

## SOCIETY OF LICENSED NURSING HOME ADMINISTRATORS – NJ

**ACCURATE MDS 3.0 CODING:**  
*“The Key to Positive Clinical and Financial Outcomes”*



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## LEARNING OBJECTIVES

- ☐ Describe 2 Challenges faced by Long-Term Care Providers
- ☐ Identify the Manual that provides specific guidance on how to code the MDS 3.0 Items
- ☐ Enumerate the components of the RAI (Resident Assessment Instrument) Process in LTC
- ☐ List two (2) Reasons why Accurate Coding of the MDS 3.0 is important to ensure a Skilled Nursing Facility's Survival
- ☐ Enumerate three (3) MDS 3.0 Sections or Items that will affect Clinical Reimbursement under PDPM
- ☐ Discuss how the MDS 3.0 affects the facility's Five Star Rating Score

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## AGENDA

**9:00 AM – 10:30 AM:**

- ☐ OVERVIEW OF CURRENT STATE OF AFFAIRS AND CHALLENGES FACED BY LONG-TERM CARE PROVIDERS
- ☐ MDS 3.0 and the RAI PROCESS
- ☐ IMPORTANCE OF THE MDS 3.0 IN LTC
  - o Resident Care Planning and Survey
  - o Five Star Rating and QM's
  - o SNF Clinical Reimbursement: PDPM

**Break: 10:30 AM – 10:45 AM**

**10:45 AM – 12:15 PM:**

- ☐ REVIEW OF MDS 3.0 SECTIONS AND ITEMS - A PRACTICAL APPROACH

**Lunch Break: 12:30 PM -1:00 PM**

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*(Continuation)*

**1:00 PM – 2:30 PM:**

- ☐ MDS 3.0: IMPACT ON- 5-STAR RATING, QUALITY MEASURES, SURVEY, CARE COMPARE

**Break: 2:30 PM -2:45 PM**

**2:45 PM – 4:15 PM:**

- ☐ MDS 3.0: IMPACT ON CASE MIX – PDPM: Understanding the Components and Logic behind the assignment of Case Mix Indices

**4:15 PM – 4:30 PM:**

- ☐ QUESTIONS and ANSWERS

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## CURRENT STATE OF AFFAIRS



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## CURRENT STATE OF AFFAIRS

**2020 Total US Health Expenditures = \$4.1 Trillion**

- ☐ Medicare Beneficiaries = **61.2 Million** (Traditional = 37.74 M & MA = 23.46 M)
- ☐ Medicare Part A Trust Fund Insolvency: **Currently projected in 2026**
- ☐ CMS CERT Program: **Reported \$79.6 Billion Improper Medicare Payments over the past three years**
- ☐ SNF's: **Improper Payments in 2021 increased to 7.79% from 5.43% in 2020. (Decreased for other Providers)**
- ☐ COVID-19-RELATED FUNDING: **Will be Scrutinized**

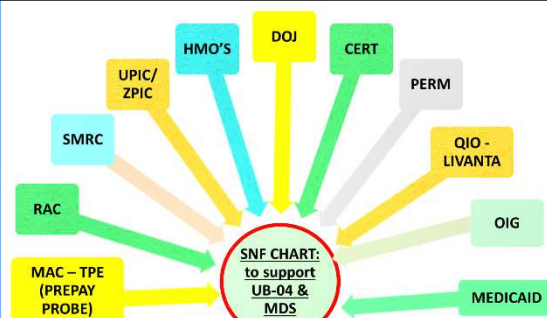
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### U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

- ❑ Most Medicare FFS improper payments: Secondary to **Insufficient documentation, Incorrect Coding, Billing errors and Lack of Medical Necessity**
- ❑ These errors could be unintentional, **due to lack of education** or review and in many cases, **lack of effective communication between the clinicians and the billers.**
- ❑ When compliance is not met, providers risk (whether intentionally or with gross negligence) **False Claims Act violations and potential criminal or civil proceedings.**

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### Many Agencies Charged with Oversight: Our Esteemed Auditors



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### CHALLENGES IN LONG-TERM CARE: FINANCIAL & BUSINESS OPERATIONS



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### CHALLENGES IN LONG-TERM CARE

1. **SUSTAINING OCCUPANCY:**
  - ❑ February 2022 - SNF Occupancy at its highest since the COVID-19 Pandemic = Average of **76.7%** (Source: National Investment Center for Seniors Housing & Care)
  - ❑ Hospitals pushing discharge to Home Health Care."
2. **HEIGHTENED LEVELS OF WORKFORCE STRESS**
  - ❑ On-going scrutiny: Federal & State Survey Agencies
  - ❑ Increased Staffing Requirements YET there is a shortage of Health Care Workers; Agency Staffing
  - ❑ Average annual Turnover Rates (Source: Journal of the American Geriatrics Society (published 5/2022): Data from PBJ Data 2018 - 2019)  
**RN 's = 44% ; Total Nursing Staff = 46%**  
Lower among nursing homes with higher star ratings.  
**STAFF RETENTION EFFORTS: CRUCIAL**

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### CHALLENGES IN LONG-TERM CARE

3. **PROPOSED FY 2023 MEDICARE PAYMENT CUTS:**
  - ❑ CMS estimates that the aggregate impact of the payment policies in this proposed rule would result in a decrease of approximately \$320 million in Medicare Part A payments to SNFs in FY 2023
4. **INCREASED SCRUTINY OF CLAIMS**
  - ❑ **Claims Audits ramping up**
  - ❑ Areas of Scrutiny: **PDPM, ICD-10-CM, and UB-04 coding and supportive documentation**, the **proper use of SNF waivers**, and **appropriate access to and accounting for Provider Relief Funds.**  
(SOURCE: Proactive Medical Review | April 20, 2021)

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### CHALLENGES IN LONG-TERM CARE

5. **PRESIDENT BIDEN'S NURSING HOME REFORM PLANS**  
*"... The only additional funding called for in the Administration's nursing home initiative is **for more survey resources**," she noted. **"Finding more deficiencies & taking money out of nursing homes is not going to get us what we want.** If this model worked, & if today's reimbursement was sufficient, we wouldn't be experiencing the crisis in access to care."*  
*"A staffing ratio mandate will not amount to more than words – and more fines for noncompliance – without meaningful changes to increase the supply of qualified workers, for example, in immigration policy,"*  
 (Statements from Leading Age MD President Allison Ciborowski)

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**PRESIDENT BIDEN'S NURSING HOME REFORM PLANS****Ensuring Taxpayer Dollars Support Nursing Homes That Provide Safe, Adequate, and Dignified Care**

1. **Establish Minimum Nursing Home Staffing Requirement**
2. Reduce Resident Room Crowding.
3. Strengthen the "SNF -VBP" Program.
4. **Reinforce Safeguards against Unnecessary Medications and Treatments.**

**Enhancing Accountability and Oversight**

5. **Adequately Fund Inspection Activities (25% increase)**
6. **Beef up Scrutiny on More of the Poorest Performers (SPECIAL FOCUS FACILITIES)**

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**PRESIDENT BIDEN'S NURSING HOME REFORM PLANS****7. Expand Financial Penalties & Other Enforcement Sanctions.**

- CMS will also use data, predictive analytics, and other information processing tools to improve enforcement.
- President Biden is also calling on Congress **to raise the dollar limit on per-instance financial penalties levied on poor-performing facilities, from \$21,000 to \$1,000,000.**

**8. Increase Accountability for Chain Owners of Substandard Facilities.**

9. **Provide Technical Assistance to Nursing Homes to Help them Improve. (QIO'S)**

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**PRESIDENT BIDEN'S NURSING HOME REFORM PLANS****Increasing Transparency**

10. Create a Database of NH Owners & Operators.
11. Improve Transparency of Facility Ownership & Finances
12. Enhance Nursing Home Care Compare: CMS will ensure that ratings more closely reflect data that is verifiable, rather than self-reported, and will hold nursing homes accountable for providing inaccurate information. The President is calling on Congress to give **CMS additional authority to validate data and take enforcement action against facilities that submit incorrect information.**
13. Examine the Role of Private Equity.

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**PRESIDENT BIDEN'S NURSING HOME REFORM PLANS****Creating Pathways to Good-paying Jobs with the Free and Fair Choice to Join a Union**

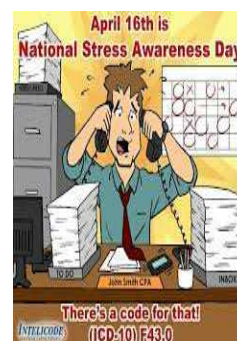
14. **Ensure Nurse Aide Training is Affordable.**
15. **Support State Efforts to Improve Staffing and Workforce Sustainability.**
16. **Launch National Nursing Career Pathways Campaign**
17. **Ensuring Pandemic & Emergency Preparedness in NH's**
17. **Continued COVID-19 Testing in LTC Facilities.**
18. **Continued COVID-19 Vaccinations and Boosters in Long-term Care Facilities.**
19. **Strengthen Requirements for On-site IP'S**
20. **Enhance Requirements for Pandemic & Emergency Preparedness.**
21. **Integrate Pandemic Lessons into NH Requirements.**

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**LET IT OUT...!!!****BREATHE...**

Never let a bad situation bring out the worst in you. Choose to stay positive and be **STRONG**

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**GROUP PSYCHOTHERAPY SESSION IS OVER**

**IT'S TRUE MISERY LOVES COMPANY BUT RIGHT NOW THERE'S NO VACANCY**

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### SO ...WHAT DO WE DO NOW?

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### LET US FOCUS... HOW CAN WE SURVIVE?

1. FEDERAL and STATE REGULATORY COMPLIANCE; LIFE SAFETY CODE
2. FACILITY ASSESSMENT & QAPI (Huge Focus on Infection Control)
3. CLINICAL REIMBURSEMENT AND BENEFITS INTEGRITY
4. CORPORATE COMPLIANCE and ETHICS
5. STAFFING RECRUITMENT and RETENTION
6. EDUCATION & TRAINING (COMPETENCIES)
7. BUDGET and RESOURCE UTILIZATION
8. SUSTAINABILITY & COMMITMENT to POSITIVE CLINICAL & FINANCIAL OUTCOMES
9. PATIENT and FAMILY (RP) SATISFACTION

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### FACILITY SURVIVAL

#### IMPORTANCE OF MDS 3.0

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### ROLE OF MDS

- ❑ The MDS 3.0 is the most important document in a Skilled Nursing Facility.
- ❑ Accuracy in coding the MDS (in accordance with the RAI MDS 3.0 Manual instructions) is key to the success of a facility.
- ❑ The role of the MDS Department has evolved into something that not only coordinates the care of each resident but also manages systems to promote the facility's survival.
- ❑ MDS Coordinators must work closely with Nursing, MD's & the IDCP team to ensure STRONG CLINICAL & NURSING DOCUMENTATION, ICD-10-CM CODING & CARE PLANNING

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### OVERCOME OBSTACLES TO ACCURATE MDS

#### COMMON OBSTACLES:

- ❑ Communication
- ❑ Education
- ❑ Lack of Collaboration
- ❑ Environment
- ❑ Time
- ❑ Documentation
- ❑ Data Collection
- ❑ Lack of Oversight and Accountability

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### TEAMWORK IS A MUST!

- ❑ ATTENDING PHYSICIAN
- ❑ ADMINISTRATOR
- ❑ DIRECTOR OF NURSING
- ❑ MDS DEPARTMENT
- ❑ IDC TEAM MEMBERS: NURSING, REHAB, SOCIAL SERVICES, DIETARY, ACTIVITIES
- ❑ FRONT-LINE CAREGIVERS
- ❑ PHYSICIANS
- ❑ ADMISSIONS DEPARTMENT
- ❑ BILLING OFFICE STAFF
- ❑ UR COMMITTEE MEMBERS
- ❑ QA COMMITTEE MEMBERS

**There is NO "I" in TEAM!!!**

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## OVERVIEW: MDS 3.0 & THE RAI PROCESS



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## BRIEF HISTORY OF THE MDS

- ❑ OBRA '87: Major Federal Nursing Home Reform
- ❑ 1990: Nursing Home Case Mix and Quality Demo
- ❑ 1991: MDS 1.0 Nationally Implemented
- ❑ 1995: MDS 2.0 Nationally Implemented
- ❑ 1998: Medicare PPS & National MDS Automation for Data Transmission
- ❑ 1999: Quality Indicators for Survey
- ❑ 2002: Quality Measures /RAI Manual revised
- ❑ 2010: MDS 3.0 implemented on October – NUMEROUS UPDATES & ERRATA DOCUMENTS (**now v1.17.1**)
- ❑ 2014: SNF-QRP; SNF-VBP
- ❑ 2018: FY 2019 - SNF PPS FINAL RULE – PDPM INTRO
- ❑ 2019: OCTOBER 1, 2019 – PDPM IMPLEMENTATION

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## MDS UPDATES SINCE COVID-19

**March 19, 2020:**

- ❑ CMS **delayed the Minimum Data Set (MDS) 3.0** v1.18.1 release, which had been scheduled for October 1, 2020, in response to stakeholder concerns. Draft was posted in December of 2019.

**October 01, 2021:**

- ❑ "MDS 3.0 RAI Manual v1.17.1R. Errata. Revisions to pages in Chapter 6 of the MDS 3.0 RAI Manual v1.17.1R that update the NTA Comorbidity Score Calculation table."



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## APPENDIX B: STATE RAI COORDINATORS

NJ	Dawn Stillwell	<a href="mailto:dawn.stillwell@doh.nj.gov">dawn.stillwell@doh.nj.gov</a>
NJ	Arlene McNinch (backup)	<a href="mailto:arlene.mcnych@doh.nj.gov">arlene.mcnych@doh.nj.gov</a>

### MDS AUTOMATION COORDINATOR

NJ	Eunice Santiago	<a href="mailto:Eunice.Santiago@doh.nj.gov">Eunice.Santiago@doh.nj.gov</a>
NJ	Cheryl Boknoski (backup)	<a href="mailto:cheryl.boknoski@doh.nj.gov">cheryl.boknoski@doh.nj.gov</a>

- ❑ **RAI Panel** : Experienced RAI Coordinators who assist CMS & other State RAI Coordinators to answer MDS-related questions.

State/Region	RAI Coordinator Panel Member	Email
CA	Susana Belda	<a href="mailto:Susana.Belda@cdph.ca.gov">Susana.Belda@cdph.ca.gov</a>
IL	Lori Brown	<a href="mailto:Lori.j.brown@illinois.gov">Lori.j.brown@illinois.gov</a>
ME	Suzanne Pinette	<a href="mailto:Suzanne.pinette@maine.gov">Suzanne.pinette@maine.gov</a>
MN	Nadine Olness	<a href="mailto:Health.mds@state.mn.us">Health.mds@state.mn.us</a>
MO	Stacey Bryan	<a href="mailto:Stacey.Bryan@health.mo.gov">Stacey.Bryan@health.mo.gov</a>
NM	Rosie Brandenberger	<a href="mailto:Rosie.Brandenberger@state.nm.us">Rosie.Brandenberger@state.nm.us</a>
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## WHAT IS THE MDS?

- ❑ A federally mandated tool that ensures collection of minimum, standardized assessments for each resident at regular intervals
- ❑ Drives the development of an **individualized plan of care based on resident's identified needs, strengths and preferences**
- ❑ Required for all residents in Medicaid/Medicare certified beds in LTC facilities & who have been in the facility for 14 days or more
- ❑ The 1<sup>st</sup> component of the RAI process

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## WHAT IS THE RAI?

- ❑ **Resident Assessment Instrument**
- ❑ A structured, standardized approach to applying a **problem identification process**
- ❑ RAI is comprised of **3 Basic Components**:
  - 1) MDS 3.0 (**Minimum** Data Set)
  - 2) Care Area Assessment Process (CAA) - Includes Care Area Triggers (CATS)
  - 3) Care Planning and RAI Utilization Guidelines - in State Operations Manual, Appendix PP.

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### RAI PROCESS

**Regulatory requirements.** Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that

- (1) the assessment accurately reflects the resident's status
- (2) a Registered Nurse conducts or coordinates each assessment with the appropriate participation of health professionals
- (3) the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts.

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### RAI PROCESS

**Nursing homes are left to determine**

- (1) who should participate in the assessment process
- (2) how the assessment process is completed
- (3) how the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within this manual.

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### RAI PROCESS

- ❑ Given the requirements of participation of appropriate health professionals and direct care staff, completion of the RAI is best accomplished by an interdisciplinary team (IDT) that includes nursing home staff with varied clinical backgrounds, including nursing staff and the resident's physician.
- ❑ IDT brings their combined experience & knowledge to the table in providing an understanding of the strengths, needs and preferences of a resident to ensure the best possible quality of care and quality of life.

