MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

OFFICE OF INSPECTOR GENERAL AND MYERS AND STAUFFER LC PRESENT

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MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

TRANSITIONING TO THE NEW MINIMUM DATA SET (MDS) ASSESSMENTS

SEPTEMBER 25-26, 2019

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RUG-IV & PDPM TRANSITION

- **There is no transition period between RUG-IV and PDPM, given that running both systems at the same time would be administratively infeasible for providers and CMS.**
  - **RUG-IV billing ends September 30, 2019**
  - **PDPM billing begins October 1, 2019**
- **To receive a PDPM HIPPS code that can be used for billing beginning October 1, 2019, all providers will be required to complete an IPA with an ARD no later than October 7, 2019 for all SNF Part A residents.**
  - **October 1, 2019 will be considered Day 1 of the Variable Per Diem schedule under PDPM, even if the resident began their stay prior to October 1, 2019.**
  - **Any "transitional IPAs" with an ARD after October 7, 2019 will be considered late and relevant penalty for late assessments would apply.**

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MDS CHANGES: NEW & REVISED ITEMS

- **Two new item sets and schedule changes:**
  1. **PPS assessment schedule changes:**
     - **Requires a 5-day PPS assessment.**
     - **IPA optional assessment (NEW).**
     - **PPS Discharge assessment.**
  2. **Other State Assessment (OSA) (NEW).**
- **I1300: Ulcerative Colitis or Crohn's Disease or Inflammatory Disease; added to NP, and IPA.**
- **I0020B, ICD-10 for primary SNF diagnosis.**
- **Section J – J2100 through J5000:**
  - **Major surgical procedures prior to admission.**

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MDS CHANGES: RESIDENT SURGICAL CATEGORIES SECTION J (NEW)

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

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MDS CHANGES: NEW & REVISED ITEMS CONT.

- **Discharge Therapy Collection Items:**
  - **Items 0425A1 – O0425C5 (NEW).**
  - **Using a look-back of the entire PPS stay, providers report, by each discipline and mode of therapy, the amount of therapy (in minutes) received by the resident.**
  - **If the total amount of group and concurrent minutes, combined, comprises more than 25% of the total amount of therapy for that discipline, a warning message is issued on the final validation report.**
- **Section GG Functional Items – Interim Performance: (NEW)**
  - **On the IPA, Section GG items will be derived from a new column "5" which will capture the interim performance of the resident.**
  - **The look-back for this new column will be the three-day window leading up to and including the ARD of the IPA (ARD and the 2 calendar days prior to the ARD).**

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PDPM ASSESSMENT SCHEDULE

- **PDPM Assessment Schedule**

Medicare MDS Assessment Schedule Type	Assessment Reference Date	Applicable Standard Medicare Payment Days
5-day Scheduled PPS Assessment	Days 1-8	All covered Part A days until Part A discharge (unless an IPA is completed)
Interim Payment Assessment (IPA)	Optional Assessment	ARD of the assessment through Part A discharge (unless another IPA assessment is completed)
PPS Discharge Assessment	PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date	N/A

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CHAPTER 2
ASSESSMENTS FOR THE RESIDENT ASSESSMENT INSTRUMENT (RAI)



8

NURSING HOME RESPONSIBILITIES FOR COMPLETING ASSESSMENTS (2.3)

RAI must be completed for any resident in a Medicare/ Medicaid certified LTC facility:

- **All residents regardless of:**
  - **Payer Source**
  - **Age**
  - **Diagnosis**
  - **Length of Stay**
  - **Hospice**
  - **Short-term or respite (<14 days)**
  - **Special populations (pediatric or psychiatric residents)**
  - **Swing beds**

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NURSING HOME RESPONSIBILITIES FOR COMPLETING ASSESSMENTS (2.3)

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

- **Newly Certified Nursing Homes**
- **Adding Certified Beds**
- **Change In Ownership**
- **Resident Transfers:**
  - **Traditional**
  - **Natural disasters**

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NURSING HOME RESPONSIBILITIES FOR MAINTAINING ASSESSMENTS (2.4)

The 15-month period for maintaining assessment data may <u>not</u> restart with each readmission to the facility:

- **When a resident is *discharged return anticipated* and returns to the facility within 30 days, facility must copy the previous RAI and transfer that copy to the new record.**
- **When a resident is *discharged return anticipated* and does <u>not</u> return within 30 days or *discharged return <u>not</u> anticipated*, facilities may develop their own policies for copying the previous record or not.**

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NURSING HOME RESPONSIBILITIES FOR MAINTAINING ASSESSMENTS (2.4)

After the 15-month period, RAI information may be thinned, provided that it is easily retrievable <u>except</u>:

- **Demographic information (A0500-A1600) from the most recent Admission assessment <u>must</u> be maintained in the active clinical record until resident discharged return not anticipated or discharged return anticipated but does not return within 30 days.**

Nursing homes may use electronic signatures:

- **Written policies must be in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.**

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NURSING HOME RESPONSIBILITIES FOR MAINTAINING ASSESSMENTS (2.4)

- ✓ **Must ensure that proper security measures are implemented via facility policy to ensure the privacy and integrity of the record.**
- ✓ **Must ensure that clinical records, regardless of form, are maintained in a centralized location as deemed by facility policy and procedure.**
- ✓ **Nursing homes that are <u>not</u> capable of maintaining the MDS electronically must adhere to the current requirement that either a hand written or a computer-generated copy be maintained in the clinical record for 15 months following the final completion date for all assessments and correction requests.**

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ASSESSMENT TYPES AND DEFINITIONS (2.5)

***<u>Admission</u>* – the date a person enters the facility and is admitted.**

- ✓ **Completion of an Admission assessment required when:**
  1. **Resident never admitted before, <u>OR</u>**
  2. **Was a previous resident, but discharged return not anticipated, <u>OR</u>**
  3. **Was a previous resident, discharged return anticipated, but returned later than 30 days from the discharge date.**

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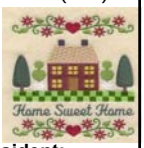
ASSESSMENT TYPES AND DEFINITIONS (2.5)



***<u>Discharge</u>* – the date resident leaves facility.**

- **Types of discharge:**
  - **Return not anticipated (10).**
  - **Return anticipated (11).**
- **Discharge assessment required when resident:**
  - **Discharged to private residence, <u>OR</u>**
  - **Admitted to hospital or other care setting, <u>OR</u>**
  - **Hospital observation stay greater than 24 hours, <u>OR</u>**
  - **Transferred from a Medicare- and/or Medicaid-certified bed to a non-certified bed, <u>OR</u>**
  - **Medicare Part A stay ends, but resident remains in facility (NPE).**

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OBRA ITEM SETS (2.5)

NC = Comprehensive assessment:

- **Admission (A0310A=01).**
- **Annual (A0310A=03).**
- **Significant Change in Status (SCSA) (A0310A=04).**
- **Significant Correction to Prior Comprehensive Assessment (SCPA) (A0310A=05).**
  - **May stand alone.**
  - **May be combined with any PPS and/or Discharge assessment.**

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OBRA ITEM SETS (2.5)

NQ = Quarterly assessment (A0310A=02):

- **May stand alone.**
- **May be combined with any type of PPS and/or Discharge assessment.**

ND = Discharge assessment (A0310F=10, 11):

- **Stand alone.**
- **Return anticipated.**
- **Return not anticipated.**

NT = Tracking Record (A0310F=01, 12):

- **Entry.**
- **Death in Facility.**
- **May <u>not</u> be combined with another assessment.**

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PPS ITEM SETS (2.5)

NP = Scheduled PPS assessment:

- **PPS 5-day (A0310B=01).**
  - **The ARD must be a day within the prescribed window of days 1 through 8 for the Part A stay to assure compliance with the SNF PPS PDPM requirements.**
  - **The ARD must be set on the MDS form itself or in the facility software before this window has passed.**

IPA = Interim Payment Assessment (Optional) (<u>NEW</u>):

- **Used for PPS payment purposes.**
- **Standalone assessment.**

OSA = Optional State Assessment (<u>NEW</u>):

- **Not required in Kentucky as of October 1, 2019.**
- **Standalone assessment.**

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ASSESSMENT TYPES AND DEFINITIONS (2.5)

Leave of Absence (LOA):

1. **Temporary home visit of at least one night, OR**
2. **Therapeutic leave of at least one night, OR**
3. **Hospital observation stay less than 24 hours with no admission.**

MDS Assessment Codes: Values that correspond to the OBRA, PPS assessments:

- **A0310A = OBRA.**
- **A0310B = PPS Assessment.**
- **A0310F = Discharge and Tracking Forms.**
- **A0310H = Is this a Part A PPS Discharge Assessment.**

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ASSESSMENT TYPES AND DEFINITIONS (2.5)

Observation (Look Back) Period:

- **Time over which resident's status is captured.**
- **Defined by counting backwards from ARD.**
- **Length is specific to each MDS item, but all end at 11:59 p.m. on the ARD.**
- **Anything occurring before or after observation period is not captured on MDS.**

Reentry: When all 3 of the following occur:

- **Resident was previously in facility, AND**
- **Discharged return anticipated, AND**
- **Returned within 30 days of discharge**

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ASSESSMENT TYPES AND DEFINITIONS (2.5)

Respite: Short-term, temporary care:

- **Required to complete;**
  - **OBRA Discharge assessment.**
  - **Entry tracking record.**
  - **OBRA Admission required for stays 14 days or longer.**

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OBRA REQUIRED ASSESSMENTS AND TRACKING RECORDS 2.6



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SUBMISSION TIME FRAME FOR OBRA MDS ASSESSMENTS (2.6)

Type	A0310A	A0310B	A0310F	MDS Completion Date	Submit By
Admission	01	99	10,11,99	Z0500B	V0200C2 + 14
Quarterly	02	99	10,11,99	Z0500B	Z0500B + 14
Annual	03	99	10,11,99	Z0500B	V0200C2 + 14
SCSA	04	99	10,11,99	Z0500B	V0200C2 + 14
SCPA	05	99	10,11,99	Z0500B	V0200C2 + 14
SCQA	06	99	10,11,99	Z0500B	Z0500B + 14

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SUBMISSION TIME FRAME FOR OBRA MDS RECORDS (2.6)

Type	A0310A	A0310B	A0310F	MDS Completion Date	Submit By
Discharge Assessments	All values	99	10 or 11	Z0500B	Z0500B + 14
Death in Facility	99	99	12	Z0500B	A2000 + 14
Entry Tracking	99	99	01	Z0500B	A1600 + 14
Correction Request	N/A	N/A	N/A	X1100E	X1100E + 14

V0200C2 = Care Plan Completion Date Z0500B = MDS Assessment Completion Date
A2000 = Date of discharge or death A1600 = Date of Entry
X1100E = Date of RN Coordinator Signature on Correction Request

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OBRA COMPREHENSIVE ASSESSMENTS (2.6)

Includes completion of:

- **MDS**
- **CAA process**
- **Care plan**

Comprehensive assessments:

- **Admission**
- **Annual**
- **Significant Change in Status Assessment (SCSA)**
- **Significant Correction to Prior Comprehensive Assessment (SCPA)**

OBRA assessment type determined at A0310A:

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COMPREHENSIVE ASSESSMENT TIPS (2.6)

- **May <u>not</u> complete SCSA until Admission completed.**
- **If Admission assessment was completed then discharges to the hospital (D=11), returns during an assessment period and most of assessment was completed prior to discharge:**
  1. **May continue original assessment but must keep original ARD and completion dates the same as originally set, <u>OR</u>**
  2. **Set new ARD and complete within 14 days of reentry.**
     - **The portion of assessment previously completed must be stored in the resident's record.**

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COMPREHENSIVE ASSESSMENTS TIPS (2.6)

- **If resident discharges or dies prior to completion deadline of assessment, completion is <u>not</u> required:**
  - **Completed portions must be maintained in medical record.**
  - **Must document reason not completed.**

- **If SCSA is identified in the process of completing any OBRA (except Admission), code and complete SCSA.**
- **May combine comprehensive assessment with Discharge assessment.**

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ADMISSION ASSESSMENT (A0310A=01) (2.6)

- **Completed when:**
  1. **Resident's first admission,** **OR**
  2. **Was a previous resident, but discharged return not anticipated,** **OR**
  3. **Was a previous resident, discharged return anticipated, but returned more than 30 days from the discharge date.**
- **ARD = No later than 14th day of admission.**

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ANNUAL ASSESSMENT (A0310A=03) (2.6)

- **Must be completed every 366 days unless SCSA or SCPA completed since most recent comprehensive assessment.**
- **ARD = No later than:**
  - **ARD of previous comprehensive + 366 days,** **AND**
  - **ARD of previous quarterly + 92 days.**

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SIGNIFICANT CHANGE IN STATUS ASSESSMENT (SCSA - A0310A=04) (2.6)

- **A decline or improvement in a resident's status that:**
  - **Will not normally resolve itself without intervention or by implementing standard disease-related clinical interventions.**
  - **Impacts more than one area of resident's health status.**
  - **Requires IDT review and/or revision of care plan.**
- **If status is unclear, may take up to 14 days to make determination.**
- **Improvement and decline examples Chapter 2.**

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SIGNIFICANT CHANGE IN STATUS ASSESSMENT (SCSA - A0310A=04) (2.6)

Significant change in condition guidelines:

- **Determine if condition is "self-limiting".**
- **Determine if there are two or more areas of decline or improvement (may include two areas of ADLs).**
- **May decide to complete SCSA for one change.**
- **Each situation is unique.**
- **Resident may benefit from SCSA.**
- **Medical record must document rationale for completing SCSA if does not meet criteria.**

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SIGNIFICANT CHANGE IN STATUS ASSESSMENT (SCSA - A0310A=04) (2.6)

- **Must be completed when IDT determines resident meets significant change guidelines:**
  - **Document initial identification in clinical record.**
- **Resident's condition <u>not</u> expected to return to baseline within 2 weeks.**
- **SCSA may <u>not</u> be completed prior to the Admission.**
- **ARD = No later than 14th day after determination that significant change occurred.**

Hospice:

- **Required when enrolls in a hospice program or changes hospice provider:**
  - **ARD must be within 14 days from effective date of hospice election.**

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SIGNIFICANT CHANGE IN STATUS ASSESSMENT (SCSA - A0310A=04) (2.6)

Hospice cont.:

- **Must be performed regardless of whether an assessment was recently conducted.**
- **If admitted on hospice benefit or elects hospice on or prior to the ARD of the Admission Assessment:**
  - **Check Hospice Care (O0100K).**
  - **SCSA is <u>not</u> required.**
- **If admitted on hospice benefit but discontinues it prior to the ARD of the Admission Assessment:**
  - **Complete Admission assessment.**
  - **Check Hospice Care (O0100K).**
  - **SCSA is <u>not</u> required.**

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SIGNIFICANT CHANGE IN STATUS ASSESSMENT (SCSA - A0310A=04) (2.6)

Hospice cont.:

- **If hospice election occurs after the Admission assessment ARD but prior to completion:**
  - **Adjust ARD to date of hospice election.**
  - **Only Admission assessment is required.**
  - **SCSA is <u>not</u> required.**
- **Required when hospice revoked:**
  - **ARD must be within 14 days of:**
    - **Effective date of revocation.**
    - **Expiration date of certification of terminally ill.**
    - **Date physician order states no longer terminally ill.**

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SIGNIFICANT CHANGE IN STATUS ASSESSMENT (SCSA - A0310A=04) (2.6)

SCSA for terminally ill:

- **Determine if change in condition expected.**
- **New onset of symptoms or condition not part of expected course of deterioration.**

Referral for PASRR Level II:

- **Required by law when SCSA is completed for an individual known or suspected to have a mental illness, intellectual disability, or related condition.**
- **Referral should be made as soon as criteria is met.**
  - **Do <u>not</u> wait until the SCSA is complete.**

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REFERRAL FOR LEVEL II RESIDENT REVIEW EVALUATIONS (2.6)

- ✓ **Increased behavioral, psychiatric, or mood-related symptoms.**
- ✓ **Behavioral, psychiatric, or mood-related symptoms not responding to ongoing treatment.**
- ✓ **Improved medical condition-such that the plan of care or placement may require modifications.**
- ✓ **Significant change is physical, but may influence adjustment to an altered pattern of daily living.**
- ✓ **Resident indicates preference to leave facility.**
- ✓ **Condition or treatment is or will be significantly different than described in the most recent PASRR Level II evaluation and determination.**

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SIGNIFICANT CORRECTION TO PRIOR COMPREHENSIVE ASSESSMENT (SCPA - A0310A=05) (2.6)

Required when uncorrected significant error is identified in a prior comprehensive assessment:

- **Significant error in an assessment where;**
  - **Resident's overall clinical status is not accurately represented, AND**
  - **Error has not been corrected via submission of a more recent assessment.**
- **Can only be completed after an Admission assessment has been completed.**
- **Must document identification of error in clinical record.**

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OBRA NON-COMPREHENSIVE ASSESSMENTS (2.6)

✓ **Includes a select number of MDS items:**

Excludes completion of:

- **CAA process**
- **Care plan**

Non-comprehensive assessment types:

- **Quarterly**
- **Significant Correction to Prior Quarterly Assessment (SCQA)**
- **Discharge – return not anticipated**
- **Discharge – return anticipated**

Tracking records:

- **Entry Tracking**
- **Death in Facility Tracking**

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NON-COMPREHENSIVE ASSESSMENTS (2.6)

If resident goes to hospital (D=11), returns during an assessment period and most of assessment completed prior to hospital:

1. **May continue original assessment but must keep original ARD and completion dates the same as originally stated, provided does not meet SCSA criteria, OR**
2. **Initiate new ARD and complete within 14 days of reentry.**
   - **The portion of assessment previously completed must be stored on the resident's record.**

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NON-COMPREHENSIVE ASSESSMENTS (2.6)

- ✓ **If resident discharged or dies prior to completion deadline of assessment, completion is <u>not</u> required:**
  - **Maintain completed portions in medical record.**
- ✓ **If SCSA is identified in the process of completing any OBRA (except Admission), complete SCSA.**
- ✓ **May combine with Discharge assessment.**
- ✓ **May combine with PPS 5-day assessment.**
- ✓ **ARD drives due date (non-comprehensive due within 92 days of prior ARD).**
- ✓ **CAAs process <u>not</u> required.**
- ✓ **Update care plan if necessary.**

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QUARTERLY (A0310A=02) (2.6)

- ✓ **Must be completed every 92 days following the ARD of the most recent OBRA assessment.**
- ✓ **Used to track resident's status between comprehensive assessments.**
- ✓ **Federal requirements dictate three Quarterly assessments in each 12-month period assuming:**
  - **SCSA or SCPA not completed previously, <u>AND</u>**
  - **No discharge.**
- ✓ **Evaluate appropriateness of care plan:**
  - **Modify care plan if appropriate.**

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SIGNIFICANT CORRECTION TO PRIOR QUARTERLY ASSESSMENT (SCQA - A0310A=06) (2.6)

Required when uncorrected significant error is identified in a prior quarterly assessment:

- **Document initial identification in clinical record.**
- **Significant error in an assessment where:**
  - **Resident's overall clinical status is <u>not</u> accurately represented.**
  - **Error has <u>not</u> been corrected via submission of a more recent assessment.**

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ENTRY TRACKING RECORD (A0310F=01) (2.6)

- ✓ **Two types:**
  - **Admission (A1700=1):**
  - **Reentry (A1700=2):**
    - **Is readmitted to the facility, AND**
    - **Discharged return anticipated, AND**
      - **Returned within 30 days of discharge date.**

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ENTRY TRACKING RECORD (2.6)

- ✓ **First item set completed for all residents (A1700=1).**
- ✓ **Completed for respite resident upon each entry or reentry.**
- ✓ **Stand alone tracking record.**
- ✓ **Cannot be combined with an assessment.**
- ✓ **Contains administrative and demographic information.**
- ✓ **Required in addition to the Admission assessment or other OBRA or PPS assessments that might be required.**

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DEATH IN FACILITY TRACKING RECORD (A0310F=12) (2.6)

Must be completed when:

- **Dies in facility, OR**
- **Dies while on leave of absence.**
- **OBRA Discharge assessment not required.**

- ✓ **Consists of demographic and administrative items.**
- ✓ **May not be combined with any type of assessment.**
- ✓ **Tracking records and standalone Discharge assessments do not impact payment.**

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DISCHARGE RETURN NOT ANTICIPATED (A0310F=10) (2.6)

- ✓ **Discharged and not expected to return within 30 days.**
- ✓ **Consists of demographic, administrative, and clinical items.**
- ✓ **If resident returns:**
  - **Entry tracking must be coded as Admission entry (A1700=1).**

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DISCHARGE RETURN ANTICIPATED (A0310F=11) (2.6)

- ✓ **Consists of demographic, administrative, and clinical items.**
- ✓ **Expected to return within 30 days.**
- ✓ **For a respite resident who comes in and out frequently and return is expected.**

If returns within 30 days:
- **Entry tracking reason must be coded as (A1700=2).**

If return is NOT by day 30:
- **Entry tracking reason must be coded as (A1700=1).**
- **Admission assessment will be required.**

If resident does not return:
- **No requirement to inactivate or complete another Discharge.**

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TYPE OF DISCHARGE (2.6)

Unplanned discharge (A0310G):
- **Unplanned conditions;**
  1. **Acute-care transfer of the resident to a hospital or an emergency department in order to either,**
     - o **Stabilize a condition, OR**
     - o **Determine if an acute-care admission is required.**
  2. **Resident unexpectedly leaving the facility against medical advice.**
  3. **Resident unexpectedly deciding to go home or to another setting.**

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TIPS FOR DISCHARGE ASSESSMENTS

- ✓ **ARD is <u>not</u> set prospectively.**
- ✓ **Discharge date and ARD <u>must</u> be the same:**
  - **May be coded on assessment any time during the assessment completion period.**
- ✓ **For unplanned discharge, facility should complete discharge to the best of its abilities.**

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THE CARE AREA ASSESSMENT (CAA) PROCESS AND CARE PLAN COMPLETION
2.7



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CAA PROCESS SUMMARY (2.7)

- ✓ **The MDS information and the CAA process provide the foundation upon which the care plan is formulated.**
- ✓ **There are 20 problem-oriented CAA's that signal the need for additional assessment and review.**
- ✓ **Detailed information regarding the CAA's and care planning development is provided in Chapter 4.**
- ✓ **However, a final CAA's review and associated documentation are still required no later than the 14th calendar day of admission.**

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CARE PLAN SUMMARY (2.7)

- ✓ **Within 48 hours of admission the facility must develop and implement a Baseline Care Plan that includes the instructions needed to provide effective and person-centered care that meets professional standards of care.**
- ✓ **Care plan completion based on the CAA process is required for OBRA comprehensive assessments.**
- ✓ **It is <u>not</u> required for non-comprehensive assessments.**
- ✓ **For Annual, SCSAs and SCPAs, the process is basically the same as that described with an Admission assessment.**
- ✓ **Facilities should have ongoing discussions with the resident and resident representatives to address changes to the resident's preferences and goals.**

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SNF MEDICARE PROSPECTIVE PAYMENT SYSTEM ASSESSMENT OVERVIEW 2.8



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SNF PPS ASSESSMENT SUMMARY (2.8)

- ✓ **Required for reimbursement under Medicare Part A.**
- ✓ **Must also meet OBRA requirements.**

PPS Assessments:

- **Scheduled 5-day assessment (A0310B=01).**

- ✓ **Defined days within which the ARD must be set:**
  - **Required to set the ARD on the MDS form itself or in the facility software within the appropriate timeline.**
- ✓ **First day of Medicare Part A coverage for the current stay is considered day 1 for PPS scheduling purposes.**
- ✓ **Standard, predetermined time period for ARD.**

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PART A PPS DISCHARGE (A0310H=1) (2.8)

- **Consists of demographic, administrative and clinical items.**
- **Completed when Part A stay ends, but resident stays in facility (unless it is an interrupted stay).**
- **When a Discharge date (A2000) occurs on the day of or one day after the End Date of the Most Recent Medicare Stay (A2400C), both the OBRA and Part A PPS Discharge are required and may be combined.**
  - **When combined, the ARD must be equal to the Discharge date (A2000=A2300).**
- **Standalone Part A Discharge ARD is always equal to the end date of the most recent Medicare Stay (A2400C).**

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PART A PPS DISCHARGE (A0310H=1) (2.8)

- **Must be completed within 14 days after the end date of the most recent Medicare stay (A2400C + 14 calendar days).**
- **Must be submitted within 14 days after the MDS completion date (Z0500B + 14 calendar days).**
- **If Part A ends and resident returns to a skilled level and Part A benefits do <u>not</u> resume within 3 days, , the Medicare schedule starts over beginning with a 5-day PPS assessment.**
- **If the Medicare Part A stay <u>does</u> resume within the 3-day interruption window, then this is an interrupted stay. (<u>NEW</u>)**

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PART A PPS DISCHARGE (A0310H=1) (2.8)

- **If the resident leaves the facility for an interrupted stay, no Part A PPS Discharge is required at the outset of the interrupted stay:**
  - **However an OBRA Discharge record is required if the discharge criteria is met.**
- **If the resident returns within the interruption window, an Entry tracking record is required, <u>no</u> new 5-day assessment is required.**

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PPS ASSESSMENTS TABLE (2.8)

Assessment Type	Reason for Assessment A0310B	ARD	Applicable Standard Payment Days
PPS 5-day	01	Days 1-8	All covered Part A days until Part A Discharge (or IPA completed)
IPA (Interim Payment Assessment)	08	Optional As Determined	ARD of assessment through Part A Discharge (or IPA completed)
Part A Discharge	A0310H=1	End Date of Most Recent PPS Stay	NA

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PPS 5-DAY ASSESSMENT (A0310B = 01) (2.9)

- **ARD must be set for Days 1-8.**
- **Must be completed within 14 days after ARD.**
- **Authorizes payment for entire PPS stay.**
- **If combined with an OBRA Admission, the assessment must be completed by the end of the 14 day of admission.**
- **Is the first PPS-required assessment when:**
  - **First admitted for a SNF Part A stay.**
  - **Readmitted following a discharge 10 or 11 and returns >30 days after discharge.**
- **NOT required following an interrupted stay.**

59

PPS INTERIM PAYMENT ASSESSMENT (A0310B = 08) (2.9) (NEW)

✓ **Interim Payment Assessment:**
- **Optional.**
- **Completed when deemed appropriate by the provider.**
- **May be completed to capture changes in the resident's status and condition.**
- **ARD may be set for any day of the SNF PPS stay, beyond the ARD of the 5-day.**
- **Authorizes payment for remainder of the PPS stay, beginning on the ARD.**
- **May not be combined with any other assessment (PPS or OBRA).**

60

PPS SNF ASSESSMENT COMBINATIONS (2.10)

- ✓ **May combine 5-day PPS assessment with any OBRA assessment.**
- ✓ **May <u>not</u> combine IPA PPS assessment with any other assessment.**

- ✓ **When combining assessments use the more stringent requirements.**
- ✓ **PPS and OBRA assessment combinations listing can be found in section 2.11.**

61

FACTORS IMPACTING THE SNF PPS ASSESSMENT SCHEDULING (2.12)

1. **Resident expires or is on leave before or on the eighth day of SNF stay:**
   - **Provider should complete a 5-day PPS required assessment and submit as required.**
   - **If there is <u>not</u> a PPS assessment in the system, provider must <u>bill default rate</u> for any Medicare days.**
   - **Must complete Death in Facility tracking record if deceased.**

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FACTORS IMPACTING THE SNF PPS ASSESSMENT SCHEDULING (2.12)

2. **Resident transfers or is discharged before or on the eighth day of stay:**
   - **Provider should complete a 5-day PPS assessment and submit as required.**
   - **If there is <u>not</u> a PPS assessment in the system, provider must <u>bill default rate</u> for any Medicare days.**
   - **When the Medicare Part A stay ends on or before the eighth day of the SNF stay and remains in the facility, a Part A PPS Discharge assessment is required.**

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FACTORS IMPACTING THE SNF PPS ASSESSMENT SCHEDULING (2.12)

2. **Resident transfers or is discharged before or on the eighth day of stay cont.:**
   - **When the beneficiary is physically discharged:**
     - **The provider must also complete an OBRA Discharge assessment.**
   - **If the Medicare Part A stay ends on or before the eighth day of the stay AND the beneficiary is physically discharged from the facility the day of or the day after the Part A stay ends:**
     - **The Part A PPS and OBRA Discharge assessments may be combined.**

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FACTORS IMPACTING THE SNF PPS ASSESSMENT SCHEDULING (2.12)

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

65

FACTORS IMPACTING THE SNF PPS ASSESSMENT SCHEDULING (2.12)

4. **Resident is sent to acute care facility, not in SNF over midnight, and not admitted to acute care facility:**
   - **If a resident is out of the facility over a midnight, but less than 24 hours, and is not admitted to an acute care facility, a new 5-day PPS assessment is not required, though an IPA may be completed, if deemed appropriate.**
   - **Payment implications: The day preceding the midnight on which the resident was absent from the SNF is not a covered Part A day pursuant to the "midnight rule".**

66

FACTORS IMPACTING THE SNF PPS ASSESSMENT SCHEDULING (2.12)

5. Leave of Absence from SNF:

- **If a resident is out of the facility for a LOA there may be payment implications (see page 2-13).**
- **Payment implications example: If a resident leaves a SNF at 6 PM on Wednesday, which is Day 27, and returns to the SNF on Thursday at 9 AM, then Wednesday becomes a non-billable day and Thursday becomes Day 27 of the stay.**

67

FACTORS IMPACTING THE SNF PPS ASSESSMENT SCHEDULING (2.12)

6. Resident Discharges from Part A skilled services and from the facility and returns to SNF Part A skilled level services:

- **When a beneficiary is discharged from Part A and is physically discharged from the facility but returns to resume SNF Part A skilled services after the interruption window has closed, the OBRA Discharge and Part A PPS Discharge must be completed and may be combined.**
- **On return to the facility, this is considered a new Part A stay (as long as resumption of Part A occurs within the 30-day window allowed by Medicare), and a new PPS 5-day and Entry tracking record must be completed.**
- **If the resident was discharged return not anticipated, the facility must complete a new OBRA Admission assessment.**

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FACTORS IMPACTING THE SNF PPS ASSESSMENT SCHEDULING (2.12)

6. Resident Discharges from Part A skilled services and from the facility and returns to SNF Part A skilled level services, cont:

- **In the case of an interrupted stay, if the resident leaves the facility and resumes Part A within the 3-day interruption window, only an OBRA Discharge is required.**
- **If the resident was discharged 11 and returns, no OBRA assessment is required.**
- **If the resident was discharged 10 and returns, the facility must complete a new OBRA Admission assessment.**

69

FACTORS IMPACTING THE SNF MEDICARE ASSESSMENT SCHEDULE (2.12)

7. **Resident Discharges from Part A skilled services but is not physically discharged from the SNF:**
   - **When a resident's Part A stay ends, but the resident is not physically discharged from the facility, remaining in a M/M certified bed with another payer source, the facility must continue with the OBRA schedule from the beneficiary's original date of admission (A1900) and must also complete a Part A PPS Discharge.**

70

FACTORS IMPACTING THE SNF MEDICARE ASSESSMENT SCHEDULE (2.12)

7. **Resident Discharges from Part A skilled services and is not physically discharged from the SNF, cont.:**
   - **If the Part A benefits resume, there is no reason to change the OBRA schedule.**
   - **The PPS schedule would start again with a 5-day assessment, unless it is a case of an interrupted stay, that is, if the resident is discharged from Part A, remains in the facility and resumes Part A within the 3-day interruption window, no PPS Discharge is completed, nor is a 5-day required when Part A resumes.**

71

FACTORS IMPACTING THE SNF PPS ASSESSMENT SCHEDULING (2.12)

8. **Late PPS Assessment:**
   - **The SNF must complete a late assessment; the ARD can be no earlier than the day the error was identified.**
   - **The SNF will bill the default rate for the number of days that the assessment is out of compliance.**
   - **This is equal to the number of days between the day following the last day of the available ARD window and the late ARD (including the late ARD).**
   - **The SNF would then bill the HIPPS code established by the late assessment for the remainder of the SNF stay, unless the SNF chooses to complete an IPA.**

72

FACTORS IMPACTING THE SNF MEDICARE ASSESSMENT SCHEDULE (2.12)

9. Missed PPS Assessment:

- **If the SNF fails to set the ARD for a 5-day PPS assessment prior to the end of the last day of the ARD window for that assessment, and the resident has been discharged from Part A, the assessment cannot be completed for Part A.**
- **All days which would have been paid by the missed assessment, had it been completed timely, may not be billed to Part A.**

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FACTORS IMPACTING THE SNF PPS ASSESSMENT SCHEDULING (2.12)

10. Non-compliance with the PPS assessment schedule:

- **Frequent late assessment scheduling practices or missed assessments may result in additional review.**
- **The default rate takes the place of the otherwise applicable Federal rate for the days the ARD is out of compliance.**
- **The default rate is equal to the rate paid for the HIPPS code reflecting the lowest acuity level for each PDPM component, and be generally lower then the Medicare rate payable if the SNF had submitted an assessment on time.**

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EXPECTED ORDER OF MDS RECORDS (2.13)

MDS records are expected to occur in a specific order:

- **Sequence order for new admission:**
  1. **Entry Tracking record (A1700= 1, Admission).**
  2. **Admission assessment, 5-day Medicare, Discharge, or Death in Facility.**

The target date determines the order of records:

- **A2300 (Assessment Reference date) for assessments.**
- **A1600 (Entry date) for entry records.**
- **A2000 (Discharge date) for discharges or death in facility.**

Out of order records will generate a warning on the CMS validation report.

