software and logic for HIPPS code calculation.

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### 6.4 Relationship between the Assessment and the Claim

- ▶ PDPM Classification
  - ▶ The first four positions of the HIPPS code contain the PDPM classification codes for each PDPM component to be billed for Medicare reimbursement.
  - ▶ Skilled nursing facilities are not permitted to submit Medicare Part A claims until the assessments have been accepted into the CMS database, and they must use the PDPM classification code as validated by CMS when bills are filed, except in cases in which the facility must bill the default code (ZZZZZ).

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Table 4. Fourth Character: NTA Component

NTA Score Range	NTA Case-Mix Group	HIPPS Character
12+	NA	A
9-11	NB	B
6-8	NC	C
3-5	ND	D
1-2	NE	E
0	NF	F

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Table 5. Assessment Indicator Table

- ▶ The PDPM HIPPS code is recorded on the MDS 3.0 in item Z0100A (Medicare Part A HIPPS code).
  - ▶ The HIPPS code included on the SNF claim depends on the specific type of assessment involved
- AI Code
- ▶ The last position of the HIPPS code represents the AI, identifying the assessment type

AI Code	Assessment Type (abbreviation)	Standard Payment Period
0	Interim Payment Assessment	See Chapter 2, Section 2.9
1	5-Day	Entire Part A Stay

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### 6.5 SNF PPS Eligibility Criteria

#### Technical Eligibility Requirements

- The beneficiary must meet the following criteria:
  - Beneficiary is enrolled in Medicare Part A and has days available to use.
  - There has been a three-day prior qualifying hospital stay (i.e., three midnights).
  - Admission for SNF-level services is within 30 days of discharge from an acute care stay or within 30 days of discharge from a SNF level of care.

Under SNF PPS, beneficiaries must meet the established eligibility requirements for a Part A SNF level stay. These requirements are summarized in this section. Refer to the Medicare General Information, Eligibility, and Enrollment Manual, Chapter 1 (Pub. 100-1), and the Medicare Benefit Policy Manual, Chapter 8 (Pub. 100-2), for detailed SNF coverage requirements and policies.

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### 6.5 SNF PPS Eligibility Criteria

#### Clinical Eligibility Requirements

- A beneficiary is eligible for SNF extended care if all of the following requirements are met:
  - The beneficiary has a need for and receives medically necessary skilled care on a daily basis, which is provided by or under the direct supervision of skilled nursing or rehabilitation professionals.
  - As a practical matter, these skilled services can only be provided in an SNF.
  - The services provided must be for a condition:
    - For which the resident was treated during the qualifying hospital stay, or
    - That arose while the resident was in the SNF for treatment of a condition for which he or she was previously treated in a hospital.

Under SNF PPS, beneficiaries must meet the established eligibility requirements for a Part A SNF level stay. These requirements are summarized in this section. Refer to the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 1 (Pub. 100-1), and the Medicare Benefit Policy Manual, Chapter 8 (Pub. 100-2), for detailed SNF coverage requirements and policies.

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### 6.5 SNF PPS Eligibility Criteria

#### Physician Certification

- ▶ The attending physician or a physician on the staff of the skilled nursing facility who has knowledge of the case—or a nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist (CNS) who does not have a direct or indirect employment relationship with the facility but who is working in collaboration with the physician—must certify and then periodically recertify the need for extended care services in the skilled nursing facility.
- ▶ Certifications are required at the time of admission or as soon thereafter as is reasonable and practicable (42 CFR 424.20).
- ▶ The initial certification
  - ▶ Affirms, per the required content found in 42 CFR 424.20, that the resident meets the existing SNF level of care definition, or
  - ▶ Validates via written statement that the resident's assignment to one of the upper PDPM groups (next slide) is correct.

Under SNF PPS, beneficiaries must meet the established eligibility requirements for a Part A SNF level stay. These requirements are summarized in this section. Refer to the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 1 (Pub. 100-1), and the Medicare Benefit Policy Manual, Chapter 8 (Pub. 100-2), for detailed SNF coverage requirements and policies.

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### 6.5 SNF PPS Eligibility Criteria

Those nursing groups encompassed by the Extensive Services, Special Care High, Special Care Low, and Clinically Complex nursing categories;

- ▶ PT and OT groups TA, TB, TC, TD, TE, TF, TG, TJ, TK, TN, and TO;
- ▶ SLP groups SC, SE, SF, SH, SI, SJ, SK, and SL; and
- ▶ The NTA component's uppermost (12+) comorbidity group.