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### LAYOUT OF RAI MANUAL

- ❑ **Chapter 1: Resident Assessment Instrument**
- ❑ **Chapter 2: Assessments for the Resident Assessment Instrument (RAI)**
- ❑ **Chapter 3: Overview to the Item-by-Item Guide to the MDS 3.0**
- ❑ **Chapter 4: Care Area Assessment (CAA) Process and Care Planning**
- ❑ **Chapter 5: Submission and Correction of the MDS Assessments**
- ❑ **Chapter 6: Medicare Skilled Nursing Facility Prospective Payment System (SNF-PPS)**

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### LAYOUT OF RAI MANUAL

#### Appendices

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

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### RESPONSIBILITIES OF NURSING HOMES FOR COMPLETING MDS ASSESSMENTS

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## The RAI PROCESS

- ❑ **Minimum Data Set (MDS)** is a screening tool that provides clues about the resident's functional and health status
- ❑ Specific MDS answer options are the clues (**Triggers**) that point to possible problem in a particular **Care Area**
- ❑ Further assessment of entire care area required to be able to draw conclusions

**Individualized and Personalized CARE  
PLAN = Outcome**

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## DEFINITIONS

- ❑ **Admission** refers to the date a person enters the facility and is admitted as a resident. A day begins at 12:00 a.m. and ends at 11:59 p.m. (DAY #1)
- ❑ **Assessment Reference Date (ARD)** refers to the **last day of the observation (or "look back") period that the assessment covers for the resident.** Since a day begins at 12:00 a.m. and ends at 11:59 p.m., the ARD must also cover this time period. The facility is **required to set the ARD on the MDS Item Set or in the facility software within the required time frame of the assessment type being completed.**

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## DEFINITIONS

- ❑ **Death in Facility** refers to when the resident dies in the facility or dies while on a leave of absence (LOA)
- ❑ **Leave of Absence (LOA)**, which **does not require completion of either a Discharge assessment or an Entry tracking record**, occurs when a resident has a:
  - *Temporary home visit of at least one night; or*
  - *Therapeutic leave of at least one night; or*
  - *Hospital observation stay less than 24 hours and the hospital does not admit the resident.*

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## DEFINITIONS

- ❑ **Discharge** refers to the date a resident leaves the facility, or the date the resident's Medicare Part A stay ends but the resident remains in the facility.
  - Resident discharged to a private residence
  - Resident is **admitted to a hospital or other care setting**
  - Resident has a **hospital observation stay greater than 24 hours**, regardless of whether the hospital admits the resident.
  - Resident is transferred from a Medicare- and/or Medicaid-certified bed to a non-certified bed.
  - Resident's Medicare Part A stay ends, but the resident remains in the facility. (NPE)

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## DEFINITIONS

- ❑ **Discharge Assessment:** Assessment required on resident discharge from the facility, or when a resident's Medicare Part A stay ends, but the resident remains in the facility (unless it is an instance of an interrupted stay).
- ❑ **Interrupted Stay:** A Medicare Part A SNF stay in which a resident is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay) and subsequently resumes SNF care in the same SNF for a Medicare Part A-covered stay during the interruption window.

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## DEFINITIONS

- ❑ **Interruption Window:** **A 3-day period, starting with the calendar day of Part A discharge and including the 2 immediately following calendar days.**
- ❑ *If a resident in a Medicare Part A SNF stay is discharged from Part A, the resident must resume Part A services, or return to the same SNF (if physically discharged) to resume Part A services, **by 11:59 p.m. at the end of the third calendar day after their Part A-covered stay ended.***
- ❑ *The interruption window begins with the first non-covered day following a Part A-covered stay and ends at 11:59 p.m. on the third consecutive non-covered day following a Part A-covered SNF stay.*

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## TYPES OF MDS 3.0 ASSESSMENTS

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### OBRA-REQUIRED TRACKING RECORDS & ASSESSMENTS

#### Tracking Records

- ☐ Entry (A0310F=01)
- ☐ Death in Facility (A0310F=12)

#### OBRA Assessments (A03010)

- ☐ Admission (Comprehensive)
- ☐ Quarterly
- ☐ Annual (Comprehensive)
- ☐ SCSA (Comprehensive)
- ☐ Discharge (Return Not Anticipated or Return Anticipated)
- ☐ SCPA (Comprehensive)
- ☐ SCQA

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### TYPES OF MDS 3.0 ASSESSMENTS (PPS ASSESSMENTS) – **A0310B**

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



**\*\*\*If completed for Medicare HMO's or other private insurances – DO NOT TRANSMIT!**

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## MDS 3.0 ITEM SETS



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### ITEM SETS

- ☐ **Comprehensive (NC2) Item Set.** This is the set of items active on an OBRA Comprehensive assessment (Admission, Annual, SCSA, and SCPA).
- ☐ **Quarterly (NQ) Item Set.** This is the set of items active on an OBRA Quarterly assessment (including Significant Correction of Prior Quarterly assessment [SCQA]). This item set is used for a standalone Quarterly Assessment, or a Quarterly assessment combined with any type of PPS assessment and/or Discharge assessment.

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### ITEM SETS

- ☐ **PPS (NP) Item Set.** This is the set of items active on a 5-Day PPS assessment
- ☐ **Interim Payment Assessment (IPA) Item Set.** This is the set of items active on an Interim Payment Assessment and used for PPS payment purposes. This is a standalone assessment.
- ☐ **Discharge (ND) Item Set.** This is the set of items active on a standalone OBRA Discharge assessment (either return anticipated or not anticipated) to be used when a resident is physically discharged from the facility.

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### ITEM SETS

- ❑ **Part A PPS Discharge (NPE) Item Set.** This is the set of items active on a standalone nursing home Part A PPS Discharge assessment for the purposes of the SNF QRP. It is completed when the resident's Medicare Part A stay ends, but the resident remains in the facility.
- ❑ **Tracking (NT) Item Set.** This is the set of items active on an Entry Tracking Record or a Death in Facility Tracking Record.

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### ITEM SETS

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

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### MDS 3.0: WHEN TO DO WHAT

	OBRA	PPS
WHO	All residents who are in the facility for at least 14 days	All residents in a Medicare Part A-covered stay
WHAT	MDS 3.0	MDS 3.0
WHEN	Completed upon Admission/Discharge to/from a nursing home, Quarterly, Yearly, and when Significant Changes occur	Scheduled 5-DAY assessment Optional IPA (Interim Payment Assessment) PPS Discharge Assessment
WHY	Quality Measurement, Facility Survey and Certification Requirements and Care Planning Purposes	Payment Rate Determination SNF-QRP

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### GENERAL KEY POINTS

### ON MDS COMPLETION



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### Completion of MDS Assessment

- ❑ Federal regulations require the RAI be conducted or coordinated with the appropriate participation of health professionals – who have the knowledge and expertise to do an accurate and comprehensive assessment in all areas.
- ❑ RAI must be conducted or coordinated by a REGISTERED NURSE (RN)  
**\*Important to consider State's Scope of Practice - RNs versus LPNs**

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### WHERE DOES INFO COME FROM?

- ❑ **Multiple Sources**
  - Resident, Resident's Family, Significant Others
  - Health Care Team Members
- ❑ **Multiple Methods**
  - Observation
  - Interview
  - Record Review



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### KEY POINTS: RESIDENT'S VOICE

- ❑ **Resident Interviews** are an integral part of the resident assessment process
- ❑ All residents capable of any communication should be asked to give information about what is important in their care
- ❑ 5 specific areas of MDS 3.0 require a direct interview of the resident as the primary source of information
- ❑ **Resident Interviews are "Stand-alone" Items (But Care Plan Accordingly)**
  - \*Appendix D of the Manual has information on interviewing, including techniques to use

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### Interview Clarifications

#### Timing of Resident Interviews:

- ❑ **Section C (BIMS)** – Conducted **during the look back period**, preferably on ARD or day before ARD
- ❑ **Section D (PHQ-9)** – **Conducted during look back period**. Preferably on the ARD or the day before ARD
- ❑ **Section F (Activities/Preferences)** – Conducted during the look back period.
- ❑ **Section J (Pain Interview)** – **Conducted anytime during the 5-day lookback period**. It is **PREFERRED** to conduct on the ARD or the day before.

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### Interview Clarifications

- ❑ Applies to all interview sections
  - Section C – BIMS
  - Section D – PHQ-9
  - Section F – Activities and Preferences
  - Section J – Pain
- ❑ **Staff interview should not be completed** in place of resident interview **if the resident interview should have been completed.**
  - Answer "Gateway" question as "yes"
  - Dash interview items
- ❑ B0700 should **NOT** be coded as "Rarely/Never Understood" if any of the **resident interviews were completed.**

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### KEY POINTS: STAFF ASSESSMENT

- ❑ When residents are unable or refuse to participate in the **4 specific resident interview items**, staff assessment interviews will need to be done
- ❑ This is the only reason to do the staff interview
- ❑ These interviews will focus on the same information as the resident interview
- ❑ Staff will base their responses on observations they have made of the resident during cares and activities in the look-back period.
- ❑ **Needs "Supporting Documentation" – unlike Resident Interviews**



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### KEY POINTS: CODING CONVENTIONS

- ❑ The standard look-back period is **7 days** unless otherwise stated
- ❑ With exception of certain items (e.g., in Sections K & O), **the look-back period does not extend into the preadmission period unless the item instructions state otherwise.**
- ❑ In case of **reentry**, **look-back period does not extend into time prior to the reentry**, unless instructions state otherwise
- ❑ For items that say "check all that apply" if specified conditions are not met, leave boxes empty (blank)
- ❑ Use numeric response for MDS items that require a coded response
- ❑ When the count or measurement of an item exceeds the number of boxes available, use the code of "9"

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## LET'S GO OVER THE THE MDS 3.0



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### RAI MANUAL CHAPTER 3: **FORMAT – HOW TO USE**

- ❑ **Intent.** The reason(s) for including this set of assessment items in the MDS.
- ❑ **Item Display.** To facilitate accurate resident assessment using the MDS, each assessment section is accompanied by screenshots, which display the item from the MDS 3.0 item set.
- ❑ **Item Rationale.** The purpose of assessing this aspect of a resident's clinical or functional status.
- ❑ **Health-related Quality of Life.** How the condition, impairment, improvement, or decline being assessed can affect a resident's quality of life, along with the importance of staff understanding the relationship of the clinical or functional issue related to quality of life.

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### RAI MANUAL CHAPTER 3: **FORMAT – HOW TO USE**

- ❑ **Planning for Care.** How assessment of the condition, impairment, improvement, or decline being assessed can contribute to appropriate care planning.
- ❑ **Steps for Assessment.** Sources of information and methods for determining the correct response for coding each MDS item.
- ❑ **Coding Instructions.** The proper method of recording each response, with explanations of individual response categories.
- ❑ **Coding Tips and Special Populations.** Clarifications, issues of note, and conditions to be considered when coding individual MDS items.
- ❑ **Examples.** Case examples of appropriate coding for most, if not all, MDS sections/items.

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## SECTIONS IN THE MDS 3.0 FORM

***“Refer to Color-Coded  
MDS 3.0 Form –  
A Practical Approach”***



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## COLOR-CODING

- ❑ **GREEN:** Payment Drivers
- ❑ **RED:** Potential triggers for CAA's and CARE PLANNING
- ❑ **BLUE (with numbers after the item):** QM Triggers
- ❑ **PURPLE (Sections outlined in purple):** Resident Review Items
- ❑ **ORANGE (Sections outlined in orange):** Alternative to Resident Interview; i.e., Staff Assessment


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## MDS 3.0 SECTIONS

- ❑ **SECTION A:** Identification Information
- ❑ **SECTION B:** Hearing, Speech and Vision
- ❑ **SECTION C:** Cognitive Patterns & Delirium
- ❑ **SECTION D: Mood** 
- ❑ **SECTION E:** Behavior
- ❑ **SECTION F:** Preferences for Customary Routine & Activities
- ❑ **SECTION G:** Functional Status
- ❑ **SECTION GG: Functional Abilities & Goals**
- ❑ **SECTION H:** Bladder & Bowel 

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## MDS 3.0 SECTIONS

- ❑ **SECTION I: Active Diagnoses**
- ❑ **SECTION J: Health Conditions**
- ❑ **SECTION K: Swallowing/Nutritional Status**
- ❑ **SECTION L:** Oral/Dental Status
- ❑ **SECTION M: Skin Conditions**
- ❑ **SECTION N:** Medications
- ❑ **SECTION O: Special Treatments, Procedures and Programs**
- ❑ **SECTION P:** Restraints & Alarms 

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## MDS 3.0 SECTIONS

- ☐ **SECTION Q:** Participation in Assessment & Goal-Setting
- ☐ **SECTION V:** CAA Summary
  - **V0100:** CARE AREA ASSESSMENT (CAA) SUMMARY
  - **V0200:** CAAs and CARE PLANNING
- ☐ **SECTION X:** Correction Request
- ☐ **SECTION Z:** Assessment Administration



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## MDS 3.0 CODING VULNERABILITIES related to PDPM; CMS CLARIFICATIONS; Focus of AUDITS



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## SECTION A

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



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## Section A, "Identification Information"

- ☐ **A0410:** Unit Certification or Licensure Designation: **Always Code #3 – If facility is Medicare and/or Medicaid certified.**
- ☐ **UNIQUE IDENTIFIERS:**
  - **A0500:** Legal Name of Resident
  - **A0600:** SS and Medicare Numbers
  - **A0800:** Gender
  - **A0900:** Birth Date

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## A2400C – End of Medicare Stay

**A2400. Medicare Stay**

**A. Has the resident had a Medicare stay?**  
 0. No → Skip to B0100, Care Planning  
 1. Yes → Continue to A2400C

**B. Start date of most recent Medicare stay:**  
 Month: [ ] Day: [ ] Year: [ ]

**C. End date of most recent Medicare stay - Enter dashes if day is ongoing:**  
 Month: [ ] Day: [ ] Year: [ ]


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## Section A, "Identification Information"

- ☐ **Enter the Start Date of that Medicare stay in A2400B;** i.e., the most recent of the Part A stays that occurred since the Entry Date.
- ☐ Enter the **end date of that stay in A2400C.** This is defined as **whichever of the ff. occurred first:**
  1. The date benefits exhausted (day 100 of Part A stay)
  2. Date of last day covered as recorded as the effective date on the Notice of Medicare Non-Coverage (NOMNC)
  3. The last paid day of Medicare A when payer source changes to another payer
  4. Date the resident was discharged from the facility (the A2000, Discharge Date)

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## SECTION B



**Intent:** *The intent of items in this section is to document the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others and whether the resident experiences visual limitations or difficulties related to diseases common in aged persons.*

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Look back period for all items is 7 days unless another time frame is indicated

### Section B Hearing, Speech, and Vision

<input type="checkbox"/>	<b>B0100. Comatose</b> Persistent vegetative state/no discernible consciousness 0. No → Continue to B0200, Hearing 1. Yes → Skip to G0110, Activities of Daily Living (ADL) Assistance
<input type="checkbox"/>	<b>B0200. Hearing</b> Ability to hear (with hearing aid or hearing appliances if normally used) 0. Adequate - no difficulty in normal conversation, social interaction, listening to TV 1. Minimal difficulty - difficulty in some environments (e.g., when person speaks softly or setting is noisy) 2. Moderate difficulty - speaker has to increase volume and speak distinctly 3. Highly impaired - absence of useful hearing
<input type="checkbox"/>	<b>B0300. Hearing Aid</b> Hearing aid or other hearing appliance used in completing B0200, Hearing 0. No 1. Yes
<input type="checkbox"/>	<b>B0600. Speech Clarity</b> Select best description of speech pattern 0. Clear speech - distinct intelligible words 1. Unclear speech - slurred or mumbled words 2. No speech - absence of spoken words
<input type="checkbox"/>	<b>B0700. Makes Self Understood</b> Ability to express ideas and wants, consider both verbal and non-verbal expression 0. Understood 1. Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time 2. Sometimes understood - ability is limited to making concrete requests 3. Rarely/never understood
<input type="checkbox"/>	<b>B0800. Ability To Understand Others</b> Understanding verbal content, however able (with hearing aid or device if used) 0. Understands - clear comprehension 1. Usually understands - misses some part/intent of message but comprehends most conversation 2. Sometimes understands - responds adequately to simple, direct communication only 3. Rarely/never understands

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### B0700: Makes Self Understood (Will affect SLP-Cognition)

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

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

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### B0700: Makes Self Understood (Will affect SLP-Cognition)

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

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### B0700: Makes Self Understood (Will affect SLP-Cognition)

**Coding Tips:**  
☐ This item **cannot be coded as "Rarely/Never Understood"** if the resident completed any of the resident interviews, as the interviews are conducted during the look-back period for this item and should be factored in when determining the residents' ability to make self understood during the entire 7-day look-back period.  
☐ While B0700 and the resident interview items are not directly dependent upon one another, **inconsistencies in coding among these items should be evaluated.**

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## SECTION C



**Intent:** *The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions.*

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## SECTION C: COGNITIVE PATTERNS

### Steps for Assessment

1. Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.
2. Determine if the resident is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip to C0700–C1000, Staff Assessment of Mental Status.
3. Review Language item (A1100), to determine if the resident needs or wants an interpreter. If the resident needs or wants an interpreter, complete the interview with an interpreter.