75

DETERMINING THE ITEM SET FOR AN MDS RECORD (2.14)

Item set is determined by the reason for assessment:

- **A0310A (OBRA).**
- **A0310B (Scheduled PPS).**
- **A0310F (Tracking records, Discharges).**
- **A0310H (Is this a Part A PPS Discharge).**

✓ **An inactivation request indicated by A0050 = 3 will display an ISC of XX.**

76

DETERMINING THE ITEM SET FOR AN MDS RECORD (2.14)

Item set is determined by the reason for assessment:

Expected Order of MDS Records

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

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

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


78

SECTION A: IDENTIFICATION INFORMATION

79

TYPE OF RECORD (A0050-A0200)

- ✓ **A0050, Type of Record (no change).**
- ✓ **A0100, Facility Provider Numbers:**
  - **In A0100B, if A0410=3 (Federal required submission) then facility CCN must not be blank. (NEW)**
  - **In A0100C, the term "State survey agency" was added to the instruction to clarify that the State Provider Number is actually assigned by this entity.**
- ✓ **A0200, Type of Provider:**
  - **Code 1, Nursing Home (SNF/NF).**
  - **Code 2, Swing Bed.**

80

OPTIONAL STATE ASSESSMENT (A0300) (NEW)


A0300. Optional State Assessment

A. Is this assessment for state payment purposes only?
0. No
1. Yes

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

- ✓ **Complete only if A0200 = 1 (Nursing Home)**

A. Is this assessment for state payment purposes only?
- **Code 0, No**
- **Code 1, Yes**

B. Assessment Type (OSA only)?
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**

81

OPTIONAL STATE ASSESSMENT (A0300) (NEW)

- ✓ **Not federally required.**
- ✓ **Not currently required in Kentucky.**
- ✓ **Allows for collection of data required for state payment reimbursement (RUG items).**
- ✓ **The OSA is a standalone assessment ONLY.**
- ✓ **Cannot be combined with any other type of assessment.**
- ✓ **Responses to the items are used to calculate the case mix group (HIPPS) code for state payment purposes.**

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TYPE OF ASSESSMENT (A0310A-B)

A0310A, Federal OBRA Reason for Assessment:

- **01-06 and 99.**

A0310B, PPS Assessment: REVISED

PPS Scheduled Assessment for a Medicare Part A Stay:

- **01. 5-day scheduled assessment.**

PPS Unscheduled Assessment for a Medicare Part A Stay:

- **08. IPA – Interim Payment assessment**

Not PPS Assessment:

- **99. None of Above.**

~~A0310C~~, DELETED

~~A0310D~~, DELETED

83

IS THIS ASSESSMENT THE FIRST ASSESSMENT (OBRA, SCHEDULED PPS, OR OBRA DISCHARGE) SINCE THE MOST RECENT ADMISSION/ENTRY OR REENTRY? (A0310E)

Code 0, No, for:

- **Entry or Death in Facility tracking forms.**
- **A standalone Part A PPS Discharge.**
- **An Interim Payment Assessment (A0310A=99, A0310B=08, A0310F=99, and A0310H=0).**

Code 1, Yes:

- **The first OBRA, Scheduled PPS or OBRA Discharge assessment that is completed and submitted once a facility obtains CMS certification.**
- ***NOTE: the first assessment may not be an OBRA Admission assessment.***

84

ENTRY/DISCHARGE REPORTING (A0310F-G)

✓ **F. Entry/Discharge Reporting:**
- **01, Entry.**
- **10, Discharge-return not anticipated.**
- **11, Discharge-return anticipated.**
- **12, Death in facility.**
- **99, None of the above.**

✓ **G. Type of Discharge (complete only if A0310F=10 or 11).**
- **1. Planned.**
- **2. Unplanned.**

NO CHANGES

85

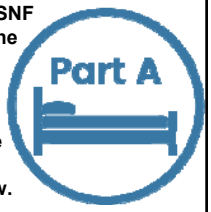
IS THIS A SNF PART A INTERRUPTED STAY? (A0310G1) (NEW)

Definition:
- **Interrupted Stay – A Medicare Part A SNF stay in which a resident is discharged from SNF care and subsequently resumes SNF care in the same SNF for a Medicare Part A covered stay during the interruption window.**
- **Interruption Window – A 3-day period, starting with the calendar day of discharge and including the 2 immediately following calendar days:**
  - **A Medicare Part A SNF stay is discharged from Part A, the resident must resume Part A services, or return to the same SNF to resume Medicare Part A services, by 11:59 p.m. at the end of the third calendar day after their Part A covered stay ended.**
  - **If these conditions are met, the subsequent stay is considered a continuation of the previous Part A covered stay.**

86

IS THIS A SNF PART A INTERRUPTED STAY? (A0310G1) (NEW)

✓ **Is this a SNF Part A Interrupted Stay?**
- **Code 0, No**
  - **If the resident was discharge from SNF care but did not resume SNF care in the same SNF within the interruption window.**
- **Code 1, Yes**
  - **If the resident was discharge from SNF care but did resume SNF care in the same SNF within the interruption window.**



87

IS THIS A SNF PART A INTERRUPTED STAY? (A0310G1) EXAMPLES (NEW)

- ✓ **Resident leaves against medical advice and returns to the same SNF to resume Part A within the interruption window.**
- ✓ **Acute care setting for evaluation/treatment due to a change in condition and returns to the same SNF to resume Part A within the interruption window.**
- ✓ **Psychiatric facility for evaluation/treatment and returns to the same SNF to resume Part A within the interruption window.**
- ✓ **Assisted living facility or private residence with home health services and returns to the same SNF to resume Part A within the interruption window.**

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IS THIS A SNF PART A INTERRUPTED STAY? (A0310G1) EXAMPLES, CONT. (NEW)

- ✓ **Elects and then revokes the hospice benefit, then resumes Part A within the interruption window.**
- ✓ **Refuses to participate in rehab, then decides to engage in planned rehab resuming Part A within the interruption window.**
- ✓ **Changes payer source from Medicare Part A to an alternate payer source then wishes to resume Part A again within the interruption window.**

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IS THIS A SNF PART A INTERRUPTED STAY? (A0310G1) (NEW)

Example #1: Resident leaves the facility and resumes Part A within the 3-day interruption window in the same SNF:

- ✓ **Is Part A Discharge required? _____**
- ✓ **Is an OBRA Discharged required? _____**
- ✓ **Is an Entry Tracking and OBRA Admission required on resumption if discharge 10? _____**
- ✓ **Is Part A 5-day assessment required? _____**
- ✓ **Is an OBRA Admission required for discharge 11? _____**
- • ***Subsequent stay is considered a continuation of the previous Part A covered stay.***
- • ***This is considered an Interrupted Stay.***

90

IS THIS A SNF PART A INTERRUPTED STAY? (A0310G1) (NEW)

Example #2: Resident is discharged from Part A, remains in the facility, and does not resume Part A within the 3-day interruption window:

- ✓ **Is Part A Discharge required? _____**
- ✓ **Is Part A 5-day assessment required on resumption if within the 30-day window? _____**
- ✓ **Would the OBRA schedule continue from the resident's original date of admission? _____**
- • ***Subsequent stay, if there is one, is considered a new Part A stay.***
- • ***This is not considered an Interrupted Stay.***

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IS THIS A SNF PART A INTERRUPTED STAY? (A0310G1) (NEW)

Example #3: Resident is discharged from Part A, leaves the facility, and does not resume Part A within the 3-day interruption window:

- ✓ **Is Part A Discharge required? _____**
- ✓ **Is an OBRA Discharge required? _____**
- ✓ **Can the Part A and OBRA discharge be combined? _____**
- ✓ **Is an Entry Tracking and 5-day required on resumption if within 30-day window? _____**
- ✓ **Is an OBRA Admission required on resumption if discharge 10? _____**
- ✓ **Is an OBRA Admission required on resumption if discharge 11? _____**
- • ***Subsequent stay, if there is one, is considered a new Part A stay.***
- • ***This is not considered an Interrupted Stay.***

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IS THIS A SNF PART A INTERRUPTED STAY? (A0310G1) (NEW)

The OBRA assessment schedule is unaffected by the interrupted stay policy.

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IS THIS A PART A PPS DISCHARGE ASSESSMENT? (A0310H)

Is this a Part A PPS Discharge Assessment?

- **Code 0, No, not a Part A PPS Discharge assessment.**
- **Code 1, Yes, this is a Part A PPS Discharge assessment.**
  - **Part A ends but resident remains in the facility.**
    - **Requires a Part A PPS Discharge assessment (NPE item set), OR**
    - **Must be combined with an OBRA Discharge if Part A ends on the same day or the day before the resident's Discharge Date (A2000).**

94

UNIT CERTIFICATION OR LICENSURE DESIGNATION (A0410)

Enter code:

- **Code 1, Unit is neither Medicare nor Medicaid certified and MDS data is not required by CMS or the State:**
  - **MDS records may not be submitted.**
  - **Rejected by QIES ASAP system.**
- **Code 2, Unit is neither Medicare nor Medicaid certified but MDS data is required by the State:**
  - **MDS records should be submitted per State's requirements.**
- **Code 3, Unit is Medicare and/or Medicaid certified:**
  - **MDS records must be submitted regardless of payer source.**
  - **Required to submit OBRA and PPS.**

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SECTION A (A0500-A1300)

- ✓ **A0500A-D, Legal Name of Resident**
- ✓ **A0600A, Social Security Number**
- ✓ **A0600B, Medicare number**
- ✓ **A0700, Medicaid Number (resident):**
  - **"+" if pending.**
  - **"N" if not a Medicaid recipient.**
- ✓ **A0800, Gender**
- ✓ **A0900, Birth Date**
- ✓ **A1000A-F, Race/Ethnicity – *Check all that apply***
- ✓ **A1100A-B, Language**
- ✓ **A12001-5, Marital Status**
- ✓ **A1300A-D, Optional Resident Items**
  - **Optional but very useful in NH**

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PASRR NO CHANGES

PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR) OVERVIEW

- ✓ **All admissions to a Medicaid certified facility must have a Level I PASRR completed regardless of payer source.**
- ✓ **Individuals who have or are suspected of having a diagnosis of MI or ID/DD or related conditions may <u>not</u> be admitted without Level II approval.**
- ✓ **Resident review (RR) is triggered whenever an individual undergoes a significant change in status (mental and/or physical) and that change has a material impact on their functioning as it relates to their MI/IDD status:**
  - **Required to contact your State mental health authority.**
- ✓ **Ensures that individuals with serious mental illness or intellectual disability or related condition are not placed in a NF inappropriately.**

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PREADMISSION SCREENING AND RESIDENT REVIEW (A1500)

- ✓ **Complete only if comprehensive assessment:**

Is the resident currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?

- **Code 0, No, skip to A1550, Conditions related to ID/DD status.**
  - **PASRR Level I screening did <u>not</u> result in a Level II screening, <u>OR</u>**
  - **Level II screening determined there is no serious mental illness and/or ID/DD or RC, <u>OR</u>**
  - **PASRR screening is <u>not</u> required because the resident was admitted from a hospital, is receiving services for the condition the resident received care in the hospital, and attending physician certified before admission that stay is likely to require <30 days.**

99

PREADMISSION SCREENING AND RESIDENT REVIEW (A1500), CONT.

Is the resident currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?

- **Code 1, Yes, continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.**
  - **Level II screening determined a serious mental illness and/or ID/DD or RC.**
- **Code 9, Not a Medicaid-certified unit, skip to A1550, Conditions Related to ID/DD Status.**
  - **Process does not apply to non-certified Medicaid units.**

100

LEVEL II PASRR CONDITIONS (A1510)

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

✓ **Complete only if comprehensive assessment.**

Check all that apply:

A. Serious mental illness.

B. Intellectual Disability

C. Other related conditions.

101

CONDITIONS RELATED TO ID/DD STATUS (A1550) OVERVIEW

- ✓ **Documents conditions associated with intellectual disability or developmental disabilities.**
- ✓ **If resident is 22 years or older as of ARD:**
  - **Complete only if Admission assessment (A0310A = 01).**
- ✓ **If resident is 21 years or younger as of ARD:**
  - **Complete only if a comprehensive assessment.**
- ✓ **Check all conditions related to ID/DD status present before age 22.**
- ✓ **When age of onset is not specified, assume that the condition meets this criterion AND is likely to continue indefinitely.**

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CONDITIONS RELATED TO ID/DD STATUS (A1550)

✓ **Complete only if comprehensive assessment.**
Check all that apply:
✓ **ID/DD With Organic Condition:**
- **A. Down syndrome.**
- **B. Autism.**
- **C. Epilepsy.**
- **D. Other organic condition related to ID/DD.**

✓ **ID/DD Without Organic Condition:**
- **E. ID/DD with no organic conditions.**

✓ **No ID/DD:**
- **Z. None of the above.**

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PASRR RESOURCES

Your State Medicaid Agency is overall responsible for PASRR and should direct you to agencies or vendors:

- **National Association of PASRR Professionals www.PASRR.org**
- **The PASRR Technical Assistance Center (PTAC) is for state agencies, but website is informative: www.PASRRassist.org**
- **Kentucky PASRR information: https://chfs.ky.gov/agencies/dms/dpo/bpb/Pages/nursing-facilities.aspx**

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(A1600) THROUGH (A2300) NO CHANGES

✓ **A1600, Entry Date**
✓ **A1700, Type of Entry**
✓ **A1800, Entered From**
✓ **A1900, Admission Date**
✓ **A2000, OBRA Discharge Date**
✓ **A2100, OBRA Discharge Status**
✓ **A2200, Previous Assessment Reference Date for Significant Correction**
✓ **A2300, Assessment Reference Date**

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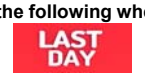
ASSESSMENT REFERENCE DATE (ARD) (A2300)

- ✓ Designates end of look-back period.
- ✓ Look-back period includes observations and behaviors through the end of the day (11:59) of the ARD.
- ✓ Team members should consider the following when selecting the ARD:
  - Reason for the assessment.
  - Compliance with timing and scheduling requirements.
- ✓ MUST adjust ARD to equal the discharge date if resident dies or is discharged prior to end of the look-back period.
- ✓ All sections have to use the same ARD; it cannot be changed after the assessment is completed.
- ✓ May not be extended simply because the resident was out of the facility (LOA, etc.).



106

MEDICARE STAY (A2400)

Complete only if not an Interrupted Stay:

A. Has the resident had a Medicare-stay since the most recent entry?
- **Code 0, No, skip to B0100, Comatose.**
- **Code 1, Yes, continue to A2400B, Start of most recent Medicare stay.**

B. Enter start date of most recent Medicare stay.

C. Enter end date of most recent Medicare stay.
- **Enter dashes ("-") if stay is on-going.**

NOTE: When a resident on Part A has an interrupted stay, this is a continuation of the Part A stay, not a new Medicare Part A stay.

Medicare Stay End Date Algorithm - page A-40

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SECTION B:
HEARING, SPEECH AND VISION
NO CHANGES

108

HEARING, SPEECH, AND VISION (B0100 THROUGH B1200)

- ✓ **B0100, Comatose**
- ✓ **B0200, Hearing**
- ✓ **B0300, Hearing Aid**
- ✓ **B0600, Speech Clarity**
- ✓ **B0700, Makes Self Understood**
- ✓ **B0800, Ability to Understand Others**
- ✓ **B1000, Vision**
- ✓ **B1200, Corrective Lenses**

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SECTION C: COGNITIVE PATTERNS NO CHANGES



110

COGNITIVE PATTERNS (C0100 THROUGH C0500)

- ✓ **C0100, Should Brief Interview for Mental Status be Conducted?**
- ✓ **C0200, Repetition of Three Words (BIMS):**
  - **Number of words repeated after first attempt?**
- ✓ **C0300, Temporal Orientation (BIMS):**
  - **A, Able to report correct year?**
  - **B, Able to report correct month?**
  - **C, Able to report correct day of the week?**
- ✓ **C0400, Recall (BIMS):**
  - **A, Able to recall "sock"?**
  - **B, Able to recall "blue"?**
  - **C, Able to recall "bed"?**
- ✓ **C0500, BIMS Summary Score (00-15).**

111

STOPPING THE INTERVIEW

Stop the interview after C0300C "Day of the Week" if:

- **All responses have been nonsensical, OR**
- **There has been no verbal or written response to any items up to that point, OR**
- **There has been no verbal or written response to some items and nonsensical responses to the other questions.**
- **If interview is stopped:**
  - **Code dash ("-") in C0400A-C.**
  - **Code 99 in C0500.**
  - **Code 1, yes in C0600.**
  - **Complete staff assessment.**

112

BIMS SUMMARY SCORE (C0500)

The total score is calculated by adding values for all questions from C0200-C0400:

- ✓ **Ranges from 00 through 15 and 99.**
- ✓ **Score <= 9 – cognitively impaired for RUG purposes.**
- ✓ **Code 99 (unable to complete interview) if:**
  - **Resident chooses not to participate or gave nonsensical responses, OR**
  - **4 or more items were coded 0 because the resident chose not to answer or gave nonsensical responses, OR**
  - **Any BIMS items is coded with a dash ("-").**

113

COGNITIVE PATTERNS (C0600 THROUGH C0900)

- ✓ **C0600, Should the Staff Assessment for Mental Status be Conducted?**
  - **Code 0, No**
  - **Code 1, Yes**
- ✓ **C0700, Short-term Memory OK:**
  - **Code 0, Memory OK.**
  - **Code 1, Memory problem.**
- ✓ **C0800, Long-term Memory OK:**
  - **Code 0, Memory OK.**
  - **Code 1, Memory problem.**
- ✓ **C0900, Memory/Recall Ability:**
  - **A. Current season.**
  - **B. Location of own room.**
  - **C. Staff names and faces.**
  - **D. That he/she is in a nursing home**
  - **Z. None of the above**

114

COGNITIVE PATTERNS (C1000)

- ✓ **C1000, Cognitive Skills for Daily Decision Making:**
  - **Code 0, Independent**
  - **Code 1, Modified independence**
  - **Code 2, Moderately impaired**
  - **Code 3, Severely impaired**

115

DELIRIUM

- ✓ **Mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness or hallucinations.**
- ✓ **Delirium can be misdiagnosed as dementia.**
- ✓ **A recent deterioration in cognitive function.**
- ✓ **May be reversible if detected and treated timely.**
- ✓ **Planning for care:**
  - **May be symptom of acute, treatable illness.**
  - **Infection or reaction to medications.**
  - **Prompt detection essential.**

116

SIGNS AND SYMPTOMS OF DELIRIUM (C1310)

A. Is there evidence of an acute change in mental status from the resident's baseline?
- **Code 0, No**
- **Code 1, Yes**

B. Inattention

C. Disorganized Thinking

D. Altered Level of Consciousness

Enter code in boxes for C1310B-D:
- **Code 0, Behavior <u>not</u> present.**
- **Code 1, Behavior continuously present, does <u>not</u> fluctuate.**
- **Code 2, Behavior present, fluctuates (comes and goes, changes in severity).**

117

SECTION D:
MOOD
NO CHANGES



118

SHOULD RESIDENT MOOD INTERVIEW BE CONDUCTED? (D0100)

- ✓ **Identify the presence or absence of clinical mood indicators, <u>not</u> to diagnose depression or a mood disorder.**
- ✓ **Determination is made by either a resident interview (PHQ-9©) or by staff assessment (PHQ-9-OV©).**
- ✓ **Attempt to conduct interview with all residents.**

D0100 – Should resident mood interview be conducted?

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

119

RESIDENT MOOD INTERVIEW PHQ-9© (D0200)

- ✓ **Look-back period is <u>14 days.</u>**
- ✓ **There are two parts for each item:**
  - **Symptom presence (column 1).**
  - **Symptom frequency (column 2).**
- ✓ **Conduct interview preferably day before or day of ARD.**
- ✓ **D0100 must = 1 (resident can be interviewed).**
- ✓ **Read each item exactly as it is written.**
- ✓ **The meaning must be based on resident's interpretation.**
- ✓ **Each question must be asked in sequential order:**
  - **Presence followed by frequency.**

120

RESIDENT MOOD INTERVIEW PHQ-9© (D0200A-I)

Code 9 if the resident was unable or chose not to complete the assessment, responded nonsensically and/or the facility was unable to complete the assessment.
Leave Column 2, Symptom Frequency, blank.
Symptom Presence (column 1):

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

Symptom Frequency (column 2):

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

✓ **If resident has difficulty selecting between two frequency responses, code for the higher frequency.**

121

TOTAL SEVERITY SCORE (D0300)

✓ **A summary of the frequency scores that indicates the extent of potential depression symptoms.**
✓ **The score does <u>not</u> diagnose a mood disorder.**
✓ **The interview is successfully completed if resident answered frequency response on 7 or more items.**
✓ **If symptom frequency is blank for 3 or more items:**

- **Interview is <u>not</u> complete.**
- **Total Severity Score is coded 99.**
- **Staff Assessment of Mood should be conducted.**

✓ **Add the numeric scores across all frequency responses from Column 2:**

- **The software will calculate the Total Severity Score.**

✓ **Total Severity Score range (00 through 27 and 99):**

- **Score <u>≥</u> 10 – depressed for RUG purposes.**
- **Enter 99 if unable to complete interview (i.e. Symptom Frequency is blank for 3 or more items).**

122

STAFF ASSESSMENT OF RESIDENT MOOD (PHQ-9-OV©) (D0500A-J)

✓ **Alternate means of assessing mood for residents who cannot communicate or refuse or are unable to participate in PHQ-9© interview.**
✓ **Look-back period is <u>14 days.</u>**
✓ **Use same interview techniques with staff as in PHQ-9© interviews.**
✓ **The staff assessment has one additional item:**

- **J, Being short-tempered, easily annoyed.**

123

TOTAL SEVERITY SCORE (D0600)

- ✓ **The interview is successfully completed if staff members were able to answer the frequency responses of at least 8 or more items.**
- ✓ **Software will calculate the Total Severity Score.**
  - **For detailed instructions on manual calculations and examples, see Appendix E.**
- ✓ **Total Severity Score range (00 through 30):**
  - **Score ≥ 10 – depressed for RUG purposes.**

D0350 THROUGH D0650

- ~~✓ D0350 = Safety Notification~~ **DELETED**
- ~~✓ D0650 = Safety Notification~~ **DELETED**

124

SECTION E: BEHAVIOR NO CHANGES



125

BEHAVIOR (E0100 THROUGH E0500)

- ✓ **E0100, Potential Indicators of Psychosis:**
  - **A. Hallucinations.**
  - **B. Delusions.**
- ✓ **E0200, Behavioral Symptoms-Presence & Frequency:**
  - **A. Physical behavior symptoms directed towards others.**
  - **B. Verbal behavior symptoms directed towards others.**
  - **C. Other behavior symptoms not directed towards others.**
- ✓ **E0300, Overall Presence of Behavioral Symptoms.**
- ✓ **E0500, Impact on Resident:**
  - **A. Put the resident at risk for physical illness or injury?**
  - **B. Significantly interfere with the resident's care?**
  - **C. Significantly interfere with the resident's participation in activities or social interaction?**

126

BEHAVIOR (E0600 THROUGH E1100)

- ✓ **E0600, Impact on Others:**
  - **A. Put others at significant risk for physical injury?**
  - **B. Significantly intrude on the privacy or activity of others?**
  - **C. Significantly disrupt care or living environment?**
- ✓ **E0800, Rejection of care – Presence & Frequency.**
- ✓ **E0900, Wandering - Presence & Frequency.**
- ✓ **E1000, Wandering – Impact:**
  - **A. Does the wandering place the resident at significant risk of getting to a potentially dangerous place?**
  - **B. Does the wandering significantly intrude on the privacy of others?**
- ✓ **E1100, Change in Behavior or Other Symptoms.**

127

SECTION F: PREFERENCE FOR CUSTOMARY ROUTINE & ACTIVITIES NO CHANGES



128

PREFERENCE FOR CUSTOMARY ROUTINE & ACTIVITIES (F0300 THROUGH F0800)

- ✓ **F0300, Should Interview for Daily and Activity Preferences be Conducted?**
- ✓ **F0400, Interview for Daily Preferences.**
- ✓ **F0500, Interview for Activity Preferences.**
- ✓ **F0600, Daily and Activity Preferences Primary Respondent.**
- ✓ **F0700, Should the Staff Assessment of Daily and Activity Preferences be Conducted?**
- ✓ **F0800, Staff Assessment of Daily and Activity Preferences.**

129

SECTION G: FUNCTIONAL STATUS NO CHANGES



130

ACTIVITIES OF DAILY LIVING (ADL) (G0110) DEFINITIONS

A. **Bed Mobility: how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture.**
B. **Transfer: how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet).**
C. **Walk in Room: how resident walks between locations in room.**
D. **Walk in Corridor: how resident walks in corridor on unit.**
E. **Locomotion on Unit: how resident moves between locations in room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair.**

131

ACTIVITIES OF DAILY LIVING (ADL) (G0110) DEFINITIONS CONT.

F. **Locomotion off Unit: how resident moves to and returns from off-unit locations. If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self- sufficiency once in chair.**
G. **Dressing: how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Includes putting on and changing pajamas and housedresses.**
H. **Eating: how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means.**

132

ACTIVITIES OF DAILY LIVING (ADL) (G0110) DEFINITIONS CONT.

I. **Toilet Use: how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag.**

J. **Personal Hygiene: how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers).**

133

ACTIVITIES OF DAILY LIVING (ADL) ASSISTANCE (G0110)

This section involves a two-part ADL evaluation:

- **Self-Performance (column 1), measures how much of the ADL the resident can do for self according to a performance scale.**
- **Support-Provided (column 2), measures the most support provided for the resident to complete the ADL even if that level of support only occurred once.**
- **Each section uses its own scale.**
- **Recommend the Self-Performance evaluation be completed for all ADL activities before beginning the Support evaluation.**

134

ACTIVITIES OF DAILY LIVING (ADL) ASSISTANCE (G0110)

Coding instructions:

- ✓ **Consider all episodes of the activity that occur over a 24-hour period during each day of the 7-day look-back period.**
- ✓ **Self-performance and support required may vary from day to day, shift to shift, or within shifts.**
- ✓ **"Facility staff" pertains to direct employees and facility-contracted employees;**
  - **Rehabilitation staff.**
  - **Nursing agency.**
- ✓ **Does not include individuals hired, compensated or not, by individuals outside the facility's management and administration.**

135

ADL SELF-PERFORMANCE CODING (G0110 COLUMN 1)

Activity Occurred 3 or More Times:

- **Code 0, Independent, no help or staff oversight at any time.**
- **Code 1, Supervision, oversight, encouragement or cueing.**
- **Code 2, Limited assistance:**
  - **Resident highly involved in activity.**
  - **Staff provide guided maneuvering of limb(s) or other non-weight-bearing assistance:**
    - **Guided maneuvering vs. weight-bearing is determined by who is supporting the weight of the resident's extremity or body.**

136

ADL SELF-PERFORMANCE CODING (G0110 COLUMN 1)

Activity Occurred 3 or More Times:

- **Code 3, Extensive assistance:**
  - **Resident involved in activity.**
  - **Staff provide weight-bearing support.**
- **Code 4, Total dependence:**
  - **Full staff performance every time during entire 7-day period.**

137

ADL SELF-PERFORMANCE CODING (G0110 COLUMN 1)

Activity Occurred 2 or Fewer Times:

- **Code 7, Activity occurred only once or twice.**
- **Code 8, Activity did not occur:**
  - **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.**

138

ACTIVITIES OF DAILY LIVING (G0110)
RULE OF 3



INSTRUCTIONS FOR ADL SELF-PERFORMANCE CODING LEVEL EXCEPTIONS FOR THE RULE OF 3

Exceptions to the Rule of 3:

- **Code 0, Independent, no help or oversight every time and the activity occurred at least three times.**
- **Code 4, Total dependence, full staff performance every time and the activity occurred three or more times.**
- **Code 7, Activity occurred only once or twice, occurred fewer than three times.**
- **Code 8, Activity did not occur or family and/or non-facility staff provided care 100% of the time.**

140

INSTRUCTIONS FOR ADL SELF-PERFORMANCE CODING LEVEL FOR THE RULE OF 3

- ✓ **Apply the steps of the Rule of 3 keeping the ADL coding level definitions and the exceptions in mind.**
- ✓ **These steps must be used in sequential order.**
- ✓ **Apply the first instruction that meets the coding scenario.**

Rule of 3:

1. **When 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.**

141

INSTRUCTIONS FOR THE RULE OF 3

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, as long as the full staff performance episodes did not occur every time the ADL was performed.
      - ✓ It is only when every episode is full staff performance that Total dependence (4) can be coded.

142

INSTRUCTIONS FOR THE RULE OF 3

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) 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).

143

INSTRUCTIONS FOR THE RULE OF 3

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:
   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 (1).

144

ADL SELF-PERFORMANCE SAMPLE EXERCISES

- EXAMPLE #1

0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	3	3	0	2	2	0

Code of Applicable Rule of 3

146

- EXAMPLE #2

4		1		0		2
2					0	
	1			3		

Code of Applicable Rule of 3

147

- EXAMPLE #3

4	8	4	4	8	8	4
0	0	0	0	0	0	0
2	2	2	0	3	2	0

Code of

Applicable Rule of 3

148

- EXAMPLE #4

3	0	1	2	0	0	2
0	4	0	0	1	0	4
0	0	0	0	3	0	0

Code of

Applicable Rule of 3

149

- EXAMPLE #5

0	4	2	2	0	2	2
1	3	4	1	1	3	1
1	2	0	1	2	0	0

Code of

Applicable Rule of 3

150

EXAMPLE #6

4	8	8	2	8	8	8
8	3	2	0	1	0	4
8	8	3	8	8	1	8

Code of
Applicable Rule of 3

151

EXAMPLE #7

3	0	0	0	0	0	2
0	0	8	0	2	0	0
8	8	8	8	8	8	8

Code of
Applicable Rule of 3

152

EXAMPLE #8

8	8	8	8	8	8	8
0	0	0	0	0	0	0
8	0	2	4	2	0	8

Code of
Applicable Rule of 3

153

TOILETING EXAMPLE #9

2/10/19	2/11/19	2/12/19	2/13/19	2/14/19	2/15/19	2/16/19
4 . 2	NA . NA	NA . NA	NA . NA	NA . NA	NA . NA	NA . NA
03:30	05:59	02:10	04:15	02:22	03:51	02:22
4 . 2	4 . 2			NA . NA	3 . 2	4 . 2
16:59	16:25			18:27	11:12	14:40
						4 . 2
						23:03

Code of Applicable Rule of 3

154

ADL SUPPORT PROVIDED GUIDELINES (G0110 COLUMN 2)

✓ **Code the <u>most support</u> provided over all shifts even if it occurred only once, regardless of self-performance code.**

Code regardless of self-performance codes:

- **Code 0, No setup or physical help from staff.**
- **Code 1, Setup help only.**
- **Code 2, One person physical assist.**
- **Code 3, Two + person physical assist.**
- **Code 8, ADL activity itself did <u>not</u> occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period.**

155

G0120 THROUGH G0400 NO CHANGES

✓ **G0120, Bathing**

✓ **G0300, Balance During Transitions and Walking:**

A. **Moving from seated to standing position.**
B. **Walking (with assistive device if used).**
C. **Turning around and facing opposite direction while walking.**
D. **Moving on and off toilet.**
E. **Surface-to-surface transfer (between bed and chair or w/c).**

✓ **G0400, Functional Limitation in Range of Motion:**

A. **Upper extremity (shoulder, elbow, wrist, hand).**
B. **Lower extremity (hip, knee, ankle, foot).**

156

G0600 THROUGH G0900 NO CHANGES

✓ **G0600, Mobility Devices:**

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

✓ **G0900, Functional Rehabilitation Potential:**

A. Resident believes he or she is capable of increased independence in at least some ADLs.
B. Direct care staff believes he or she is capable of increased independence in at least some ADLs.