Re-certifications are used to document the continued need for skilled extended care services.

- ▶ The first re-certification is required no later than the 14th day of the SNF stay.
- ▶ Subsequent re-certifications are required at no later than 30-day intervals after the date of the first re-certification.
- ▶ The initial certification and first re-certification may be signed at the same time.

Under SNF PPS, beneficiaries must meet the established eligibility requirements for a Part A SNF level stay. These requirements are summarized in this section. Refer to the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 1 (Pub. 100-1), and the Medicare Benefit Policy Manual, Chapter 8 (Pub. 100-2), for detailed SNF coverage requirements and policies.

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### ICD-10 CM Diagnosis & Medicare Reimbursement

- Patient-Driven Payment Model (PDPM)**
- Primary Diagnosis (I0020B) is used in the PT, OT, and SLP components
- I0100-I8000 is used in the SLP, nursing, and non-therapy ancillary (NTA) components
- Diagnosis of HIV/AIDS (B20) is identified only on the Medicare claim, but will impact both the nursing and NTA components

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### Future Payment Model - Unified Payment

- The Medicare Payment Advisory Commission (MedPac) has recommended a unified payment system for post-acute care providers
- Impacts SNFs, home health, inpatient rehabilitation facilities, and long-term care hospitals
- All would redistribute current payments among the type of stays and settings
- Goal is to have such a system by 2024 but MedPac believes it could be done as early as 2021

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See Handout

#### Patient-Driven Payment Model (PDPM): At-a-Glance

The PDPM establishes a rate on the 5-day MDS for the entire stay by combining five different case-mix components (PT, OT, SLP, Nursing, and Non-Therapy Ancillary) with the non-case-mix components. The rate may be changed during the Medicare Part A stay by completing the optional Secondary Payment Assessment (SPA).

Use the following at-a-glance tools to identify the case-mix group for each component and improve your understanding of the Patient-Driven Payment Model.

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ICD-10 CM Diagnosis and Quality Measures (QMs)

QMs are calculated based on MDS data & hospital Medicare claims data

Within the CMS program, there are several different types of Quality Measures programs

- MDS 3.0 QMs
- Five-Star Rating System
- SNF Quality Reporting Program (QRP)
- SNF Value-Based Purchasing program (VBPP)

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ICD-10 CM Diagnosis and Quality Measures

- ▶ Diagnoses can be used to either
- ▶ Include or exclude a resident from a measure,
- ▶ Covariate for risk adjustment

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ICD-10 CM Diagnosis and Quality Measures

**Inclusion**

- ▶ A resident may be included in a QM as part of the denominator, which includes all residents within the target period who could have triggered for the condition of the measure
- ▶ If the resident did trigger for the condition of measure, then the resident would also be included as part of the numerator
- ▶ If a resident has a qualifying assessment within a target window, the resident would be considered included, unless specifically excluded

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**ICD-10 CM  
Diagnosis and  
Quality  
Measures**

**Exclusions**

- ▶ Most QMs are shaped by one or more exclusions
- ▶ For each QM, the prevalence of the outcome across all residents in a nursing facility, after exclusions, is the *facility-level observed QM score*
- ▶ Exclusions remove the triggered resident from that particular QM calculation (numerator and denominator)

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**ICD-10 CM  
Diagnosis and  
Quality  
Measures**

**Risk Adjustments (covariates)**

- ▶ This method of adjustment employs *resident-level covariates* that are found to increase the risks of an outcome
- ▶ Does not exclude the resident from the measure but adjusts the outcome score by calculating residents with covariates at a lower weighting

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**ICD-10 CM  
Diagnosis and  
Quality  
Measures**

**SNF Value-Based Purchasing (VBP)**

- ▶ Measure used: SNF 30-Day All-Cause Readmission Measure (SNFRM)
- ▶ While this measure uses ICD-10-CM diagnoses for risk adjustments,
  - ▶ The data comes only from the hospital Medicare claims data
  - ▶ This measure is difficult for SNF staff to manage due to the data being reliant on the accuracy and completeness of diagnosis coding from the hospital

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**ICD-10 CM Diagnosis and Quality Measures**

Accuracy of the facility's QM outcomes relies on the accuracy of diagnosis coding on the MDS