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## SECTION C: SHOULD BIMS BE CONDUCTED?

### Coding Instructions:

- ☐ **Code 0, NO:** if the interview should not be conducted *because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available.* Skip to C0700, Staff Assessment of Mental Status.
- ☐ **Code 1, YES:** if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words.

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**C0100: Should Brief Interview for Mental Status (C0200-C0500) be Conducted?**  
 Attempt to conduct interview with all residents.  
 Enter Code: ☐ 0. No (resident is rarely/never understood) → Skip to and complete C0700-C1000, Staff Assessment for Mental Status.  
 1. Yes → Continue to C0200, Repetition of Three Words.

**Brief Interview for Mental Status (BIMS)**

**C0200. Repetition of Three Words**  
 Ask resident: "You're going to say three words for me to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words."  
 Number of words repeated after first attempt  
 Enter Code: ☐ 0. None  
 1. One  
 2. Two  
 3. Three  
 After the resident's first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.

**C0300. Temporal Orientation (orientation to year, month, and day)**  
 Ask resident: "Please tell me what year it is right now."  
 Enter Code: ☐ A. Able to report correct year  
 0. Missed by > 5 years or no answer  
 1. Missed by 2-5 years  
 2. Missed by 1 year  
 3. Correct  
 Ask resident: "What month are we in right now?"  
 Enter Code: ☐ B. Able to report correct month  
 0. Missed by > 1 month or no answer  
 1. Missed by 6 days to 1 month  
 2. Accurate within 5 days  
 Ask resident: "What day of the week is today?"  
 Enter Code: ☐ C. Able to report correct day of the week  
 0. Incorrect or no answer  
 1. Correct

**C0400. Recall**  
 Ask resident: "Let's go back to an earlier question. What were those three words that I asked you to repeat?"  
 If unable to remember a word, give cue (something to wear, a color, a piece of furniture) for that word.  
 Enter Code: ☐ A. Able to recall "sock"  
 0. No; could not recall  
 1. Yes, after cueing ("something to wear")  
 2. Yes, no cue required  
 Enter Code: ☐ B. Able to recall "blue"  
 0. No; could not recall  
 1. Yes, after cueing ("a color")  
 2. Yes, no cue required  
 Enter Code: ☐ C. Able to recall "bed"  
 0. No; could not recall  
 1. Yes, after cueing ("a piece of furniture")  
 2. Yes, no cue required

**C0500. BIMS Summary Score**  
 Add score for questions C0200-C0400 and fill in total score (00-15)  
 Enter 99 if the resident was unable to complete the interview

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## SECTION C: BIMS (Will affect SLP-Cognition)

### Coding Tips

- ☐ Attempt to conduct the interview with ALL residents.
- ☐ Conducted during the look-back period of the ARD
- ☐ If the resident needs an interpreter, every effort should be made to have an interpreter present for the BIMS. Includes residents who use American Sign Language (ASL).
- ☐ If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item C0100 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items.
- ☐ Do not complete the Staff Assessment for Mental Status items (C0700-C1000) if the resident interview should have been conducted but was not done.

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## PDPM Cognitive Scoring

- ☐ Because a PDPM cognitive level is utilized in the speech language pathology (SLP) payment component of PDPM, assessment of resident cognition with the BIMS or Staff Assessment for Mental Status is a requirement for all PPS assessments. As such, only in the case of PPS assessments, staff may complete the Staff Assessment for Mental Status for an interviewable resident when the resident is unexpectedly discharged from a Part A stay prior to the completion of the BIMS. In this case, the assessor should enter 0, No in C0100: Should Brief Interview for Mental Status Be Conducted? and proceed to the Staff Assessment for Mental Status. (RAI 2019, C-2)

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## Section C, BIMS – BRIEF INTERVIEW FOR MENTAL STATUS (Will affect SLP-Cognition)

### C0500. BIMS Summary Score

Enter Score:  Add scores for questions C0200-C0400 and fill in total score (00-15)  
 Enter 99 if the resident was unable to complete the interview

### BIMS Total Score:

- ☐ 13-15: Cognitively Intact
- ☐ 8-12: Moderately Impaired
- ☐ 0-7: Severe Impairment

**\*Resident Interview (BIMS) is a Stand-alone Document – Must be completed on or before the ARD during the look back period.**

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Staff Assessment for Mental Status	
Do not conduct if Brief Interview for Mental Status (C0700-C1000) was completed	
<b>C0700. Short-term Memory OK</b>	
Enter Code	Seems or appears to recall after 5 minutes
<input type="checkbox"/>	0. Memory OK
<input type="checkbox"/>	1. Memory problem
<b>C0800. Long-term Memory OK</b>	
Enter Code	Seems or appears to recall long past
<input type="checkbox"/>	0. Memory OK
<input type="checkbox"/>	1. Memory problem
<b>C0900. Memory/Recall Ability</b>	
Check all that the resident was normally able to recall	
<input type="checkbox"/>	A. Current season
<input type="checkbox"/>	B. Location of own room
<input type="checkbox"/>	C. Staff names and faces
<input type="checkbox"/>	D. That he or she is in a nursing home/hospital swing bed
<input type="checkbox"/>	Z. None of the above were recalled
<b>C1000. Cognitive Skills for Daily Decision Making</b>	
Enter Code	Made decisions regarding tasks of daily life
<input type="checkbox"/>	0. Independent - decisions consistent/reasonable
<input type="checkbox"/>	1. Modified independence - some difficulty in new situations only
<input type="checkbox"/>	2. Moderately impaired - decisions poor; cues/supervision required
<input type="checkbox"/>	3. Severely impaired - never/rarely made decisions

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C0500. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?	
Enter Code	0. No (resident was able to complete Brief Interview for Mental Status) → Skip to C1310, Signs and Symptoms of Delirium
<input type="checkbox"/>	1. Yes (resident was unable to complete Brief Interview for Mental Status) → Continue to C0700, Short-term Memory OK

**Review whether BIMS Summary Score item (C0500), is coded 99, unable to complete interview. Coding Instructions:**

**Code 0, No:** if the BIMS was completed and scored between 00 and 15. Skip to C1310.

**Code 1, Yes:** if the resident chooses not to participate in the BIMS or if four or more items were coded 0 because the resident chose not to answer or gave a nonsensical response. Continue to C0700-C1000 and perform the Staff Assessment for Mental Status. Note: C0500 should be coded 99.

**If a resident is scored 00 on C0500, C0700-C1000, Staff Assessment, should not be completed. 00 is a legitimate value for C0500 & indicates that the interview was complete. To have an incomplete interview, a resident had to choose not to answer or had to give completely unrelated, nonsensical responses to 4 or more BIMS items.**

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C0700: SHORT-TERM MEMORY (Will affect SLP-Cognition)	
<b>C0700. Short-term Memory OK</b>	
Enter Code	Seems or appears to recall after 5 minutes
<input type="checkbox"/>	0. Memory OK
<input type="checkbox"/>	1. Memory problem

*Determine the resident's short-term memory status by asking him or her: **to describe an event 5 minutes after it occurred if you can validate the resident's response, or to follow through on a direction given 5 minutes earlier.***

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C0900: MEMORY/RECALL ABILITY (Will affect SLP-Cognition)	
<b>C0900. Memory/Recall Ability</b>	
Check all that the resident was normally able to recall	
<input type="checkbox"/>	A. Current season
<input type="checkbox"/>	B. Location of own room
<input type="checkbox"/>	C. Staff names and faces
<input type="checkbox"/>	D. That he or she is in a nursing home/hospital swing bed
<input type="checkbox"/>	Z. None of the above were recalled

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C1000: COGNITIVE SKILLS FOR DAILY DECISION-MAKING (Will affect SLP-Cognition)	
<b>C1000. Cognitive Skills for Daily Decision Making</b>	
Enter Code	Made decisions regarding tasks of daily life
<input type="checkbox"/>	0. Independent - decisions consistent/reasonable
<input type="checkbox"/>	1. Modified independence - some difficulty in new situations only
<input type="checkbox"/>	2. Moderately impaired - decisions poor; cues/supervision required
<input type="checkbox"/>	3. Severely impaired - never/rarely made decisions

**If the resident "rarely or never" made decisions, despite being provided with opportunities and appropriate cues, Item C1000 would be coded 3, severely impaired.**

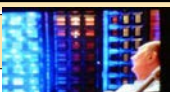
**If the resident makes decisions, although poorly, code 2, moderately impaired.**

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Section C, Staff Assessment for Mental Status	
IMPAIRED COGNITION = CPS ≥ 3: If one of the (3) following conditions exists:	
1. B0100 Coma (B0100 = 1) & Completely ADL Dependent or ADL did not occur (G0110A1, G0110B1, G0110H1, G0100I1 all = 4 or 8)	
2. C1000 Severely Impaired Cognitive Skills (C1000 = 3)	
3. B0700, C0700, C1000: Two or more of the following impairment indicators are present:	
<input type="checkbox"/> B0700 > 0: Problem being understood	
<input type="checkbox"/> C0700 = 1: Short-term memory problem	
<input type="checkbox"/> C1000 > 0: Cognitive Skills Problem and 1 or more of the ff. severe impairment indicators are present:	
o B0700 ≥ 2: Severe problem being understood	
o C1000 ≥ 2: Severe cognitive skills problem	
<b>*Staff Assessment requires supporting documentation</b>	
<b>NOTE *Scoring for CFS under PDPM will be different (Score of 1 – 6 will trigger Impaired Cognition)*</b>	

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## SECTION D



**Intent:** The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable. It is important to note that coding the presence of indicators in Section D does not automatically mean that the resident has a diagnosis of depression or other mood disorder. Assessors do not make or assign a diagnosis in Section D; they simply record the presence or absence of specific clinical mood indicators. Facility staff should recognize these indicators and consider them when developing the resident's individualized care plan.

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### Section D: MOOD (NURSING DEPRESSION END-SPLIT FOR CLINICALLY COMPLEX; SPECIAL CARE HIGH & SPECIAL CARE LOW)

- ☐ The resident mood interview is attempted with all residents, using either the PHQ-9 or the staff assessment, PHQ-9-OV.
- ☐ If the resident seems unable to communicate, offer alternatives, such as writing, pointing, sign language, or cue cards. Utilizing the techniques in Appendix D of the RAI User's Manual as well as cue cards will enhance the resident interview.

#### Findings suggesting mood distress should lead to:

- ☐ Identifying causes & contributing factors for Symptoms
- ☐ Identifying interventions (Tx, personal support, or environmental modifications) to address symptoms, &
- ☐ Ensuring resident safety.

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- ☐ Most residents who are capable of communicating can answer questions about how they feel.
- ☐ Obtaining information about mood directly from the resident, sometimes called "hearing the resident's voice," is more reliable and accurate than observation alone for identifying a mood disorder.
- ☐ Explain the reason for the interview before beginning. Suggested language: "I am going to ask you some questions about your mood and feelings over the past 2 weeks. I will also ask about some common problems that are known to go along with feeling down. Some of the questions might seem personal, but everyone is asked to answer them. This will help us provide you with better care."

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### Interviewing Tips and Techniques:

- ☐ **UNFOLDING:** If the resident has difficulty selecting a frequency response, start by offering a single frequency response and follow with a sequence of more specific questions.
- ☐ **PROBING:** Noncommittal responses such as "not really" should be explored. Residents may be reluctant to report symptoms and should be gently encouraged to tell you if the symptom bothered him or her, even if it was only some of the time.
  - o "What do you mean?"; "Tell me what you have in mind."; "Tell me more about that."; "Please be more specific."; "Give me an example."

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### Interviewing Tips and Techniques

- ☐ **ECHOING:** Sometimes respondents give a long answer to interview items. It can be useful to summarize their longer answer and then ask them which response option best applies.
- o **Poor Appetite or Overeating.** The resident responds "the food is always cold, and it just doesn't taste like it does at home. The doctor won't let me have any salt."
- o **Possible interviewer response:** "You're telling me the food isn't what you eat at home, and you can't add salt. How often would you say that you were bothered by poor appetite or over-eating during the last 2 weeks?"

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### Interviewing Tips and Techniques

- ☐ **DISENTANGLING:** If the resident has difficulty with longer items, separate the item into shorter parts, and provide a chance to respond after each part.
- Example:** Item D0200E, Poor Appetite or Overeating.
  - o You can simplify this item by asking: "In the last 2 weeks, how often have you been bothered by poor appetite?" (pause for a response) "Or overeating?"
- Example:** Item D0200C, Trouble Falling or Staying Asleep, or Sleeping Too Much.
  - o You can break the item down as follows: "How often are you having problems falling asleep?" (pause for response) "How often are you having problems staying asleep?"

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**Section D Mood**

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

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

**D0200. Resident Mood Interview (PHQ-9-C)**  
Say to resident: "Over the last 2 weeks, have you been bothered by any of the following problems?"  
If symptom is present, enter 1 (yes) in column 1, Symptom Presence.  
If yes in column 1, then ask the resident, "About how often have you been bothered by this?"  
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

	1. Symptom Presence	2. Symptom Frequency	1. Symptom Presence	2. Symptom Frequency
A. Little interest or pleasure in doing things	0. No (enter 0 in column 2) 1. Yes (enter 0-3 in column 2) 9. No response (leave column 2 blank)	0. Never or 1 day 1. 2-6 days (several days) 2. 7-11 days (half or more of the days) 3. 12-14 days (nearly every day)	1. Symptom Presence	2. Symptom Frequency
B. Feeling down, depressed, or hopeless				
C. Trouble falling or staying asleep, or sleeping too much				
D. Feeling tired or having little energy				
E. Poor appetite or overeating				
F. Feeling bad about yourself - or that you are a failure or have let yourself or your family down				
G. Trouble concentrating on things, such as reading the newspaper or watching television				
H. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual				
I. Thoughts that you would be better off dead, or of hurting yourself in some way				

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

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### Coding Instructions for Column 1

#### Symptom Presence

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

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### Coding Instructions for Column 2. Symptom Frequency

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

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

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### D0300: TOTAL SEVERITY SCORE

#### D0300. Total Severity Score

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

#### TOTAL SEVERITY SCORE

- ☐ **A summary of the frequency scores that indicates the extent of potential depression symptoms. The score does not diagnose a mood disorder but provides a standard of communication with clinicians / mental health specialists.**

#### After completing D0200 A-I:

1. Add the numeric scores across all frequency items in Resident Mood Interview (D0200) Column 2.
  2. The maximum resident score is 27 (3 x 9).
- A SCORE OF 10 OR MORE WILL INCREASE THE NURSING COMPONENT CMI SCORE IF RUG SCORE IS CLINICALLY COMPLEX, SPECIAL CARE HIGH OR SPECIAL CARE LOW.**

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Resident: \_\_\_\_\_ Identifier: \_\_\_\_\_ Date: \_\_\_\_\_

**Section D Mood**

**D0500. Staff Assessment of Resident Mood (PHQ-9-OV)**  
Do not conduct if Resident Mood Interview (D0200-D0300) was completed.  
Over the last 2 weeks, did the resident have any of the following problems or behaviors?  
If symptom is present, enter 1 (yes) in column 1, Symptom Presence.  
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

	1. Symptom Presence	2. Symptom Frequency	1. Symptom Presence	2. Symptom Frequency
A. Little interest or pleasure in doing things	0. No (enter 0 in column 2) 1. Yes (enter 0-3 in column 2)	0. Never or 1 day 1. 2-6 days (several days) 2. 7-11 days (half or more of the days) 3. 12-14 days (nearly every day)	1. Symptom Presence	2. Symptom Frequency
B. Feeling or appearing down, depressed, or hopeless				
C. Trouble falling or staying asleep, or sleeping too much				
D. Feeling tired or having little energy				
E. Poor appetite or overeating				
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down				
G. Trouble concentrating on things, such as reading the newspaper or watching television				
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual				
I. States that life isn't worth living, wishes for death, or attempts to harm self				
J. Being short-tempered, easily annoyed				

**D0600. Total Severity Score**  
Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30.

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### D0600: TOTAL SEVERITY SCORE

#### D0600. Total Severity Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30.

#### TOTAL SEVERITY SCORE

#### After completing items D0500 A-J:

1. Add the numeric scores across all frequency items for Staff Assessment of Mood, Symptom Frequency (D0500) Column 2.
  2. Maximum score is 30 (3 x 10).
- A SCORE OF 10 OR MORE WILL INCREASE THE NURSING COMPONENT CMI SCORE IF RUG SCORE IS CLINICALLY COMPLEX, SPECIAL CARE HIGH OR SPECIAL CARE LOW.**  
**\*STAFF ASSESSMENT REQUIRES DOCUMENTATION DURING THE 14-DAY LOOK BACK PERIOD. (FREQUENCY OF OCCURRENCES)**

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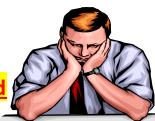
## Section D: MOOD

### Resident Interview (PHQ-9):

- ☐ Items D02002A through D02002I
- ☐ Requires no further documentation
- ☐ **RESIDENT responses on the MDS Item Set will be accepted as "Stand Alone" documentation.**
- ☐ **Must be completed on or before the ARD during the look back period. (Z0400 – SIGN ON COMPLETION DATE, WHICH IS ON OR BEFORE ARD DURING THE LOOK BACK PERIOD)**

### Staff Interview (PHQ-9-OV)

- ☐ Items D05002A through J
- ☐ **Supporting Documentation Required for Staff Interview\***



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## SECTION E: BEHAVIOR



**Intent:** The items in this section identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment. These behaviors may place the resident at risk for injury, isolation, and inactivity and may also indicate unrecognized needs, preferences or illness.