157

SECTION GG:
FUNCTIONAL ABILITIES AND GOALS


SECTION GG: INTENT

- **Includes items about functional abilities and goals.**
- **Items focus on prior function, admission performance, discharge goals, and discharge performance.**

159

GG0100 PRIOR FUNCTIONING: EVERYDAY ACTIVITIES (GG0100)

- ✓ **Complete only if PPS 5-day assessment:**
  1. **Ask the resident or his or her family about his or her prior functioning with everyday activities.**
  2. **Review the resident's medical records describing the resident's prior functioning with everyday activities.**
     - **A. Self-care: Code the need for assistance with bathing, dressing, toileting, or eating prior to current illness.**
     - **B. Indoor Mobility (Ambulate): Code the need for assistance with walking from room to room (with or without device) prior to current illness.**
     - **C. Stairs: Code the need for assistance with internal or external stairs (with or without device) prior to current illness.**
     - **D. Functional Cognition: Code the need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to illness.**

160

GG0100 PRIOR FUNCTIONING: EVERYDAY ACTIVITIES (GG0100)

Coding Options:

Code 3, Independent – resident completed the activities by self, with or without an assistive device, with no assistance from a helper.

Code 2, Needed Some Help – resident needed partial assistance from another person to complete activities.

Code 1, Dependent – a helper completed the activities for the resident.

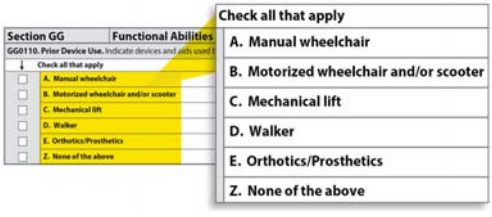
Code 8, Unknown.

Code 9, Not Applicable.

161

PRIOR DEVICE USE (GG0110)

- ✓ **Indicate devices and aids used by the resident prior to the current illness, exacerbation, or injury.**
- ✓ **Complete only if A0310B = 01**



162

GENERAL CODING TIP (GG0130)

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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163

CODING TIPS (GG0130)

- ✓ **Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance during the assessment period.**
- ✓ **Do not record the staff's assessment of the resident's potential capability to perform the activity.**
- ✓ **If two or more helpers are required to assist the resident to complete the activity, code as 01, Dependent.**

164

CODING TIPS (GG0130)

- ✓ **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.**
- ✓ **To clarify your own understanding of the resident's performance of an activity, ask probing questions to staff about the resident, beginning with the general and proceeding to the more specific.**

165

SELF-CARE (3-DAY ASSESSMENT PERIOD) ADMISSION/INTERIM (START/INTERIM/END OF PART A STAY) (GG0130)

- ✓ **Code the resident's usual performance at the start of the SNF PPS stay (admission).**
- ✓ **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.**
- ✓ **Use of codes 07, 09, 10, or 88 is permissible to code end of SNF PPS stay (discharge) goal's.**
- ✓ **For the Interim Payment Assessment (A0310B=08), the assessment period for Section GG is the last 3 days (ARD plus two days prior).**

166

SELF-CARE (3-DAY ASSESSMENT PERIOD) ADMISSION (START/END OF PART A STAY) (GG0130)

Admission:

- **The 5-day PPS assessment is the first Medicare required assessment to be completed when the stay is a SNF Part A.**
- **The functional status/assessment should be based on a clinical assessment and completed within the first three days of the Medicare Part A stay.**
- **The admission function scores reflect the resident's admission baseline status prior to any interventions.**
- **Even if treatment started on the day of admission, a baseline functional status can be conducted.**
- **Treatment should not be withheld in order to conduct the functional assessment.**

167

SELF-CARE (3-DAY ASSESSMENT PERIOD) ADMISSION/INTERIM/DISCHARGE

Performance Coding:

- **Code 06, Independent: resident completes activity by self with no assistance from helper.**
- **Code 05, Setup or clean-up assistance: helper sets up or cleans up; resident completes activity. Helper assists only prior to or following activity.**
- **Code 04, Supervision or touch assistance: helper provides verbal cues or touching/steading/contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.**
- **Code 03, Partial/moderate assistance: helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs.**

168

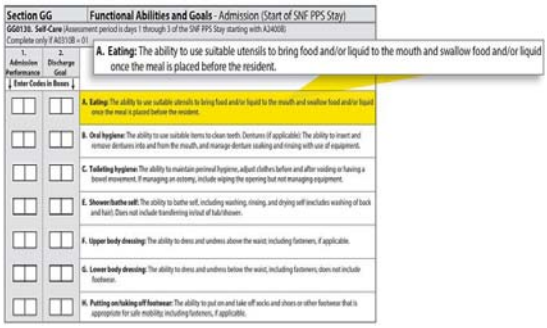
SELF-CARE (3-DAY ASSESSMENT PERIOD) ADMISSION/INTERIM/DISCHARGE

Performance Coding cont.:

- **Code 02, Substantial/maximal assistance: helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs.**
- **Code 01, Dependent: helper does ALL of the effort. Resident does none of the effort to complete activity: or the assistance of two or more helpers is required.**
- **Code 07, Resident refused: resident refused to complete activity.**
- **Code 09, Not applicable: activity was not attempted and resident did not perform activity prior to the current illness or injury.**
- **Code 10, Not attempted due to environmental limitations: activity was not attempted due to environmental limitations.**
- **Code 88, Not attempted due to medical condition or safety concerns: activity was not attempted due to medical condition or safety concerns.**

169

EATING (GG0130A)



170

EATING (GG0130A)

- **Definition of Eating:**
  - ✓ **The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.**
  - ✓ **Tube feedings and parenteral nutrition are not considered when coding this activity.**

171

CODING TIPS (EATING - GG0130A)

- **Eating:**
  - ✓ **Assesses eating and drinking by mouth only:**
    - **If the resident eats and drinks by mouth and relies partially on obtaining nutrition and liquids via tube feedings or total parenteral nutrition (TPN), code the Eating item based on the amount of assistance the resident requires to eat and drink by mouth.**
    - **Assistance with tube feedings or TPN is <u>not</u> considered when coding the Eating item.**
    - **If the resident eats finger foods with his or her hands, code based upon the amount of assistance provided.**

172

PRACTICE CODING SCENARIO (GG0130A)

- **Eating scenario:**
  - ✓ **The dietary aide opens all of Mr. S' cartons and containers on his food tray before leaving the room. There are no safety concerns regarding Mr. S' ability to eat. Mr. S eats the food himself, bringing the food to his mouth, using appropriate utensils, and swallowing the food safely.**
- **How would you code GG0130A, Eating? What is your rationale?**

173

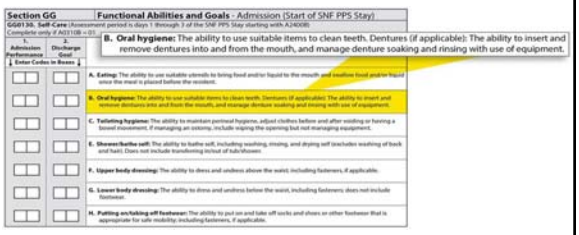
HOW WOULD YOU CODE GG0130A?

A. **Code 03, Partial/moderate assistance**
B. **Code 04, Supervision or touching assistance**
C. **Code 05, Setup or clean-up assistance**
D. **Code 88, Not attempted due to medical condition or safety concerns**

<u>Rationale</u>:

174

ORAL HYGIENE (GG0130B)



- **Definition of Oral hygiene:**
  - ✓ **The ability to use suitable items to clean teeth.**
    - **Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.**

175

GG0130B PRACTICE CODING SCENARIO

- **Oral hygiene scenario:**
  - ✓ **Ms. K suffered a stroke a few months ago that resulted in cognitive limitations. She brushes her teeth at the sink, but is unable to initiate the task on her own. The occupational therapist cues Ms. K to put the toothpaste onto the toothbrush, brush all areas of her teeth, and rinse her mouth after brushing. The occupational therapist remains with Ms. K providing verbal cues until she has completed the task of brushing her teeth.**
- **How would you code GG0130B, Oral hygiene? What is your rationale?**

HOW WOULD YOU CODE GG0130B?

A. **Code 05, Setup or clean-up**
B. **Code 04, Supervision or touching assistance**
C. **Code 03, Partial/moderate assistance**
D. **Code 02, Substantial/maximal assistance**

Rationale:

177

TOILETING HYGIENE (GG0130C)

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	
1. Admission Performance / Enter Codes in Boxes	2. Discharge Goal / Enter Codes in Boxes
☐☐	☐☐
☐☐	☐☐
☐☐	☐☐
☐☐	☐☐
☐☐	☐☐
☐☐	☐☐
☐☐	☐☐

C. Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

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

B. **Oral hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment.

C. **Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

E. **Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (includes washing of back and hair). Does not include transferring in/out of tub/shower.

F. **Upper body dressing:** The ability to dress and undress above the waist, including fasteners, if applicable.

G. **Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.

H. **Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

178

TOILETING HYGIENE (GG0130C)

- **Definition of Toileting Hygiene:**
  - ✓ **The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.**

179

CODING TIPS (GG0130C)

- **Toileting hygiene:**
  - ✓ **Includes managing undergarments, clothing, and incontinence products, and performing perineal cleansing before and after voiding or having a bowel movement.**
  - ✓ **Takes place before and after use of the toilet, commode, bedpan, or urinal.**
- **If the resident does <u>not</u> usually use undergarments, then assess the resident's need for assistance to manage lower- body clothing and perineal hygiene.**
- **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 when moving bowels.**

180

PRACTICE CODING SCENARIO GG0130C

- **Toileting hygiene scenario:**
  - ✓ **Ms. Q has a progressive neurological disease that affects her fine and gross motor coordination, balance, and activity tolerance. She wears a gown and underwear during the day. Ms. Q uses a bedside commode as she steadies herself in standing with one hand and initiates pulling down her underwear with the other hand, but needs assistance to complete this activity due to her coordination impairment. After voiding, Ms. Q wipes her perineal area without assistance while sitting on the commode. When Ms. Q has a bowel movement, a certified nursing assistant performs perineal hygiene as Ms. Q needs to steady herself with both hands to stand for this activity. Ms. Q is usually too fatigued at this point and requires full assistance to pull up her underwear.**
- **How would you code GG0130C, Toileting hygiene?**
- **What is your rationale?**

181

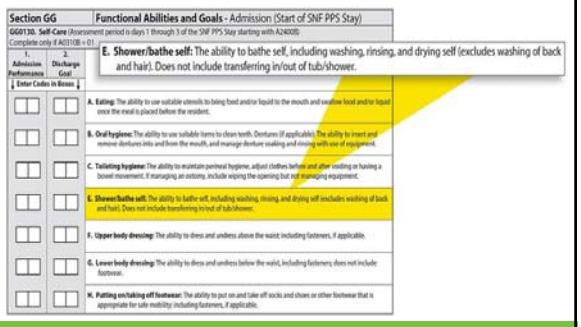
HOW WOULD YOU CODE GG0130C?

A. Code 04, Supervision or touching assistance
B. Code 03, Partial/moderate assistance
C. Code 02, Substantial/maximal assistance
D. Code 01, Dependent

Rationale:

182

SHOWER/BATHE SELF (GG0130E)



183

SHOWER/BATHE SELF (GG0130E)

- **Definition of Shower/bathe self:**
  - ✓ **The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.**

184

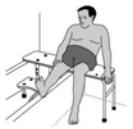
CODING TIPS (GG0130E)

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

185

PRACTICE CODING SCENARIO GG0130E

- **Shower/bathe self scenario:**
  - ✓ **Mr. J sits on a tub bench as he washes, rinses, and dries himself. A certified nursing assistant stays with him to ensure his safety, as Mr. J has had instances of losing his sitting balance. The certified nursing assistant also provides lifting assistance as Mr. J gets onto and off of the tub bench.**
- **How would you code G0130E, Shower/bathe self? What is your rationale?**



186

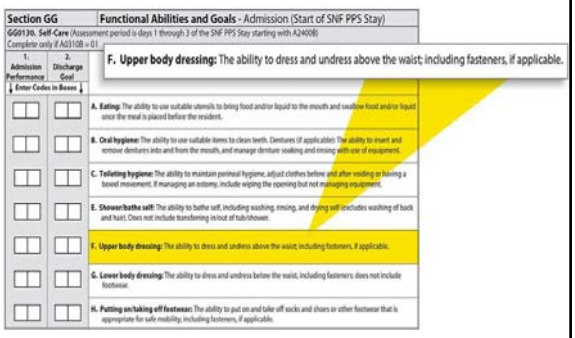
HOW WOULD YOU CODE GG0130E?

A. **Code 04, Supervision or touching assistance**
B. **Code 03, Partial/moderate assistance**
C. **Code 02, Substantial/maximal assistance**
D. **Code 01, Dependent**

Rationale:

187

UPPER BODY DRESSING (GG0130F)



188

UPPER BODY DRESSING (GG0130F)

- **Definition of Upper body dressing:**

✓ **The ability to dress and undress above the waist; including fasteners, if applicable:**

- **Includes bra, undershirt, T-shirt, button-down shirt, pullover shirt, dresses, sweatshirt, nightgown, sweater, pajama top, thoracic-lumbar-sacrum orthosis, abdominal binder, back brace, etc.**
- **Upper body dressing <u>cannot</u> be assessed based solely on donning/doffing a hospital gown.**
- **If the resident dresses him/herself and a helper retrieves or puts away the clothing, then code 05, Set-up or clean-up assistance.**
- **Helper assistance with buttons and/or fasteners is considered touching assistance.**

189

PRACTICE CODING SCENARIO GG0130F

Upper body dressing scenario:

- **Mr. K sustained a spinal cord injury that has affected both movement and strength in both upper extremities. He places his left hand into one-third of his left sleeve of his shirt with much time and effort and is unable to continue with the activity. A certified nursing assistant then completes the remaining upper body dressing for Mr. K.**
- **How would you code GG0130F, Upper body dressing? What is your rationale?**

190

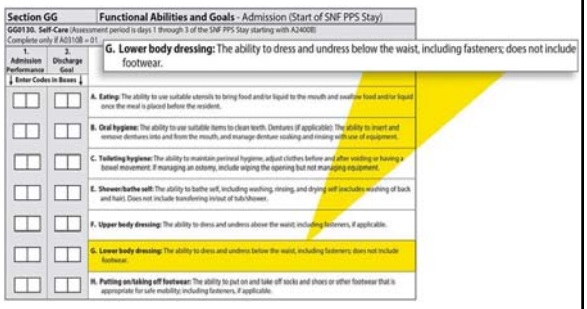
HOW WOULD YOU CODE GG0130F?

A. Code 04, Supervision or touching assistance
B. Code 03, Partial/moderate assistance
C. Code 02, Substantial/maximal assistance
D. Code 01, Dependent

Rationale:

191

LOWER BODY DRESSING (GG0130G)



192

LOWER BODY DRESSING (GG0130G)

- **Definition of Lower body dressing:**
- ✓ **The ability to dress and undress below the waist; including fasteners, does <u>not</u> include footwear:**
  - **Helper assistance with buttons and/or fasteners is considered touching assistance.**
  - **Lower body dressing include underwear, incontinence brief, slacks, shorts, capri pants, pajama bottoms, skirts.**
  - **Lower body examples: knee brace, elastic bandage, stump sock/shrinker, lower-limb prosthesis.**

193

PRACTICE CODING SCENARIO GG0130G

- **Lower body dressing scenario:**
  - ✓ **Mrs. R has peripheral neuropathy in her upper and lower extremities. Each morning, Mrs. R needs assistance from a helper to place her lower limb into, or to take it out of (don/doff), her lower limb prosthesis. She needs no assistance to put on and remove her underwear or slacks.**
- **How would you code GG0130G, Lower body dressing? What is your rationale?**

194

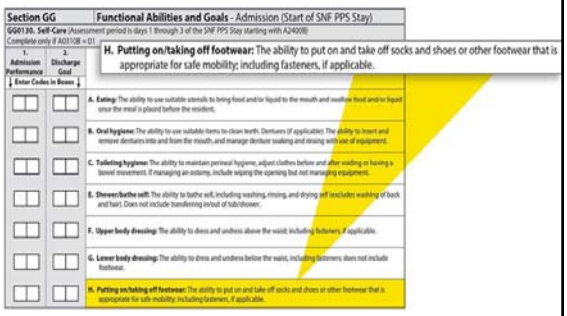
HOW WOULD YOU CODE GG0130G?

A. Code 05, Setup or clean-up assistance
B. Code 04, Supervision or touching assistance
C. Code 03, Partial/moderate assistance
D. Code 02, Substantial/maximal assistance

<u>Rationale</u>:

195

PUTTING ON/TAKING OFF FOOTWEAR (GG0130H)



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

H. **Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

196

PUTTING ON/TAKING OFF FOOTWEAR (GG0130H)

- **Definition of Putting on/taking off footwear:**
  - **The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.**
  - **Footwear examples: ankle-foot orthosis (AFO), elastic bandages, foot orthotics, orthopedic walking boots, compression stockings.**
  - **Footwear includes socks, shoes, boots, and running shoes.**

197

PRACTICE CODING SCENARIO GG0130H

Putting on/taking off footwear scenario:

- **Mr. M is undergoing rehabilitation for right-side upper and lower body weakness following a stroke. He has made significant progress toward his independence and will be discharged to home tomorrow. Mr. M wears an ankle-foot orthosis (AFO) that he puts on his foot and ankle after he puts on his socks but before he puts on his shoes. He always places his AFO, socks, and shoes within easy reach of his bed. While sitting on the bed, he needs to bend over to put on and take off his AFO, socks, and shoes, and he occasionally loses his sitting balance, requiring staff to place their hands on him to maintain his balance while performing this task.**
- **How would you code GG0130H, Putting on/taking off footwear? What is your rationale?**

198

HOW WOULD YOU CODE GG0130H?

A. Code 05, Setup or clean-up assistance
B. Code 04, Supervision or touching assistance
C. Code 03, Partial/moderate assistance
D. Code 02, Substantial/maximal assistance

Rationale:

199

SELF-CARE (3-DAY ASSESSMENT PERIOD) INTERIM (GG0130) (NEW)

Interim Performance (IPA) (Optional):

- **Optional assessment may be completed to report a change in the PDPM classification.**
- **Will capture the interim functional performance.**
- **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.**

200

SELF-CARE (3-DAY ASSESSMENT PERIOD) INTERIM PERFORMANCE (INTERIM PAYMENT ASSESSMENT OPTIONAL) (GG0130) (NEW)

A. Eating (refer to slides 170 slide through 172)
B. Oral Hygiene (refer to slide 175)
C. Toileting Hygiene (refer to slides 178 through 180)

201

SELF-CARE (3-DAY ASSESSMENT PERIOD) DISCHARGE (END OF PART A STAY) (GG0130)

Discharge:

- **The Part A PPS Discharge is required when:**
  - **Part A ends and remains in the facility, OR**
  - **Part A ends and the resident is physically discharged on the day of, or one day before the discharge.**
  - **Code the resident's discharge functional status that occurs as close to the time of discharge from Part A as possible.**
  - **Must be completed within the last three calendar days of the Part A stay, which includes the day of discharge from Part A and the two days prior to the discharge.**

202

SELF-CARE (3-DAY ASSESSMENT PERIOD) DISCHARGE (END OF PART A STAY) (GG0130)

A. Eating
B. Oral Hygiene
C. Toileting Hygiene
E. Shower / Bathe Self
F. Upper Body Dressing
G. Lower Body Dressing
H. Putting on/Taking Off Footwear

NO CHANGES

(Refer to slides 170 through 199)

203

SELF-CARE (3-DAY ASSESSMENT PERIOD) DISCHARGE (END OF MEDICARE PART A STAY) (GG0130)

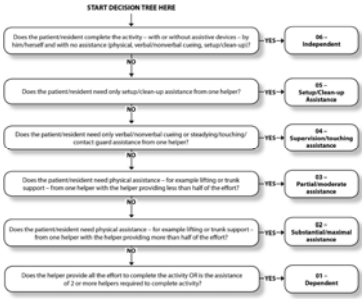
✓ **Coding: No change (refer to slides 168 through 169)**
- **06, Independent**
- **05, Setup or clean-up**
- **04, Supervision or touching assistance**
- **03, Partial/moderate assistance**
- **02, Substantial/maximal assistance**
- **01, Dependent**
- **07, Resident refused**
- **09, No applicable**
- **10, Not attempted due to environmental limitation**
- **88, Not attempted due to medical condition or safety concerns**

204

SELF-CARE (3-DAY ASSESSMENT PERIOD) ADMISSION/INTERIM/DISCHARGE (START/INTERIM/END OF PART A STAY) (GG0130)

Decision Tree

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



205

SELF-CARE DISCHARGE GOAL (GG0130)

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

206

DISCHARGE GOAL: CODING TIPS (GG0130)

- ✓ **Use the six-point scale or "activity was not attempted" codes to code the resident's Discharge Goal(s). Use of codes 07, 09, 10, or 88 is permissible to code discharge goal(s).**
- ✓ **For the SNF QRP, a minimum of one self-care or mobility goal must be coded. However, facilities may choose to complete more than one self-care or mobility discharge goal.**
- ✓ **Use of a dash (–) is permissible for any remaining self-care or mobility goals that were not coded.**
  - **Using the dash in this allowed instance after the coding of at least one goal does not affect Annual Payment Update (APU) determination.**

207

DISCHARGE GOALS: (GG0130)

- **Discharge Goal Code Is Higher Than 5-Day PPS Admission Assessment Performance Code:**
  - **If the clinician and resident determine that the resident is expected to make gains in function by discharge.**
- **Discharge Goal Code Is the Same as 5-Day PPS Admission Assessment Performance Code:**
  - **If the clinician and resident determine that the resident is expected to maintain function and is not anticipated to progress to a higher level of functioning for an activity.**

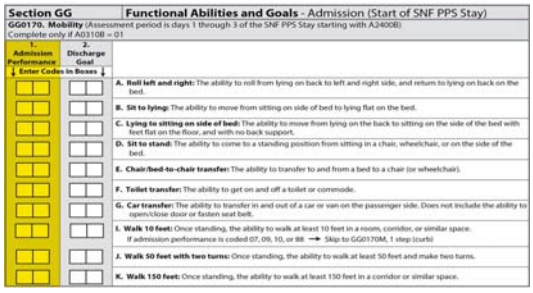
208

DISCHARGE GOALS: (GG0130)

- **Discharge Goal Code Is Lower Than 5-Day PPS Assessment Admission Performance Code:**
  - **The clinician determines that a resident with a progressive condition is expected to rapidly decline and that receiving skilled therapy services may slow the decline of function.**

209

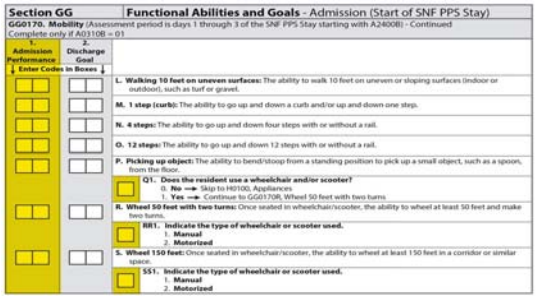
MOBILITY (3-DAY ASSESSMENT PERIOD) ADMISSION (START OF MEDICARE PART A STAY) (GG0170)



Section GG	Functional Abilities and Goals - Admission (Start of SNF PPS Stay)	
GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B) Complete only if A0310B = 01		
1. Admission Performance Enter Codes in Boxes	2. Discharge Goal	
		A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
		B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.
		C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
		D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
		E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).
		F. Toilet transfer: The ability to get on and off a toilet or commode.
		G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
		I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
		J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.
		K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.

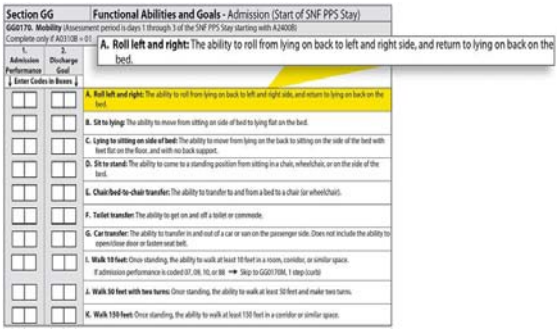
210

MOBILITY (3-DAY ASSESSMENT PERIOD) ADMISSION (START OF MEDICARE PART A STAY) (GG0170)



211

ROLL LEFT AND RIGHT (GG0170A)



212

ROLL LEFT AND RIGHT (GG0170A)

- **Definition of Roll left and right:**
  - **The ability to roll from lying on back to left and right side, and return to lying on back on the bed.**

Roll left and right scenario:
Mr. Z had a stroke that resulted in paralysis on his right side and is recovering from cardiac surgery. He requires the assistance of two certified nursing assistants when rolling onto his right side and returning to lying on his back and also when rolling onto his left side and returning to lying on his back.

- **How would you code GG0170A, Roll left and right? What is your rationale?**

213

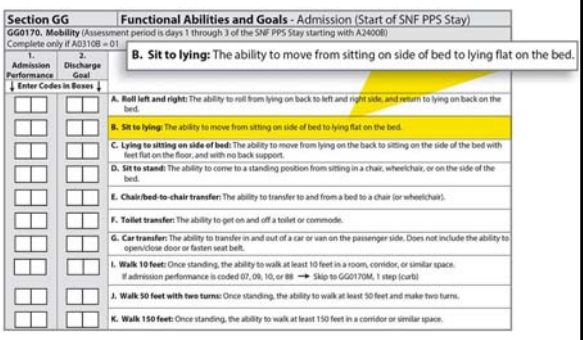
HOW WOULD YOU CODE GG0170A?

A. **Code 01, Dependent**
B. **Code 04, Supervision and touching assistance**
C. **Code 09, Not applicable, not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury**
D. **Code 88, Not attempted due to medical condition or safety concerns**

Rationale:

214

SIT TO LYING (GG0170B)



Section GG	Functional Abilities and Goals - Admission (Start of SNF PPS Stay)	
GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)		
Complete only if A0310B = 01		
↓ Enter Codes in Boxes ↓	1. Admission Performance	2. Discharge Goal
		A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
		B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
		C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
		D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
		E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
		F. **Toilet transfer:** The ability to get on and off a toilet or commode.
		G. **Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
		I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
		J. **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
		K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

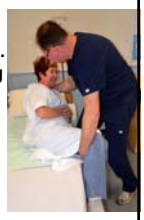
B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.

215

GG0170B PRACTICE CODING SCENARIO

- **Definition of Sit to lying:**
  - **The ability to move from sitting on side of bed to lying flat on the bed.**

Sit to lying scenario:
Mr. F had a stroke about 2 weeks ago and is unable to sequence the necessary movements to complete an activity (apraxia). He can maneuver himself when transitioning from sitting on the side of the bed to lying flat on the bed if the certified nursing assistant provides verbal instructions as to the steps needed to complete this task.



- **How would you code GG0170B, Sit to lying? What is your rationale?**

216

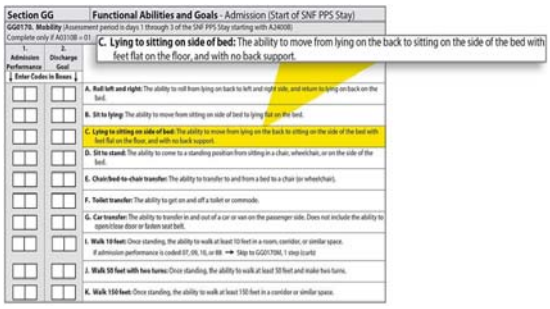
HOW WOULD YOU CODE GG0170B?

A. **Code 05, Setup or clean-up assistance**
B. **Code 04, Supervision or touching assistance**
C. **Code 03, Partial/moderate assistance**
D. **Code 02, Substantial/maximal assistance**

Rationale:

217

LYING TO SITTING ON SIDE OF BED (GG0170C)



218

CODING TIPS (GG0170C)

- ✓ **Clinical judgment should be used to determine what is considered a "lying" position for a particular resident.**
- ✓ **If the resident's feet do not reach the floor upon lying to sitting, the clinician will determine if a bed height adjustment or a footstool is required.**
- ✓ **Back support refers to an object or person providing support for the resident's back.**
- ✓ **If bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, then code the activities GG0170A, Roll left and right; GG0170B, Sit to lying; and GG0170C, Lying to sitting on side of bed as 88, Not attempted due to medical condition or safety concern.**

219

GG0170C PRACTICE CODING SCENARIO

Lying to sitting on side of bed scenario:

- ✓ **Ms. P is being treated for sepsis and has multiple infected wounds on her lower extremities. Full assistance from the certified nursing assistant is needed to move Ms. P from a lying position to sitting on the side of her bed because she usually has pain in her lower extremities upon movement.**

- **How would you code GG0170C, Lying to sitting on side of bed? What is your rationale?**

220

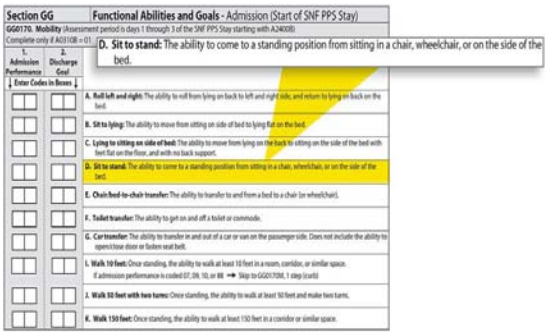
HOW WOULD YOU CODE GG0170C?

A. Code 04, Supervision or touching assistance
B. Code 03, Partial/moderate assistance
C. Code 02, Substantial/maximal assistance
D. Code 01, Dependent

Rationale:

221

SIT TO STAND (GG0170D)



222

GG0170D PRACTICE CODING SCENARIO

- **Definition of Sit to stand:**
  - ✓ **The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed:**
  - ✓ **If a mechanical lift is used and two helpers are needed, then code 01, Dependent.**

Sit to stand scenario:

- ✓ **Ms. R has severe rheumatoid arthritis and uses forearm crutches to ambulate. The certified nursing assistant brings Ms. R her crutches and helps her to stand at the side of the bed. The certified nursing assistant provides some lifting assistance to get Ms. R to a standing position but provides less than half the effort to complete the activity.**

- **How would you code GG0170D, Sit to stand? What is your rationale?**

223

HOW WOULD YOU CODE GG0170D?

A. Code 03, Partial/moderate assistance
B. Code 02, Substantial/maximal assistance
C. Code 01, Dependent
D. Code 88, Not attempted due to medical condition or safety concerns

***Rationale*:**

224

CHAIR/BED-TO-CHAIR TRANSFER (GG0170E)

Section GG	Functional Abilities and Goals - Admission (Start of SNF PPS Stay)	
GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B)		
Complete only if A0310B = 01		
	1. Admission Performance ↓ Enter Codes in Boxes ↓	2. Discharge Goal
A. Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.		
B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.		
C. Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.		
D. Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.		
E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).		
F. Toilet transfer: The ability to get on and off a toilet or commode.		
G. Car transfer: The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.		
I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)		
J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.		
K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.		

E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).