It is important to have the most accurate ICD-10 listing in the medical record and assigned on the MDS so that the QMs are properly calculated

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**Quality Assessment & Assurance Committee (QAA)**  
 Disclosure of Information and Good Faith Attempts

- ▶ The survey process is intended to be an objective assessment of facility compliance with the requirements of participation. This assessment is guided by facility performance and outcomes as reported by Quality Measures (QMs) and Minimum Data Set (MDS) data, as well as complaints and surveyor observations, interviews, and record reviews.
- ▶ The surveyor task to review the QAPI Plan/QAA is intended to occur at the end of the survey, after completion of investigation into all other requirements to ensure that concerns are identified by the survey team independent of the QAPI Plan/QAA review.

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**Quality Assessment & Assurance Committee (QAA)**  
 Disclosure of Information and Good Faith Attempts cont.

Surveyors must use critical thinking and investigatory skills to identify noncompliance, rather than using information provided during the QAA review as a source to identify deficiencies. The intent of §483.75(h), (i) is to:

- ▶ • Ensure information obtained from QAA committee documents that is related to the committee's good faith attempt to identify and correct quality deficiencies are not used by surveyors to identify additional concerns not previously identified during the survey; and
- ▶ • Foster a culture where nursing homes can openly conduct their internal QAA investigations and performance improvement efforts.

Surveyors may only require facilities to disclose QAA committee records if they are used to determine the extent to which facilities are compliant with the provisions for QAA.

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### Use QM Data Effectively

- Operational Strategies
- Collect and use CASPER QM data
- Collect real-time data from the electronic health record system
- Armed with the CASPER and facility reports, create reports and trends for targeted QMs

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### Conduct MDS Accuracy Checks

- Operational Strategies
- Pull the facility-level reports to identify the QM to review
- Pull the resident-level data to determine which residents triggered the QMs
- Conduct accuracy audits of the designated MDSs to ensure that coding was accurate
- Use the audit results to:
  - Correct errors
  - Train coders
  - Determine inadequate charting
  - Assess for poor care practices
- Take results to QAA

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### Conduct Root-Cause Analysis

- Operational Strategies
- Help determine root causes of adverse finding!
- Five whys
- Fish-bone diagram
- Flowcharts
- Brainstorming

The diagram is a fishbone (Ishikawa) diagram. The main horizontal arrow points to the right towards a circle labeled 'Problem'. Above the arrow are three boxes labeled 'Equipment', 'Process', and 'People'. Below the arrow are three boxes labeled 'Materials', 'Environment', and 'Management'. From each of these boxes, several lines branch out to the main arrow, representing potential causes. The text '© 2010 by Pearson Education, Inc. and Cengage Learning' is visible at the bottom of the diagram.

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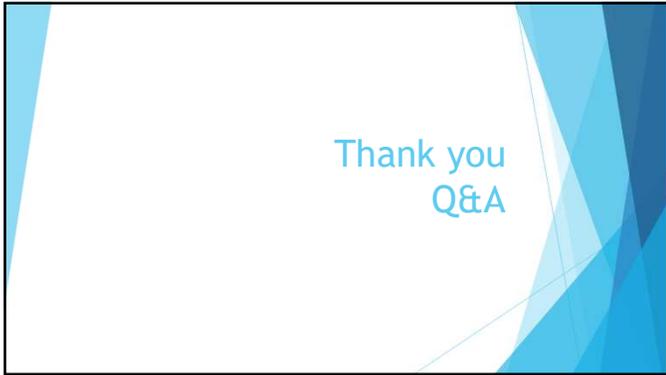
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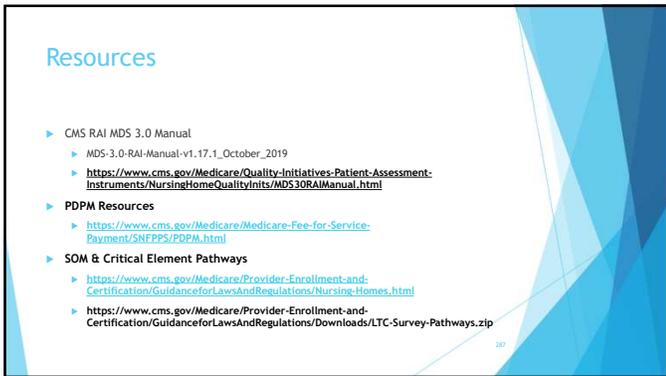
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