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Resident	Identifier	Date
<b>Section E Behavior</b>		
<b>E0100. Potential Indicators of Psychosis</b>		
Check all that apply		
<input type="checkbox"/> A. Hallucinations (perceptual experiences in the absence of real external sensory stimuli) <input type="checkbox"/> B. Delusions (misconceptions or beliefs that are firmly held, contrary to reality) <input type="checkbox"/> Z. None of the above		
<b>Behavioral Symptoms</b>		
<b>E0200. Behavioral Symptom - Presence &amp; Frequency</b>		
Note presence of symptoms and their frequency		
Enter Codes in Boxes		
Coding: 0. Behavior not exhibited 1. Behavior of this type occurred 1 to 3 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily		
<input type="checkbox"/> A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) <input type="checkbox"/> B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others) <input type="checkbox"/> C. Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, drooling in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)		
<b>E0800. Rejection of Care - Presence &amp; Frequency</b>		
Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being? Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals.		
<input type="checkbox"/> 0. Behavior not exhibited <input type="checkbox"/> 1. Behavior of this type occurred 1 to 3 days <input type="checkbox"/> 2. Behavior of this type occurred 4 to 6 days, but less than daily <input type="checkbox"/> 3. Behavior of this type occurred daily		
<b>E0900. Wandering - Presence &amp; Frequency</b>		
Has the resident wandered?		
<input type="checkbox"/> 0. Behavior not exhibited <input type="checkbox"/> 1. Behavior of this type occurred 1 to 3 days <input type="checkbox"/> 2. Behavior of this type occurred 4 to 6 days, but less than daily <input type="checkbox"/> 3. Behavior of this type occurred daily		

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## Section E: BEHAVIOR (NURSING COMPONENT – BEHAVIOR/COGNITION QUALIFIER)

**Presence of Behavior(s):** Need Documentation during the Look Back period to support Coding:

- ☐ E0100A Hallucinations
- ☐ E0100B Delusions

**Presence and Frequency of Behavior(s):** Need Daily Documentation during the Look Back period to support Coding:

- ☐ E0200A Physical Behaviors
- ☐ E0200B Verbal Behaviors
- ☐ E0200C Other Behaviors
- ☐ E0800 Rejection of Care
- ☐ E0900 Wandering

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## Section E: BEHAVIOR

- ☐ **Rejection of Care, Item E0800:** "Behavior that interrupts or interferes with the delivery or receipt of care" (p. E-14).
  - o Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family) **AND** determined to be consistent with the resident's values, preferences, or goals. Residents who have made an informed choice about not wanting a particular treatment, procedure, etc., should not be identified as "rejecting care."

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## SECTION F: PREFERENCES FOR CUSTOMARY ROUTINE & ACTIVITIES

**Intent:** The intent of items in this section is to obtain information regarding the resident's preferences for his or her daily routine and activities. This is best accomplished when the information is obtained directly from the resident or through family or significant other, or staff interviews if the resident cannot report preferences. Nursing homes should use this as a guide to create an individualized plan based on the resident's preferences and is not meant to be all-inclusive.

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## SECTION G

**Intent:** *Items in this section assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion. In addition, on admission, resident and staff opinions regarding functional rehabilitation potential are noted.*

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### Section G: Functional Status

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

[Step] 1. When an activity occurs **3 or more times at any one level**, code that level.

[Step] 2. When an activity occurs **3 or more times at multiple levels, code the most dependent level that occurred three or more times.**

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### Section G: Functional Status

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

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### G0400, Functional Limitation in Range of Motion

- ☐ Code for limitations “that interfered with daily functions or placed resident at risk of injury” during the seven-day observation period.
- ☐ The existence of a limitation in ROM is not enough to result in coding of that limitation on the MDS. The limitation must interfere with the resident’s functional ability to perform ADLs.
- ☐ The same concept applies when a resident has had a digit or limb amputated.

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## SECTION GG: Safety & Quality of Performance “FUNCTIONAL ABILITIES AND GOALS



**Intent:** *This section includes items about functional abilities and goals. It includes items focused on prior function, admission performance, discharge goals, and discharge performance.*

**Functional status is assessed based on the need for assistance when performing self-care and mobility activities.**

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## INTENT - Section GG

- ☐ Functional status is assessed based on the need for assistance when performing self-care and mobility activities
- ☐ Residents in SNFs have self-care and mobility limitations and are at risk for further functional decline and complications because of limited mobility

115

## IPA ITEM SET UNDER PDPM: GG0130 & GG0170

S.	Interim Performance
Enter Codes in Boxes	
B. Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.	<input type="checkbox"/>
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.	<input type="checkbox"/>
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.	<input type="checkbox"/>
E. Chair-bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair).	<input type="checkbox"/>
F. Toilet transfer: The ability to get on and off a toilet or commode.	<input type="checkbox"/>
I. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. If interim performance is coded 07, 09, 10, or 88 → Skip to H0100, Appliances	<input type="checkbox"/>
J. Walk 50 feet with two turns: Once standing, the ability to walk at least 50 feet and make two turns.	<input type="checkbox"/>
K. Walk 150 feet: Once standing, the ability to walk at least 150 feet in a corridor or similar space.	<input type="checkbox"/>

116

## GG0130 & GG0170: Review of Coding Instructions

Code the resident's usual performance for each activity using the six - point scale:

- ☐ Code "06" for Independent
- ☐ Code "05" for Setup or clean - up assistance
- ☐ Code "04" for Verbal Cues, Supervision or Touching/Steadying Assistance, CGA
- ☐ Code "03" for Partial/moderate assistance
- ☐ Code "02" for Substantial/maximal assistance
- ☐ Code "01" for Dependent or the assistance of two or more helpers to complete the activity.

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## GG0130 & GG0170: Review of Coding Instructions

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

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## GG0130 & GG0170: Review of Coding Instructions

### Steps for Assessment:

- ☐ Assess the resident's self-care performance based on direct observation, INCORPORATING resident's self-report and reports from qualified clinicians, care staff, or family documented in the resident's medical record during the three-day assessment period.
- ☐ CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period.
- ☐ **QUALIFIED CLINICIAN:** Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.

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## GG0130 & GG0170: Review of Coding Instructions

- ☐ *Information added to Steps for Assessment strengthening concept of collaboration to collect the resident's self-performance in the items to be assessed during the 3-Day Assessment Period.*
- ☐ *Documentation in the medical record is used to support assessment coding of section GG*

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### GG0130 & GG0170: Review of Coding Instructions

- ☐ The admission functional assessment, when possible, should be conducted prior to the person benefitting from treatment interventions in order to determine a true baseline functional status on admission. If treatment has started, for example, on the day of admission, a **baseline functional status assessment** can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.
- ☐ Refer to facility, Federal, and State policies and procedures to determine which staff members may complete an assessment. Resident assessments are to be done in compliance with facility, Federal, and State requirements.

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### GG0130 & GG0170: Review of Coding Instructions

#### Assessment Period

- ☐ Admission: The 5-Day PPS assessment (A0310B = 01) is the first Medicare-required assessment to be completed when the resident is admitted for a SNF Part A stay.
  - o For the 5-Day PPS assessment, **code the resident's functional status based on a clinical assessment of the resident's performance that occurs soon after the resident's admission.**
  - o This functional assessment must be completed within the **1<sup>st</sup> 3 calendar days of Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, & the following two days, ending at 11:59 PM on day 3.**
  - o The admission function scores are to reflect the resident's admission baseline status & are to be based on an assessment.

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### GG0130 & GG0170: Review of Coding Instructions

#### Assessment Period

- o The scores should reflect the resident's status prior to any benefit from interventions. The assessment should occur, when possible, prior to the resident benefitting from treatment interventions in order to determine the resident's true admission baseline status.
- o Even if treatment started on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional assessment.

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### GG0130 & GG0170: Review of Coding Instructions

- ☐ To clarify your own understanding of the resident's performance of an activity, ask probing questions to the care staff about the resident, beginning with the general and proceeding to the more specific.
- ☐ **Documentation in the medical record is used to support assessment coding of Section GG.**
- ☐ **Data entered should be consistent with the clinical assessment documentation in the resident's medical record.**
- ☐ **This assessment can be conducted by appropriate healthcare personnel as defined by facility policy and in accordance with State and Federal regulations.**

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### Section GG (Affects PT & OT; NURSING under PDPM )

PDPM Therapy Function Score	PDPM Nursing Function Score
<input type="checkbox"/> Self Care: Eating <input type="checkbox"/> Self Care: Oral hygiene <input type="checkbox"/> Self Care: Toileting Hygiene <input type="checkbox"/> Mobility: Sit to lying of bed <input type="checkbox"/> Mobility: Lying to sitting on side of bed <input type="checkbox"/> Mobility: Sit to stand <input type="checkbox"/> Mobility: Chair/bed transfer <input type="checkbox"/> Mobility: Toilet Transfer <input type="checkbox"/> Mobility: Walk 50 feet w/ 2 turns <input type="checkbox"/> Mobility: Walk 150 feet	<input type="checkbox"/> Self Care: Eating <input type="checkbox"/> Self Care: Toileting Hygiene <input type="checkbox"/> Mobility: Sit to lying <input type="checkbox"/> Mobility: Lying to sitting on side of bed <input type="checkbox"/> Mobility: Sit to stand <input type="checkbox"/> Mobility: Chair/bed transfer <input type="checkbox"/> Mobility: Toilet Transfer

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### GG0130: EATING

- ☐ **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.
  - o **If the resident eats and drinks by mouth and relies partially on obtaining nutrition and liquids via tube feedings or TPN, code Eating based on the amount of assistance the resident requires to eat and drink by mouth. Assistance with tube feedings or TPN is not considered when coding Eating.**
  - o **If the resident eats finger foods using his or her hands, then code Eating based upon the amount of assistance provided. If the resident eats finger foods with his or her hands independently, for example, the resident would be coded as 06, Independent.**

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**GG0130: ORAL HYGIENE**

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

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**GG0130: TOILETING HYGIENE**

- ❑ **Toileting hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment..
- *Toileting hygiene includes managing undergarments, clothing, and incontinence products and performing perineal cleansing before and after voiding or having a bowel movement.*
- *If the resident does not usually use undergarments, then assess the resident's need for assistance to manage lower-body clothing and perineal hygiene.*

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**GG0130: TOILETING HYGIENE**

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

129

**GG0170: BED MOBILITY**

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

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**GG0170: TRANSFERS**

- ❑ **Sit to Stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed
- ❑ **Chair/Bed-to-Chair Transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
- ❑ **Toilet Transfer:** The ability to get on and off a toilet or commode.

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**GG0170: WALKING**

- ❑ **Walk 50 feet with two turns:** Once standing, the ability to walk at least 50 feet and make two turns.
- ❑ **Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.

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## Section GG

### Overview of Coding Instructions:

- ☐ **Admission Performance** – code based on first 3 days of Medicare Part A stay (based on A2400B)
- ☐ **Discharge Performance** – code based on last 3 days of Medicare Part A stay (based on A2400C).
- ☐ Coding is based on “**Usual Performance**” – will require **clinical judgment**
- ☐ If activity occurs multiple times (e.g., eating, toileting, dressing, bed mobility activities, bed/chair transfers, do not code most dependent, do not code most independent.
- ☐ Some items may only be assessed once, code that status. (e.g., car transfers, curbs, stairs).

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## Section GG: RECAP of Important Points

- ☐ Section GG assesses the need for assistance with self-care and mobility activities
- ☐ **Must be a collaboration & integration between Therapy and Nursing!**
- ☐ **Requires supporting documentation**
- ☐ Master the art of Coding Section GG – will be utilized not just for SNF-QRP's but also for PDPM!!!

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## SECTION H

*Intent: The intent of the items in this section is to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns. Each resident who is incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment (medications, non-medicinal treatments and/or devices) and services to achieve or maintain as normal elimination function as possible.*

135

Resident	Identifier	Date
<b>Section H Bladder and Bowel</b>		
<b>H0100. Appliances</b>		
Check all that apply		
<input type="checkbox"/> A. Indwelling catheter (including suprapubic catheter and nephrostomy tube) <input type="checkbox"/> B. External catheter <input type="checkbox"/> C. Ostomy (including urostomy, ileostomy, and colostomy) <input type="checkbox"/> D. Intermittent catheterization <input type="checkbox"/> E. None of the above		
<b>H0200. Urinary Toileting Program</b>		
<input type="checkbox"/> A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission, entry or reentry or since urinary incontinence was noted in this facility? 0. No → Skip to H0300. Urinary Continence 1. Yes → Continue to H0200C. Current toileting program or trial <input type="checkbox"/> B. Unable to determine → Continue to H0200C. Current toileting program or trial <input type="checkbox"/> C. Current toileting program or trial - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence? 0. No 1. Yes		
<b>H0300. Urinary Continence</b>		
Urinary continence - Select the one category that best describes the resident <input type="checkbox"/> 0. Always continent 1. Occasionally incontinent (less than 7 episodes of incontinence) 2. Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding) 3. Always incontinent (no episodes of continent voiding) 4. Not rated, resident had a catheter (indwelling, condom, urinary ostomy, or no urine output for the entire 7 days)		
<b>H0400. Bowel Continence</b>		
Bowel continence - Select the one category that best describes the resident <input type="checkbox"/> 0. Always continent 1. Occasionally incontinent (one episode of bowel incontinence) 2. Frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement) 3. Always incontinent (no episodes of continent bowel movements) 4. Not rated, resident had an ostomy or did not have a bowel movement for the entire 7 days		
<b>H0500. Bowel Toileting Program</b>		
<input type="checkbox"/> Is a toileting program currently being used to manage the resident's bowel continence? 0. No 1. Yes		

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### Section H0100C & H0100D: Ostomy & Intermittent Catheterization (Will affect NTA Component)

Resident	Identifier	Date
<b>H0100. Appliances</b>		
Check all that apply		
<input type="checkbox"/> A. Indwelling catheter (including suprapubic catheter and nephrostomy tube) <input type="checkbox"/> B. External catheter <input type="checkbox"/> C. Ostomy (including urostomy, ileostomy, and colostomy) <input type="checkbox"/> D. Intermittent catheterization <input type="checkbox"/> E. None of the above		

**INTERMITTENT CATHETERIZATION:** Insertion & removal of a catheter through the urethra for bladder drainage.

#### Coding Tips and Special Populations:

- ☐ Suprapubic catheters & nephrostomy tubes should be coded as an indwelling catheter
- ☐ Do not include one-time catheterization for urine specimen during look-back period as intermittent catheterization.

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### Section H0100C: OSTOMY (NTA Component)

**H0100C, Ostomy (includes Urostomy/Ileostomy/Colostomy):**  
**OSTOMY:** Any type of surgically created opening of the GI or GU tract for discharge of body waste.

**UROSTOMY:** A stoma for the urinary system used in cases where long-term drainage of urine through the bladder and urethra is not possible, e.g., after extensive surgery or in case of obstruction.

**ILEOSTOMY:** A stoma that has been constructed by bringing the end or loop of small intestine (the ileum) out onto the surface of the skin.

**COLOSTOMY:** A stoma that has been constructed by connecting a part of the colon onto the anterior abdominal wall.

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**Section H0200C: URINARY TOILETING PROGRAM (NURSING RESTORATIVE END-SPLIT)**

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

0. No  
1. Yes

1. Review medical record for evidence of a toileting program being used to manage incontinence during the 7-day look-back period.  
**Note the # of days during the look-back period** that the toileting program was implemented or carried out.

2. Documentation in medical record **MUST SHOW 3 requirements**:

- ☐ Implemented an **individualized, resident-specific toileting program – based on an assessment of resident's unique voiding pattern;**
- ☐ Evidence that the individualized program was communicated to staff & resident verbally and through a care plan, flow records, and a written report;
- ☐ Notations of the **resident's response to the toileting program and subsequent evaluations**, as needed.