225

CODING TIPS (GG0170E)

- **Definition of Chair/bed to chair transfer:**
  - ✓ **The ability to transfer to and from a bed to a chair (or wheelchair):**
- **Chair/bed-to-chair transfer begins with the resident sitting in a chair or wheelchair or sitting upright at the edge of the bed and returning to sitting in a chair or wheelchair or sitting upright at the edge of the bed.**

- **If a mechanical lift is used to assist in transferring a resident for a chair/bed-to-chair transfer and two helpers are needed to assist with the mechanical lift transfer, then code as *01, Dependent*, even if the resident assists with any part of the chair/bed-to-chair transfer.**

226

GG0170E PRACTICE CODING SCENARIO

Chair/bed-to-chair transfer scenario:

- ✓ **Mr. U had his left lower leg amputated because of gangrene associated with his diabetes mellitus, and he has reduced sensation and strength in his right leg. He has not yet received his below-the-knee prosthesis. Mr. U uses a transfer board for chair/bed-to-chair transfers. The therapist places the transfer board under his buttock. Mr. U then attempts to scoot from the bed onto the transfer board. Mr. U has reduced sensation in his hands and limited upper body strength. The physical therapist assists him in side scooting by lifting his trunk in a rocking motion as Mr. U scoots across the transfer board and into the wheelchair. Overall, the therapist provides more than half of the effort.**

- **How would you code GG0170E, Chair/bed-to-chair transfer? What is your rationale?**

227

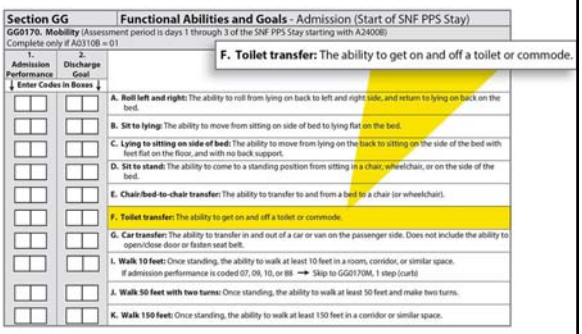
HOW WOULD YOU CODE GG0170E?

A. Code 04, Supervision or touching assistance
B. Code 03, Partial/moderate assistance
C. Code 02, Substantial/maximal assistance
D. Code 01, Dependent

***Rationale*:**

228

TOILET TRANSFER (GG0170F)



Section GG	Functional Abilities and Goals - Admission (Start of SNF PPS Stay)	
GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B) Complete only if A0310B = 01		
1. Admission Performance ↓ Enter Codes in Boxes ↓	2. Discharge Goal	
		A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
		B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
		C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
		D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
		E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
		F. **Toilet transfer:** The ability to get on and off a toilet or commode.
		G. **Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
		I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
		J. **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
		K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

F. Toilet transfer: The ability to get on and off a toilet or commode.

229

GG0170F PRACTICE CODING SCENARIO

- **Definition of Toilet transfer:**
  - ✓ **The ability to get on and off a toilet or commode:**

Toilet transfer scenario:

- ✓ **Mr. H has paraplegia incomplete, pneumonia, and a chronic respiratory condition. Mr. H prefers to use the bedside commode when moving his bowels. Due to his severe weakness, history of falls, and dependent transfer status, two certified nursing assistants assist during the toilet transfer.**

- **How would you code GG0170F, Toilet transfer? What is your rationale?**

230

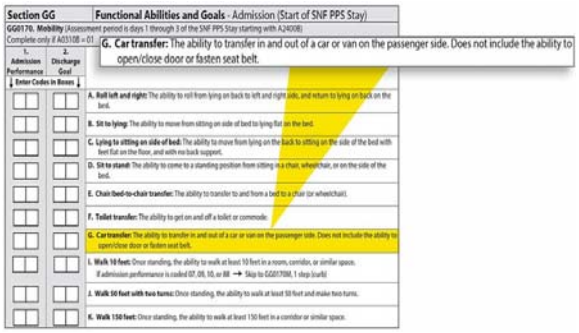
HOW WOULD YOU CODE GG0170F?

A. Code 05, Setup or clean-up assistance
B. Code 04, Supervision or touching assistance
C. Code 02, Substantial/maximal assistance
D. Code 01, Dependent

***Rationale*:**

231

CAR TRANSFER (GG0170G)



GG0170G PRACTICE CODING SCENARIO

- **Definition of Car transfer:**
  - ✓ **The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or seat belt.**

Car transfer scenario:

- ✓ **During her rehabilitation stay, Mrs. N works with an occupational therapist on transfers in and out of the passenger side of a car. On the day before discharge, when performing car transfers, Mrs. N requires verbal reminders for safety and light touching assistance. The therapist instructs her on strategic hand placement while Mrs. N transitions to sitting in the car's passenger seat. The therapist opens and closes the door.**

- **How would you code GG0170G, Car transfer? What is your rationale?**

HOW WOULD YOU CODE GG0170G?

A. Code 05, Setup or clean-up assistance
B. Code 04, Supervision or touching assistance
C. Code 02, Substantial/maximal assistance
D. Code 01, Dependent

***Rationale*:**

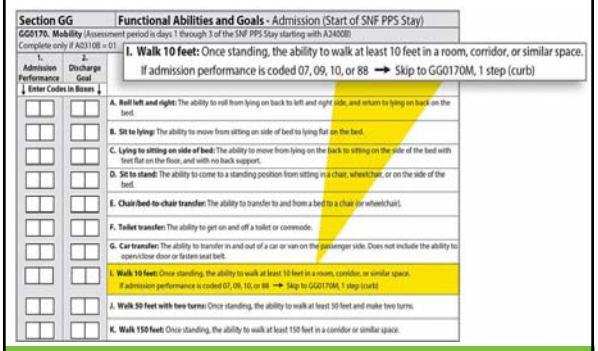
CAR TRANSFER (GG0170G)

Coding Tips for Car transfer:

- **Use of an indoor car can be used to simulate outdoor car transfers. These need to have similar features of a real care.**
- **Does <u>not</u> include transfer into the driver's seat, opening/closing the car door, fastening/unfastening the seat belt.**
- **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 lack of car door available during the entire 3-day assessment period, code 10.**
- **If the resident is unable to attempt task, code 09.**

235

WALK 10 FEET (GG0170I)



236

CODING TIPS FOR WALKING ITEMS

- **Walking activities do not need to occur during one session.**
- **When coding GG0170 walking items, do <u>not</u> consider the resident's mobility performance when using parallel bars.**
- **The turns included in the items GG0170J (walking with two turns) are 90-degree turns. The turns may be in the same direction <u>or</u> may be in different directions.**
- **The 90-degree turn should occur at the person's ability level and can include use of an assistive device.**

237

CHANGES TO GG0170I

- **Definition of Walk 10 feet:**
  - ✓ **Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space.**
- **GG0170I. If admission performance is coded *07, 09, 10, or 88*, skip to GG0170M, 1 step curb.**

238

GG0170I PRACTICE CODING SCENARIO

Walk 10 feet scenario:

- ✓ **Mr. L had bilateral amputations 3 years ago, and prior to the current admission, he used a wheelchair and did not walk. Currently, Mr. L does not use prosthetic devices and uses only a wheelchair for mobility. Mr. L's care plan includes fitting and use of bilateral lower extremity prostheses.**

- **How would you code GG0170I, Walk 10 feet? What is your rationale?**

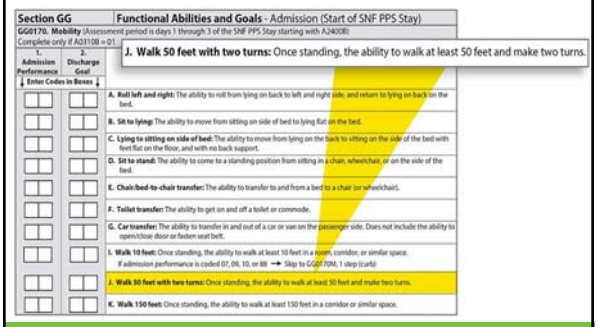
HOW WOULD YOU CODE GG0170I?

A. **Code 01, Dependent**
B. **Code 09, Not applicable, not attempted and the resident did not perform this activity prior to the current illness, exacerbation, or injury**
C. **Code 88, Not attempted due to medical condition or safety concerns**
D. **Code 07, Refused**

Rationale:

240

WALK 50 FEET WITH TWO TURNS (GG0170J)



Section GG	Functional Abilities and Goals - Admission (Start of SNF PPS Stay)
GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B) Complete only if A0310B = 01	
1. Admission Performance ↓ Enter Codes in Boxes ↓	2. Discharge Goal
	A. **Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
	B. **Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
	C. **Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
	D. **Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
	E. **Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
	F. **Toilet transfer:** The ability to get on and off a toilet or commode.
	G. **Car transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
	I. **Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If admission performance is coded 07, 09, 10, or 88 → Skip to GG0170M, 1 step (curb)
	J. **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
	K. **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.

241

GG0170J PRACTICE CODING SCENARIO

- **Definition of Walk 50 feet with two turns:**
  - ✓ **Once standing, the ability to walk at least 50 feet and make two turns.**

Walk 50 feet with two turns scenario:

- ✓ **Mrs. L is unable to bear her full weight on her left leg. As she walks 60 feet down the hall with her crutches and makes two turns, the certified nursing assistant supports her trunk and provides less than half the effort.**

- **How would you code GG0170J, Walk 50 feet with two turns? What is your rationale?**

242

HOW WOULD YOU CODE GG0170J?

A. **Code 04, Supervision or touching assistance**
B. **Code 03, Partial/moderate assistance**
C. **Code 02, Substantial/maximal assistance**
D. **Code 01, Dependent**

Rationale:

243

WALK 150 FEET (GG0170K)

GG0170K PRACTICE CODING SCENARIO

- **Definition of Walk 150 feet:**
  - ✓ **Once standing, the ability to walk at least 150 feet in a corridor, or similar space.**

Walk 150 feet scenario:

- ✓ **Mrs. D walks down the hall using her walker, and the certified nursing assistant usually needs to provide touching assistance to Mrs. D, who intermittently loses her balance while she uses the walker.**

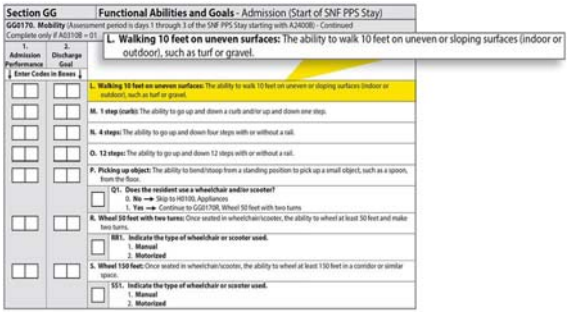
- **How would you code GG0170K, Walk 150 feet? What is your rationale?**

HOW WOULD YOU CODE GG0170K?

A. Code 04, Supervision or touching assistance
B. Code 03, Partial/moderate assistance
C. Code 02, Substantial/maximal assistance
D. Code 01, Dependent

***Rationale*:**

WALKING 10 FEET ON UNEVEN SURFACES (GG0170L)



247

WALKING 10 FEET ON UNEVEN SURFACES (GG0170L)

- **Definition of Walking 10 feet on uneven surfaces:**
  - ✓ **The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.**

248

GG0170L PRACTICE CODING SCENARIO

Walking 10 feet on uneven surfaces scenario:

- ✓ **Mrs. N has severe joint degenerative disease and is recovering from sepsis. Upon discharge, Mrs. N will need to be able to walk on the uneven and sloping surfaces of her driveway. During her SNF stay, a physical therapist takes Mrs. N outside to walk on uneven surfaces.**
- ✓ **Mrs. N requires the therapist's weight-bearing assistance less than half of the time during walking to prevent Mrs. N from falling as she navigates walking 10 feet over uneven surfaces.**

- **How would you code GG0170L, Walking 10 feet on uneven surfaces? What is your rationale?**

249

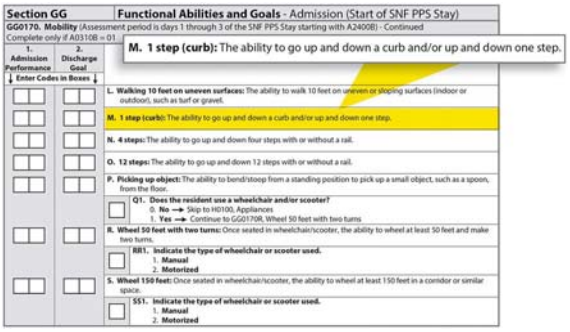
HOW WOULD YOU CODE GG0170L?

A. **Code 04, Supervision or touching assistance**
B. **Code 03, Partial/moderate assistance**
C. **Code 02, Substantial/maximal assistance**
D. **Code 01, Dependent**

Rationale:

250

1 STEP (CURB) (GG0170M)



251

1 STEP (CURB) (GG0170M)

- **Definition of 1 step (curb): The ability to go up and down a curb and/or up and down one step.**
  - ✓ ***Note the skip pattern:***
    - **If the resident's admission performance is coded 07, 09, 10, or 88; Skip to GG0170P, Picking up object.**

252

GG0170M PRACTICE CODING SCENARIO

1 step (curb) scenario:

- ✓ **Mrs. Z has had a stroke; she must be able to step up and down one step to enter and exit her home. A physical therapist provides standby assistance as she uses her quad cane to support her balance in stepping up one step. The physical therapist provides steadying assistance as Mrs. Z uses her cane for balance and steps down one step.**

- **How would you code GG0170M, 1 step curb? What is your rationale?**

253

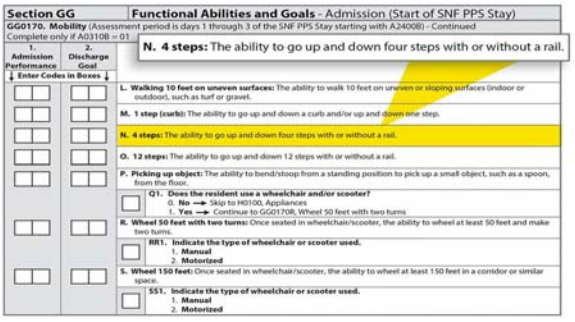
HOW WOULD YOU CODE GG0170M?

A. Code 04, Supervision or touching assistance
B. Code 03, Partial/moderate assistance
C. Code 02, Substantial/maximal assistance
D. Code 01, Dependent

Rationale:

254

4 STEPS (GG0170N)



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

GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B) - Continued
Complete only if A0310B = 01

1. Admission Performance	2. Discharge Goal	
Enter Codes in Boxes		
☐☐	☐☐	L. **Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	☐☐	M. **1 step (curb):** The ability to go up and down a curb and/or up and down one step.
☐☐	☐☐	N. **4 steps:** The ability to go up and down four steps with or without a rail.
☐☐	☐☐	O. **12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	☐☐	P. **Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
		☐ Q1. **Does the resident use a wheelchair and/or scooter?** 0. **No** → Skip to H0100, Appliances 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	☐☐	R. **Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
		☐ RR1. **Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**
☐☐	☐☐	S. **Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
		☐ SS1. **Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

N. 4 steps: The ability to go up and down four steps with or without a rail.

255

4 STEPS (GG0170N)

- **Definition of 4 steps: The ability to go up and down four steps with or without a rail.**
  - ✓ ***Note the skip pattern:***
    - **If admission performance is coded 07, 09, 10, or 88; Skip to GG0170P, Picking up object.**

256

12 STEPS (GG0170O)

Section GG	Functional Abilities and Goals - Admission (Start of SNF PPS Stay)
GG0170. Mobility (Assessment period is days 1 through 3 of the SNF PPS Stay starting with A2400B) - Continued Complete only if A0310B = 01	
1. Admission Performance ↓ Enter Codes in Boxes ↓	2. Discharge Goal
☐☐	☐☐ L. **Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
☐☐	☐☐ M. **1 step (curb):** The ability to go up and down a curb and/or up and down one step.
☐☐	☐☐ N. **4 steps:** The ability to go up and down four steps with or without a rail.
☐☐	☐☐ O. **12 steps:** The ability to go up and down 12 steps with or without a rail.
☐☐	☐☐ P. **Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
	☐ Q1. **Does the resident use a wheelchair and/or scooter?** 0. **No** → Skip to H0100, Appliances 1. **Yes** → Continue to GG0170R, Wheel 50 feet with two turns
☐☐	☐☐ R. **Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
	☐ RR1. **Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**
☐☐	☐☐ S. **Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
	☐ SS1. **Indicate the type of wheelchair or scooter used.** 1. **Manual** 2. **Motorized**

257

12 STEPS (GG0170O)

- **Definition of 12 steps: The ability to go up and down 12 steps with or without a rail.**

12 steps scenario:

- ✓ **Ms. Y is recovering from a stroke resulting in motor issues and poor endurance. Ms. Y's home has 12 stairs, with a railing, and she needs to use these stairs to enter and exit her home. Her physical therapist uses a gait belt around her trunk and supports less than half of the effort as Ms. Y ascends and then descends 12 stairs.**

- **How would you code GG0170O, 12 steps? What is your rationale?**

258

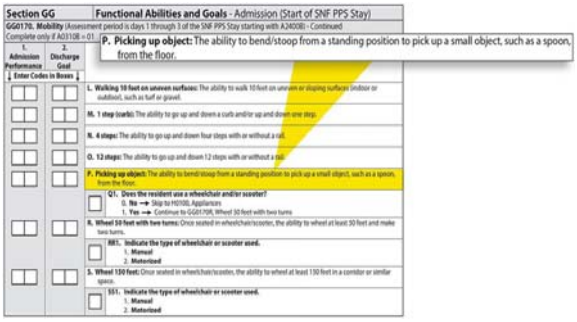
HOW WOULD YOU CODE GG0170O?

A. **Code 05, Setup or clean-up assistance**
B. **Code 04, Supervision or touching assistance**
C. **Code 03, Partial/moderate assistance**
D. **Code 02, Substantial/maximal assistance**

Rationale:

259

PICKING UP OBJECT (GG0170P)



260

GG0170P PRACTICE CODING SCENARIO

- **Definition of Picking up object: The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.**

Picking up object scenario:

- ✓ **Ms. C has recently undergone a hip replacement. When she drops items, she uses a long-handled reacher that she had been using at home prior to admission. She is ready for discharge and can now ambulate with a walker without assistance. When she drops objects from her walker basket, she requires a certified nursing assistant to locate her long-handled reacher and bring it to her in order for her to use it. She does not need assistance to pick up the object after the helper brings her the reacher.**

- **How would you code GG0170P, Picking up object? What is your rationale?**

261

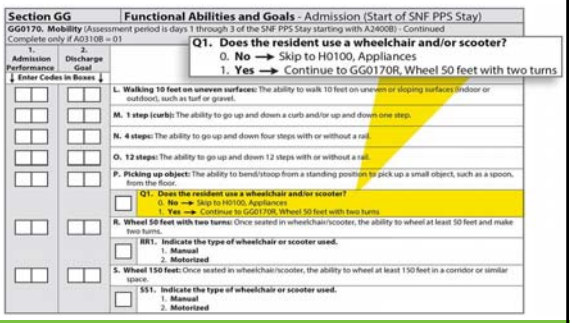
HOW WOULD YOU CODE GG0170P?

A. Code 06, Independent
B. Code 05, Setup or clean-up assistance
C. Code 04, Supervision or touching assistance
D. Code 03, Partial/moderate assistance

Rationale:

262

DOES THE RESIDENT USE A WHEELCHAIR AND/OR SCOOTER (GG0170Q1)?



263

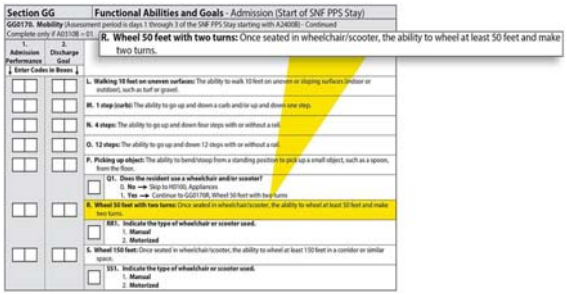
CODING TIP (GG0170Q)

✓ **If the resident uses a wheelchair for self-mobility and is not exclusively transported by others using a wheelchair, then the gateway wheelchair item GG0170Q1; Does the resident use a wheelchair and or scooter?**

- **Code No, Skip to GG0130**
- **Code Yes, Continue to GG0170R**

264

WHEEL 50 FEET WITH TWO TURNS (GG0170R)



265

GG0170R PRACTICE CODING SCENARIO

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

Wheel 50 feet with two turns scenario:

- ✓ **Once seated in the manual wheelchair, Ms. R wheels about 10 feet, then asks the certified nursing assistant to push the wheelchair an additional 40 feet into her room and her bathroom.**

- **How would you code GG0170R, Wheel 50 feet with two turns? What is your rationale?**

266

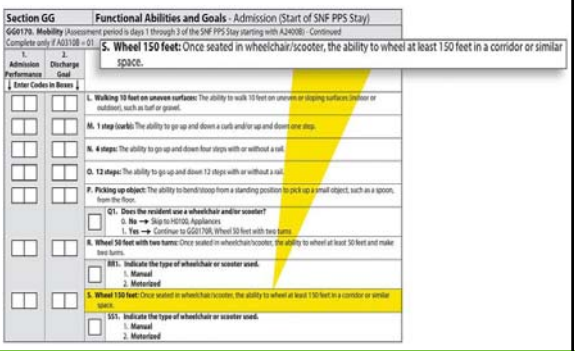
HOW WOULD YOU CODE GG0170R?

A. Code 04, Supervision or touching assistance
B. Code 03, Partial/moderate assistance
C. Code 02, Substantial/maximal assistance
D. Code 01, Dependent

***Rationale*:**

267

WHEEL 150 FEET (GG0170S)



268

GG0170S PRACTICE CODING SCENARIO

- **Definition of Wheel 150 feet:**
  - ✓ **Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in corridor or similar space.**

Wheel 150 feet scenario:

- **Wheel 150 feet:**
  - ✓ **Mr. G always uses a motorized scooter to mobilize himself down the hallway and the certified nursing assistance provides cues due to safety issues.**
- **How would you code GG0170S, Wheel 150 feet? What is your rationale?**

269

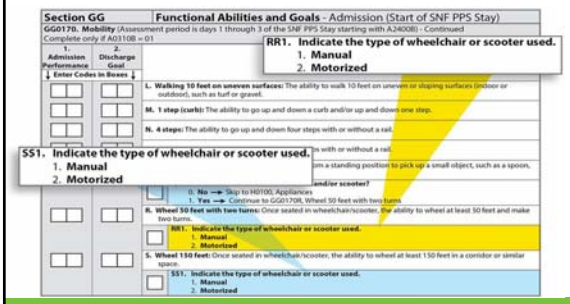
HOW WOULD YOU CODE GG0170S?

A. Code 04, Supervision or touching assistance
B. Code 03, Partial/moderate assistance
C. Code 02, Substantial/maximal assistance
D. Code 01, Dependent

Rationale:

270

- INDICATE THE TYPE OF WHEELCHAIR AND/OR SCOOTER USED (GG0170RR1 & GG0170SS1)



- DISCHARGE PERFORMANCE:

Discharge Performance:

- **Discharge performance coding (refer to slides 168-169)**
- ***For additional information on coding the resident's performance on the assessment, refer to the Decision Tree on page GG-12 or slide 205.***

SECTION H: BLADDER & BOWEL NO CHANGES

SECTION H: BLADDER AND BOWEL

- **H0100: Appliances**
  - A. Indwelling catheter
  - B. External catheter
  - C. Ostomy
  - D. Intermittent catheterization
  - Z. None of the above
- **H0200: Urinary Toileting Program**
  - A. Has a toileting trial been attempted
  - B. Response to trial
  - C. Current program or trial
- **H0300: Urinary Continence**
- **H0400: Bowel Continence**
- **H0500: Bowel Toileting Program**
- **H0600: Bowel Patterns**

274

SECTION I: ACTIVE DIAGNOSIS

275

INDICATE THE RESIDENT'S PRIMARY MEDICAL CONDITION CATEGORY (I0020) (NEW)

Section I | **Active Diagnoses**

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

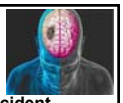
276

INDICATE THE RESIDENT'S PRIMARY MEDICAL CONDITION CATEGORY (I0020) (NEW)

- ✓ **Indicate the resident's primary medical condition category that best describes the primary reason for Medicare Part A stay.**
- ✓ **Complete only if PPS 5-day or IPA assessment.**
  - **Start of Part A Prospective Payment System (PPS) stay (5-day scheduled assessment) OR**
  - **PPS Unscheduled Assessment for a Medicare Part A Stay (IPA).**
  - **Then proceed to I0020B and enter the ICD code for that condition, including the decimal.**

277

CODING INSTRUCTIONS (I0020)

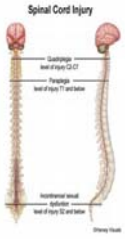


- **Code 01, Stroke:**
  - **Examples include ischemic stroke, subarachnoid hemorrhage, cerebral vascular accident (CVA), and other cerebrovascular disease.**
- **Code 02, Non-traumatic Brain Dysfunction:**
  - **Examples include Alzheimer's disease, dementia with or without behavioral disturbance, malignant neoplasm of brain, and anoxic brain damage.**
- **Code 03, Traumatic Brain Dysfunction:**
  - **Examples include traumatic brain injury, severe concussion, and cerebral laceration and contusion.**
- **Code 04, Non-traumatic Spinal Cord Dysfunction:**
  - **Examples include spondylosis with myelopathy, transverse myelitis, spinal cord lesion due to spinal stenosis, and spinal cord lesion due to dissection of aorta.**

278

CODING INSTRUCTIONS (I0020)

- **Code 05, Traumatic Spinal Cord Dysfunction:**
  - **Examples include paraplegia and quadriplegia following trauma.**
- **Code 06, Progressive Neurological Conditions:**
  - **Examples include multiple sclerosis and Parkinson's disease.**
- **Code 07, Other Neurological Conditions:**
  - **Examples include cerebral palsy, polyneuropathy, and myasthenia gravis.**
- **Code 08, Amputation:**
  - **For example, acquired absence of limb.**
- **Code 09, Hip and Knee Replacement:**
  - **For example, total knee replacement.**
  - **If hip replacement is secondary to hip fracture, code as fracture (code 10).**



279

CODING INSTRUCTIONS (I0020)

- **Code 10, Fractures and Other Multiple Trauma:**
  - **Examples include hip fracture, pelvic fracture, and fracture of tibia and fibula.**
- **Code 11, Other Orthopedic Conditions:**
  - **For example, unspecified disorders of joint.**
- **Code 12, Debility, Cardiorespiratory Conditions:**
  - **Examples include chronic obstructive pulmonary disease (COPD), asthma, and other malaise and fatigue**

280

CODING INSTRUCTIONS (I0020)

- **Code 13, Medically Complex Conditions:**
  - **Examples include diabetes, pneumonia, chronic kidney disease, open wounds, pressure ulcer/injury, infection, and disorders of fluid, electrolyte, and acid-base balance.**

~~• Code 14, Other Medical Complex Conditions~~, DELETED

~~I0020A~~, DELETED

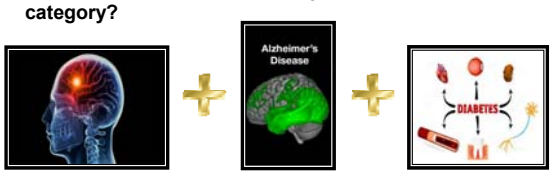
I0020B, ICD Code, NEW

281

PRACTICE CODING SCENARIO

- **Ms. K is a 67-year-old female with a history of Alzheimer's dementia and diabetes who is admitted after a stroke. The diagnosis of stroke, as well as the history of Alzheimer's dementia and diabetes, is documented in Ms. K's history and physical by the admitting physician.**

✓ **What is the appropriate primary medical condition category?**



282

HOW WOULD YOU CODE I0020?

Indicate the resident's primary medical condition category:

A. Code 01, Stroke

B. Code 06, Progressive Neurological Conditions

C. Code 12, Debility, Cardiorespiratory Conditions

D. Code 13, Medically Complex Conditions

Rationale:

283

ACTIVE DIAGNOSES (I0100 THROUGH I8000)

Two (2) look back periods:

- **Step 1, Diagnosis identification in a 60-day look-back window:**
  - ✓ **Must have physician-documented diagnosis (or by NP, PA, or CNS) in the last 60 days.**
- **Step 2, Diagnosis Status: Active or Inactive 7-day look-back window (except UTI)**
- **Medical record sources for physician diagnosis include progress note, most recent history and physical, transfer documents, discharge summaries, diagnosis/problem list, and other resources as available. A diagnosis/problem list must be confirmed by the physician.**
- **Do not include conditions that have been resolved.**

284

ACTIVE DIAGNOSES (I0100 THROUGH I8000)

Coding Tips:

- ✓ **If disease/condition not specifically listed, enter the diagnosis and ICD code in I8000.**
- ✓ **If diagnosis is a Z code, another diagnosis for the related primary medical condition should be checked in I0100-I7900 or I8000.**
- ✓ **When there is no specific documentation that a disease is "active", may confirm this using other indicators; tests, procedures, positive study, etc.**

285

ACTIVE DIAGNOSES (I2300)

Special criteria for UTI:

- ✓ **Physician diagnosis of UTI in last 30 days.**
- ✓ **Signs and symptoms attributed to UTI.**
  - **Use evidence-based criteria such as McGreer, NHSN, or Loeb in the last 30-days.**
- ✓ **Positive test, study, labs or procedure.**
- ✓ **Current medication or treatment for UTI in last 30 days.**

286

ACTIVE DIAGNOSES CATEGORIES IN THE LAST 7 DAYS (I0100-I8000)

Check all that applies:

- **I0100, Cancer (with or without metastasis)**
- **I0200-I0900, Heart/Circulation**
- **I1100-I1300, Gastrointestinal**
- **I1400-I1650, Genitourinary**
- **I1700-I2500, Infections**
- **I2900-I3400, Metabolic**
- **I3700-I4000, Musculoskeletal**
- **I4200-I5500, Neurological**
- **I5600, Nutritional**
- **I5700-I6100, Psychiatric/Mood Disorder**
- **I6200-I6300, Pulmonary**
- **I6500, Vision**
- **I7900, None of Above**
- **I8000, Additional Active Diagnosis**

287

QUADRIPLEGIA (I5100)

Item I5100 Quadriplegia:

- ✓ **Quadriplegia primarily refers to the paralysis of all four limbs, arms and legs, caused by spinal cord injury.**
- ✓ **Coding is limited to spinal cord injuries and must be a primary diagnosis and not the result of another condition.**
- ✓ **Functional quadriplegia refers to complete immobility due to severe physical disability or frailty. Conditions such as cerebral palsy, stroke, contractures, brain disease, advanced dementia, etc. can also cause functional paralysis that may extend to all limbs hence, the diagnosis functional quadriplegia. For individuals with these types of severe physical disabilities, where there is minimal ability for purposeful movement, their primary physician-documented diagnosis should be coded on the MDS and not the resulting paralysis or paresis from that condition. For example, an individual with cerebral palsy with spastic quadriplegia should be coded in I4400 Cerebral Palsy, and not in I5100, Quadriplegia.**

288

SECTION J:
HEALTH CONDITIONS



289

PAIN MANAGEMENT (J0100)

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

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

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

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

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

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

- **A, Scheduled pain medication regimen?**
  - **Code 0, No**
  - **Code 1, Yes**
- **B, PRN pain medications OR was offered and declined?**
  - **Code 0, No**
  - **Code 1, Yes**
- **C, Non-medication intervention for pain?**
  - **Code 0, No**
  - **Code 1, Yes**

290

SHOULD PAIN ASSESSMENT INTERVIEW BE CONDUCTED? (J0200)

J0200. Should Pain Assessment Interview be Conducted?

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

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

Attempt to conduct the interview if the resident is at least sometimes understood and an interpreter is present (or not required):

- **Code 0, No, resident is rarely/never understood, skip to J0800.**
- **Code 1, Yes, continue to J0300.**

Note: if the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.

291

SHOULD PAIN ASSESSMENT INTERVIEW BE CONDUCTED? (J0200)

Coding Tips:

- ✓ **Attempt to conduct the interview with ALL residents.**
- ✓ **The interview is <u>not</u> contingent upon item B0700, Makes Self Understood.**
- ✓ **If the interview should have been conducted, but was <u>not</u> done within the look-back period of the ARD, item J0200 must be coded 1, Yes, and the standard "no information" code (dash) entered in items J0300 – J0700. J0700 is coded as 0, No.**
- ✓ **Do not complete Staff Assessment for Pain items (J0800 – J0850) if the resident interview should have been conducted, but was <u>not</u> done.**

292

PAIN ASSESSMENT INTERVIEW (J0300 - J0600)

- **Assessment should be conducted on the day before or the day of the ARD date.**
- **The look back period is 5 days.**
- **Directly ask the resident each item in J0300 thru J0600 in the order provided.**
- **Use resident's terminology for pain - such as hurting, aching, burning.**


Pain Assessment Interview

J0300. Pain Presence

J0400. Pain Frequency

J0500. Pain Effect on Function

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

293

PAIN DEFINITION (J0300 - J0600)

- **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.**

294

PAIN PRESENCE (J0300)

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

- **Code for the presence or absence of pain regardless of pain management efforts:**
  - ✓ **Code 0, No, resident says there was no pain even if the reason for no pain was due to receipt of pain management interventions, skip to J1100.**
  - ✓ **Code 1, Yes, continue to J0400.**
  - ✓ **Code 9, Unable to answer, does <u>not</u> respond, or gives nonsensical response, skip to J0800.**

295

PAIN FREQUENCY (J0400)

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

- **Code 1, Almost constantly**
- **Code 2, Frequently**
- **Code 3, Occasionally**
- **Code 4, Rarely**
- **Code 9, Unable to answer**
  - ✓ **Response should be based on resident's interpretation of the frequency options.**
  - ✓ **Facility policy should provide a standardize tool to assess pain and ensure consistency.**

296

PAIN EFFECT ON FUNCTION (J0500)

A, Ask resident: "Over the past 5 days, has pain made it hard for you to sleep at night"?

B, Ask resident: "Over the past 5 days, have you limited your day-to-day activities because of pain"?

Coding for all of the above:

- **Code 0, No, pain did <u>not</u> interfere with sleep or activities.**
- **Code 1, Yes, pain interfered with sleep or activities.**
- **Code 9, Unable to answer, does not respond or gives nonsensical response.**

297

PAIN INTENSITY (J0600)

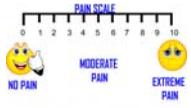
Administer ONLY ONE of the Pain Intensity questions (A or B).

- **Leave the unused scale blank.**

A, Numeric Rating Scale (00-10)

- **Code 00-10, Record resident two-digit response**
- **Code 99, Unable to answer**

B, Verbal Descriptor Scale



- **Code 1, Mild**
- **Code 2, Moderate**
- **Code 3, Severe**
- **Code 4, Very severe, horrible**
- **Code 9, Unable to answer**

Note: For each resident, try to use the same scale used on prior assessments.

298

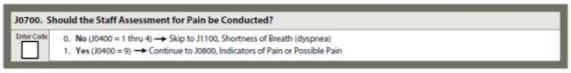
SHOULD THE STAFF ASSESSMENT FOR PAIN BE CONDUCTED (J0700)

Closes the pain interview and determines if the resident interview was complete or incomplete:

- **The pain interview is successfully completed if:**
  - **The resident reported no pain (J0300 = No), <u>OR</u>**
  - **The resident reported pain (J0300 = Yes) and the follow-up question J0400 is answered.**

Should the Staff Assessment for Pain be conducted?

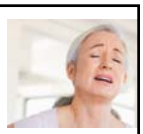
- **Code 0, No (J0400 = 1 thru 4), skip to J1100**
- **Code 1, Yes (J0400 = 9), continue to J0800**


J0700. Should the Staff Assessment for Pain be Conducted?

Enter Code ☐ 0. No (J0400 = 1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea)
1. Yes (J0400 = 9) → Continue to J0800, Indicators of Pain or Possible Pain

299

INDICATORS OF PAIN (J0800)



Complete only if Pain Assessment Interview (J0200-J0600) was <u>not</u> completed.

Check all indicators that apply:

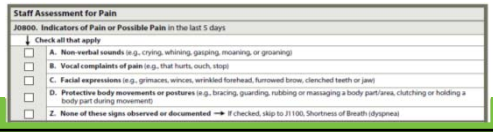
A. Non-verbal sounds (crying, whining, moaning).

B. Vocal complaints of pain (that hurts, ouch, stop).

C. Facial expressions (grimaces, winces).

D. Protective body movements or postures (bracing, guarding, rubbing body part/area).

Z. None of these signs observed or documented, skip to J1100.


Staff Assessment for Pain

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

Check all that apply

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

300

INDICATORS OF PAIN (J0800)

- ✓ **Behavior change, depressed mood, rejection of care and decreased activity participation may be related to pain.**
- ✓ **These behaviors and symptoms are identified in other sections and not reported here as pain screening item.**
- ✓ **The contribution of pain should be considered when following up on those symptoms and behaviors.**

301

FREQUENCY OF INDICATOR OF PAIN OR POSSIBLE PAIN (J0850)

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

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

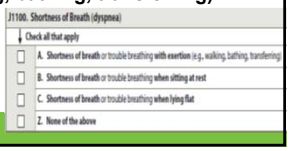
302

SHORTNESS OF BREATH (DYSPNEA) (J1100)

- **Document the presence of SOB in certain positions or activities.**
- **Document the observation of SOB.**
- **Document the history of SOB (allergies, environmental triggers, etc.).**

Check all that apply:

- **Resident has shortness of breath or trouble breathing:**
  - **A. With exertion (walking, bathing, transferring).**
  - **B. When sitting at rest.**
  - **C. When lying flat.**
  - **Z. None of the above.**



CURRENT TOBACCO USE (J1300)

J1300. Current Tobacco Use

Enter Code ☐ Tobacco use
0. No
1. Yes

Includes tobacco used in any form:

- **Code 0, No**
- **Code 1, Yes**


304

PROGNOSIS (J1400)

J1400. Prognosis

Enter Code ☐ Does the resident have a condition or chronic disease that may result in a **life expectancy of less than 6 months?** (Requires physician documentation)
0. No
1. Yes

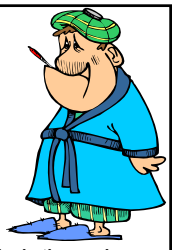
- **In the physician's judgment the resident has less than 6 months to live.**
- **Resident has a terminal illness.**
- **Physician documentation must be in the medical record to substantiate coding this item.**

Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?

- ✓ **Code 0, No, medical record has no physician documentation to support terminal illness and is not receiving hospice services.**
- ✓ **Code 1, Yes, medical record documentation by the physician supports terminal illness or resident is receiving hospice services.**

305

PROBLEM CONDITIONS (J1550)



Check all that apply:

A. Fever
- **Must be 2.4 degrees F above baseline.**
- **Temperature of 100.4 on admission.**

B. Vomiting

C. Dehydrated
- **Must have 2 of the 3 criteria to code:**
  - o **Takes in less than 1500 cc fluids daily.**
  - o **One or more potential clinical signs of dehydration such as dry mucous membranes, dark urine, abnormal labs values, etc.**
  - o **Fluid loss exceeds fluid intake.**

D. Internal bleeding
- **Frank**
- **Occult**

Z. None of the above

J1550. Problem Conditions

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

306

FALL HISTORY ON ADMISSION/ENTRY OR REENTRY (J1700)

Fall Definition:

- **Unintentional change in position coming to rest on the ground, floor or onto the next lower surface.**
- **Includes any fall, no matter where it occurs.**
- **Falls are <u>not</u> the result of an overwhelming external force (resident pushes another resident).**
- **An intercepted fall is still considered a fall.**
- **A resident found on the floor or ground without knowledge of how they got there, is a fall.**
- **Fall may be witnessed or reported by resident or observer.**

307

FALL HISTORY ON ADMISSION/ENTRY OR REENTRY (J1700)

Complete only on Admission or the first assessment since the most recent admission/entry or reentry.

Ask resident and family or significant other about falls in the past month and prior 6 months prior to admission/entry or reentry":

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

Enter Code ☐	**A.** Did the resident have a fall any time in the **last month** prior to admission/entry or reentry? 0. **No** 1. **Yes** 9. **Unable to determine**
Enter Code ☐	**B.** Did the resident have a fall any time in the **last 2-6 months** prior to admission/entry or reentry? 0. **No** 1. **Yes** 9. **Unable to determine**
Enter Code ☐	**C.** Did the resident have any **fracture related to a fall in the 6 months** prior to admission/entry or reentry? 0. **No** 1. **Yes** 9. **Unable to determine**

Coding for all of the above:

- **Code 0, No, no falls or fractures in time frame**
- **Code 1, Yes, a fall (A-B) or fracture (C) occurred in the time frame**
- **Code 9, Unable to determine**

308

ANY FALLS SINCE ADMISSION/ENTRY OR REENTRY OR PRIOR ASSESSMENT (OBRA OR SCHEDULED PPS) (J1800)

Coding instructions were updated to allow for a new skip pattern:

- **Code 0, No**
  - **If the assessment is being completed as an OBRA assessment, skip to Swallowing Disorder item (K0100).**
  - **If the assessment being completed is a Scheduled PPS assessment, skip to Prior Surgery item (J2000).**
- **Code 1, Yes, continue to J1900.**

309

NUMBER OF FALLS SINCE ADMISSION/ENTRY OR REENTRY OR PRIOR ASSESSMENT (OBRA OR SCHEDULED PPS) (J1900)

- ✓ **If this is <u>not</u> the first assessment, review the record for the time period from the day after the ARD of last MDS to the ARD of current MDS.**
- ✓ **If resident has multiple injuries in a single fall, code for the highest level of injury.**
- ✓ **Code each fall only once.**
- ✓ **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, the assessment must be modified to update the level of injury that occurred with that fall.**

310

PRIOR SURGERY (J2000)

- ✓ **Complete only if PPS 5-day assessment:**


J2000. Prior Surgery

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

- **Code 0, No**
  - **The resident did not have major surgery during the 100 days prior to admission.**
- **Code 1, Yes**
  - **The resident had major surgery during the 100 days prior to admission.**
- **Code 8, Unknown**
  - **Unknown or cannot be determined whether the resident had major surgery during the 100 days prior to admission.**

311

CODING TIPS (J2000)

- ✓ **Generally, major surgery for item J2000 refers to a procedure that meets the following criteria:**
  - **The resident was an inpatient in an acute care hospital or at least one day in the 100 days prior to admission to the SNF, <u>AND</u>**
  - **The surgery carried some degree of risk to the resident's life or the potential for severe disability.**

312

PRACTICE CODING SCENARIO

- **Mrs. T reports that she required surgical removal of a skin tag from her neck a month and a half ago.**
- **She had the procedure as an outpatient.**
- **She reports no other surgeries in the past 100 days.**

How would you code prior surgery? What is your rationale?

313

HOW WOULD YOU CODE J2000?

Did the resident have major surgery during the 100 days prior to admission?

A. Code 0, No

B. Code 1, Yes

C. Code 8, Unknown

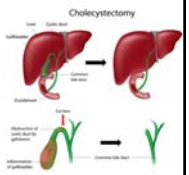
***Rationale*:**

314

PRACTICE CODING SCENARIO

- **Mrs. G. was admitted to the facility for wound care related to dehiscence of a surgical wound subsequent to a complicated cholecystectomy for which she received general anesthesia.**
- **The attending physician also noted diagnoses of anxiety, diabetes, and morbid obesity in her medical record.**
- **She was transferred to the facility immediately following a 4-day hospitalization.**

How would you code prior surgery? What is your rationale?



315

HOW WOULD YOU CODE J2000?

Did the resident have major surgery during the 100 days prior to admission?

A. Code 0, No

B. Code 1, Yes

C. Code 8, Unknown

Rationale:

316

RECENT SURGERY REQUIRING ACTIVE SNF CARE (J2100) (NEW)

✓ **Complete only if PPS 5-day or Interim Payment assessment.**

Did the resident have a major surgical procedure during the prior inpatient hospital stay that requires active care during the SNF stay?

- **Code 0, No**
- **Code 1, Yes**
- **Code 8, Unknown**

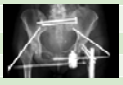
✓ **Generally, major surgery refers to a procedure that meets the following criteria:**

- **Was a hospital inpatient for at least one day in the last 30 days prior to admission to the SNF, and**
- **Surgery carried some degree of risk to the resident's life or the potential for severe disability.**

317

SURGICAL PROCEDURES (J2300-J5000) (NEW)

Surgical Procedures – Complete only if J2100 = 1 Check all that apply:	
Major Joint Replacements	
J2100	Recent Surgery Requiring Active SNF Care
J2300	Knee Replacement – partial or total
J2310	Hip Replacement – partial or total
J2320	Ankle Replacement – partial or total
J2330	Shoulder Replacement – partial or total
Spinal Surgery	
J2400	Spinal cord or major spinal nerves
J2410	Fusion of spinal bones
J2420	Lamina, discs, or facets
J2499	Spinal surgery - Other
Other Orthopedic Surgery	
J2500	Repair fractures of shoulder or arm
J2510	Repair fractures of the pelvis, hip, leg, knee, or ankle
J2520	Repair but not replace joints
J2530	Repair other bones
J2599	Orthopedic surgery- Other



318

SURGICAL PROCEDURES (J2300-J5000) (NEW)

Surgical Procedures – Complete only if J2100 = 1 Check all that apply:	
Neurological Surgery	
J2600	Brain, surrounding tissue, or blood vessels
J2610	Peripheral or autonomic nervous system (open or percutaneous)
J2620	Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, and CSF drainage devices
J2699	Neurological surgery - Other
Cardiopulmonary Surgery	
J2700	Heart or major blood vessels – open or percutaneous procedures
J2710	Respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords – open or endoscopic
J2799	Cardiopulmonary surgery - Other
Genitourinary Surgery	
J2800	Male or female organs
J2810	Kidneys, ureters, adrenal glands, or bladder – open or laparoscopic
J2899	Other major genitourinary surgery

319

SURGICAL PROCEDURES (J2300-J5000) (NEW)

Surgical Procedures – Complete only if J2100 = 1 Check all that apply:	
Major Surgery	
J2900	Tendons, ligaments, or muscles
J2910	Gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas or spleen – open or laparoscopic
J2920	Endocrine organs (such as thyroid, parathyroid), neck, lymph nodes, or thymus – open
J2930	The breast
J2940	Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant
J5000	Other major surgery not listed above

320

SURGICAL PROCEDURES (J2300-J5000) (NEW)

- ✓ **Coding Instructions:**
  - **Check all surgeries that:**
    - **Are documented to have occurred in the last 30 days.**
    - **Occurred during the inpatient stay that immediately preceded the resident's Part A admission.**
    - **Have a direct relationship to the resident's primary SNF diagnosis, as coded in I0020B.**
    - **Drive the resident's plan of care during the 7-day look-back period.**

321

SURGICAL PROCEDURES (J2300-J5000) (NEW)

✓ **Coding Instructions:**

- **Surgeries must have been documented by a physician, NP, PA, or clinical specialist.**
- **Resident information communicated verbally must be documented in the medical record by the physician to ensure follow-up.**
- **Do <u>not</u> include conditions that have been resolved, as these would be considered surgeries that do <u>not</u> require active care during the SNF stay.**

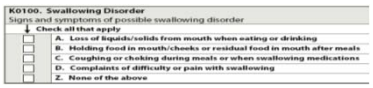
322

SECTION K: SWALLOWING/NUTRITIONAL STATUS NO CHANGES



323

SWALLOWING DISORDER (K0100)



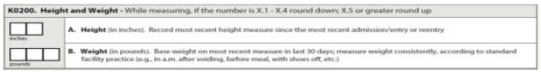
Check all that apply (even if occurred only once):

- **A. Loss of liquids/solids from mouth when eating or drinking.**
- **B. Holding food in mouth/cheeks or residual food in mouth after meals.**
- **C. Coughing or choking during meals or when swallowing medications.**
- **D. Complaints of difficulty or pain with swallowing.**
- **Z. None of the above.**

NOTE: Do <u>not</u> code a problem when interventions have been successful in treating the problem and no signs/symptoms are present. Code even if symptom occurred only once.

324

HEIGHT AND WEIGHT (K0200)



Record a current height and weight in order to monitor nutrition and hydration over time.

A. Height (in inches):

- **On admission, measure and record height in inches to the nearest whole inch.**
- **Use mathematical rounding (.1" to .4" inches round down, .5" or greater round up).**
- **Re-measure if last height was over a year ago.**
- **Measure consistently.**

325

HEIGHT AND WEIGHT (K0200)

B. Weight (in pounds):

- **Base weight on most recent measure in last 30 days.**
- **On subsequent assessments, enter weight taken within 30 days of ARD.**
- **If multiple weights in preceding month, record most recent one.**
- **Use mathematical rounding (.1# to .4# round down, .5# or more round up).**
- **Weigh consistently.**
- **If unable to weigh, code with a dash ("-") and document reason in medical record.**

326

WEIGHT LOSS (K0300)

Compares resident's current weight to the weight from two distinct points in time only.

- **Mathematically round weights.**

Loss 5% or more weight in the last 30 days or 10% or more in last 180 days:

- **Code 0, No or unknown.**
- **Code 1, Yes, on physician-prescribed weight-loss regimen.**
- **Code 2, Yes, <u>not</u> on physician-prescribed weight-loss regimen.**
- **Physician-prescribed weight-loss regimen is ordered by the physician with the care plan goal of weight reduction. Includes planned diuresis; it is important that weight loss is intentional.**

327

WEIGHT GAIN (K0310)

K0310. Weight Gain

Enter Code ☐ Gain of 5% or more in the last month or gain of 10% or more in last 6 months
0. No or unknown
1. Yes, on physician-prescribed weight-gain regimen
2. Yes, not on physician-prescribed weight-gain regimen

Compares resident's current weight to the weight from two distinct points in time only.

- **Mathematically round weights.**

Gain of 5% or more in the last 30 days or gain of 10% or more in last 6 months:

- **Code 0, No or unknown.**
- **Code 1, Yes, on physician-prescribed weight-gain regimen.**
- **Code 2, Yes, not on physician-prescribed weight-gain regimen.**

✓ **A weight variance between snapshots is not captured on MDS.**

✓ **If yes, the expressed goal of weight gain must be documented.**

328

NUTRITIONAL APPROACHES (K0510)

Identify nutritional approaches that vary from the normal or that rely on alternative methods.

Check all that apply for "while NOT a resident" and "while a resident" during the last 7 days:

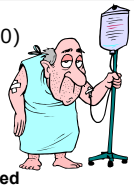
K0510. Nutritional Approaches

Check all of the following nutritional approaches that were performed during the last **7 days**

1. While NOT a Resident Performed ***while NOT a resident*** of this facility and within the ***last 7 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank 2. While a Resident Performed ***while a resident*** of this facility and within the ***last 7 days***	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
A. **Parenteral/IV feeding**	☐	☐
B. **Feeding tube** - nasogastric or abdominal (PEG)	☐	☐
C. **Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)		☐
D. **Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)		☐
Z. **None of the above**	☐	☐

329

NUTRITIONAL APPROACHES (K0510)



A. **Parenteral/IV feeding administered for nutrition or hydration.**
B. **Feeding tube.**
C. **Mechanically altered diet *(DELETED Col. 1)***
D. **Therapeutic diet *(DELETED Col. 1)***
   ✓ **Not defined by the content of what is provided or when it is served, but why the diet is required.**
Z. **None of the above**

✓ ***Food elimination diets related to food allergies can be coded as a therapeutic diet.***

✓ ***A nutritional supplement cannot be coded as a therapeutic diet.***

330

PARENTERAL/IV FEEDING (K0510A)

Supporting documentation must reflect the need for additional fluid intake specifically addressing the nutritional or hydration need.

The following fluids may be included:

- **IV fluids for hyperalimentation.**
- **TPN.**
- **IV fluids running KVO.**
- **IV fluids contained in IV piggybacks.**
- **Hypodermoclysis and subcutaneous ports in hydration therapy.**
- **IV fluids to prevent dehydration if specifically needed for nutrition and hydration.**
  - **Dehydration must be documented in the medical record.**

331

PARENTERAL/IV FEEDING (K0510A)

The following fluids may NOT be coded:

- **IV medications.**
- **IV fluids used to reconstitute and/or dilute medications.**
- **IV fluids as a routine part of an operative or diagnostic procedure or recovery room stay.**
- **IV fluids administered solely as flushes.**
- **IV fluids administered in conjunction with chemotherapy or dialysis.**

332

PARENTERAL/IV FEEDING (K0510B)

Enteral feeding formulas:

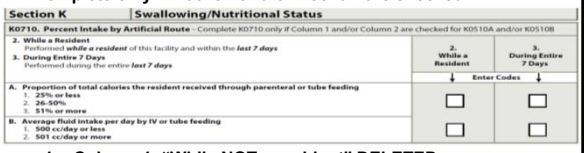
- **Should not be coded as a mechanically altered diet.**
- **Should only be coded as K0510D, Therapeutic Diet when the enteral formula is altered to manage problematic health conditions, e.g. enteral formulas specific to diabetics.**

333

PERCENT INTAKE BY ARTIFICIAL ROUTE (K0710)

K0710A, Proportion of total calories the resident received through parenteral or tube feeding.

Complete only if K0510A and/or K0510B are checked.



Section K	Swallowing/Nutritional Status	
K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B		
2. While a Resident Performed *while a resident* of this facility and within the *last 7 days* 3. During Entire 7 Days Performed during the entire *last 7 days*	2. While a Resident	3. During Entire 7 Days
	Enter Codes	
A. Proportion of total calories the resident received through parenteral or tube feeding 1. 25% or less 2. 26-50% 3. 51% or more	☐	☐
B. Average fluid intake per day by IV or tube feeding 1. 500 cc/day or less 2. 501 cc/day or more	☐	☐

1. ~~Column 1. "While NOT a resident"~~ **DELETED**
2. **While a resident.**
3. **During entire 7 days:**
   - **Review intake record for actual intake received:**
     - **Code 1, 25% or less.**
     - **Code 2, 26-50%.**
     - **Code 3, 51% or more.**

334

CALCULATION FOR PROPORTION OF TOTAL CALORIES FROM TUBE FEEDING EXAMPLE

Date	Oral	Tube
Sunday	500	2,000
Monday	250	2,250
Tuesday	250	2,250
Wednesday	350	2,250
Thursday	500	2,000
Friday	250	2,250
Saturday	350	2,000
Total	2,450	15,000

K0710A
Total calories = 17,450
Percentage of calories:
15,000 ÷ 17,450 = 0.859
0.859 x 100 = 85.9%

K0710A2= 3 (51% or more)

335

PERCENT INTAKE BY ARTIFICIAL ROUTE (K0710)

K0710B, Average fluid intake per day by IV or tube feeding.

Complete only if K0510A and/or K0510B are checked:

1. ~~Column 1. "While NOT a resident"~~ **DELETED**
2. **While a resident.**
3. **During entire 7 days:**
   - **Code for the average number of cc per day of fluids.**
   - **Review intake record for actual intake received:**
     - **Code 1, 500 cc/day or less**
     - **Code 2, 501 cc/day or more**

336

CALCULATION FOR AVERAGE DAILY FLUID INTAKE EXAMPLE

Date	Hospital	NF
Sunday	400cc	
Monday	520cc	
Tuesday	500cc	
Wednesday	480cc	
Thursday		510cc
Friday		520cc
Saturday		490cc
Total	1,900cc	1,520cc

K0710B2
Total fluids at NF = 1,520. Average intake while a resident totaled 507cc; (1520/3 days = 507)
K0710B2 = 2 (501cc or +)

K0710B3
Total fluids at hospital = 1,900cc AND while at SNF = 1,520cc equal a grand total of 3,420cc. (3420/7 days = 489)
Average fluid intake during entire 7 days = 489cc;
K0710B3 = 1 (500cc or -)

337

SECTION L: ORAL/DENTAL STATUS NO CHANGES



338

ORAL/DENTAL STATUS (L0200)

Dental, check all that apply:

A. Broken or loosely fitting full or partial denture.
B. No natural teeth or tooth fragments.
C. Abnormal mouth tissue.
D. Obvious or likely cavity or broken natural teeth.
E. Inflamed or bleeding gums or loose natural teeth.
F. Mouth or facial pain, discomfort or difficulty chewing.
G. Unable to examine.
Z. None of above were present.

Mouth or facial pain coded here should also be coded in Section J, items J0100 through J0850, in any items in which the coding requirements of Section J are met.

339

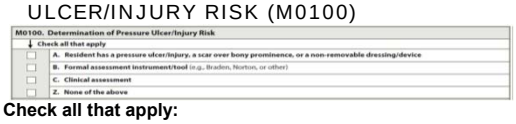
SECTION M: SKIN CONDITIONS NO CHANGES

Viewer Discretion advised



340

DETERMINATION OF PRESSURE ULCER/INJURY RISK (M0100)



M0100. Determination of Pressure Ulcer/Injury Risk

Check all that apply

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

Check all that apply:

A. Resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/device:
- **Review pressure ulcer description/staging.**
- **Non-removable dressing/device.**

B. Formal assessment instrument/tool has been used:
- **Braden Scale.**
- **Norton Scale.**

C. Clinical assessment:
- **Head-to-toe physical examination.**
- **Medical record review.**
- **Identify risk factors.**

Z. None of the above.

341

RISK OF PRESSURE ULCERS/INJURIES (M0150)

M0150. Risk of Pressure Ulcers/Injuries

Enter Code | Is this resident at risk of developing pressure ulcers/injuries?
0. No
1. Yes

Based on items reviewed for M0100.

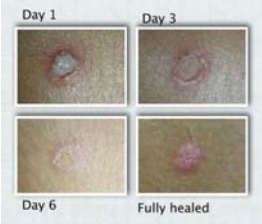
Is this resident at risk of developing pressure ulcers/injuries?
- **Code 0, No**
- **Code 1, Yes**

342

PRESSURE ULCER/INJURY

Definition: 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.**



343

UNHEALED PRESSURE ULCERS/INJURIES (M0210)

- ✓ **Pressure ulcer/injury definitions in RAI are adapted from the National Pressure Ulcer Advisory Panel (NPUAP) 2016.**
- ✓ **Numeric staging or DTI should be coded as assessed in look-back period.**
- ✓ **Facilities may adopt the NPUAP guidelines:**
  - **In clinical practice.**
  - **Nursing documentation.**
- ✓ **The RAI staging definitions do not perfectly correlate with the NPUAP staging definitions.**
- ✓ **MDS must be coded according to the instructions in the RAI manual!!**
- ✓ **Pressure ulcer/injury staging is an assessment system that provides a description and classification based on visual appearance and/or anatomic depth of soft tissue damage:**
  - **Tissue damage can be visible or palpable in the ulcer bed.**
  - **Pressure ulcer/injury staging also informs expectations for healing time.**

344

UNHEALED PRESSURE ULCERS/INJURIES (M0210)

- ✓ **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 prolonged pressure, or pressure in combination with shear.**
- ✓ **If an ulcer/injury arises from a combination of factors that are primarily caused by pressure;**
  - **Code as a pressure ulcer/injury.**
- ✓ **If a pressure ulcer/injury is surgically closed with a flap or graft:**
  - **Code as a surgical wound and not as a pressure ulcer.**
  - **If the flap or graft fails, code as a surgical wound until healed.**

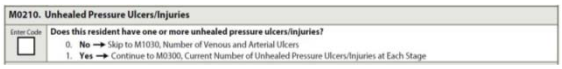
345

UNHEALED PRESSURE ULCERS/INJURIES (M0210)

- ✓ **Oral mucosal ulcers caused by pressure should <u>not</u> be coded in Section M;**
  - **Code in item L0200C, Abnormal mouth tissue.**
- ✓ **Residents with diabetes mellitus can have a pressure, venous, arterial, or diabetic neuropathic ulcer;**
  - **Primary etiology should be considered.**
- ✓ **Scab and eschar are different both physically and chemically;**
  - **Scab is evidence of wound healing.**
  - **Eschar is a collection of dead tissue within the wound.**
- ✓ **If a pressure ulcer/injury that healed during the look-back period of the current assessment, do <u>not</u> code the ulcer/injury on the assessment.**

346

UNHEALED PRESSURE ULCERS/INJURIES (M0210)



M0210. Unhealed Pressure Ulcers/Injuries

Enter Code | **Does this resident have one or more unhealed pressure ulcers/injuries?**

0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers
1. **Yes** → Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Does this resident have one or more unhealed pressure ulcers/injuries?

- **Code 0, No; Skip to M1030, Number of Venous and Artrial Ulcers.**
  - ✓ **If a pressure ulcer healed during the look-back period, and was <u>not</u> present on prior assessment, code 0.**
- **Code 1, Yes; Continue to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage.**

347

HEALED PRESSURE ULCER

Definition: 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.**

348

CURRENT NUMBER OF UNHEALED PRESSURE ULCERS/INJURIES AT EACH STAGE (M0300A–G)

Step 1, determine deepest anatomical stage:

- **Ulcer staging should be based on the deepest anatomic soft tissue damage that is visible or palpable.**
- **If ulcer tissue is obscured, consider it to be unstageable.**
- **Review ulcer history and maintain in medical record.**
- **Once the initial staging is identified, the pressure ulcer remains that stage until the ulcer heals, worsens or becomes unstageable.**
- **As pressure ulcers heal they are NEVER reverse staged.**

349

CURRENT NUMBER OF UNHEALED PRESSURE ULCERS/INJURIES AT EACH STAGE (M0300A–G)

Step 2, identify unstageable pressure ulcers:

- **Must visualize wound bed.**
- **Pressure ulcers that have eschar or slough – anatomic depth cannot be visualized or palpated – should be classified as unstageable.**
- **If wound bed is partially covered by eschar or slough – anatomical depth can be visualized or palpated – stage the ulcer—do not code as unstageable.**
- **A pressure injury with intact skin is a deep tissue injury (DTI), should be coded as unstageable.**
- **Pressure ulcers/injuries covered by a non-removable dressing/device should be coded unstageable.**

350

CURRENT NUMBER OF UNHEALED PRESSURE ULCERS/INJURIES AT EACH STAGE (M0300A–G)

Step 3, determine "present on admission":

If the pressure ulcer/injury was present on admission/entry or reentry and subsequently increased in numerical stage during the stay:

- **Code at the higher stage.**
- **The higher stage should not be considered as "present on admission".**

If the pressure ulcer/injury was present on admission/entry or reentry and becomes unstageable due to slough/eschar, during the stay:

- **Should not be considered as "present on admission".**

351

CURRENT NUMBER OF UNHEALED PRESSURE ULCERS/INJURIES AT EACH STAGE (M0300A–G)

Step 3, determine "present on admission" cont.:
If the pressure ulcer/injury was unstageable on admission/entry or reentry, then becomes numerically stageable later:

- ✓ **Should be considered as "present on admission";**
  - **Code at the numerical stage.**
- ✓ **If the ulcer/injury subsequently increases in numerical stage;**
  - **The higher stage is <u>not</u> considered "present on admission".**

Resident who has a pressure ulcer/injury originally acquired in the facility is hospitalized:

- ✓ **Returns with that pressure ulcer/injury at the same numerical stage;**
- ✓ **The pressure ulcer/injury should <u>not</u> be considered "present on admission".**

352

CURRENT NUMBER OF UNHEALED PRESSURE ULCERS/INJURIES AT EACH STAGE (M0300A–G)

Step 3, determine "present on admission" cont.:
Resident who has a pressure ulcer/injury that was "present on admission" is hospitalized and returns at the same numerical stage:

- **The pressure ulcer/injury is still coded as "present on admission" (because it was originally acquired outside the facility and has not changed stage).**

If a resident who has a pressure ulcer/injury is hospitalized and returns at a higher numerical stage or becomes unstageable due to slough/eschar:

- **Should be coded as "present on admission" upon reentry.**

353

CURRENT NUMBER OF UNHEALED PRESSURE ULCERS/INJURIES AT EACH STAGE (M0300A–G)

Step 3, determine "present on admission" cont.:
If a pressure ulcer was numerically staged, then became unstageable, as is subsequently debrided to be numerically staged, compare its numerical stage before and after it was unstageable:

- **If the numerical stage increased, code this pressure ulcer as <u>not</u> "present on admission".**

If two pressure ulcers merge, that were both "present on admission," continue to code the merged pressure ulcer as "present on admission."

- **Although two merged pressure ulcers might increase the overall surface area, there needs to be an increase in numerical stage or a change to unstageable due to slough/eschar in order for it to be considered not "present on admission."**

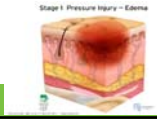
354

DEFINITION OF STAGE 1 PRESSURE INJURY

Observable, pressure-related alteration of intact skin, as compared to adjacent or opposite area on the body.