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**Section H0500: BOWEL TOILETING PROGRAM (NURSING RESTORATIVE END-SPLIT)**

H0500. Bowel Toileting Program

Is a toileting program currently being used to manage the resident's bowel continence?

0. No  
1. Yes


1. Review the medical record for evidence of a bowel toileting program being used to manage bowel incontinence during the 7-day look-back period.

2. Must meet **3 requirements** in medical records/documentation:

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

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**SECTION I: ACTIVE DIAGNOSIS**



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

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**I0020B. Indicate the Resident's Primary Medical Condition Category (Will affect PT, OT & SLP Clinical Category)\*\*\***

**Item I0020B:** Enter the code that represents the primary medical condition that resulted in the resident's SNF admission. Include the **primary medical condition coded in this item in Section I: Active Diagnoses in last 7 days.**

**Section I: Active Diagnoses**

I0020. Indicate the resident's primary medical condition category that best describes the primary reason for admission. Complete only if A0110B = 01 or 08.

Enter Code

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

**I0020B. ICD Code**

FOR SNF QRP

FOR PDPM \$\$\$\$\$\$\$\$

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**I0020B. Indicate the Resident's Primary Medical Condition Category (Will affect PT, OT & SLP Clinical Category)\*\*\***

**Item I0020B:** Enter the code that represents the primary medical condition that resulted in the resident's SNF admission. Include the **primary medical condition coded in this item in Section I: Active Diagnoses in last 7 days.**

**Section I: Active Diagnoses**

I0020. Indicate the resident's primary medical condition category that best describes the primary reason for admission. Complete only if A0110B = 01 or 08.

Enter Code

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

**I0020B. ICD Code**

FOR SNF QRP

FOR PDPM \$\$\$\$\$\$\$\$

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**PDPM: I0020B. Indicate the Primary Diagnosis for the SNF Stay (Affects PT/OT/SLP Clinical Categories)**

**I0020B. ICD Code**

☐ The item asks **"What is the main reason this person is being admitted to the SNF?"**

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### J01000. PAIN MANAGEMENT

☐ SCHEDULED PAIN MEDICATION REGIMEN; PRN PAIN MEDICATIONS; NON-MEDICATION PAIN INTERVENTION

☐ **PAIN INTERVIEW: Must be conducted ON or before the ARD during the 5-day look back period.**

---

**J0400. Pain Frequency**

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

Enter Code: ☐

1. Almost constantly
2. Frequently
3. Occasionally
4. Rarely
9. Unable to answer

---

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

Enter Rating: ☐

**A. Numeric Rating Scale (00-10)**

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

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

Enter Code: ☐

**B. Verbal Descriptor Scale**

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

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

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### J1100C. SOB when Lying Flat (Nursing Qualifier for Special Care High with COPD)

**J1100. Shortness of Breath (dyspnea)**

Check all that apply

☐ A. Shortness of breath or trouble breathing with exertion (e.g., walking, bathing, transferring)

☐ B. Shortness of breath or trouble breathing when sitting at rest

☐ C. Shortness of breath or trouble breathing when lying flat

☐ D. None of the above

**COPD + SOB when Lying Flat: Will be a NURSING Qualifier**

**Check J1100C:**

- ☐ If shortness of breath or trouble breathing is present when the resident attempts to lie flat.
- ☐ Also code this as present if the resident avoids lying flat because of shortness of breath.
- ☐ 7-Day Look Back Period

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### J1550A & J1550B. FEVER; VOMITING (NURSING Qualifiers)

**J1550. Problem Conditions**

Check all that apply

☐ A. Fever

☐ B. Vomiting

☐ C. Dehydrated

☐ D. Internal bleeding

☐ E. None of the above

**Fever:**

- o Temperature **2.4 degrees F higher than baseline** temperature (should be established **prior to the ARD**).
- o Fever assessment **prior to establishing base line temperature: A temperature of 100.4 degrees F (38 degrees C)**

**Vomiting:** Regurgitation of stomach contents; may be caused by many factors (e.g., drug toxicity, infection, psychogenic).

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### J2000: PRIOR SURGERY

Item J2000 is used as a **risk adjustor for new SNF-QRP functional outcome quality measures:**

- ☐ Application of (IRF) Functional Outcome Measure: Change in Self - Care Score for Medical Rehabilitation Patients (National Quality Forum (NQF) #2633)
- ☐ Application of IRF Functional Outcome Measure: Discharge Self-Care Score for Medical Rehab Patients (NQF #2635)
- ☐ Application of IRF Functional Outcome Measure: Change in Mobility Score for Medical Rehab Patients (NQF #2634)
- ☐ Application of IRF Functional Outcome Measure: Discharge Mobility Score for Medical Rehab Patients (NQF #2636)

154

### Section J2100 and J2300 – J5000: ITEMS UNDER PDPM (Used to determine PT & OT Clinical Category)

☐ In order to capture surgical information which may be relevant to classifying the patient into a PDPM Clinical Category, CMS is adding new items in Section J of the MDS.

☐ Used to capture any major surgical procedures that occurred during the inpatient hospital stay that immediately preceded the SNF admission, i.e. the Qualifying Hospital Stay.

☐ Used in conjunction with the diagnosis code captured in I0020B, to classify patients into the PT and OT case-mix classification groups for PDPM.

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### Section J2100: ITEM UNDER PDPM

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

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

Enter Code: ☐

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

☐ 0. No

☐ 1. Yes

☐ 8. Unknown

**Complete only if 5-Day or IPA. If YES, proceed to J2300 – J5000**

**GATEWAY QUESTION**

156

## Section J2300 – J500: (Used to determine PT & OT Clinical Category for specified ICD-10 Codes)

Section J	Health Conditions
Surgical Procedures - Complete only if J2100 = 1	
Check all that apply	
Major Joint Replacement	
<input type="checkbox"/>	J2300. Knee Replacement - partial or total
<input type="checkbox"/>	J2310. Hip Replacement - partial or total
<input type="checkbox"/>	J2320. Ankle Replacement - partial or total
<input type="checkbox"/>	J2330. Shoulder Replacement - partial or total
Spinal Surgery	
<input type="checkbox"/>	J2400. Involving the spinal cord or major spinal nerves
<input type="checkbox"/>	J2410. Involving fusion of spinal bones
<input type="checkbox"/>	J2420. Involving lamina, discs, or facets
Other major spinal surgery	
<input type="checkbox"/>	J2499. Other major spinal surgery
Other Orthopedic Surgery	
<input type="checkbox"/>	J2500. Repair fractures of the shoulder (including clavicle and scapula) or arm (but not hand)
<input type="checkbox"/>	J2510. Repair fractures of the pelvis, hip, leg, knee, or ankle (not foot)
<input type="checkbox"/>	J2520. Repair but not replace joints
<input type="checkbox"/>	J2530. Repair other bones (such as hand, foot, jaw)
<input type="checkbox"/>	J2599. Other major orthopedic surgery
Neurological Surgery	
<input type="checkbox"/>	J2600. Involving the brain, surrounding tissue or blood vessels (includes skull and skin but excludes cranial nerves)
<input type="checkbox"/>	J2610. Involving the peripheral or autonomic nervous system - open or percutaneous
<input type="checkbox"/>	J2620. Insertion or removal of spinal or brain neurostimulators, electrodes, catheters, or CSF drainage devices
<input type="checkbox"/>	J2699. Other major neurological surgery

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## Section J2300 – J500:

Cardiopulmonary Surgery	
<input type="checkbox"/>	J2700. Involving the heart or major blood vessels - open or percutaneous procedures
<input type="checkbox"/>	J2710. Involving the respiratory system, including lungs, bronchi, trachea, larynx, or vocal cords - open or endoscopic
Other major cardiopulmonary surgery	
<input type="checkbox"/>	J2799. Other major cardiopulmonary surgery
Genitourinary Surgery	
<input type="checkbox"/>	J2800. Involving male or female organs (such as prostate, testes, ovaries, uterus, vagina, external genitalia)
<input type="checkbox"/>	J2810. Involving the kidneys, ureters, adrenal glands, or bladder - open or laparoscopic (includes creation or removal of nephrostomies or urostomies)
Other major genitourinary surgery	
<input type="checkbox"/>	J2899. Other major genitourinary surgery
Other Major Surgery	
<input type="checkbox"/>	J2900. Involving tendons, ligaments, or muscles
<input type="checkbox"/>	J2910. Involving the gastrointestinal tract or abdominal contents from the esophagus to the anus, the biliary tree, gall bladder, liver, pancreas, or spleen - open or laparoscopic (including creation or removal of ostomies or percutaneous feeding tubes, or hernia repair)
<input type="checkbox"/>	J2920. Involving the endocrine organs (such as thyroid, parathyroid, neck, lymph nodes, or thymus) - open
<input type="checkbox"/>	J2930. Involving the breast
<input type="checkbox"/>	J2940. Repair of deep ulcers, internal brachytherapy, bone marrow or stem cell harvest or transplant
<input type="checkbox"/>	J5000. Other major surgery not listed above

158

## SECTION K

**Intent:** *The items in this section are intended to assess the many conditions that could affect the resident's ability to maintain adequate nutrition and hydration. This section covers swallowing disorders, height and weight, weight loss, and nutritional approaches. The assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately.*

159

159

## K0100: SWALLOWING DISORDER (Will affect SLP Component)

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

☐ Assess for signs and symptoms that suggest a swallowing disorder **that has NOT been successfully treated or managed with diet modifications or other interventions (e.g., tube feeding, double swallow, turning head to swallow, etc.) and therefore represents a functional problem for the resident.**

160

## K0100: SWALLOWING DISORDER

- ☐ When necessary, the resident should be **evaluated** by the physician, speech language pathologist and/or occupational therapist to assess for any need for swallowing therapy and/or to provide recommendations regarding the consistency of food and liquids.
- ☐ **Care plan should be developed to assist resident to maintain safe and effective swallow using compensatory techniques, alteration in diet consistency, and positioning during and following meals.**

161

## K0100: SWALLOWING DISORDER

### Steps for Assessment

1. **Ask the resident if he or she has had any difficulty swallowing during the 7-day look-back period.** Ask about each of the symptoms in K0100A through K0100D. **Observe the resident during meals or at other times when he or she is eating, drinking, or swallowing** to determine whether any of the listed symptoms of possible swallowing disorder are exhibited.
2. **Interview staff members on all shifts who work with the resident** and ask if any of the four listed symptoms were evident during the 7-day look-back period.
3. **Review the medical record, including nursing, physician, dietitian, and speech language pathologist notes, and any available information on dental history or problems.** Dental problems may include poor fitting dentures, dental caries, edentulous, mouth sores, tumors and/or pain with food consumption.

162

**K0100: SWALLOWING DISORDER****CODING INSTRUCTIONS:**

- ☐ **Do not code a swallowing problem when interventions have been successful in treating the problem and therefore the signs/symptoms of the problem (K0100A through K0100D) did not occur during the 7-day look-back period.**

163

**K0200: HEIGHT AND WEIGHT**

K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up

- ☐ **A. Height (in inches).** Record most recent height measure since the most recent admission/entry or reentry
- ☐ **B. Weight (in pounds).** Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)

**Steps for Assessment for K0200A, Height**

1. Base height on the most recent height since the most recent admission/entry or reentry.
2. Measure height consistently over time in accordance with the facility policy and procedure, which should reflect current standards of practice (shoes off, etc.).
3. For subsequent assessments, check the medical record. If the last height recorded was more than one year ago, measure and record the resident's height again.

164

**K0300: WEIGHT LOSS  
(Will Affect Nursing Component)**

K0300. Weight Loss

Loss of 5% or more in the last month or loss of 10% or more in last 6 months

- ☐ Enter Code
0. No or unknown
  1. Yes, on physician-prescribed weight-loss regimen
  2. Yes, not on physician-prescribed weight-loss regimen

**5% WEIGHT LOSS IN 30 DAYS:** Start with the resident's weight closest to 30 days ago and multiply it by .95 (or 95%). The resulting figure represents a 5% loss from the weight 30 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost more than 5% body weight.

**10% WEIGHT LOSS IN 180 DAYS:** Start with the resident's weight closest to 180 days ago and multiply it by .90 (or 90%). The resulting figure represents a 10% loss from the weight 180 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost 10% or more body weight.

165

**K0300: WEIGHT LOSS  
(Will Affect Nursing Component)**

K0300. Weight Loss

Loss of 5% or more in the last month or loss of 10% or more in last 6 months

- ☐ Enter Code
0. No or unknown
  1. Yes, on physician-prescribed weight-loss regimen
  2. Yes, not on physician-prescribed weight-loss regimen

**PHYSICIAN-PRESCRIBED WEIGHT-LOSS REGIMEN**

A weight reduction plan ordered by the resident's physician with the care plan goal of weight reduction. May employ a calorie-restricted diet or other weight loss diets and exercise. Also includes planned diuresis. It is important that weight loss is intentional.

166

**K0510A: Parenteral/IV Feeding (Will affect Nursing & NTA)  
K0510B: Feeding Tube (Will affect Nursing & NTA Components)  
K0510C: Mechanically Altered Diet (Will affect SLP Component)****K0510. Nutritional Approaches**

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

	1. While NOT a Resident	2. While a Resident
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		
	Check all that apply	
A. Parenteral/IV feeding	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeding tube - nasogastric or abdominal (PEG)	<input type="checkbox"/>	<input type="checkbox"/>
C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)	<input type="checkbox"/>	<input type="checkbox"/>

167

**K0710: % INTAKE BY ARTIFICIAL ROUTE  
(Will Affect Nursing & NTA Components)**

K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B

	1. While NOT a Resident	2. While a Resident	3. During Entire 7 Days
1. While NOT a Resident			
Performed while NOT a resident of this facility and within the last 7 days. Only enter a code in column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank.			
2. While a Resident			
Performed while a resident of this facility and within the last 7 days			
3. During Entire 7 Days			
Performed during the entire last 7 days			
A. Proportion of total calories the resident received through parenteral or tube feeding			
1. 25% or less	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. 26-50%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. 51% or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Average fluid intake per day by IV or tube feeding			
1. 500 cc/day or less	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. 501 cc/day or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**K0710A, Total Calories Resident Received via Parental/Tube Feeding**

1. 25% or less
2. 26% to 50%
3. 51% or more

**K0710B, Average Fluid Intake per Day by IV or Tube Feeding (Code what was Received, not Ordered)**

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

168



## SECTION L

**Intent:** *This item is intended to **record any dental problems present in the 7-day look-back period.***

169

## SECTION M

**Intent:** *The items in this section **document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is important to recognize and evaluate each resident's risk factors and to identify and evaluate all areas at risk of constant pressure***

170

### SECTION M0210: UNHEALED PRESSURE ULCERS/INJURIES (GATEWAY QUESTION)

**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

#### **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.*

171

### SECTION M0300B: STAGE 2 (Will Affect NURSING COMPONENT)

**B. Stage 2:** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.  
Enter Number ☐  
1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3  
2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry

#### **STAGE 2 PRESSURE ULCER**

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

172

### SECTION M0300C: STAGE 3 (Will Affect NURSING COMPONENT)

**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  
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

#### **STAGE 3 PRESSURE ULCER**

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

173

### SECTION M0300D: STAGE 4 (Will Affect NURSING & NTA COMPONENTS)

**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  
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

#### **STAGE 4 PRESSURE ULCER**

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

174

SECTION M0300F: UNSTAGEABLE –SLOUGH OR ESCHAR (Will Affect NURSING COMPONENT)	
F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar	
Enter Number <input type="checkbox"/>	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
Enter Number <input type="checkbox"/>	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
<p><b>SLOUGH TISSUE:</b> Non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to base of the wound or present in clumps throughout the wound bed.</p> <p><b>ESCHAR TISSUE:</b> Dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/ edges of the wound</p>	

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SECTION M1030: VENOUS/ARTERIAL ULCERS (Will Affect NURSING & NTA COMPONENTS)	
M1030. Number of Venous and Arterial Ulcers	
Enter Number <input type="checkbox"/>	Enter the total number of venous and arterial ulcers present
<p><b>VENOUS ULCERS:</b> Ulcers caused by peripheral venous disease, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg.</p> <p><b>ARTERIAL ULCERS:</b> Ulcers caused by peripheral arterial disease, which commonly occur on the tips and tops of the toes, tops of the foot, or distal to the medial malleolus.</p>	