May include changes in one or more parameters:

- ✓ **Redness of tissue that does not turn white or pale when pressure is applied (non-blanchable).**
- ✓ **Skin may include changes in temperature, tissue consistency, sensation or coloration.**
- ✓ **Darker skin tones may not have visible blanching (may appear with persistent red, blue or purple hues).**
- ✓ **Color may differ from the surrounding area.**
- ✓ **Does not include deep tissue injury.**



STAGE 1 PRESSURE INJURIES (M0300A)

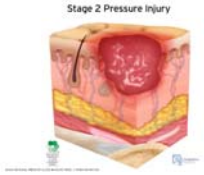
Section M	Skin Conditions
M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	
Enter Number	A. **Stage 1:** Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues 1. Number of Stage 1 pressure injuries

- **Coding Instructions:**
  - **Enter the number of Stage 1 pressure injuries that are currently present.**
  - **Enter 0 if no Stage 1 pressure injuries are currently present.**

356

DEFINITION OF STAGE 2 PRESSURE ULCER/INJURY

- **Partial thickness loss of dermis:**
  - **Presents as a shallow open ulcer with a red-pink wound bed, without slough or bruising.**
- **May appear as an intact or open/ruptured blister.**
- **Granulation tissue, slough, and eschar are not present.**
- **Do not include:**
  - **Skin tears.**
  - **Tape burns.**
  - **Moisture associated skin damage.**
  - **Excoriation.**



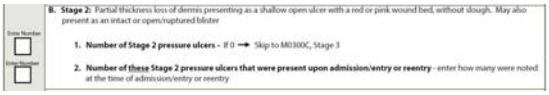
357

DEFINITION OF STAGE 2 PRESSURE ULCER/INJURY

- **When a pressure ulcer/injury 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 <u>not</u> code as a Stage 2.**
- **Most Stage 2 pressure ulcers/injuries should heal in a reasonable time frame (60 days).**
- **If pressure ulcer fails to show some evidence of healing in 14 days:**
  - **Reassess for potential complications.**
  - **Reassess overall clinical condition.**

358

STAGE 2 PRESSURE ULCERS (M0300B)



- **Coding Tip:**
  - **Stage 2 pressure ulcers by definition have partial-thickness loss of the dermis.**

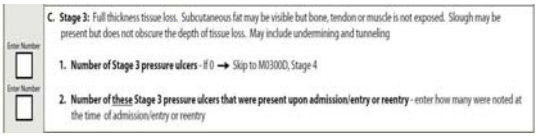
359

DEFINITION OF STAGE 3 PRESSURE ULCER/INJURY

- **Full thickness tissue loss.**
- **Subcutaneous fat may be visible, but bone, tendon or muscle is <u>not</u> exposed.**
- **Slough may be present but does <u>not</u> obscure depth of tissue loss.**
- **May include undermining or tunneling.**
- **May be shallow in areas that do <u>not</u> have subcutaneous tissue, such as bridge of nose, ear, occiput, malleolus.**
- **Areas of significant adiposity can develop extremely deep Stage 3 pressure ulcers.**
- **Bone/tendon/muscle is <u>not</u> visible or directly palpable.**
- **Do <u>not</u> code moisture-associated skin damage or excoriation here.**

360

STAGE 3 PRESSURE ULCERS (M0300C)


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

Enter Number

1. **Number of Stage 3 pressure ulcers** - If 0 → Skip to M0300D, Stage 4

Enter Number

2. **Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

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

361

DEFINITION OF STAGE 4 PRESSURE ULCER/INJURY

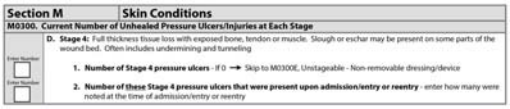
- **Full thickness tissue loss with exposed bone, tendon or muscle.**
- **At risk for osteomyelitis.**
- **Cartilage serves the same anatomical function as bone:**
  - **Pressure ulcers that has exposed cartilage should be classified as a Stage 4.**
- **Slough or eschar may be present on some parts of 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 so that the pressure ulcer is larger at its base than at the skin surface.**

362

STAGE 4 PRESSURE ULCERS (M0300D)


Section M | **Skin Conditions**

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

D. **Stage 4:** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling

Enter Number

1. **Number of Stage 4 pressure ulcers** - If 0 → Skip to M0300E, Unstageable - Non-removable dressing/device

Enter Number

2. **Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

- **Coding Tips:**
  - **Assessment of the pressure ulcer for tunneling and undermining is an important part of the complete pressure ulcer assessment.**
  - **Measurement of tunneling and undermining is not recorded on the MDS, but tunneling and undermining should be assessed, monitored, and treated as part of the comprehensive care plan.**

363

UNSTAGEABLE PRESSURE ULCER/INJURY RELATED TO NON-REMOVABLE DRESSING/DEVICE (M0300E)

✓ **Examples include a primary surgical dressing that cannot be removed, an orthopedic device, or cast.**

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

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

364

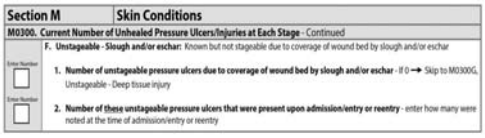
UNSTAGEABLE PRESSURE ULCERS/INJURY RELATED TO SLOUGH/ESCHAR (M0300F)

Slough tissue
- **Non-viable yellow, tan, gray, green or brown tissue.**
- **Usually moist.**
- **Can be soft, stringy and mucinous in texture.**
- **May be adherent to the base of the wound or present in clumps throughout the wound bed.**

Eschar tissue
- **Dead or devitalized tissue.**
- **Hard or soft in texture.**
- **Usually black, brown, or tan in color.**
- **May appear scab-like.**
- **Usually firmly adherent to the base of the wound and often the sides/edges of the wound.**

365

UNSTAGEABLE DUE TO SLOUGH OR ESCHAR (M0300F)



Section M	Skin Conditions
M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage - Continued	
	F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar
Enter Number ☐	1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar - If 0 → Skip to M0300G, Unstageable - Deep tissue injury
Enter Number ☐	2. Number of these unstageable pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry

- **Coding Tip:**
  - **Pressure ulcers that are covered with slough and/or eschar, and the wound bed cannot be visualized, should be coded as unstageable because the true anatomic depth of soft tissue damage (and therefore stage) cannot be determined. 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.**

366

UNSTAGEABLE - DEEP TISSUE INJURY (M0300G)

- Purple or maroon area of discolored intact skin due to damage of underlying soft tissue.
- Area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
- If suspected deep tissue injury opens to an ulcer, reclassify the ulcer into appropriate stage.
- In dark skin tones, area is probably <u>not</u> purple/maroon, rather darker than surrounding tissue.

Unstageable – Deep tissue injury:

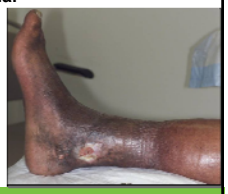
1. Number of unstageable pressure injuries presenting as deep tissue injury:
   - If 0; Skip to M1030, Number of Venous and Arterial Ulcers.
2. Number of <u>these</u> unstageable pressure injuries that were present upon admission/entry or reentry – enter how many were noted at the time of admission/entry or reentry.

367

NUMBER OF VENOUS AND ARTERIAL ULCERS (M1030)

Definition of Venous Ulcers:

- Caused by peripheral venous disease.
- Commonly occur proximal to medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of leg.
- Wound may start due to minor trauma.
- Characterized by:
  - Irregular wound edges.
  - Leg edema.
  - Possible pain.
  - Red granular wound bed.
  - Yellow fibrinous material.
  - Exudate.

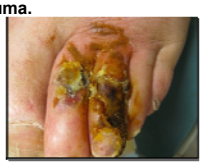


368

NUMBER OF VENOUS AND ARTERIAL ULCERS (M1030)

Definition of Arterial Ulcers:

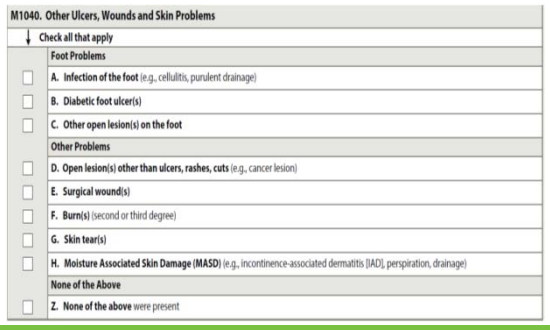
- Caused by peripheral arterial disease.
- Wound may start due to minor trauma.
- Ischemia is major etiology.
- Common location:
  - Tips and top of toes.
  - Top of foot.
  - Distal to medial malleolus.



- Characterized by:
  - Necrotic tissue or pale pink wound bed.
  - Lower extremity and foot pulses may be diminished or absent.
  - Often painful.
  - Minimal exudate.
  - Minimal bleeding.

369

OTHER ULCERS, WOUNDS AND SKIN PROBLEMS (M1040)



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

370

OTHER ULCERS, WOUNDS AND SKIN PROBLEMS (M1040)

Check all that apply in the last 7 days:
Pressure ulcers/injuries coded in M0200 – M0300 should <u>not</u> be coded here!

A. Infection of the foot (cellulitis, purulent drainage).
B. Diabetic foot ulcer(s).
C. Other open lesion(s) on the foot (cuts, fissures).
D. Open lesion(s) other than ulcers, rashes, cuts (bullous pemphigoid).

371

OTHER ULCERS, WOUNDS AND SKIN PROBLEMS (M1040)

Check all that apply in the last 7 days, cont.:
Pressure ulcers/injuries coded in M0200 – M0300 should <u>not</u> be coded here!

E. Surgical wound(s).
F. Burn(s) (second or third degree).
G. Skin tear(s).
H. Moisture Associated Skin Damage (MASD) (incontinence-associated dermatitis (IAD), perspiration, drainage).
Z. None of the above were present.

372

SKIN AND ULCER/INJURY TREATMENTS (M1200)

Section M	Skin Conditions
M1200. Skin and Ulcer/Injury Treatments	
↓ Check all that apply	
☐	A. Pressure reducing device for chair
☐	B. Pressure reducing device for bed
☐	C. Turning/repositioning program
☐	D. Nutrition or hydration intervention to manage skin problems
☐	E. Pressure ulcer/injury care
☐	F. Surgical wound care
☐	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
☐	H. Applications of ointments/medications other than to feet
☐	I. Application of dressings to feet (with or without topical medications)
☐	Z. None of the above were provided

373

SKIN AND ULCER/INJURY TREATMENTS (M1200)

Check all that apply:

A. Pressure reducing device for chair.
B. Pressure reducing device for bed.
C. Turning/repositioning program.
D. Nutrition or hydration intervention to manage skin problem.
E. Pressure ulcer/injury care.
F. Surgical wound care.
G. Application of nonsurgical dressings other than to feet.
H. Application of ointments/medications other than to feet.
I. Applications of dressings to feet.
Z. None of the above were provided.

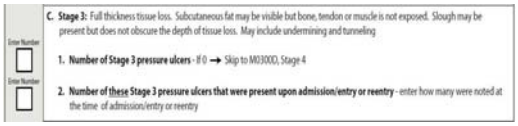
374

SECTION M: SKIN CONDITIONS PRACTICE SCENARIOS


PRESSURE ULCER PRACTICE CODING SCENARIO 1 (M0300)

A resident develops a Stage 2 pressure ulcer while at the nursing facility. The resident is hospitalized due to pneumonia for 8 days and returns with a Stage 3 pressure ulcer in the same location.

- **How would you code M0300C1 and M0300C2 on the 5-Day PPS assessment?**



376

HOW WOULD YOU CODE M0300C?

1. Number of Stage 3 pressure ulcers.
- **A. 0**
- **B. 1**
- **C. Enter a dash (–)**

2. Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry.
- **A. 0**
- **B. 1**
- **C. Enter a dash (–)**

***Rationale*:**

377

M0300 PRESSURE ULCER PRACTICE CODING SCENARIO 2

- **A resident is admitted to a nursing facility with a short leg cast to the right lower extremity.**
- **He has no visible wounds on admission but arrives with documentation that a pressure ulcer exists under the cast.**
- **Two weeks after admission to the nursing facility, the cast is removed by the physician.**
- **Following the removal of the cast, the right heel is observed and assessed as a Stage 3 pressure ulcer, which remains until the subsequent assessment.**

378

HOW WOULD YOU CODE M0300C ON THE SUBSEQUENT ASSESSMENT?

1. **Number of Stage 3 pressure ulcers?**
   - **A. 0**
   - **B. 1**
   - **C. Enter a dash (–)**

2. **Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry?**
   - **A. 0**
   - **B. 1**
   - **C. Enter a dash (–)**

379

HOW WOULD YOU CODE M0300C ON THE SUBSEQUENT ASSESSMENT?

Rationale:

380

PRESSURE ULCER PRACTICE CODING SCENARIO 3

- **Mr. M. was admitted to the nursing facility with eschar tissue covering both the right and left heels, as well as a Stage 2 pressure ulcer on the coccyx.**
- **Mr. M's pressure ulcers were reassessed before the subsequent assessment, and the Stage 2 coccyx pressure ulcer had healed.**
- **The left-heel eschar became fluctuant, showed signs of infection, had to be debrided at the bedside, and was subsequently numerically staged as a Stage 4 pressure ulcer.**
- **The right-heel eschar remained stable and dry (i.e., remained unstageable).**

381

HOW WOULD YOU CODE M0300D ON THE SUBSEQUENT ASSESSMENT?

1. **Number of Stage 4 pressure ulcers.**
   - **A. 0**
   - **B. 1**
   - **C. Enter a dash (–)**

2. **Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry.**
   - **A. 0**
   - **B. 1**
   - **C. Enter a dash (–)**

382

HOW WOULD YOU CODE M0300F ON THE SUBSEQUENT ASSESSMENT?

1. **Number of unstageable pressure ulcers – slough and/or eschar.**
   - **A. 0**
   - **B. 1**
   - **C. Enter a dash (–)**

2. **Number of these unstageable pressure ulcers – slough and/or eschar that were present upon admission/entry or reentry.**
   - **A. 0**
   - **B. 1**
   - **C. Enter a dash (–)**

383

HOW WOULD YOU CODE M0300D & F ON THE SUBSEQUENT ASSESSMENT?

***Rationale*:**

384

M0300 PRESSURE ULCER PRACTICE CODING SCENARIO 4

- **A resident is admitted to the nursing facility with a blood-filled blister on the right heel.**
- **After further assessment of the surrounding tissues, it is determined that the heel blister is a DTI.**
- **Three weeks after admission, the right-heel blister is drained and conservatively debrided at the bedside.**
- **After debridement, the right heel is staged as a Stage 3 pressure ulcer.**
- **On the subsequent assessment, the right heel remains at Stage 3.**

385

HOW WOULD YOU CODE M0300C ON THE SUBSEQUENT ASSESSMENT?

1. **Number of Stage 3 pressure ulcers at M0300C1.**
   - **A. 0**
   - **B. 1**
   - **C. Enter a dash (–)**
2. **Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry at M0300C2.**
   - **A. 0**
   - **B. 1**
   - **C. Enter a dash (–)**

386

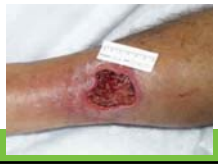
HOW WOULD YOU CODE M0300C ON THE SUBSEQUENT ASSESSMENT?

***Rationale*:**

387

M0300 PRESSURE ULCER PRACTICE CODING SCENARIO 5

- **Mr. H was admitted with a known pressure ulcer/injury due to a non-removable dressing.**
- **Ten days after admission, the surgeon removes the dressing, and a Stage 2 pressure ulcer is identified.**
- **Two weeks later the pressure ulcer is determined to be a full thickness ulcer and is at that point Stage 3.**
- **It remains Stage 3 at the time of the next assessment.**



388

HOW WOULD YOU CODE M0300C ON THE SUBSEQUENT ASSESSMENT?

1. **Number of Stage 3 pressure ulcers at M0300C1.**
   - **A. 0**
   - **B. 1**
   - **C. Enter a dash (–)**

2. **Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry at M0300C2.**
   - **A. 0**
   - **B. 1**
   - **C. Enter a dash (–)**

389

HOW WOULD YOU CODE M0300C ON THE SUBSEQUENT ASSESSMENT?

Rationale:

390

SECTION N: MEDICATIONS NO CHANGES



391

MEDICATIONS(N0300 THROUGH N0410)

- **N0300, Injections:**
  - **Days that injections of any type were received.**
- **N0350, Insulin:**
  - **A. Days insulin injections were received.**
  - **B. Days that insulin orders were changed.**
- **N0410, Medications Received (days):**
  - **A. Antipsychotic**
  - **B. Antianxiety**
  - **C. Antidepressant**
  - **D. Hypnotic**
  - **E. Anticoagulant**
  - **F. Antibiotic**
  - **G. Diuretic**
  - **H. Opioid**

392

MEDICATIONS(N0450 THROUGH N2005)

- **N0450, Antipsychotic Medication Use:**
  - **A. Did resident receive antipsychotics since admission/entry or reentry or the prior OBRA assessment.**
  - **B. Has a gradual dose reduction been attempted?**
  - **C. Date of last attempted GDR.**
  - **D. Physician documented GRD as clinically contraindicated.**
  - **E. Date physician documented GRD as clinically contraindicated.**
- **N2001, Drug Regimen Review:**
  - **Did drug regimen review identify potential medication issues?**
- **N2003, Medication Follow-Up**
  - **Did facility contact physician by midnight and complete recommendations?**
- **N2005, Medication Intervention**
  - **Did facility contact and complete physician recommendations by midnight of the next day?**

393

SECTION O: SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS



394

SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS (O0100)

Section O	Special Treatments, Procedures, and Programs	
O0100. Special Treatments, Procedures, and Programs Check all of the following treatments, procedures, and programs that were performed during the last **14 days**		
1. While NOT a Resident Performed ***while NOT a resident*** of this facility and within the ***last 14 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank **2. While a Resident** Performed ***while a resident*** of this facility and within the ***last 14 days***	**1. While NOT a Resident**	**2. While a Resident**
	↓ Check all that apply ↓	
Cancer Treatments		
A. Chemotherapy	☐	☐
B. Radiation	☐	☐
Respiratory Treatments		
C. Oxygen therapy	☐	☐
D. Suctioning	☐	☐
E. Tracheostomy care	☐	☐
F. Invasive Mechanical Ventilator (ventilator or respirator)	☐	☐
G. Non-invasive Mechanical Ventilator (BIPAP/CPAP)	☐	☐
Other		
H. IV medications	☐	☐
I. Transfusions	☐	☐
J. Dialysis	☐	☐
K. Hospice care	☐	☐
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	☐	☐
None of the Above		
Z. None of the above	☐	☐

395

SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS (O0100)

- **Look-back period is the last 14 days.**
- **Code even if resident performs procedure themselves or after set up.**
- **Do <u>not</u> code if service was provided solely in conjunction with a surgical procedure (including routine pre-and post-operative procedures) or diagnostic procedure (such as IV medications or ventilators).**
- **Two columns to record information:**
  - **Column 1 – While <u>not</u> a resident.**
  - **Column 2 – While a resident.**

396

SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS (O0100)

Cancer Treatments:

A. Chemotherapy:

- **Antineoplastic given by any route.**
- **Only drugs actually used for cancer treatment - evaluate reason for medication use.**
- **IV, IV med, blood transfusions during chemo are not coded.**
- **Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer should not be coded in this item, as they are not considered chemotherapy for the purpose of coding the MDS.**

397

SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS (O0100)

Cancer Treatments, cont.:

B. Radiation:

- **Intermittent therapy.**
- **Radiation implant.**

Respiratory Treatments:

C. Oxygen therapy:

- **Continuous or intermittent to relieve hypoxia.**
- **Code when used in BiPAP/CPAP.**
- **Hyperbaric oxygen for wound therapy not coded.**

398

SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS (O0100)

Respiratory Treatments, cont.:

D. Suctioning:

- **Tracheal or nasopharyngeal only.**
- **Oral suctioning not included.**

E. Tracheostomy care:

- **Cleansing of trach or cannula.**

F. Invasive Mechanical Ventilator (ventilator or respirator):

- **Any electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation:**
  - **Includes residents receiving ventilation via an endotracheal tube (nasally or orally intubated) or a tracheostomy.**
  - **Do not code when used only as a substitute for BiPAP or CPAP.**
  - **Code a resident who has been weaned off or is currently being weaned of a respirator or ventilator in the last 14 days.**

399

SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS (O0100)

Respiratory Treatments, cont.:

G. Non-invasive Mechanical Ventilator (BiPAP/CPAP):

- **Any type that prevent airways from closing.**
- **If ventilator or respirator is used as a substitute for BiPAP or CPAP may code here.**

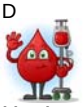
Other:

H. IV Medications:

- **Do not code flushes to keep IV patent.**
- **Do not code subcutaneous pumps.**
- **Do not code Dextrose 50% or Lactated Ringers.**
- **Do not code IV meds administered during dialysis or chemotherapy.**
- **Does include intrathecal and baclofen pumps.**

400

SPECIAL TREATMENTS, PROGRAMS AND PROCEDURES (O0100)



Other, cont.:

I. Transfusions:

- **Blood or any blood products (platelets, synthetic blood products), administered directly into the bloodstream.**
  - **Do not code when administered during dialysis or chemotherapy.**

J. Dialysis:

- **Peritoneal or renal dialysis/inside or outside the facility.**
- **Do not code IV, IV med, blood transfusions during dialysis.**

K. Hospice Care:

- **Hospice must be licensed by the state and/or certified under Medicare program as a provider.**

~~L. Respite Care~~: DELETED

401

SPECIAL TREATMENTS, PROGRAMS AND PROCEDURES (O0100)

Other, cont.:

M. Isolation or quarantine for active infectious disease:

- **Does not include standard precautions.**
- **Code only when transmission-based precautions required.**

- **Code only when a single room isolation is required because of active infection with highly transmissible or epidemiologically significant pathogens acquired by physical contact or airborne or droplet transmission.**

- **Do not code for history of infectious disease (MRSA).**
- **Do not code for UTI, encapsulated pneumonia and wound infections.**

Z. None of the above.

402

CONDITIONS FOR "SINGLE ROOM ISOLATION"

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

403

INFLUENZA VACCINE (O0250)

A. Did the resident receive Influenza vaccine in this facility for this year's Influenza season?
- **Code 0, No, skip to O0250C.**
- **Code 1, Yes, continue to O0250B.**

B. Date vaccine received:
- **MM-DD-YYYY (if month/day a single digit, fill first box with "0").**
- **If date is unknown or not available, a single dash ("-") is entered in the first box.**

- **If vaccinated status cannot be determined, administer vaccine according to standards of clinical practice.**

404

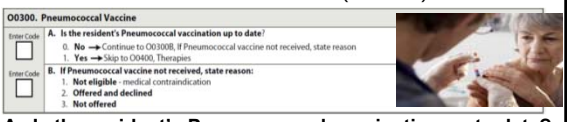
INFLUENZA VACCINE (O0250)

C. If influenza vaccine <u>not</u> received, state reason:
- **Code 1, Resident <u>not</u> in facility during flu season.**
- **Code 2, Received outside of this facility.**
- **Code 3, <u>Not</u> eligible (medical contraindication).**
- **Code 4, Offered and declined.**
- **Code 5, <u>Not</u> offered.**
- **Code 6, Inability to obtain vaccine due to a declared shortage.**
- **Code 9, None of the above.**

✓ **Influenza season ends when influenza is no longer active in area.**
✓ **O0250C value carries forward until new season begins.**

405

PNEUMOCOCCAL VACCINE (O0300)


O0300. Pneumococcal Vaccine

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

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

A. Is the resident's Pneumococcal vaccination up to date?

- **Code 0, No, continue to O0300B.**
- **Code 1, Yes, skip to O0400.**

B. If Pneumococcal vaccination <u>not</u> received, state reason:

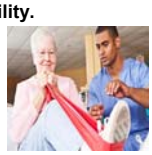
- **Code 1, <u>Not</u> eligible (medical contraindication).**
- **Code 2, Offered and declined.**
- **Code 3, <u>Not</u> offered.**

406

THERAPIES (O0400)

Code only medically necessary therapies that occurred after admission/readmission.

- **Therapy can occur inside or outside facility.**
- **All Therapies must be:**
  - **Ordered by a physician (or approved extender).**
  - **Based on a qualified therapist's assessment and treatment plan.**
  - **Documented in the resident's medical record.**
  - **Care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective.**



407

MINUTES FOR ST, OT AND PT (O0400)

1. Individual Minutes:

- **Total number of minutes of therapy provided by one therapist or assistant to one resident at a time.**

2. Concurrent Minutes:

- **<u>Medicare Part A</u> – total number of minutes while treating 2 residents at the same time, <u>NOT</u> performing the same or similar activities, both within line-of-sight of treating therapist or assistant.**
- **<u>Medicare Part B</u> - residents <u>cannot</u> be treated concurrently.**
- **All other payers follow Medicare Part A instructions.**

408

MINUTES FOR ST, OT AND PT (O0400)

3. **Group Minutes:**
   - **Total number of minutes of therapy provided in a group setting.**
   - **Medicare Part A – treatment of 2 to 6 residents performing same or similar activities and supervised by a therapist or assistant who is not supervising anyone else.**
   - **Medicare Part B – treatment of 2 or more residents at the same time.**
   - **All other payers follow Medicare Part A instructions.**

409

DAYS AND DATES FOR ST, OT, AND PT (O0400)

3. **A. Co-treatment Minutes:**
   - **Total number of minutes each discipline of therapy was administered to the resident in co-treatment session.**
4. **Days:**
   - **Number of days therapy services were provided in the last 7 days (a day = skilled treatment for 15 minutes or more).**
   - **Use total minutes of therapy (individual + concurrent + group), without any adjustment, to determine if the day is counted.**

410

THERAPY- FOR ST, OT, AND PT (O0400)

5. **Therapy Start Date:**
   - **Record the date the most recent therapy regimen (since the most recent entry/reentry) started.**
   - **Count the date the initial therapy evaluation is conducted regardless if treatment was rendered or not, OR**
   - **The date of resumption.**
6. **Therapy End Date:**
   - **Record the date the most recent therapy regimen (since the most recent entry/reentry) ended.**
   - **Last date resident received skilled therapy.**
   - **If therapy is ongoing, enter dashes.**

411

RESPIRATORY THERAPY (O0400D)

Appendix A: Respiratory Therapy:

- **Services provided by a qualified professional (respiratory therapist, respiratory nurse).**
- **Services include coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc.**
- **A respiratory nurse must be proficient in the modalities either through formal nursing or specific training and may provide these modalities as allowed under the state Nurse Practice Act and applicable State laws.**

412

PSYCHOLOGICAL THERAPY (O0400E) RECREATIONAL THERAPY (O0400F)

Appendix A:

- **Psychological Therapy:**
  - **Provided by a psychiatrist, psychologist, clinical social worker, or clinical nurse specialist in mental health as allowable under state laws.**

- **Recreational Therapy:**
  - **Services provided or directly supervised by a qualified recreational therapist.**
  - **Includes treatment and activities using a variety of techniques; including arts and crafts, animals, games, etc.**

413

MINUTES OF THERAPY (O0400)

- ✓ **Include only therapies provided after resident admitted to the nursing home.**
- ✓ **If a resident returns from a hospital stay, an initial evaluation must be done again after entry and only those therapies that occurred since reentry can be coded on the MDS.**
- ✓ **Do <u>not</u> count initial evaluation or documentation time.**
- ✓ **Can count subsequent re-evaluation time if part of the treatment process.**
- ✓ **Can count family education when resident is present and must be documented.**

414

MINUTES OF THERAPY (O0400)

- ✓ **Resident's treatment time starts when they begin the first treatment activity or task, and ends when resident finishes the last task or last apparatus.**
- ✓ **Only skilled therapy time shall be coded in the MDS.**
- ✓ **Time required to adjust equipment or prepare for individualized therapy is set-up time and can be included in the count of minutes.**
- ✓ **COTA and PTA services for OT and PT only count as long as they function under the direction of the licensed therapist.**
- ✓ **Do not round up minutes.**
- ✓ **Conversion of units to minutes or minutes to units is not allowed.**

415

MINUTES OF THERAPY (O0400)

Skilled therapy services must meet all of the following:

- **Ordered by a physician.**
- **Must be directly and specifically related to an active written treatment plan approved by the physician.**
- **Services must be of a level of complexity and sophistication requiring the judgement, knowledge, and skills of a therapist.**
- **Must be an expectation that the condition will;**
  - **Improve materially in a reasonable and generally predictable period of time, OR**
  - **Services must be necessary for a safe and effective maintenance plan, OR**
  - **Services must require the skills of a qualified therapist.**

416

MINUTES OF THERAPY (O0400)

Skilled therapy services must meet all of the following:

- **Services must be under accepted standards of medical practices for the resident's condition.**
- **Services must be reasonable and necessary including amount, frequency, and duration.**
- **Medicare does not recognize speech-language pathology assistants.**
- **Therapy logs should be used to verify services and validate information reported on the MDS.**
- **Different modes of therapy must be documented separately.**

417

NON-SKILLED SERVICES

- ✓ **Services provided at the request of the resident or family that is not medically necessary shall not be counted on the MDS.**
- ✓ **When the performance of a maintenance program does not require the skills of a therapist, such services are not considered therapy services in this context and may not be coded on the MDS.**
- ✓ **Services provided by therapy aides are not skilled services.**
- ✓ **When a resident refuses therapy, the time spent investigating the refusal or trying to persuade the resident to participate is not skilled services and shall not be included in therapy minutes.**

418

CO-TREATMENT (O04003A)

Medicare Part A:

- **Two clinicians (therapists or therapy assistant), each from a different discipline, treat one resident at the same time with different treatments.**
- **Both disciplines may code the treatment in full.**

Medicare Part B:

- **Therapists or therapy assistants, working together as a "team" to treat one or more residents cannot each bill separately for the same or different service provided at the same time to the same resident(s).**

419

THERAPY AIDES AND STUDENTS

Therapy Aides:

- **May not provide skilled services.**
- **Only time spent on set-up preceding skilled therapy may be coded.**
- **Must be under direct supervision of the therapist or assistant.**

Therapy Students:

- **Medicare Part A:**
  - **Therapy students are not required to be in line-of-sight.**
- **Medicare Part B:**
  - **Qualified professional must be present the entire session.**
  - **Practitioner not engaged in treating another resident or other tasks at the same time.**
  - **Qualified professional is responsible for services and signs all documentation.**

420

DISTINCT CALENDAR DAYS OF PART A THERAPY (O0420)

O0420. Distinct Calendar Days of Therapy

Enter Number of Days	Record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 minutes in the past 7 days.
☐	

Record the number of calendar days the resident received therapy for at least 15 minutes in the past 7 days:

- ✓ **When resident receives more than one therapy discipline on a given calendar day, counts for one calendar day.**

421

CONCURRENT & GROUP LIMIT: COMPLIANCE

- **Compliance with the concurrent/group therapy limit will be monitored by new items on the PPS Discharge Assessment (O0425).**
  - **Providers will report the number of minutes, per mode and per discipline, for the entirety of the PPS stay.**
  - **If the total number of concurrent and group minutes, combined, comprises more than 25% of the total therapy minutes provided to the resident, for any therapy discipline, then the provider will receive a warning message on their final validation report.**
- **How to calculate compliance with the concurrent/group therapy limit.**
  - **Step 1: Total Therapy Minutes, by discipline (O0425X1 + O0425X2 + 0425X3).**
  - **Step 2: Total Concurrent and Group Therapy Minutes, by discipline (O0425X2 + O0425X3).**
  - **Step 3: C/G Ratio (Step 2 Result / Step 1 Result).**
  - **Step 4: If Step 3 result is greater than 0.25, then non-compliant.**

422

CONCURRENT & GROUP LIMIT: EXAMPLE 1

- **Example 1:**
  - **Total PT Individual Minutes (O0425C1): 2,000**
  - **Total PT Concurrent Minutes (O0425C2): 600**
  - **Total PT Group Minutes (O0425C3): 1,000**
- **Does this comply with the concurrent/group therapy limit?**
  - **Step 1: Total PT Minutes (O0425C1 + O0425C2 + O0425C3): 3,600 minutes**
  - **Step 2: Total PT Concurrent and Group Therapy Minutes (O0425C2 + O0425C3): 1,600 minutes**
  - **Step 3: C/G Ratio (Step 2 Result / Step 1 Result): 0.44**
  - **Step 4: 0.44 is greater than 0.25, therefore this is non-compliant.**

423

CONCURRENT & GROUP LIMIT: EXAMPLE 2

- **Example 2:**
  - **Total SLP Individual Minutes (O0425C1): 1,200**
  - **Total SLP Concurrent Minutes (O0425C2): 100**
  - **Total SLP Group Minutes (O0425C3): 200**
- **Does this comply with the concurrent/group therapy limit?**
  - **Step 1: Total SLP Minutes (O0425C1 + O0425C2 + O0425C3): _____**
  - **Step 2: Total PT Concurrent and Group Therapy Minutes (O0425C2 + O0425C3): _____**
  - **Step 3: C/G Ratio (Step 2 Result / Step 1 Result): _____**
  - **Step 4: _____**

424

PART A THERAPIES (O0425) (NEW)

Complete only if a Part A Discharge (A0310H = 1).

1. **Individual Minutes - Code the total number of minutes that were provided on an individual basis during the entire Part A stay.**
2. **Concurrent Minutes - Code the total number of minutes that were provided on a concurrent basis during the entire Part A stay.**
3. **Group Minutes - Code the total number of minutes that were provided in a group during the entire Part A stay.**
4. **Co-treatment Minutes - Code the total number of minutes each discipline of therapy was administered in co-treatment sessions during the entire Part A stay.**

425

PART A THERAPIES (O0425) (NEW)

Complete only if a Part A Discharge (A0310H = 1).

A5. **Speech-Language Pathology Days - Code the number of days that SLP therapy services were provided over the entire Part A stay.**

B5. **Occupational Therapy Days - Code the number of days OT services were provided over the entire Part A stay.**

C5. **Physical Therapy Days - Code the number of days PT services were provided over the entire Part A stay.**

426

PART A THERAPIES (O0425) (NEW)

Complete only if a Part A Discharge (A0310H = 1).

- **A. Speech-Language Pathology and Audiology Services:**
  - ✓ **O0425A1, 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).**
  - ✓ **O0425A2, 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).**

427

PART A THERAPIES (O0425) (NEW)

Complete only if a Part A Discharge (A0310H = 1).

- **A. Speech-Language Pathology and Audiology:**
  - ✓ **O0425A3, Group minutes – record total number of minutes this therapy was administered to the resident as part of a group of residents since the start date of the resident's most recent Medicare Part A stay (A2400B).**

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

  - ✓ **O0425A4, 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).**
  - ✓ **O0425A5, 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).**

428

PART A THERAPIES (O0425) (NEW)

Complete only if a Part A Discharge (A0310H = 1).

- **B. Occupational Therapy:**
  - ✓ **O0425B1, 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).**
  - ✓ **O0425B2, 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).**

429

PART A THERAPIES (O0425) (NEW)

Complete only if a Part A Discharge (A0310H = 1).

- **B. Occupational Therapy:**
  - ✓ **O0425B3, Group Minutes - record total number of minutes this therapy was administered to the resident as part of a group of residents since the start date of the resident's most recent Medicare Part A stay (A2400B).**

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

- ✓ **O0425B4, 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).**
- ✓ **O0425B5, 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).**

430

PART A THERAPIES (O0425) (NEW)

Complete only if a Part A Discharge (A0310H = 1).

C. Physical Therapy:

- ✓ **O0425C1, 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).
- ✓ **O0425C2, 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).**

431

PART A THERAPIES (O0425) (NEW)

Complete only if a Part A Discharge (A0310H = 1).

C. Physical Therapy:

- ✓ **O0425C3, Group minutes - record total number of minutes this therapy was administered to the resident as part of a group of residents since the start date of the resident's most recent Medicare Part A stay (A2400B).**

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

- ✓ **O0425C4, 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).**
- ✓ **O0425C5, 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).**

432

DISTINCT CALENDAR DAYS OF PART A THERAPY (O0430) (NEW)

Complete only if a Part A Discharge (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).**

433

RESUMPTION OF THERAPY (O0450)

- ~~✓ Has the previous rehabilitation therapy regimen (speech, occupational, and/or physical therapy) ended, as reported on the End of Therapy OMRA, and has this regimen now resumed at exactly the same level for each discipline?~~
- ✓ **CMS no longer requires this item.**
- ✓ **Not required in Kentucky.**

434

RESTORATIVE NURSING PROGRAMS (O0500)

- **Nursing interventions that promote resident's ability to adapt and adjust to living as independently and safely as possible.**
- **Focus is to achieve and maintain optimal physical, mental and psychosocial functioning.**

O0500. Restorative Nursing Programs

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

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

435

RESTORATIVE NURSING PROGRAMS (O0500)

Must meet specific criteria in order to code:

- **Measurable objectives and interventions documented in care plan and medical record.**
- **Evaluation by licensed nurse in medical record.**
- **Nursing assistants/aides must be trained in the techniques that promote resident involvement.**
- **An RN or LPN must supervise the activities in a nursing restorative program.**
- **Groups no larger than 4 residents per supervising helper or caregiver.**

436

RESTORATIVE NURSING PROGRAMS (O0500)

Techniques:

A. **Range of Motion (Passive)**
B. **Range of Motion (Active)**
C. **Splint or Brace Assistance**

Training and Skill Practice:

D. **Bed Mobility**
E. **Transfer**
F. **Walking**
G. **Dressing and/or Grooming**
H. **Eating and/or Swallowing**
I. **Amputation/Prosthesis Care**
J. **Communication**

437

RESTORATIVE NURSING PROGRAMS (O0500)

- **Record the number of days that each of the restorative nursing programs were performed for at least 15 minutes/day in the last 7 days.**
- **Enter 0 days if none or programs were less than 15 minutes daily.**
- **The time provided for each restorative program must be coded separately.**
- **Cannot claim techniques that therapists claim under O0400A, B, C <u>OR</u> O0425A, B, C.**
- **Does <u>not</u> require a physician order.**

438

PHYSICIAN EXAMINATIONS (O0600)
PHYSICIAN ORDERS (O0700)

O0600. Physician Examinations

Enter Days | Over the last 14 days, on how many days did the physician (or authorized assistant or practitioner) examine the resident?

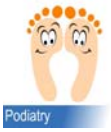
O0700. Physician Orders

Enter Days | Over the last 14 days, on how many days did the physician (or authorized assistant or practitioner) change the resident's orders?

- **Required for RUG-III**

439

PHYSICIAN EXAMINATIONS (O0600)



- **Enter number of days in the last 14 days that the physician <u>examined</u> the resident.**
- **Includes MDs, DOs, Podiatrists, Dentists and PAs, NPs or CNSs as allowable by state law.**
- **Examination (full or partial) can occur in facility or in physician's office.**
- **Telehealth included per requirements.**
- **Does <u>not</u> include exams prior to admission or readmission, in ER, while in hospital observation stay or by a Medicine Man.**
- **Does include off-site exam (dialysis or radiation therapy) with documentation in the medical record.**
- **Psychological therapy visits by a licensed psychologist (PhD) may <u>not</u> be coded here.**
  - ✓ **Instead code at O0400E, Psychological Therapy.**

440

PHYSICIAN ORDERS (O0700)

- **Enter number of <u>days</u> in last 14 days that the physician <u>changed the orders.</u>**
- **Includes written, telephone, fax or consultation orders for new or altered treatment.**
- **<u>Excludes</u> standard admit orders, return admit orders, renewal orders, clarification orders without changes.**
- **Orders on day of admission as a result of an unexpected change/deterioration or injury are considered new or altered orders and do count.**

441

PHYSICIAN ORDERS (O0700)

- **Sliding scale dosage schedule to cover dosages depending on lab values does not count as an order change when a dose is given.**
- **PRN orders already on file and notification of the physician to activate order does not count as new order.**
- **Medicare certification/recertification does not count.**
- **Order for a consultant may count but must be reasonable (for a new or altered treatment).**
- **Order on the last day of observation period for a consult planned 3-6 months in the future should be reviewed carefully.**
- **Order to transfer care to another physician is not counted.**
- **Order written by a pharmacist does not count.**

442

SECTION P: RESTRAINTS NO CHANGES



443

RESTRAINTS AND ALARMS (P0100)

P0100, Physical Restraints:

- **A. Bed rail**
- **B. Trunk restraint**
- **C. Limb restraint**
- **D. Other**

Used in Chair or Out of Bed:

- **E. Trunk restraint**
- **F. Limb restraint**
- **G. Chair prevents rising**
- **H. Other**

444

RESTRAINTS AND ALARMS (P0200)

P0200, Alarms:

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

445

SECTION Q: PARTICIPATION IN ASSESSMENT AND GOAL SETTING NO CHANGES


446

PARTICIPATION IN ASSESSMENT AND GOAL SETTING (Q0100 THROUGH Q0600)

- **Q0100, Participation in Assessment**
- **Q0300, Resident's Overall Expectation**
- **Q0400, Discharge Plan**
- **Q0490, Resident's Preference to Avoid Being Asked Question Q0500B**
- **Q0500, Return to Community**
- **Q0550, Resident's Preference to Avoid Being Asked Question Q0500B Again**
- **Q0600, Referral**

447

(Q0300) PRACTICE CODING SCENARIO

- **Mrs. G, an 84 year old female with severe dementia, is admitted by her daughter for a 7-day period. Her daughter stated that she "just needs to have a break." Her mother has been wandering at times and has little interactive capacity. The daughter is planning to take her mother back home at the end of the week.**

How would you code "resident's overall expectation?"

What is the rational?

448

HOW WOULD YOU CODE Q0300?

A. Select one for resident's overall goal established during assessment process?
1. **Expects to be discharged to the community.**
2. **Expects to remain in this facility.**
3. **Expects to be discharged to another facility.**
9. **Unknown or uncertain.**

B. Indicate information source for Q0300A.
1. **Resident.**
2. **Family or significant other.**
3. **Guardian or legally authorized representative.**
9. **Unknown or uncertain.**

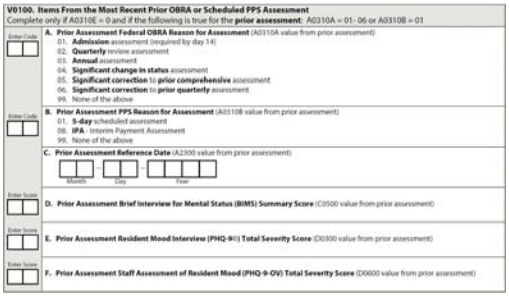
***Rationale*:**

449

SECTION V: CARE AREA ASSESSMENT (CAA) SUMMARY NO CHANGES


450

ITEMS FROM THE MOST RECENT PRIOR OBRA OR PPS ASSESSMENT (V0100)



V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment
Complete only if A0310E = 0 and if the following is true for the **prior assessment**: A0310A = 01- 06 or A0310B = 01

Enter Code
A. Prior Assessment Federal OBRA Reason for Assessment (A0310A value from prior assessment)
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. None of the above

Enter Code
B. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment)
01. **5-day** scheduled assessment
08. **IPA** - Interim Payment Assessment
99. None of the above

C. Prior Assessment Reference Date (A2300 value from prior assessment)
Month – Day – Year

Enter Score
D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 value from prior assessment)

Enter Score
E. Prior Assessment Resident Mood Interview (PHQ-9©) Total Severity Score (D0300 value from prior assessment)

Enter Score
F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score (D0600 value from prior assessment)

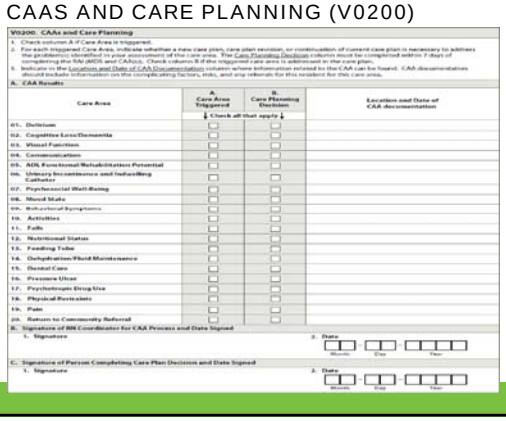
451

ITEMS FROM THE MOST RECENT PRIOR OBRA OR PPS ASSESSMENT (V0100)

A. Prior assessment federal OBRA reason for assessment.
B. Prior assessment PPS reason for assessment.
C. Prior assessment reference date.
D. Prior assessment BIMS summary score.
E. Prior assessment PHQ-9 total severity score.
F. Prior assessment staff assessment of resident mood PHQ-9-OV total severity score.

452

CAAS AND CARE PLANNING (V0200)



V0200. CAAs and Care Planning

1. Check column A if Care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and CAAs). Check column B if the triggered care area is addressed in the care plan.
3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks, and any referrals for this resident for this care area.

A. CAA Results

Care Area	A. Care Area Triggered (Check all that apply)	B. Care Planning Decision (Check all that apply)	Location and Date of CAA documentation
01. Delirium			
02. Cognitive Loss/Dementia			
03. Visual Function			
04. Communication			
05. ADL Functional/Rehabilitation Potential			
06. Urinary Incontinence and Indwelling Catheter			
07. Psychosocial Well-Being			
08. Mood State			
09. Behavioral Symptoms			
10. Activities			
11. Falls			
12. Nutritional Status			
13. Feeding Tube			
14. Dehydration/Fluid Maintenance			
15. Dental Care			
16. Pressure Ulcer			
17. Psychotropic Drug Use			
18. Physical Restraints			
19. Pain			
20. Return to Community Referral			

B. Signature of RN Coordinator for CAA Process and Date Signed
1. Signature
2. Date: Month – Day – Year

C. Signature of Person Completing Care Plan Decisions and Date Signed
1. Signature
2. Date: Month – Day – Year

453

CAAS AND CARE PLANNING (V0200)

- **V0200A, 1-20, Care Area's**
- **V0200AA, Care Area(s) Triggered**
- **V0200AB, Care Planning Decision**
- **V0200B1, Signature of RN Coordinator**
- **V0200B2, Date RN coordinator certifies that the CAAs have been completed**
- **V0200C1, Signature of staff person facilitating the care planning decision-making. Does not have to be an RN.**
- **V0200C2, Date of staff person completing care planning decision-making.**

454

CAAS AND CARE PLANNING CLARIFICATIONS

- **The signatures at V0200B1 and V0200C1 can be provided by the same person, however it is not required.**
- **If the resident is discharge prior to completion of Section V, and a comprehensive assessment is in progress, the facility may complete and submit the comprehensive assessment as follows:**
  - **Complete all required items from Section A through Z.**
  - **Complete care areas triggered process.**
  - **Sign and date the CAAs as complete.**
  - **Dash fill all of the Care Planning Decision" items.**
  - **Sign and date that care planning decisions were complete.**
  - **Submit record.**

455

SECTION X: CORRECTION REQUEST

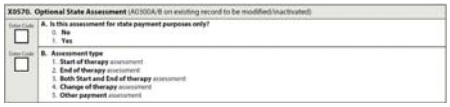

456

CORRECTION REQUEST (X0150 THROUGH X0500)

- **X0150, Type of Provider (A0200)**
- **X0200, Name of Resident (A0500)**
- **X0300, Gender (A0800)**
- **X0400, Birth Date (A0900)**
- **X0500, Social Security Number (A0600A)**

457

OPTIONAL STATE ASSESSMENT (X0570) (NEW)



✓ **Contains the reason for assessment from the prior erroneous Optional State Assessment record to be modified/inactivated (A0300A).**

A. Is this assessment for state payment purposes only?
Code 0, No
Code 1, Yes

B. Assessment type (OSA only):
1. **Start of therapy**
2. **End of therapy**
3. **Both Start and End of therapy**
4. **Change of therapy**
5. **Other payment**

458

CORRECTION REQUEST (X0600 THROUGH X0110)

- **X0600, Type of Assessment/Tracking (A0310) (PPS changes)**
- **X0700, Date on Existing Record to Be Modified/Inactivated – Complete one only:**
  - **A. ARD (A2300)**
  - **B. Discharge dare (A2000)**
  - **C. Entry date (A1600)**
- **X0800, Correction Attestation Section**
- **X0900, Reasons for Modification**
  - **A. Transcription error**
  - **B. Data entry error**
  - **C. Software product error**
  - **D. Item coding error**
  - **~~E. EOT – Resumption~~ (DELETED)**
  - **Z. Other error requiring modification**
- **X1050, Reasons for Inactivation**
- **X1100, RN Assessment Coordinator Attestation of Completion**

459

SECTION Z:
ASSESSMENT ADMINISTRATION

460

MEDICARE PART A BILLING (Z0100)

Medicare Part A Billing

A. Medicare Part A HIPPS code:

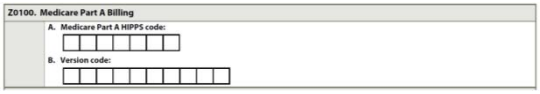
- **Used to capture the PDPM case mix version code followed by the HIPPS modifier based on the type of assessment.**
- **Does not include stays billable to Medicare Advantage HMO plans.**

B. Version code:

- **Xxxx**

~~C. Is this a Medicare Short Stay assessment?~~ (DELETED)

Items A and B typically calculated by software product



461

MEDICARE PART A NON-THERAPY BILLING (Z0150)

- **~~A, Medicare Part A non-therapy HIPPS code.~~ (DELETED)**
- **~~B, RUG version code.~~ (DELETED)**
- **Not needed for PDPM.**

462

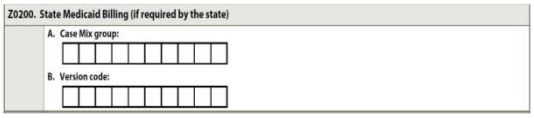
STATE MEDICAID BILLING (IF REQUIRED BY THE STATE) (Z0200)

Z0200 – State Medicaid Billing:

A. Case Mix group

B. Version code

- **If the state has selected a standard payment model, these items will usually be populated automatically by the software data entry product.**



463

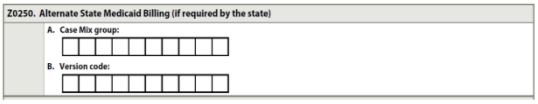
ALTERNATE STATE MEDICAID BILLING (IF REQUIRED BY THE STATE) (Z0250)

Z0250 – Alternate State Medicaid Billing:

A. Case Mix group

B. Version code

- **States may want to capture a second payment group for Medicaid purposes to allow evaluation of the fiscal impact of changing to a new payment model.**



464

INSURANCE BILLING (Z0300)

Allows providers and vendors to capture case-mix codes required by other payers (e.g. private insurance or the Department of Veterans Affairs).

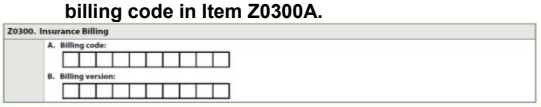
Insurance Billing:

A. Billing code:

- **This code is for use by other payment systems such as private insurance or the Department of Veterans Affairs.**

B. Billing version:

- **This is the billing version appropriate to the billing code in Item Z0300A.**



465

SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT OR ENTRY/DEATH REPORTING (Z0400)

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

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

	Signature	Title	Sections	Date Section Completed
A.				
B.				
C.				
D.				
E.				
F.				
G.				
H.				
I.				
J.				
K.				
L.				

466

SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT OR ENTRY/DEATH REPORTING (Z0400)

- **Signatures of Persons Completing Assessment or Entry/Death Reporting (Z0400).**
  - **Signature**
  - **Title**
  - **Section(s)**
  - **Date Section(s) completed**
- **All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed.**
- **If a staff member cannot sign Z0400 on the same day that he or she completed a section or portion of a section, when the staff member signs, use the date the item originally was completed.**

467

SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT OR ENTRY/DEATH REPORTING (Z0400)

- **Two or more staff can complete items within the same section, however any staff member who completed a sub-set of item(s) within a section should identify which item(s) were completed within that section.**
- ***Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response.***

468

SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT OR ENTRY/DEATH REPORTING (Z0400)

- **If electronic signatures are used there must be a written policy in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.**
- **If an individual who completed a portion of the MDS is <u>not</u> available or is no longer employed, there are portions that may be verified with the medical record and/or resident/staff/family/ interview as appropriate.**
- **For these sections, the person signing the attestation must review the information to assure accuracy and sign on the date the review was conducted.**
- **For sections requiring interviews, the person signing the attestation should interview the resident and sign on the date this verification occurred.**

469

SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT OR ENTRY/DEATH REPORTING

The importance of accurately completing and submitting the MDS cannot be over-emphasized. The MDS is the basis for:

- **The development of an individualized care plan.**
- **The Medicare Prospective Payment System.**
- **Medicaid reimbursement programs.**
- **Quality monitoring activities.**
- **The data-driven survey and certification process.**
- **The quality measures used for public reporting.**
- **Research and policy development.**

470

SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT OR ENTRY/DEATH REPORTING

<u>Read and Understand the Attestation Statement:</u>

- **You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident's status.**

- **Penalties may be applied for submitting false information.**

471

CERTIFICATION (Z0400)

"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."

472

SIGNATURE OF RN ASSESSMENT COORDINATOR VERIFYING ASSESSMENT COMPLETION (Z0500)

- **Signature of RN Assessment Coordinator Verifying Assessment Completion:**
  - **Verify that all items on this assessment or tracking record are complete.**
  - **Verify that Item Z0400 (Signature of Persons Completing the Assessment) contains attestation for all MDS sections.**
  - **Signature certifies completion of assessment.**
  - **When copy of MDS is printed and dates are automatically encoded, be sure to note that it is a "copy" document and not the original.**

473

SIGNATURE OF RN ASSESSMENT COORDINATOR VERIFYING ASSESSMENT COMPLETION (Z0500B)

- **Use the actual date that the MDS was completed, reviewed, and signed as complete by the Registered Nurse (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 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.**

474

- SIGNATURE OF RN ASSESSMENT COORDINATOR VERIFYING ASSESSMENT COMPLETION (Z0500)

Coding Tips:

- **The RN assessment coordinator is <u>not</u> certifying the accuracy of portions of the assessment that were completed by other health professionals.**
- **When the facility uses electronic signatures, the facility must have written policies in place that meet any and all state and federal privacy and security requirements to ensure proper security measures.**
- **These security measures must protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs.**
- **Whenever copies of the MDS are printed and dates are automatically encoded, be sure to note that it is a "copy" document and not the original.**

475

CHAPTER 4
CARE AREA ASSESSMENT (CAA) PROCESS AND CARE PLANNING
NO CHANGES

476

CHAPTER 5
SUBMISSION AND CORRECTION OF THE MDS ASSESSMENTS
A FEW CHANGES

477

ADDITIONAL MEDICARE SUBMISSION REQUIREMENTS THAT IMPACT BILLING UNDER THE SNF PPS (5.4)

HIPPS Code: (NEW)

- **The HIPPS code consists of five positions:**
  1. **PT/OT payment group.**
  2. **SLP payment group.**
  3. **Nursing payment group.**
  4. **Non-therapy Ancillary (NTA) payment group.**
  5. **Assessment Indicator (AI) code indicating which type of assessment was completed.**

478

ADDITIONAL MEDICARE SUBMISSION REQUIREMENTS THAT IMPACT BILLING UNDER THE SNF PPS (5.4)

HIPPS Code:

- **The HIPPS codes to be used for Medicare Part A SNF claims are included on the MDS. There are two different HIPPS codes:**
  - **The Medicare Part A HIPPS code (Z0100A) is most often used on the claim.**
  - **The PDPM version code (Z0100B) documents which version of PDPM was used to determine the PDPM payment groups represented in the Medicare Part A HIPPS code.**

479

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


480

SNF PPS ELIGIBILITY CRITERIA (6.5)

- **Beneficiaries must meet the established eligibility requirements for Part A.**
- **Refer to:**
  - ***Medicare General Information, Eligibility, and Entitlement Manual*; Chapter 1.**
  - ***Medicare Benefit Policy Manual*; Chapter 8.**

Summary of three Part A eligibility requirements:

- **Technical Eligibility.**
- **Clinical Eligibility.**
- **Physician Certification.**

481

TECHNICAL ELIGIBILITY REQUIREMENTS (6.5)

- **Beneficiary is enrolled in Part A and has days available.**
- **3-day prior qualifying hospital stay:**
  - **3 consecutive midnights in inpatient status.**
- **Admission for SNF services is within 30 days of discharge from acute care stay or within 30 days of discharge from SNF level of care.**

482

CLINICAL ELIGIBILITY REQUIREMENTS (6.5)

- **Beneficiary needs and receives:**
  - **Medically necessary skilled care, <u>AND</u>**
  - **On a daily basis, <u>AND</u>**
  - **Provided by or under the direct supervision of skilled nursing or rehabilitation professionals.**
- **Skilled services can only be provided in SNF.**
- **The services must be for a condition:**
  - **Which resident was treated during the qualifying hospital stay, <u>OR</u>**
  - **Arose while in SNF for treatment of condition related to the previous hospital stay.**

483

PHYSICIAN CERTIFICATION (6.5)

✓ **Must certify and then periodically recertify the need for extended care.**

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 that the resident meets the existing SNF level of care definition, OR**
- **Validates via written statement that the beneficiary's assignment to one of the upper PDPM groups is correct.**
  - **See page 6-11 for the list of upper PDPM groups.**

484

PHYSICIAN CERTIFICATION CONT. (6.5)

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 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.**

485

PATIENT DRIVEN PAYMENT MODEL "PDPM" OCTOBER 1, 2019 6.6

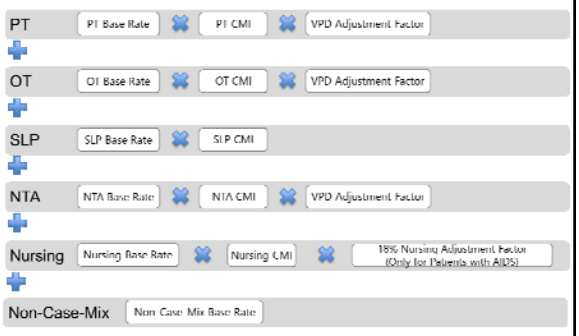
486

PDPM OVERVIEW (6.6)

- **There are five case-mix adjusted components; each resident is classified into one and only one of each group:**
  - **PT group (16 total PT groups).**
  - **OT group (16 total OT groups).**
  - **SLP group (12 total SLP groups).**
  - **NTA group (6 total NTA groups).**
  - **Nursing group (25 total Nursing groups).**
- **Each separate group has its own associated base rates and case-mix indexes.**
- **PDPM applies a variable per diem adjustment to three components; PT, OT, NTA, to account for changes in resource use over a stay.**

487

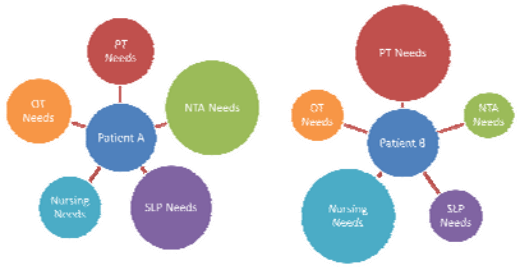
PDPM SNAPSHOT



488

EFFECT OF PDPM

- **By addressing each individual resident's unique needs independently, PDPM improves payment accuracy and encourages a more patient-driven care model.**



489

PDPM PATIENT CLASSIFICATION

- **Under PDPM, each resident is classified into a group for each of the five case-mix adjusted components: PT, OT, SLP, NTA, and Nursing.**
- **Each component utilizes different criteria as the basis for resident classification:**
  - **PT: Clinical Category, Functional Score.**
  - **OT: Clinical Category, Functional Score.**
  - **SLP: Presence of Acute Neurologic Condition, SLP-related Comorbidity or Cognitive Impairment, Mechanically-altered Diet, Swallowing Disorder.**
  - **NTA: NTA Comorbidity Score.**
  - **Nursing: Same characteristics as under RUG-IV.**

490

PDPM CLINICAL CATEGORIES

- **SNF residents are first classified into a clinical category based on the primary clinical condition for the SNF stay coded at I0020.**
- **ICD-10-CM codes, coded on the MDS in Item I0020B, are mapped to a PDPM clinical category.**
  - **Clinical classification may be adjusted by a surgical procedure that occurred during the prior inpatient stay, as coded in Section J.**
  - **ICD-10 mapping available at: https://www.cms.gov/Medicare/Medicare- Fee-for-Service-Payment/SNFPPS/PDPM.html**

491

CALCULATION OF PDPM FUNCTION SCORE AND CLASSIFICATION FOR PT AND OT
6.6


492

CALCULATION OF FUNCTIONAL SCORE FOR PT AND OT (6.6)

MDS Item	MDS Field Location	Score
GG0130A1	Eating	Eating Score (0-4)
GG0130B1	Oral Hygiene	Oral Hygiene Score (0-4)
GG0130C1	Toileting Hygiene	Toileting Hygiene Score (0-4)
GG0170B1 GG0170C1	Bed Mobility – Sit to Lying Bed Mobility – Lying/Sitting	Average of 2 Bed Mobility Scores Rounded to the Nearest Whole Number (0-4)
GG0170D1 GG0170E1 GG0170F1	Transfer – Sit to Stand Transfer – Chair/Bed to Chair Transfer – Toilet Transfer	Average of 3 Transfer Scores Rounded to the Nearest Whole Number (0-4)
GG0170J1 GG0170K1	Walking – Walk 50 ft. with 2 Turns Walking – Walk 150 ft.	Average of 2 Walking Scores Rounded to the Nearest Whole Number (0-4)
Sum of the Function Score for PT or OT Payment:		0 – 24

493

CALCULATION OF FUNCTIONAL SCORE FOR PT AND OT (6.6)

Enter the Function Score for each item:

Admission (Column 1) = Interim Performance (Column 5) =	Description	Function Score =
05, 06	Set-up assistance, Independent	4
04	Supervision or touching assistance	3
3	Partial/moderate assistance	2
02	Substantial/maximal assistance	1
01, 07, 09, 10, 88, missing	Dependent, Refused, Not applicable due to environment, Not attempted due to medical condition or safety, Resident cannot walk *(coded based on response to GG0170I1 (Walk 10 feet)*	0

494

PDPM CLINICAL CATEGORIES

PDPM Clinical Categories for PT and OT	
Major Joint Replacement or Spinal Surgery	Cancer
Non-Surgical Orthopedic/Musculoskeletal	Pulmonary
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Cardiovascular and Coagulations
Acute Infections	Acute Neurologic
Medical Management	Non-Orthopedic Surgery

- SNF residents are first classified into a clinical category based on the primary clinical condition for the SNF stay coded at I0020.
- ICD-10-CM codes, coded on the MDS in Item I0020B, are mapped to a PDPM clinical category.
  - Clinical classification may be adjusted by a surgical procedure that occurred during the prior inpatient stay, as coded in Section J.
  - ICD-10 mapping available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html
- Clinical classification may be adjusted if the resident received a surgical intervention associated with the diagnosis.