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SECTION M1040 A, B, C: FOOT PROBLEMS (Will Affect NURSING & NTA COMPONENTS)									
M1040. Other Ulcers, Wounds and Skin Problems									
Check all that apply									
<table border="1"> <thead> <tr> <th>Foot Problems</th> <th>PRESENCE OF ANY, A COMBINATION, OR ALL OF ITEMS = 1 NTA POINT</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> A. Infection of the foot (e.g., cellulitis, purulent drainage)</td> <td></td> </tr> <tr> <td><input type="checkbox"/> B. Diabetic foot ulcer(s)</td> <td></td> </tr> <tr> <td><input type="checkbox"/> C. Other open lesion(s) on the foot</td> <td></td> </tr> </tbody> </table>		Foot Problems	PRESENCE OF ANY, A COMBINATION, OR ALL OF ITEMS = 1 NTA POINT	<input type="checkbox"/> A. Infection of the foot (e.g., cellulitis, purulent drainage)		<input type="checkbox"/> B. Diabetic foot ulcer(s)		<input type="checkbox"/> C. Other open lesion(s) on the foot	
Foot Problems	PRESENCE OF ANY, A COMBINATION, OR ALL OF ITEMS = 1 NTA POINT								
<input type="checkbox"/> A. Infection of the foot (e.g., cellulitis, purulent drainage)									
<input type="checkbox"/> B. Diabetic foot ulcer(s)									
<input type="checkbox"/> C. Other open lesion(s) on the foot									
<p><input type="checkbox"/> <b>Infection of the foot (e.g., cellulitis, purulent drainage)</b></p> <p><input type="checkbox"/> <b>DIABETIC FOOT ULCERS:</b> Caused by the neuropathic &amp; small blood vessel complications of DM. Typically occur over plantar (bottom) surface of foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful.</p> <p><input type="checkbox"/> <b>Other open lesion(s) on the foot (e.g., cuts, fissures)</b></p>									

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SECTION M1040 D, E, F: OTHER PROBLEMS (Will Affect Nursing Component)	
Other Problems	
<input type="checkbox"/>	D. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion)
<input type="checkbox"/>	E. Surgical wound(s)
<input type="checkbox"/>	F. Burn(s) (second or third degree)
<p><input type="checkbox"/> <b>OPEN LESION(S) OTHER THAN ULCERS, RASHES, CUTS:</b> Most typically skin lesions that develop as a <u>result of diseases and conditions such as syphilis and cancer.</u></p> <p><input type="checkbox"/> <b>SURGICAL WOUNDS:</b> Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites.</p> <p><input type="checkbox"/> <b>BURNS (SECOND OR THIRD DEGREE):</b> Skin &amp; tissue injury caused by heat or chemicals and may be in any stage of healing.</p>	

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SECTION M1200: SKIN AND ULCER/INJURY TREATMENT(S) (Will Affect Nursing Component)	
M1200. Skin and Ulcer/Injury Treatments	
Check all that apply	
<input type="checkbox"/>	A. Pressure reducing device for chair
<input type="checkbox"/>	B. Pressure reducing device for bed
<input type="checkbox"/>	C. Turning/repositioning program
<input type="checkbox"/>	D. Nutrition or hydration intervention to manage skin problems
<input type="checkbox"/>	E. Pressure ulcer/injury care
<input type="checkbox"/>	F. Surgical wound care
<input type="checkbox"/>	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
<input type="checkbox"/>	H. Applications of ointments/medications other than to feet
<input type="checkbox"/>	I. Application of dressings to feet (with or without topical medications)

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SECTION M1200: SKIN & ULCER/INJURY TREATMENT(S) (Will Affect Nursing Component)	
<p><b>PRESSURE REDUCING DEVICE(S):</b> Equipment that aims to relieve pressure away from areas of high risk. May include foam, air, water gel, or other cushioning placed on a chair, wheelchair, or bed. (e.g. pressure relieving, pressure reducing, &amp; pressure redistributing)</p> <p><b>TURNING/ REPOSITIONING PROGRAM:</b> Includes a consistent program for changing the resident's position and realigning the body. "Program" is defined as a <u>specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs.</u></p> <p><b>NUTRITION OR HYDRATION INTERVENTION TO MANAGE SKIN PROBLEMS:</b> Dietary measures received by resident for the purpose of <u>preventing or treating specific skin conditions</u>, e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplementation to prevent skin breakdown, high-protein supplementation for wound healing.</p>	

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## SECTION M

CMS adheres to the following guidelines:

- ☐ Stage 1 pressure injuries and deep tissue injuries (DTIs) are termed “pressure injuries” because they are closed wounds
- ☐ Stage 2, 3, or 4 pressure ulcers, or unstageable ulcers due to slough or eschar, are termed “pressure ulcers” because they are usually open wounds
- ☐ Unstageable ulcers/injuries due to non-removable dressing/device are termed “pressure ulcers/injuries” because they may be open or closed wounds

181

## Section M

- ☐ Significant Change in Definition related to “Present on Admission”
  - o If the **pressure ulcer/injury was present on admission/entry or reentry and becomes unstageable due to slough or eschar**, during the resident’s stay, the pressure ulcer/injury is coded at M0300F and **should not be coded as “present on admission.”**

182



## SECTION N

**Intent: To record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and/or select medications were received by the resident.**

**In addition, an Antipsychotic Medication Review has been included.** Including this information will assist facilities to evaluate the use and management of these medications. Each aspect of antipsychotic medication use and management has important associations with the quality of life and quality of care of residents receiving these medications.

183

## Section N0350: INSULIN

(Will affect Nursing Component)

### N0350. Insulin

Enter Date

Enter Date

- A. Insulin injections - Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days.

- B. Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders during the last 7 days or since admission/entry or reentry if less than 7 days.

### Coding Instructions for N0350A

- ☐ Enter in Item N0350A, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that insulin injections were received.

### Coding Instructions for N0350B

- ☐ Enter in Item N0350B, the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that the physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) changed the resident's insulin orders.

184

## Section N: N0410

### N0410. Medications Received

Indicate the number of DAYS the resident received the following medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days. Enter “0” if medication was not received by the resident during the last 7 days.

- Enter Date
- ☐ A. Antipsychotic
- Enter Date
- ☐ B. Antianxiety
- Enter Date
- ☐ C. Antidepressant
- Enter Date
- ☐ D. Hypnotic
- Enter Date
- ☐ E. Anticoagulant (e.g., warfarin, heparin, or low molecular weight heparin)
- Enter Date
- ☐ F. Antibiotic
- Enter Date
- ☐ G. Diuretic
- Enter Date
- ☐ H. Opioid

For emphasis, CMS added directly to the item set and coding instructions that in Items N0410A-G, **medications should be coded according to the pharmacological classification, regardless of how they are being used.**

185

## SECTION N: N0450

### ANTIPSYCHOTIC MED REVIEW

#### N0450. Antipsychotic Medication Review

Enter Date

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Enter Date

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

0. No - Antipsychotics were not received → Skip to Q0190, Special Treatments, Procedures, and Programs
1. Yes - Antipsychotics were received on a routine basis only → Continue to N0450B. Has a GDR been attempted?

2. Yes - Antipsychotics were received on a PRN basis only → Continue to N0450B. Has a GDR been attempted?

3. Yes - Antipsychotics were received on a routine and PRN basis → Continue to N0450B. Has a GDR been attempted?

0. No → Skip to N0450D. Physician documented GDR as clinically contraindicated

1. Yes → Continue to N0450C. Date of last attempted GDR

2. Yes → Continue to N0450C. Date of last attempted GDR

3. Yes → Continue to N0450C. Date of last attempted GDR

4. Yes → Continue to N0450C. Date of last attempted GDR

5. Yes → Continue to N0450C. Date of last attempted GDR

6. Yes → Continue to N0450C. Date of last attempted GDR

7. Yes → Continue to N0450C. Date of last attempted GDR

8. Yes → Continue to N0450C. Date of last attempted GDR

9. Yes → Continue to N0450C. Date of last attempted GDR

0. No → Skip to N0450D. Physician documented GDR as clinically contraindicated

1. Yes → Continue to N0450C. Date of last attempted GDR

2. Yes → Continue to N0450C. Date of last attempted GDR

3. Yes → Continue to N0450C. Date of last attempted GDR

4. Yes → Continue to N0450C. Date of last attempted GDR

5. Yes → Continue to N0450C. Date of last attempted GDR

6. Yes → Continue to N0450C. Date of last attempted GDR

7. Yes → Continue to N0450C. Date of last attempted GDR

8. Yes → Continue to N0450C. Date of last attempted GDR

9. Yes → Continue to N0450C. Date of last attempted GDR

0. No → Skip to N0450D. Physician documented GDR as clinically contraindicated

1. Yes → Continue to N0450C. Date of last attempted GDR

2. Yes → Continue to N0450C. Date of last attempted GDR

3. Yes → Continue to N0450C. Date of last attempted GDR

4. Yes → Continue to N0450C. Date of last attempted GDR

5. Yes → Continue to N0450C. Date of last attempted GDR

6. Yes → Continue to N0450C. Date of last attempted GDR

7. Yes → Continue to N0450C. Date of last attempted GDR

8. Yes → Continue to N0450C. Date of last attempted GDR

9. Yes → Continue to N0450C. Date of last attempted GDR

0. No → Skip to N0450D. Physician documented GDR as clinically contraindicated

1. Yes → Continue to N0450C. Date of last attempted GDR

2. Yes → Continue to N0450C. Date of last attempted GDR

3. Yes → Continue to N0450C. Date of last attempted GDR

4. Yes → Continue to N0450C. Date of last attempted GDR

5. Yes → Continue to N0450C. Date of last attempted GDR

6. Yes → Continue to N0450C. Date of last attempted GDR

7. Yes → Continue to N0450C. Date of last attempted GDR

8. Yes → Continue to N0450C. Date of last attempted GDR

9. Yes → Continue to N0450C. Date of last attempted GDR

0. No → Skip to N0450D. Physician documented GDR as clinically contraindicated

1. Yes → Continue to N0450C. Date of last attempted GDR

2. Yes → Continue to N0450C. Date of last attempted GDR

3. Yes → Continue to N0450C. Date of last attempted GDR

4. Yes → Continue to N0450C. Date of last attempted GDR

5. Yes → Continue to N0450C. Date of last attempted GDR

6. Yes → Continue to N0450C. Date of last attempted GDR

7. Yes → Continue to N0450C. Date of last attempted GDR

8. Yes → Continue to N0450C. Date of last attempted GDR

9. Yes → Continue to N0450C. Date of last attempted GDR

0. No → Skip to N0450D. Physician documented GDR as clinically contraindicated

1. Yes → Continue to N0450C. Date of last attempted GDR

2. Yes → Continue to N0450C. Date of last attempted GDR

3. Yes → Continue to N0450C. Date of last attempted GDR

4. Yes → Continue to N0450C. Date of last attempted GDR

5. Yes → Continue to N0450C. Date of last attempted GDR

6. Yes → Continue to N0450C. Date of last attempted GDR

7. Yes → Continue to N0450C. Date of last attempted GDR

8. Yes → Continue to N0450C. Date of last attempted GDR

9. Yes → Continue to N0450C. Date of last attempted GDR

0. No → Skip to N0450D. Physician documented GDR as clinically contraindicated

1. Yes → Continue to N0450C. Date of last attempted GDR

2. Yes → Continue to N0450C. Date of last attempted GDR

3. Yes → Continue to N0450C. Date of last attempted GDR

4. Yes → Continue to N0450C. Date of last attempted GDR

5. Yes → Continue to N0450C. Date of last attempted GDR

6. Yes → Continue to N0450C. Date of last attempted GDR

7. Yes → Continue to N0450C. Date of last attempted GDR

8. Yes → Continue to N0450C. Date of last attempted GDR

9. Yes → Continue to N0450C. Date of last attempted GDR

0. No → Skip to N0450D. Physician documented GDR as clinically contraindicated

1. Yes → Continue to N0450C. Date of last attempted GDR

2. Yes → Continue to N0450C. Date of last attempted GDR

3. Yes → Continue to N0450C. Date of last attempted GDR

4. Yes → Continue to N0450C. Date of last attempted GDR

5. Yes → Continue to N0450C. Date of last attempted GDR

6. Yes → Continue to N0450C. Date of last attempted GDR

7. Yes → Continue to N0450C. Date of last attempted GDR

8. Yes → Continue to N0450C. Date of last attempted GDR

9. Yes → Continue to N0450C. Date of last attempted GDR

0. No → Skip to N0450D. Physician documented GDR as clinically contraindicated

1. Yes → Continue to N0450C. Date of last attempted GDR

2. Yes → Continue to N0450C. Date of last attempted GDR

3. Yes → Continue to N0450C. Date of last attempted GDR

4. Yes → Continue to N0450C. Date of last attempted GDR

5. Yes → Continue to N0450C. Date of last attempted GDR

6. Yes → Continue to N0450C. Date of last attempted GDR

7. Yes → Continue to N0450C. Date of last attempted GDR

8. Yes → Continue to N0450C. Date of last attempted GDR

9. Yes → Continue to N0450C. Date of last attempted GDR

0. No → Skip to N0450D. Physician documented GDR as clinically contraindicated

1. Yes → Continue to N0450C. Date of last attempted GDR

2. Yes → Continue to N0450C. Date of last attempted GDR

3. Yes → Continue to N0450C. Date of last attempted GDR

4. Yes → Continue to N0450C. Date of last attempted GDR

5. Yes → Continue to N0450C. Date of last attempted GDR

6. Yes → Continue to N0450C. Date of last attempted GDR

7. Yes → Continue to N0450C. Date of last attempted GDR

8. Yes → Continue to N0450C. Date of last attempted GDR

9. Yes → Continue to N0450C. Date of last attempted GDR

0. No → Skip to N0450D. Physician documented GDR as clinically contraindicated

1. Yes → Continue to N0450C. Date of last attempted GDR

2. Yes → Continue to N0450C. Date of last attempted GDR

3. Yes → Continue to N0450C. Date of last attempted GDR

4. Yes → Continue to N0450C. Date of last attempted GDR

5. Yes → Continue to N0450C. Date of last attempted GDR

6. Yes → Continue to N0450C. Date of last attempted GDR

7. Yes → Continue to N0450C. Date of last attempted GDR

8. Yes → Continue to N0450C. Date of last attempted GDR

9. Yes → Continue to N0450C. Date of last attempted GDR

0. No → Skip to N0450D. Physician documented GDR as clinically contraindicated

1. Yes → Continue to N0450C. Date of last attempted GDR

2. Yes → Continue to N0450C. Date of last attempted GDR

3. Yes → Continue to N0450C. Date of last attempted GDR

4. Yes → Continue to N0450C. Date of last attempted GDR

5. Yes → Continue to N0450C. Date of last attempted GDR

6. Yes → Continue to N0450C. Date of last attempted GDR

7. Yes → Continue to N0450C. Date of last attempted GDR

8. Yes → Continue to N0450C. Date of last attempted GDR

9. Yes → Continue to N0450C. Date of last attempted GDR

0. No → Skip to N0450D. Physician documented GDR as clinically contraindicated

1. Yes → Continue to N0450C. Date of last attempted GDR

2. Yes → Continue to N0450C. Date of last attempted GDR

3. Yes → Continue to N0450C. Date of last attempted GDR

4. Yes → Continue to N0450C. Date of last attempted GDR

5. Yes → Continue to N0450C. Date of last attempted GDR

6. Yes → Continue to N0450C. Date of last attempted GDR

7. Yes → Continue to N0450C. Date of last attempted GDR

8. Yes → Continue to N0450C. Date of last attempted GDR

9. Yes → Continue to N0450C. Date of last attempted GDR

0. No → Skip to N0450D. Physician documented GDR as clinically contraindicated

1. Yes → Continue to N0450C. Date of last attempted GDR

2. Yes → Continue to N0450C. Date of last attempted GDR

3. Yes → Continue to N0450C. Date of last attempted GDR

4. Yes → Continue to N0450C. Date of last attempted GDR

5. Yes → Continue to N0450C. Date of last attempted GDR

6. Yes → Continue to N0450C. Date of last attempted GDR

7. Yes → Continue to N0450C. Date of last attempted GDR

8. Yes → Continue to N0450C. Date of last attempted GDR

9. Yes → Continue to N0450C. Date of last attempted GDR

0. No → Skip to N0450D. Physician documented GDR as clinically contraindicated

### SECTION N: N0450 ANTIPSYCHOTIC MED REVIEW

**Coding Tips and Special Populations**

☐ Physician documentation indicating dose reduction attempts are clinically contraindicated **must include the clinical rationale for why an attempted dose reduction is inadvisable.** This decision should be based on the fact that tapering of the medication would not achieve the desired therapeutic effects and the current dose is necessary to maintain or improve the resident's function, well-being, safety, and quality of life.

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### SECTION N0450: ANTIPSYCHOTIC MED REVIEW

**Coding Tips and Special Populations**

☐ ***Within the first year*** in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, the facility must ***attempt a GDR in two separate quarters (with at least one month between the attempts)***, unless physician documentation is present in the medical record indicating a GDR is clinically contraindicated. ***After the first year, a GDR must be attempted at least annually***, unless clinically contraindicated.

188

### DRUG REGIMEN REVIEW

☐ N2001. Drug Regimen Review


☐ N2003. Medication Follow-Up have been added to the Admission (Start of Prospective Payment System (PPS))

Section N	Medications
N2001. Drug Regimen Review	
Enter Code	Did a complete drug regimen review identify potential clinically significant medication issues?
<input type="checkbox"/>	0. No - No issues found during review → Skip to O0100, Special Treatments, Procedures, and Programs
	1. Yes - Issues found during review → Continue to N2003, Medication Follow-up
	9. NA - Resident is not taking any medications → Skip to O0100, Special Treatments, Procedures, and Programs
N2003. Medication Follow-up	
Enter Code	Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?
<input type="checkbox"/>	0. No
	1. Yes

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### DRR

The DRR includes all medications:



**Prescribed and over-the-counter**

- Including nutritional supplements, vitamins, and homeopathic and herbal products



**Administered by any route**

- Including oral, topical, inhalant, injection, sublingual, parenteral, and by infusion

Includes total parenteral nutrition (TPN) and oxygen

190

### Clinically Significant Issues

☐ A clinically significant medication issue is a potential or actual issue that, in the clinician's professional judgment, warrants:

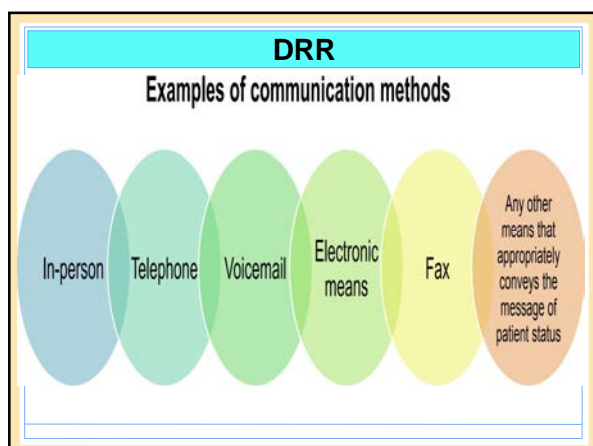
- Physician (or physician-designee) communication and
- Completion of prescribed/recommended actions by **midnight of the next calendar day** (at the latest)

191

### Clinically Significant Issues

Medication prescribed despite medication allergy noted in the patient's medical record	Adverse reactions to medications	Ineffective drug therapy	Drug interactions • Serious drug-drug, drug-food, and drug-disease interactions
Duplicate therapy • For example, generic name and brand name-equivalent drugs are co-prescribed	Wrong patient, drug, dose, route, and time errors	Omissions (drugs missing from a prescribed regimen)	Nonadherence (purposeful or accidental)

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193

**DRUG REGIMEN REVIEW**

**Who can perform the DRR?**

- ☐ No guidance on who can or cannot code the DRR items
- ☐ Each facility determines their P&P for completion
- ☐ Each facility provides patient care according to their unique characteristics and standards
- ☒ **Not strictly a Pharmacy function!**

**When should DRR be performed?**

- ☐ Upon Admission, or as close to Admission as possible  
Would try to get done within first 24 hours
- ☐ DRR is then ongoing throughout stay: **Each new drug order; Each revision/change in drug order; Change in clinical status**

194

**DRR Overview**

**Medication Reconciliation**

- 1) Compare admission orders with meds taken in hospital, prior to hospitalization?
- 2) Review diagnoses! Possible medications missing?
- 3) Labs (renal status, therapeutic levels)
- 4) Ongoing lab monitoring (digoxin, coumadin, etc.) – watch for increased frequency related to ATB usage, if applicable
- 5) Review allergies

195

**DRR Overview**

Admission Assessment	Discharge Assessment
<p><b>N2001</b></p> <ul style="list-style-type: none"> <li>Identifies if a drug regimen review was conducted upon admission, and if the clinician identified any potential or actual clinically significant medication issues</li> </ul>	<p><b>N2005</b></p> <ul style="list-style-type: none"> <li>Identifies if the facility contacted a physician (or physician-designee) and completed all physician- (or physician-designee)-prescribed/ recommended actions by midnight of the next calendar day each time potential or actual clinically significant medication issues were identified throughout the stay</li> </ul>
<p><b>N2003</b></p> <ul style="list-style-type: none"> <li>Identifies if the facility contacted a physician (or physician-designee) and completed all physician- (or physician-designee)-prescribed/ recommended actions by midnight of the next calendar day in response to all potential or actual clinically significant medication issues identified upon admission</li> </ul>	

196

**DRR Overview**

- ☐ Need to develop/review current process!
- ☐ Involve consulting pharmacist in developing P&P
- ☐ Need to educate nursing staff on what to look for upon admission and ongoing
- ☐ Educate physicians on regulations & need for immediate response
- ☐ **Documentation:**
  - o **Statement by nurse that Admission DRR completed with no significant issues identified**
  - o **Statement by nurse that Admission DRR completed with physician notified of significant clinical issues.**
  - o **Statement by nurse that recommendations/new orders received and completed.**

197

**SECTION O**

**Intent: The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received during the specified time periods.**

198



Section O0100 A, B, C, D, E, F		
<b>O0100. Special Treatments, Procedures, and Programs</b> 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.	1. While NOT a Resident	2. While a Resident
2. While a Resident Performed while a resident of this facility and within the last 14 days.	Check all that apply	
<b>Cancer Treatments</b>		
A. Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
B. Radiation	<input type="checkbox"/>	<input type="checkbox"/>
<b>Respiratory Treatments</b>		
C. Oxygen therapy	<input type="checkbox"/>	<input type="checkbox"/>
D. Suctioning	<input type="checkbox"/>	<input type="checkbox"/>
E. Tracheostomy care	<input type="checkbox"/>	<input type="checkbox"/>
F. Invasive Mechanical Ventilator (ventilator or respirator)	<input type="checkbox"/>	<input type="checkbox"/>

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

199

Section O0100A: CHEMOTHERAPY (Will affect Nursing Component)		
<b>Cancer Treatments</b>		
A. Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
B. Radiation	<input type="checkbox"/>	<input type="checkbox"/>

☐ Code any type of chemotherapy agent **administered as an antineoplastic** given by any. Each medication should be evaluated to determine its reason for use before coding it here. Medications coded here are those **actually used for cancer treatment**.

☐ 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.

200

Section O0100B: RADIATION (Will affect Nursing & NTA Components)		
<b>Cancer Treatments</b>		
A. Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
B. Radiation	<input type="checkbox"/>	<input type="checkbox"/>

**RADIATION THERAPY:** Code intermittent radiation therapy, as well as radiation administered via radiation implant in this item.

201

Section O0100C: OXYGEN THERAPY (Will affect Nursing Component)		
<b>Respiratory Treatments</b>		
C. Oxygen therapy	<input type="checkbox"/>	<input type="checkbox"/>
D. Suctioning	<input type="checkbox"/>	<input type="checkbox"/>
E. Tracheostomy care	<input type="checkbox"/>	<input type="checkbox"/>

**OXYGEN THERAPY:** Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item. This item may be coded if the resident places or removes his/her own oxygen mask, cannula.

202

Section O0100D: SUCTIONING (Will affect NTA Component)		
<b>Respiratory Treatments</b>		
C. Oxygen therapy	<input type="checkbox"/>	<input type="checkbox"/>
D. Suctioning	<input type="checkbox"/>	<input type="checkbox"/>
E. Tracheostomy care	<input type="checkbox"/>	<input type="checkbox"/>

**SUCTIONING:** Code only tracheal and/or nasopharyngeal suctioning in this item. Do not code oral suctioning here. This item may be coded if the resident performs his/her own tracheal and/or nasopharyngeal suctioning.

203

Section O0100E: TRACHEOSTOMY CARE (Will affect Nursing, SLP & NTA Components)		
<b>Respiratory Treatments</b>		
C. Oxygen therapy	<input type="checkbox"/>	<input type="checkbox"/>
D. Suctioning	<input type="checkbox"/>	<input type="checkbox"/>
E. Tracheostomy care	<input type="checkbox"/>	<input type="checkbox"/>

**TRACHEOSTOMY CARE:** Code cleansing of the tracheostomy and/or cannula in this item. This item may be coded if the resident performs his/her own tracheostomy care.

204

**Section O0100F: INVASIVE MECHANICAL VENTILATOR**  
(Will affect Nursing, SLP & NTA Components)

F. Invasive Mechanical Ventilator (ventilator or respirator) ☐ ☐

**INVASIVE MECHANICAL VENTILATOR:** Code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become (such as during weaning attempts) unable to support his or her own respiration in this item. During invasive mechanical ventilation the resident's breathing is controlled by the ventilator. Residents receiving closed-system ventilation include those residents receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) or tracheostomy.

205

**Section O0100H: IV MEDICATIONS**  
(Will affect Nursing & NTA Components)

Other ☐ ☐

H. IV medications ☐ ☐

I. Transfusions ☐ ☐

J. Dialysis ☐ ☐

**IV MEDICATIONS:** Code any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Do not code flushes to keep an IV access port patent, or IV fluids without medication here. Epidural, intrathecal, and baclofen pumps may be coded here, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Subcutaneous pumps are not coded in this item. Do not include IV medications of any kind that were administered during dialysis or chemotherapy. Dextrose 50% and/or Lactated Ringers given IV are not considered medications, and should not be coded here.

206

**Section O0100I: TRANSFUSIONS**  
(Will affect Nursing & NTA Components)

Other ☐ ☐

H. IV medications ☐ ☐

I. Transfusions ☐ ☐

J. Dialysis ☐ ☐

**TRANSFUSIONS:** Code transfusions of blood or any blood products (e.g., platelets, synthetic blood products), that are administered directly into the bloodstream in this item. Do not include transfusions that were administered during dialysis or chemotherapy.

207

**Section O0100J: DIALYSIS**  
(Will affect Nursing Component)

Other ☐ ☐

H. IV medications ☐ ☐

I. Transfusions ☐ ☐

J. Dialysis ☐ ☐

**DIALYSIS:** Code peritoneal or renal dialysis which occurs at the nursing home or at another facility, record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are not to be coded under items K0510A (Parenteral/IV), O0100H (IV medications), or O0100I (transfusions). This item may be coded if the resident performs his/her own dialysis.

208

**Section O0100M: ISOLATION**  
(Will affect Nursing Component)\$\$\$

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

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

209

**Section O0100M: ISOLATION**  
(Will affect Nursing Component)\$\$\$

Code for "single room isolation" only when **ALL of the ff. are met:**

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

210

Section O0400D: RESPIRATORY THERAPY (Will affect Nursing Component)	
<b>D. Respiratory Therapy</b> 1. Total minutes - record the total number of minutes this therapy was administered to the resident in the last 7 days. If zero, → skip to O0400E, Psychological Therapy. 2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days.	
<b>Respiratory Therapy</b> - Only minutes that the respiratory therapist or respiratory nurse spends with the resident shall be recorded on the MDS. This time includes resident evaluation/assessment, treatment administration and monitoring, and setup and removal of treatment equipment. Time that a resident self-administers a nebulizer treatment without supervision of the respiratory therapist or respiratory nurse is not included in the minutes recorded on the MDS. Do not include administration of metered-dose and/or dry powder inhalers in respiratory minutes.	

211

Section O0500: RESTORATIVE NURSING (Affects Nursing Restorative End-Split for Impaired Cognition/Behaviors & Physical Reduced)	
Resident	Identifier
<b>Section O</b> Special Treatments, Procedures, and Programs <b>O0500. Restorative Nursing Programs</b> Record the number of days each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)	
Number of Days	Technique
<input type="checkbox"/>	A. Range of motion (passive)
<input type="checkbox"/>	B. Range of motion (active)
<input type="checkbox"/>	C. Splint or brace assistance
Number of Days	Training and Skill Practice In:
<input type="checkbox"/>	D. Bed mobility
<input type="checkbox"/>	E. Transfer
<input type="checkbox"/>	F. Walking
<input type="checkbox"/>	G. Dressing and/or grooming
<input type="checkbox"/>	H. Eating and/or swallowing
<input type="checkbox"/>	I. Amputation/prostheses care
<input type="checkbox"/>	J. Communication

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

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Section O0500: RESTORATIVE NURSING
a) Measurable objectives and interventions must be documented in the care plan and in the medical record. If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process. b) Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record. When not contraindicated by state practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established.

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Section O0500: RESTORATIVE NURSING
c) <u>Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity.</u> d) A <u>registered nurse or a licensed practical (vocational) nurse</u> must supervise the activities in a restorative nursing program. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents. Restorative nursing does not require a physician's order. Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services.

215

Section O0500: RESTORATIVE NURSING
In situations where such services do not actually require the involvement of a qualified therapist, the services may not be coded as therapy in item O0400, Therapies, because the specific interventions are considered restorative nursing services (see item O0400, Therapies). The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes. <u>Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.</u> e) This category <u>does not include groups with more than four residents per supervising helper or caregiver.</u>

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## Section O0500: RESTORATIVE NURSING

In situations where such services do not actually require the involvement of a qualified therapist, the services may not be coded as therapy in item O0400, Therapies, because the specific interventions are considered restorative nursing services (see item O0400, Therapies). The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes. **Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs.**

**e) This category does not include groups with more than four residents per supervising helper or caregiver.**

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## SECTION O: Reporting of Therapy Minutes and Days per Discipline

**FOR MONITORING OF REHAB UTILIZATION**

218

Section O Special Treatments, Procedures, and Programs

O0400. Therapies

A. Speech-Language Pathology and Audiology Services

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

B. Occupational Therapy

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

2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days.

C. Physical Therapy

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

2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days.

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

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

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

6. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started - enter (dd/mm/yyyy) if therapy is ongoing.

7. Therapy end date - record the date the most recent therapy regimen ended - enter (dd/mm/yyyy) if therapy is ongoing.

**7-DAY LOOK BACK FROM THE ARD**

219

Section O Special Treatments, Procedures, and Programs

O0400. Therapies

A. Speech-Language Pathology and Audiology Services

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

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

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

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

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

B. Occupational Therapy

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

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

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

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

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

C. Physical Therapy

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

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

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

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

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

**FOR PPS DC NPE**

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O0430. Distinct Calendar Days of Part A Therapy

Complete only if A0310H = 1

Enter Number of Days

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

**LOOK BACK = A2400B (Medicare start date) to A2400C (End of Medicare Stay)**

**FOR PPS DC NPE**

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## SECTION P: RESTRAINTS & ALARMS



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

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SECTION P: RESTRAINTS & ALARMS	
<b>P0100: Physical Restraints</b>	
Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body	
Coding: 0. Not used 1. Used less than daily 2. Used daily	Enter Codes in Boxes
	Used in Bed
	<input type="checkbox"/> A. Bed rail
	<input type="checkbox"/> B. Trunk restraint
	<input type="checkbox"/> C. Limb restraint
	<input type="checkbox"/> D. Other
	Used in Chair or Out of Bed
	<input type="checkbox"/> E. Trunk restraint
	<input type="checkbox"/> F. Limb restraint
	<input type="checkbox"/> G. Chair prevents rising
<input type="checkbox"/> H. Other	

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SECTION P: RESTRAINTS & ALARMS	
<b>P0200: Alarms</b>	
An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected	
Coding: 0. Not used 1. Used less than daily 2. Used daily	Enter Codes in Boxes
	<input type="checkbox"/> A. Bed alarm
	<input type="checkbox"/> B. Chair alarm
	<input type="checkbox"/> C. Floor mat alarm
	<input type="checkbox"/> D. Motion sensor alarm
	<input type="checkbox"/> E. Wander/elopement alarm
	<input type="checkbox"/> F. Other alarm

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SECTION Q: PARTICIPATION IN ASSESSMENT & GOAL SETTING
<p><b>Intent:</b> <u>Record the participation &amp; expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals.</u> Discharge planning follow-up is already a regulatory requirement (CFR 483.21(c)(1)). Section Q of the MDS uses a person-centered approach to ensure that all individuals have the opportunity to learn about home- and community-based services and to receive long term care in the least restrictive setting possible. This is also a civil right for all residents. Interviewing the resident or designated individuals places the resident or their family at the center of decision-making.</p>

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SECTION Q: PARTICIPATION IN ASSESSMENT & GOAL SETTING
<p><b>Q0550A:</b> Does resident (or family, etc.) want to be asked about returning to the community on all the assessments?</p> <ol style="list-style-type: none"> <li>No</li> <li>Yes</li> <li>Information not available</li> </ol> <p><b>Q0550B:</b> Indicate source for Q0550A</p> <ol style="list-style-type: none"> <li>Resident</li> <li>Family or Significant Other</li> <li>Guardian or Legally authorized representative</li> <li>None of the above</li> </ol>

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SECTION S: STATE-SPECIFIC ITEMS

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SECTION V: CARE AREA ASSESSMENT (CAA) SUMMARY
<p><b>Intent:</b> The MDS does not constitute a comprehensive assessment. Rather, it is a preliminary assessment to identify potential resident problems, strengths, and preferences. Care Areas are triggered by MDS item responses that indicate the need for additional assessment based on problem identification, known as "triggered care areas," which form a critical link between the MDS and decisions about care planning.</p>

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## SECTION X: CORRECTION REQUEST

**Intent:** The purpose of Section X is to identify an MDS record to be modified or inactivated. The following items identify the existing assessment record that is in error. Section X is only completed if Item A0050, Type of Record, is coded a 2 (Modify existing record) or a 3 (Inactivate existing record). In Section X, the facility must reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

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## SECTION Z: ASSESSMENT ADMINISTRATION

**Intent:** The intent of the items in this section is to provide billing information and signatures of persons completing the assessment.