495

PT & OT CLINICAL CATEGORIES

- **Based on similar costs CMS collapsed certain clinical categories together under the PT and OT components for resident classification.**

PDPM Clinical Categories (10)	PT & OT Clinical Categories (4)
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Acute Neurologic Non-Orthopedic Surgery	Non-Orthopedic Surgery & Acute Neurologic
Non-Surgical Orthopedic/Musculoskeletal Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	Other Orthopedic
Medical Management Cancer Pulmonary Cardiovascular & Coagulations Acute Infections	Medical Management

496

PT & OT CASE-MIX CLASSIFICATION GROUPS

Clinical Category	PT & OT Function Score	PT & OT Case Mix Group	PT CMI	OT CMI
Major Joint Replacement or Spinal Surgery	0-5	TA	1.53	1.49
Major Joint Replacement or Spinal Surgery	6-9	TB	1.70	1.63
Major Joint Replacement or Spinal Surgery	10-23	TC	1.88	1.69
Major Joint Replacement or Spinal Surgery	24	TD	1.92	1.53
Other Orthopedic	0-5	TE	1.42	1.41
Other Orthopedic	6-9	TF	1.61	1.60
Other Orthopedic	10-23	TG	1.67	1.64
Other Orthopedic	24	TH	1.16	1.15
Medical Management	0-5	TI	1.13	1.18
Medical Management	6-9	TJ	1.42	1.45
Medical Management	10-23	TK	1.52	1.54
Medical Management	24	TL	1.09	1.11
Non-Orthopedic Surgery and Acute Neurologic	0-5	TM	1.27	1.30
Non-Orthopedic Surgery and Acute Neurologic	6-9	TN	1.48	1.50
Non-Orthopedic Surgery and Acute Neurologic	10-23	TO	1.55	1.55
Non-Orthopedic Surgery and Acute Neurologic	24	TP	1.08	1.09

497

CALCULATION OF PDPM COGNITIVE LEVEL AND CLASSIFICATION FOR SLP 6.6


498

SLP COMPONENT

- **For the SLP component, PDPM uses a number of different resident characteristics that were predictive of increased SLP costs:**
  - **Acute Neurologic clinical classification.**
  - **Certain SLP-related comorbidities.**
  - **Presence of cognitive impairment.**
  - **Use of a mechanically-altered diet.**
  - **Presence of swallowing disorder.**

499

CALCULATION OF PDPM COGNITIVE LEVEL (6.6)

The PDPM Cognitive Level is utilized in the SLP payment component.

Step #1:

- **Determine the BIMS Score based on the resident interview.**
- **The BIMS includes:**
  - **Repletion of three words**
  - **Temporal orientation**
  - **Recall**
- **The BIMS Score ranges from 00-15.**
- **If the interview is not successful, the BIMS Score = 99.**

500

CALCULATION OF PDPM COGNITIVE LEVEL (6.6)

Calculation of PDPM Level from BIMS

PDPM Cognitive Level	BIMS Score
Cognitively Intact	13 – 15
Mildly Impaired	8 – 12
Moderately Impaired	0 – 7
Severely Impaired	--

- **If the Summary Score = 99, or**
- **The Summary Score = blank, or**
- **The Summary Score = dash (-),**
- **Proceed to the next step (Step 2) to use the Staff Assessment for Mental Status.**

501

CALCULATION OF PDPM COGNITIVE LEVEL (6.6)

The PDPM Cognitive Level is utilized in the SLP payment component.

Step #2:

A. The resident classifies as Severely Impaired if one of the following conditions exists:

1. **Comatose and completely dependent or activity did not occur at admission.**
2. **Severely impaired cognitive skills for daily decision making.**

If <u>not</u> then;

502

CALCULATION OF PDPM COGNITIVE LEVEL (6.6)

The PDPM Cognitive Level is utilized in the SLP payment component.

Step #2 cont.:

B. If the resident is <u>not</u> severely impaired based on Step A, then determine the <u>Basic Impairment Count</u>.

- **For each of the conditions below, add one to the Basic Impairment Count:**
  - **a) In "Cognitive Skills for Daily Decision Making", the resident has modified independence or is moderately impaired (C1000 = 1 or 2) _____.**
  - **b) In "Makes Self Understood", the resident is usually understood, sometimes understood, or rarely/never understood (B0700=1, 2, or 3) _____.**
  - **c) Based on the Staff assessment for Mental Status, the resident has a memory problem (C0700=1) _____.**
  - **Sum a, b, and c to get the <u>Basic Impairment Count</u>: _____ (0-3)**

503

CALCULATION OF PDPM COGNITIVE LEVEL (6.6)

The PDPM Cognitive Level is utilized in the SLP payment component.

Step #2 cont.:

B. If the resident is <u>not</u> severely impaired based on Step A, then determine the <u>Severe Impairment Count</u>.

- **For each of the conditions below, add one to the Severe Impairment Count:**
  - **a) In "Cognitive Skills for Daily Decision Making", the resident is moderately impaired (C1000 = 2) _____.**
  - **b) In "Makes Self Understood", the resident is sometimes understood, or rarely/never understood (B0700= 2, or 3) _____.**
  - **Sum a, and b to get the <u>Severe Impairment Count</u>: _____ (0-2)**

504

CALCULATION OF PDPM COGNITIVE LEVEL (6.6)

The PDPM Cognitive Level is utilized in the SLP payment component.

Step #2 cont.:

C. The resident classifies as moderately impaired if Severe Impairment Count is 1 or 2 and the Basic Impairment Count is 2 or 3.

D. The resident classifies as mildly impaired if;

- **The Basic Impairment Count is 1 and the Severe Impairment Count is 0, 1, or 2, OR**
- **If the Basic Impairment Count is 2 or 3 and the Severe Impairment Count is 0.**

E. The resident classifies as cognitively intact if both the Severe Impairment Count and Basic Impairment Count are 0.

PDPM Cognitive Level:_____

505

SLP-RELATED COMORBIDITIES

- **Twelve SLP comorbidities were identified as predictive of higher SLP costs:**
  - **Conditions and services combined into a single SLP-related comorbidity flag.**
  - **Resident qualifies if any of the conditions/services is present.**

SLP-Related Comorbidities	
Aphasia	Laryngeal Cancer
CVA,TIA, or Stroke	Apraxia
Hemiplegia or Hemiparesis	Dysphagia
Traumatic Brain Injury	ALS
Tracheostomy (while Resident)	Oral Cancers
Ventilator (while Resident)	Speech & Language Deficits

506

SLP COMPONENT: PAYMENT GROUPS

- **The presence of a swallowing disorder or mechanically altered diet captured in items K0100 and K0510C2 apply.**

Presence of Acute Neurologic Condition, SLP Related Comorbidity, or Cognitive Impairment	Mechanically Altered Diet or Swallowing Disorder	SLP Case Mix Group	SLP Case Mix Index
None	Neither	SA	0.68
None	Either	SB	1.82
None	Both	SC	2.67
Any one	Neither	SD	1.46
Any one	Either	SE	2.34
Any one	Both	SF	2.98
Any two	Neither	SG	2.04
Any two	Either	SH	2.86
Any two	Both	SI	3.53
All three	Neither	SJ	2.99
All three	Either	SK	3.70
All three	Both	SL	4.21

507

NTA COMPONENT: COMORBIDITY CODING

- **50 comorbidities and extensive services for NTA classification are derived from a variety of MDS sources, with some comorbidities identified by ICD-10-CM codes reported in Item I8000.**
- **A mapping between ICD-10-CM codes and NTA comorbidities used for NTA classification is available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service- Payment/SNFPPS/PDPM.html**
- **One comorbidity (HIV/AIDS) is reported on the SNF claim:**

509

NTA COMPONENT: CONDITION LISTING

Condition/Extensive Service	Source	Points
HIV/AIDS	SNF Claim	8
Parenteral IV Feeding: Level High	MDS Item K0510A2, K0710A2	7
Special Treatments/Programs: Intravenous Medication Post-admit Code	MDS Item O0100H2	5
Special Treatments/Programs: Ventilator or Respirator Post-admit Code	MDS Item O0100F2	4
Parenteral IV feeding: Level Low	MDS Item K0510A2, K0710A2, K0710B2	3
Lung Transplant Status	MDS Item I8000	3
Special Treatments/Programs: Transfusion Post-admit Code	MDS Item O0100I2	2
Major Organ Transplant Status, Except Lung	MDS Item I8000	2
Multiple Sclerosis Code	MDS Item I5200	2
Opportunistic Infections	MDS Item I8000	2
Asthma COPD Chronic Lung Disease Code	MDS Item I6200	2
Bone/Joint/Muscle Infections/Necrosis - Except Aseptic Necrosis of Bone	MDS Item I8000	2
Chronic Myeloid Leukemia	MDS Item I8000	2
Wound Infection Code	MDS Item I2500	2
Diabetes Mellitus (DM) Code	MDS Item I2900	2

509

NTA COMPONENT: CONDITION LISTING

Condition/Extensive Service	Source	Points
Endocarditis	MDS Item I8000	1
Immune Disorders	MDS Item I8000	1
End-Stage Liver Disease	MDS Item I8000	1
Other Foot Skin Problems: Foot Infection Code, Other Open Lesion on Foot Code, Except Diabetic Foot Ulcer Code	MDS Item M1040A, M1040B, M1040C	1
Complications of Specified Implanted Device or Graft	MDS Item I8000	1
Bladder and Bowel Appliances: Intermittent Catheterization	MDS Item H0100D	1
Inflammatory Bowel Disease	MDS Item I1300	1
Aseptic Necrosis of Bone	MDS Item I8000	1
Special Treatments/Programs: Suctioning Post-admit Code	MDS Item O0100D2	1
Cardio-Respiratory Failure and Shock	MDS Item I8000	1
Myelodysplastic Syndromes and Myelofibrosis	MDS Item I8000	1
Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	MDS Item I8000	1
Diabetic Retinopathy - Except Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	MDS Item I8000	1
Nutritional Approaches While a Resident: Feeding Tube	MDS Item K0510B2	1

510

NTA COMPONENT: CONDITION LISTING

Condition/Extensive Service	Source	Points
Severe Skin Burn or Condition	MDS Item I8000	1
Intractable Epilepsy	MDS Item I8000	1
Malnutrition Code	MDS Item I5600	1
Disorders of Immunity - Except : RxCC97: Immune Disorders	MDS Item I8000	1
Cirrhosis of Liver	MDS Item I8000	1
Bladder and Bowel Appliances: Ostomy	MDS Item H0100C	1
Respiratory Arrest	MDS Item I8000	1
Pulmonary Fibrosis and Other Chronic Lung Disorders	MDS Item I8000	1

Total points of NTA Comorbidities: _____

511

NTA COMPONENT: PAYMENT GROUPS

NTA Score Range	NTA Case Mix Group	NTA Case Mix Index
12+	NA	3.25
9-11	NB	2.53
6-8	NC	1.85
3-5	ND	1.34
1-2	NE	0.96
0	NF	0.72

512

CALCULATION OF PDPM FUNCTION SCORE AND CLASSIFICATION FOR NURSING 6.6


513

CALCULATION OF FUNCTIONAL SCORE FOR NURSING (6.6)

Enter the Function Score for each item:

Admission Performance (Column 1) =	Function Score =
05, 06	4
04	3
3	2
02	1
01, 07, 09, 10, 88, missing	0

- **The higher the Function Score the more independent.**
- **The lower the Function Score the more dependent.**

514

CALCULATION OF FUNCTIONAL SCORE FOR NURSING (6.6)

MDS Item	MDS Field Location	Score
GG0130A1	Eating	Eating Score
GG0130C1	Toileting Hygiene	Toileting Hygiene Score
GG0170B1 GG0170C1	Bed Mobility – Sit to Lying Bed Mobility – Lying to Sitting on Side of Bed	Average of Bed Mobility Scores Rounded to the Nearest Whole Number
GG0170D1 GG0170E1 GG0170F1	Transfer – Sit to Stand Transfer – Chair/Bed to Chair Transfer – Toilet Transfer	Average of Transfer Scores Rounded to the Nearest Whole Number
Sum of the Function Score for Nursing Payment:		0 – 16

515

CATEGORYI: EXTENSIVE SERVICES

- **PDPM Nursing Function Score of 14 or less.**
- **PDPM Nursing Function Score of 15 or 16 classifies as Clinically Complex.**

Extensive Service Conditions	RUG Class	CMI
Tracheostomy care* AND Ventilator/respirator*	ES3	4.06
Tracheostomy care* OR Ventilator/respirator*	ES2	3.07
Infection isolation* without tracheostomy care* without ventilator/respirator*	ES1	2.93

*while a resident

516

CATEGORY: SPECIAL CARE HIGH

- **PDPM Nursing Function Score of 14 or less.**
- **PDPM Nursing Function Score of 15 or 16 classifies as Clinically Complex.**

Special Care High:

- **Comatose & completely dependent, or activity did not occur.**
- **Septicemia.**
- **Diabetes with both:**
  - **Insulin injections (7 days) and**
  - **Insulin order changes (2 or more days).**
- **Quadriplegia with NFS <=11.**
- **COPD and SOB when lying flat.**

517

CATEGORY: SPECIAL CARE HIGH

Special Care High, cont.:

- **Fever and one of the following:**
  - **Pneumonia.**
  - **Vomiting.**
  - **Weight loss (1 or 2).**
  - **Feeding tube*.**
- **Parenteral/ IV feedings.**
- **Respiratory therapy (7 days).**

Tube feeding intake ≥ 51% of total calories or 26-50% of total calories and 501cc fluid or more per day fluid enteral intake

518

CATEGORY: SPECIAL CARE HIGH

✓ **Depression Evaluation:**

- **Resident Mood Interview (PHQ-9©):**
  - **D0200A-I**
  - **D0300; Total Severity Score >=10 but not 99**
- **Staff Assessment Resident Mood (PHQ-9-OV©):**
  - **D0500A-J**
  - **D0600; Total Severity Score >=10**

519

CATEGORY: SPECIAL CARE HIGH

NFS Score	Depressed	PDPM Class	CMI
0 – 5	Yes	HDE2	2.39
0 – 5	No	HDE1	1.99
6 – 14	Yes	HBC2	2.24
6 – 14	No	HBC1	1.86

520

CATEGORY: SPECIAL CARE LOW

- **PDPM Nursing Function Score of 14 or less.**
- **PDPM Nursing Function Score of 15 or 16 classifies as Clinically Complex.**

Special Care Low:

- **Cerebral Palsy with NFS <=11.**
- **Multiple Sclerosis with NFS <=11.**
- **Parkinson's Disease with NFS <=11.**
- **Respiratory failure and oxygen while a resident.**
- **Feeding tube with intake requirement.**
- **2+ Stage 2 pressure ulcers with 2+ skin treatments.****
- **Stage 3 or 4 pressure ulcer with 2+ skin treatments.****

521

CATEGORY: SPECIAL CARE LOW "CONT."

Special Care Low, cont.:

- **2+ venous/arterial ulcers with 2+ skin treatments.****
- **1 Stage 2 pressure ulcer and 1 venous/arterial ulcer with 2+ skin treatments.****
- **Foot infection, diabetic foot ulcer or other open lesion of foot with dressings to feet.**
- **Radiation treatment while a resident.**
- **Dialysis treatment while a resident.**

522

CATEGORY: SPECIAL CARE LOW "CONT."

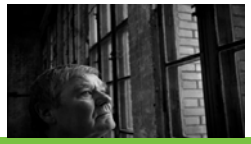
✓ ****Skin treatments:**
- **Pressure relieving chair.***
- **Pressure relieving bed.***

****Count as one treatment even if both provided***
- **Turning/repositioning program.**
- **Nutrition or hydration interventions.**
- **Pressure ulcer care.**
- **Dressings (not to feet).**
- **Ointments (not to feet).**

523

CATEGORY: SPECIAL CARE LOW "CONT."

Depression Evaluation:
- **Resident Mood Interview (PHQ-9©):**
  - **D0200A-I**
  - **D0300; Total Severity Score >=10 but not 99**
- **Staff Assessment Resident Mood (PHQ-9-OV©):**
  - **D0500A-J**
  - **D0600; Total Severity Score >=10**



524

CATEGORY: SPECIAL CARE LOW "CONT."

NFS Score	Depressed	PDPM Class	CMI
0 – 5	Yes	LDE2	2.08
0 – 5	No	LDE1	1.73
6 – 14	Yes	LBC2	1.72
6 – 14	No	LBC1	1.43

525

CATEGORY: CLINICALLY COMPLEX

Clinically Complex:

- **Pneumonia.**
- **Hemiplegia/hemiparesis with NFS <= 11.**
- **Open lesions or Surgical wounds with skin treatment:**
  - **Surgical wound care.**
  - **Dressings (not to feet).**
  - **Ointments (not to feet).**
- **Burns.**
- **Chemotherapy while a resident.**
- **Oxygen while a resident.**
- **IV medications while a resident.**
- **Transfusions while a resident.**

526

CATEGORY: CLINICALLY COMPLEX

Depression Evaluation:

- **Resident Mood Interview (PHQ-9©):**
  - **D0200A-I**
  - **D0300; Total Severity Score >=10 but not 99**
- **Staff Assessment Resident Mood (PHQ-9-OV©):**
  - **D0500A-J**
  - **D0600; Total Severity Score >=10**

527

CATEGORY: CLINICALLY COMPLEX

NFS Score	Depressed	PDPM Class	CMI
0 – 5	Yes	CDE2	1.87
0 – 5	No	CDE1	1.62
6 – 14	Yes	CBC2	1.55
6 – 14	No	CBC1	1.34
15 – 16	Yes	CA2	1.09
15 – 16	No	CA1	0.94

528

CATEGORY: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

Behavioral Symptoms and Cognitive Performance:

NFS >= 11:

- **If NFS< 11, classifies into Reduced Physical Function.**

Cognitive Performance determined by:

- **Brief Interview for Mental Status (BIMS) if interview was completed.**
- **Cognitive Performance Scale (CPS) items if the BIMS interview was <u>not</u> completed.**

If resident doesn't qualify via Cognitive Performance, then evaluate Behavioral Symptoms items.

529

CATEGORY: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

1. **Brief Interview for Mental Status (BIMS):**
   - **Resident Interview:**
     - **Repetition of 3 words.**
     - **Temporal orientation.**
     - **Recall.**
   - **Score range 0-15:**
     - **15 - best cognitive performance.**
     - **0 – worst performance.**
   - **Qualify with BIMS Score <=9.**
   - **If score is >9 but <u>not</u> 99, evaluate Behavioral Symptoms.**

530

CATEGORY: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

2. **If <u>not</u> able to interview; cognitively impaired if one of the 3 following conditions is met:**
   1. **Coma and NFS completely dependent or activity did not occur.**
   2. **Severely impaired cognitive skills for daily decision.**
   3. **2 or more of these impairment indicators:**
      - **Problem being understood >0**
      - **Short-term memory problem = yes (1)**
      - **Cognitive skills problem >0**

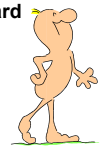
        <u>AND</u>
      - **1 or more severe impairment indicators:**
        - **Severe problem being understood >=2**
        - **Severe cognitive skills problem >=2**

531

CATEGORY: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

If criteria for Cognitive Impairment not met, evaluate the following Behavioral Symptoms:

- **Hallucinations.**
- **Delusions.**
- **Physical behavioral symptom directed toward others.***
- **Verbal behavioral symptoms directed toward others.***
- **Other behavioral symptoms not directed. toward others.***
- **Rejection of care.***
- **Wandering.***



Code 2 or 3 = behavior occurred 4-6 days or daily

532

CATEGORY: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

If meets criteria via Cognitive Impairment or Behavioral symptoms, determine Restorative Nursing Count:

- **Urinary toileting program.****
- **Bowel toileting program.****
- **Passive ROM.****
- **Active ROM.****
- **Splint or brace assistance.**
- **Bed mobility.****
- **Walking training.****
- **Transfer training.**
- **Dressing and/or grooming training.**
- **Eating and/or swallowing training.**
- **Amputation/Prosthesis care.**
- **Communication training.**

****Count as one service even if both provided***

533

CATEGORY: BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE

NFS Score	Restorative Nursing	PDPM Class	CMI
11 – 16	2 or more	BAB2	1.04
11 – 16	0 or 1	BAB1	0.99

534

CATEGORY: REDUCED PHYSICAL FUNCTION

Reduced Physical Function:

- **Residents who do <u>not</u> meet criteria in other categories.**
- **Residents met criteria for the Behavioral Symptoms and Cognitive Performance category with NFS < 11.**
- **Determine Restorative Nursing Count.**

535

CATEGORY: REDUCED PHYSICAL FUNCTION

NFS Score	Restorative Nursing	PDPM Class	CMI
0 – 5	2 or more	PDE2	1.57
0 – 5	0 or 1	PDE1	1.47
6 – 14	2 or more	PBC2	1.22
6 – 14	0 or 1	PBC1	1.13
15 – 16	2 or more	PA2	0.71
15 – 16	0 or 1	PA1	0.66

536

CALCULATION OF VARIABLE PER DIEM PAYMENT ADJUSTMENT

- ✓ **PDPM incorporates per diem payment adjustments to account for changes in resource use over the course of the stay.**
- ✓ **This adjustment includes payment components: PT, OT, and NTA.**
- ✓ **Component per diem payment =**
  - **Component base rate times,**
  - **Resident group CMI times,**
  - **VPD component factor.**

537

PT / OT VARIABLE PER DIEM ADJUSTMENT FACTORS

Day in Stay	PT / OT Adjustment Factor
1 – 20	1.00
21 – 27	0.98
28 – 34	0.96
35 – 41	0.94
42 – 48	0.92
49 – 55	0.90
56 – 62	0.88
63 – 69	0.86
70 – 76	0.84
77 – 83	0.82
84 – 90	0.80
91 – 97	0.78
98 – 100	0.76

538

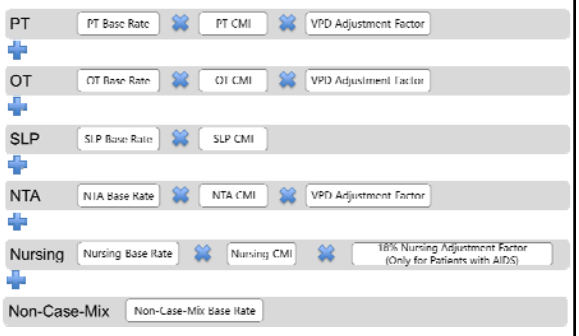
NTA VARIABLE PER DIEM ADJUSTMENT FACTORS

Day in Stay	NTA Adjustment Factor
1 – 3	3.00
4 – 100	1.00

✓ **Component per diem payment =**
- **NTA base rate times,**
- **Resident group CMI times,**
- **VPD component factor.**

539

PDPM SNAPSHOT



540

PATIENT CLASSIFICATION EXAMPLE

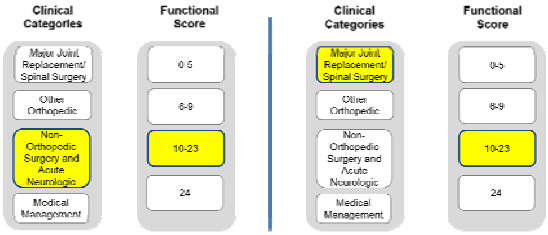
- **Consider two residents with the following characteristics:**

Resident Characteristics	Resident A	Resident B
Rehabilitation Received	Yes	Yes
Therapy Minutes	730	730
Extensive Services	No	No
ADL Score	9	9
Clinical Category	Acute Neurologic	Major Joint Replacement
PT & OT Functional Score	10	10
Nursing Function Score	7	7
Cognitive Impairment	Moderate	Intact
Swallowing Disorder	No	No
Mechanically Altered Diet	Yes	No
SLP Comorbidity	No	No
Comorbidities	IV Medication and Diabetes	Chronic Pancreatitis
Other Conditions	Dialysis	Septicemia
Depression	No	Yes

541

PDPM CLASSIFICATION: PT & OT COMPONENTS

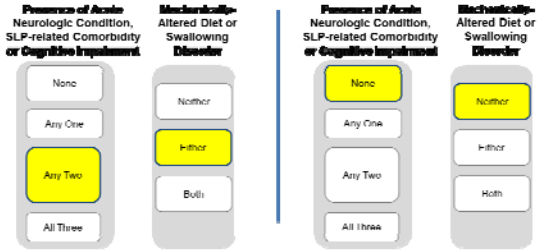
- **Resident A (left) is classified into Acute Neurologic with PT and OT Functional Score of 10; Resident B (right) is classified into Major Joint Replacement/Spinal Surgery with a PT and OT Functional Score of 10.**



542

PDPM CLASSIFICATION: SLP COMPONENT

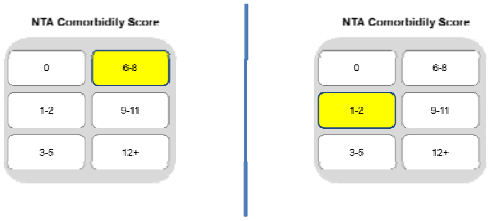
- **Resident A (left) is classified into Acute Neurologic, has moderate cognitive impairment, and is on a mechanically-altered diet; and Resident B (right) is classified into non-neurologic with no SLP-classification related issue.**



543

PDPM CLASSIFICATION: NTA COMPONENT

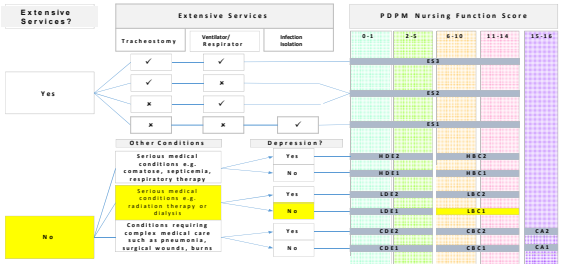
- **Resident A (left) has an NTA Comorbidity Score of 7 from IV medication(5 points) and diabetes mellitus (2 points); Resident B (right) has an NTA Comorbidity Score of 1 from chronic pancreatitis (1 point).**



544

PDPM CLASSIFICATION: NURSING COMPONENT (1)

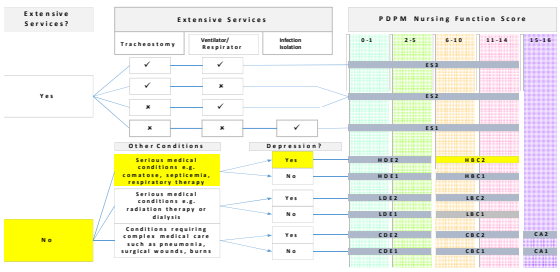
- **Resident A is receiving dialysis services with a Nursing Function Score of 7 and is classified into LBC1.**



545

PDPM CLASSIFICATION: NURSING COMPONENT (2)

- **Resident B has septicemia and a Nursing Function Score of 7, exhibits signs of depression, and is classified into HBC2.**



546

ADMINISTRATIVE PRESUMPTION: BACKGROUND

- **The SNF PPS includes an administrative presumption in which a beneficiary who is correctly assigned one of the designated, more intensive case-mix classifiers on the 5-day PPS assessment is automatically classified as requiring an SNF level of care through the assessment reference date for that assessment.**
- **Those beneficiaries not assigned one of the designated classifiers are not automatically classified as either meeting or not meeting the level of care definition, but instead receive an individual determination using the existing administrative criteria.**

547

ADMINISTRATIVE PRESUMPTION: CLASSIFIERS

- **The following PDPM classifiers are designated under the presumption:**
  - **Those nursing groups encompassed by the Extensive Services, Special Care High, Special Care Low, and Clinically Complex nursing categories;**
  - **PT & 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.**

548

SNF PPS POLICIES (6.7)

Medical Appropriateness Exception (Deferred Treatment):

- ✓ **An elapsed period of more than 30 days is permitted for starting SNF Part A services when a resident's condition makes it inappropriate to begin an active course of treatment immediately after a qualifying hospital stay discharge;**
  - **Applicable only under accepted medical practice,**
  - **Is medically predictable at the time of hospital discharge,**
  - **The physician must write an order indicating expected initiation of skilled treatment.**

549

SNF PPS POLICIES (6.7)

Interrupted Stay:

- ✓ **Defined as a resident discharged from the SNF care and subsequently readmitted to the same SNF within 3 days or less after discharge.**
- ✓ **Starting with the calendar day of discharge and including the 2 immediately following calendar days, ending at midnight.**
- ✓ **The subsequent stay is considered a continuation of the previous Part A stay;**
  - **For purposes of the variable per diem schedule, AND**
  - **The assessment schedule.**

550

SNF PPS POLICIES (6.7)

Interrupted Stay, cont.:

- ✓ **The variable per diem schedule continues from the day of the previous discharge.**
- ✓ **For example;**
  - **Resident is discharged on day 7,**
  - **Payment rates resume at day 7 upon readmission.**
  - **The assessment schedule also continues from the day of the previous discharge.**
  - **No new 5-day assessment is required.**
  - **IPA optional.**

551

SNF PPS POLICIES (6.7)

Interrupted Stay, cont.:

- ✓ **If a resident is readmitted to the same SNF more than 3 consecutive calendar days after discharge, OR**
- ✓ **Any instance when the resident is admitted to a different SNF (regardless of the length of time between stays),**
- ✓ **The Interrupted Stay Policy does not apply.**
- ✓ **The subsequent stay is considered a new stay.**
  - **The variable per diem schedule and the assessment schedule resets to day 1 payment rates.**
  - **The completion of a new 5-day assessment is required.**

552

INTERRUPTED STAY POLICY: EXAMPLES

1. Resident A is admitted to SNF on 11/07/19, admitted to hospital on 11/20/19, and returns to same SNF on 11/25/19:
   - New stay.
   - Assessment Schedule: Reset; stay begins with new 5-day assessment.
   - Variable Per Diem: Reset: stay begins on Day 1 of VPD schedule.
2. Resident B is admitted to SNF on 11/07/19, admitted to hospital on 11/20/19, and admitted to different SNF on 11/22/19:
   - New stay.
   - Assessment Schedule: Reset; stay begins with new 5-day assessment.
   - Variable Per Diem: Reset; stay begins on Day 1 of VPD Schedule.
3. Resident C is admitted to SNF on 11/07/19, admitted to hospital on 11/20/19, and returns to same SNF on 11/22/19:
   - Continuation of previous stay.
   - Assessment Schedule: No PPS assessments required, IPA optional.
   - Variable Per Diem: Continues from Day 14 (Day of Discharge).

553

SNF PPS POLICIES (6.7)

Resident Discharged from Part A Skilled Services and Returns to SNF Part A Skilled Level Services (not an instance of an interrupted stay):

✓ **A skilled level of care services under this circumstance would require the following criteria to be met:**

1. **Less than 30 days have elapsed since the last day on which SNF level of care services were required and received.**
2. **SNF-level services are for a condition treated during the qualifying hospital stay <u>OR</u> for a condition that arose while receiving care in the SNF for a condition for which the beneficiary was previously treated in the hospital.**

554

SNF PPS POLICIES

Resident Discharged from Part A Skilled Services and Returns to SNF Part A Skilled Level Services (not an instance of an interrupted stay), cont.:

✓ **A skilled level of care services under this circumstance would require the following criteria to be met:**

3. **Services must be reasonable and necessary.**
4. **Services can only be provided on an inpatient basis.**
5. **Resident must require and receive the services on a daily basis, and**
6. **Resident has remaining days in the SNF benefit period.**

Refer to the Medicare Benefit Policy Manual, Chapter 8 for more detail.

555

10/1/2019 CROSS-OVER RULE (NEW)

- **Providers may <u>not</u> submit a modification to change a target date on an assessment completed prior to October 1, 2019 to a target date on or after October 1, 2019, nor can they submit a modification to change a target date on an assessment completed on or after October 1, 2019 to a target date prior to October 1, 2019.**
- **It is the target date of the assessment that identifies the required version of the item set, and, because of the substantial changes in the item sets, they are not interchangeable.**

556

10/1/2019 CROSS-OVER RULE (NEW)

- **Modification records that contain a target date crossing over October 1, 2019 will result in a FATAL error and be REJECTED from the QIES ASAP system.**
- **To correct the target date of the assessment that violates the cross-over rule, providers must inactivate the incorrect assessment and submit a replacement assessment.**

557

10/1/2019 CROSS-OVER RULE

Original Assessment Target Date	Modified Assessment Target Date	Allowed or <u>NOT</u> Allowed
8/15/19	9/30/19	Allowed
10/1/19	11/1/19	Allowed
9/15/19	10/15/19	Not Allowed
10/15/19	9/15/19	Not Allowed

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RESOURCES

- PDPM website:
  - https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html
- Questions related to PDPM implementation and policy:
  - PDPM@cms.hhs.gov
- Questions related to the OSA:
  - OSAMedicaidinfo@cms.hhs.gov
- RAI Manual
  - https://www.cms.gov/Medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/mds30raimanual.html
- SNF QRP
  - https://www.cms.gov/Medicare/quality-initiatives-patient-assessment-instruments/nursinghomequalityinits/skilled-nursing-facility-quality-reporting-program/SNF-quality-reporting-program-training.html

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RAI MANUAL APPENDICES

A. Glossary and Common Acronyms.
B. State Agency and CMS Regional Office RAI/MDS Contacts.
C. Care Area Assessment (CAA) Resources
D. Interviewing to Increase Resident Voice in MDS Assessments.
E. PHQ-9© Scoring Rules and Instructions for BIMS.
F. MDS Item Matrix.
G. References.
H. MDS 3.0 Forms

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THANK YOU FOR COMING!