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## SECTION Z: ASSESSMENT ADMINISTRATION

**Section Z: Assessment Administration**

**Z0100. Medicare Part A Billing**

A. Medicare Part A HPPS code:

B. Version code:

**Z0200. State Medicaid Billing (if required by the state)**

A. Case Mix group:

B. Version code:

**Z0250. Alternate State Medicaid Billing (if required by the state)**

A. Case Mix group:

B. Version code:

**Z0300. Insurance Billing**

A. Billing code:

B. Billing version:

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## SECTION Z0400: ASSESSMENT ADMINISTRATION

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

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

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

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

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## SECTION Z0500: ASSESSMENT ADMINISTRATION

**Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion**

A. Signature:

B. Date RN Assessment Coordinator signed assessment as complete:

-  -

Month Day Year

- ☐ Federal regulation requires the RN assessment coordinator to sign and thereby certify that the assessment is complete.
- ☐ The RN assessment coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals.

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## IMPORTANCE OF THE MDS 3.0 IN LONG-TERM CARE



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### IMPORTANCE OF THE MDS 3.0 IN LTC

- ❑ Primary: **Resident Care Planning**
- ❑ Monitoring Quality of Care: **Survey**
- ❑ Consumer Access to Information: **Care Compare – Impact on Admissions (Five Star Rating System; Quality Measures Reporting; SNF-QRP)**
- ❑ Reimbursement: **Medicare & Other Payor Sources**



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### RAI PROCESS:

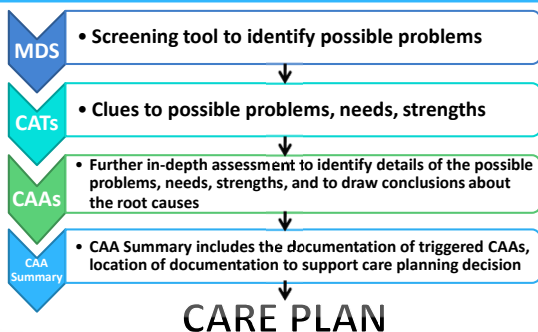
#### RESIDENT CARE PLANNING

#### MONITORING QUALITY OF CARE: SURVEY



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### MDS 3.0: Anatomy of the RAI



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### CARE AREAS

1. Delirium	11. Falls
2. Cognitive Loss	12. Nutrition Status
3. Visual Function	13. Feeding Tube(s)
4. Communication	14. Dehydration/Fluid Maintenance
5. ADLs-Functional Status	15. Dental Care
6. Urinary Incontinence and Indwelling Catheter	16. Pressure Ulcer(s)
7. Psychosocial Well-Being	17. Psychotropic Medication Use
8. Mood State	18. Physical Restraints
9. Behavioral Symptoms	19. Pain
10. Activities	20. Return to Community Referral

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### 4 PARTS OF THE CARE PLAN PROCESS

- ❑ **Assessment** – Problem identification through RAI process and in-depth review of clinical data
- ❑ **Planning** – Goal setting, development of individualized interventions
- ❑ **Implementation** – Putting plan into place
- ❑ **Evaluation** – Periodically review progress to goals and revision of established goals or interventions as indicated

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### FOOD FOR THOUGHT



High Quality assessments lead to improved quality of care and better quality of life

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**IMPORTANCE: Imperative for Facility Survival**

- ☐ The Original Goal: **For Consumers**
- ☐ **MANAGED CARE, ACO'S & Other Non-FFS Payor**  
Sources : Use ratings to establish networks & partnerships
- ☐ **CMS DEMONSTRATION PROJECTS/INITIATIVES:** Will waive 3-day hospital stay to qualify for SNF stay if SNF has 3-Stars: e.g.
  - o Hospitals in CJR model
  - o Hospitals in Advanced ACO demonstration
- ☐ **Liability Insurance Carriers:** Use to set rates
- ☐ **Trial Lawyers:** Use to fish for cases & to support allegations of poor-quality care

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**What Do The Stars Mean?**

- ☐ System that assigns 1 to 5 Stars to every Medicare and/or Medicaid certified nursing home

★★★★★	<b>Much Above Average</b>
★★★★	<b>Above Average</b>
★★★	<b>Average</b>
★★	<b>Below Average</b>
★	<b>Much Below Average</b>

**BASED ON 3 DOMAINS: HEALTH INSPECTIONS; NURSING STAFFING; AND QUALITY MEASURES**

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**REVISIONS: APRIL 2022**

**Quality Measure Rating Threshold Changes:**

- ☐ Effective with the April 2022 refresh, CMS implemented the planned, regular increases to the Quality Measure (QM) rating thresholds, increasing each rating threshold by one-half of the average improvement in QM scores since the last time the thresholds were set.
- ☐ For the April 2022 refresh, the average improvement is determined from the period of April 2019 – January 2022.

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**REVISIONS: JANUARY 2022**

**Public Reporting of Turnover and Weekend Staffing Information on Medicare.gov Care Compare Website:**

- ☐ Effective with the January 2022 refresh, CMS began posting the following information for each nursing home on the Medicare.gov Care Compare website:
  - o Weekend Staffing: The level of total nurse and registered nurse (RN) staffing on weekends (Saturdays and Sundays) provided by each nursing home over a quarter.
  - o Staff Turnover: The percentage of nursing staff and number of administrators that stopped working at the nursing home over a 12-month period.

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**OVERVIEW: HEALTH INSPECTION**

**HEALTH INSPECTION DOMAIN:** *Ratings for the health inspections domain are based on the number, scope, and severity of deficiencies identified during the 3 most recent annual inspection surveys, as well as substantiated findings from the most recent 36 months of complaint investigations and focused infection control surveys. All deficiency findings are weighted by scope and severity. The health inspections rating also takes into account the number of revisits required to ensure that deficiencies identified during health inspection surveys have been corrected.*

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### OVERVIEW: STAFFING DOMAIN

**STAFFING DOMAIN:** Ratings for the staffing domain are based on two measures:

- 1) **Registered Nurse (RN) hours per resident per day; and**
  - 2) **Total Nursing (the sum of RN, LPN, and Nurse Aide) hours per resident per day.**
- ❑ Other types of nursing home staff, such as clerical or housekeeping staff, are not included in the staffing rating calculation.
  - ❑ Derived from data submitted each quarter through the **Payroll-Based Journal (PBJ) System**, along with **daily resident census derived from MDS 3.0 assessments** and are **case-mix adjusted** based on the distribution of MDS 3.0 assessments by RUG-IV groups.

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### OVERVIEW: QUALITY MEASURES DOMAIN

#### QUALITY MEASURES DOMAIN

- ❑ Based on **MDS-Based QMs and Claims-Based QMs**
- ❑ Ratings for the quality measures are based on performance on **15 of the QMs** that are currently posted on the Care Compare website.
  - **9 Long-Stay Measures**
  - **6 Short-Stay Measures**
- ❑ Note: In addition to an overall quality of resident care rating, separate ratings for the quality of resident care for short-stay residents and long-stay residents are also reported.

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### OVERVIEW: FIVE STAR RATING

- ❑ Nursing Home Compare—Five Star Quality Rating System: Technical Users' Guide—State-Level Cut Point Tables) provides the data for the **State-Level Cut Points for the Health Inspection Star Ratings - Updated Monthly**
- ❑ **The cut points for the staffing ratings are included in Tables 3 and 4 in the Technical Users' Guide.**
- ❑ **Table 6 provides the cut points for the QM ratings, and the cut points for the individual QMs are in Appendix Table A2.**

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## METHODOLOGY FOR CONSTRUCTING THE RATINGS

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## STATE HEALTH INSPECTION RATING DOMAIN

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### STATE HEALTH INSPECTIONS RATING

=  
(WEIGHTED DEFICIENCIES)  
AND  
(# OF REPEAT VISITS)  
From 3 most recent Recertification Surveys,  
Complaint Deficiencies during the most recent 3-  
year period,  
Deficiencies cited on Focused Infection Control  
Surveys in the most recent 3-year period

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### STATE HEALTH INSPECTIONS RATING: SCOPE & SEVERITY OF DEFICIENCIES

#### STATE SURVEY RESULTS (Standard Surveys, Complaint Surveys & Infection Control Focused Surveys)

- ☐ **Points** are assigned to individual health deficiencies according to their **Scope & Severity**
- ☐ **Substandard Quality of Care = Additional points assigned**
- ☐ "Past Non-compliance" & "Severity is Immediate Jeopardy" (i.e., "J", "K" or "L"-level) = Points associated with a "G" level deficiency are assigned.

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### NOT INCLUDED in Health Inspection Score Calculation

- ☐ F-731 (Waiver of requirement to provide licensed nurses on a 24-hour basis) and
- ☐ F-884 (COVID-19 Reporting to the Centers for Disease Control) - are not considered.
- ☐ Health citations with a deficiency status code indicating that a waiver has been granted
- ☐ Deficiencies from Life Safety Surveys
- ☐ Deficiencies from Federal Comparative Surveys

*NOTE: Results of State Survey Agency determinations made during a Federal Oversight Survey are included.*

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### HEALTH INSPECTION SCORE: Weights for Different Types of Deficiencies

( )=Substandard QOC	* = Past	Non-Compliance	and IJ
SEVERITY	ISOLATED	PATTERN	WIDESPREAD
Immediate Jeopardy to Resident Health or Safety	J 50 POINTS* (75 POINTS)	K 100 POINTS* (125 POINTS)	L 150 POINTS* (175 POINTS)
Actual Harm that is Not Immediate Jeopardy	G 20 POINTS	H 35 POINTS (40 POINTS)	I 45 POINTS (50 POINTS)
No actual harm with potential for More than Minimal Harm that is NOT IJ	D 4 POINTS	E 8 POINTS	F 16 POINTS (20 POINTS)
No Actual Harm with Potential for Minimal Harm	A 0 POINTS	B 0 POINTS	C 0 POINTS

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### STATE HEALTH INSPECTIONS RATING: Standard Surveys

#### STANDARD SURVEYS

- ☐ **3 most recent Annual Inspection Surveys:** Each deficiency is weighted by **Scope and Severity**
- ☐ More recent annual surveys weighted more heavily than earlier surveys

#### STATE HEALTH INSPECTIONS:

- Most recent period (cycle 1) = 1/2
- The previous period (cycle 2) = 1/3
- The 2<sup>ND</sup> prior survey (cycle 3) = 1/6

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### STATE HEALTH INSPECTIONS RATING: Deficiencies from Complaint & Focused Infection Control Surveys

#### Complaint and Focused IC Surveys:

- ☐ Based on the **12-month period** in which the complaint or infection control survey occurred.
- ☐ Includes the most recent 36 months
- ☐ **WEIGHTS:**
  - Within Most recent 12 months = 1/2
  - 13 - 24 months ago = 1/3
  - 25 - 36 months ago = 1/6

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### STATE HEALTH INSPECTIONS RATING: Deficiencies from Complaint & Focused Infection Control Surveys

- ☐ There are some deficiencies that appear on both standard and complaint inspections. To avoid potential double-counting, deficiencies that appear on complaint inspections that are conducted within 15 days of a recertification inspection (either prior to or after the recertification inspection) are counted only once.
- ☐ If the scope or severity differs between the two inspections, the highest scope-severity combination is used.

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### STATE HEALTH INSPECTIONS RATING: Deficiencies from Complaint & Focused Infection Control Surveys

- ☐ **Deficiencies cited on focused infection control surveys** are treated slightly differently.
- ☐ If two or more infection control inspections cite the same deficiency within a 15-day period, **all are included**; however, **if one or more of these deficiencies was also cited on a recertification survey and/or a complaint inspection within the same 15-day window, only the infection control citations are included.**
- ☐ **Points from complaint deficiencies and deficiencies cited on infection control surveys from a given period are added to the health inspection score before calculating revisit points**, if applicable.

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### STATE HEALTH INSPECTIONS RATING: REPEAT REVISITS (RE-SURVEY FOR COMPLIANCE)

**Repeat Revisits - Number of repeat revisits required to confirm that correction of deficiencies have restored compliance:**

- 1<sup>st</sup> Revisit = NO POINTS
- 2<sup>nd</sup> Revisit = 50% Health Inspection Score
- 3<sup>rd</sup> Revisit = 70% Health Inspection Score
- 4<sup>th</sup> Revisit = 85% Health Inspection Score

\* The health inspections score include points from deficiencies cited on the standard health inspection & complaint inspections during a given survey cycle.

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### STATE HEALTH INSPECTIONS RATING: CUT POINTS

Re-calibrated each month BUT rating for facility is held constant until a change in facility's survey deficiencies:

<https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/fsqrs.html>

#### ITEMS THAT COULD CHANGE HEALTH INSPECTION SCORE:

1. A New Health Inspection Survey
2. A complaint survey or focused infection control survey that results in one or more deficiency citations;
3. A 2<sup>nd</sup>, 3<sup>rd</sup> or 4<sup>th</sup> Re-visit
4. Resolution of an IDR or I-IDR resulting in changes to scope and/or severity of deficiencies
5. The "aging" of complaint and/or focused infection control deficiencies (time period based on the calendar year in which complaint/IC survey occurred)

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### Rating Methodology with Abuse Citation(s)

Care Compare includes an **abuse icon** that

identifies facilities that meet either of the following criteria:

- 1) **Harm-level abuse citation in the most recent survey cycle:**  
Facilities cited for abuse where **residents were found to be harmed (Scope/Severity of G or higher) on the most recent standard survey or on a complaint or focused infection control survey within the past 12 months.**
- 2) **Repeat abuse citations:** Cited for abuse where residents were found to be potentially harmed (**Scope/Severity of D or higher**) **on the most recent standard survey OR on a complaint or focused infection control survey within the past 12 months AND on the previous (i.e., second most recent) standard survey OR on a complaint survey in the prior 12 months (i.e., from 13 to 24 months ago).**

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### Rating Methodology for Facilities with Abuse Citation(s)

- ☐ Nursing homes that receive the abuse icon have their **health inspection rating capped at a maximum of two stars.**
- ☐ Due to the methodology used to calculate the overall rating, **the best overall rating a facility that receives the abuse icon can have = 4 stars.**
- ☐ The abuse icon (and the cap on the health inspection rating) will be removed as of the first monthly website refresh following when a nursing home no longer meets the abuse icon criteria.

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### Abuse Citation(s)

- ☐ **F600** (Protect each resident from all types of abuse, such as physical, mental, sexual abuse, physical punishment, and neglect by anybody);
- ☐ **F602** (Protect each resident from the wrongful use of the resident's belongings or money);
- ☐ **F603** (Protect each resident from separation from other residents, his/her room, or confinement to his/her room);
- ☐ **F223** (Protect each resident from all abuse, physical punishment, and involuntary separation from others); and
- ☐ **F224** (Protect each resident from mistreatment, neglect, and misappropriation of personal property).

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### STATE HEALTH INSPECTIONS RATING

#### Step 1: Calculate weighted 3-year average survey score

- ☐ 3 Annual Inspection Surveys (Scope & Severity)
- ☐ Complaint & IC Focused Surveys (S/S) = 36 months
- ☐ Number of Revisits to correct deficiencies.

#### Step 2: Rank all facilities w/in each state based on scores

- ☐ **Top 10 percent** (with the lowest health inspection weighted scores) receive a health inspection rating of **5 Stars**.
- ☐ **Middle 70 percent** of facilities receive a rating of **2, 3 or 4 stars**, (23.33 percent) in each rating category.
- ☐ **Bottom 20 percent** receive a **1-Star Rating**.

#### Step 3: Assign 1 to 5 stars based on ranking

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### How to Avoid 1 or 2 stars on Survey

- ☐ **Mock Surveys – Be Proactive!!!**
- ☐ No Substandard Quality Deficiencies
- ☐ Focus on INFECTION CONTROL
- ☐ No ABUSE Citations
- ☐ Know your State's Health Inspection Cut-points (updated monthly)
- ☐ Most common reason for deficiencies:
  - o Staff did not follow SNF policy, procedure, care plan or orders

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## STAFFING RATING DOMAIN

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### STAFFING RATING

The rating for staffing is based on two quarterly case-mix adjusted measures:

- ☐ **RN hours per resident day**
- ☐ **Total nursing hours per resident day** (RN + LPN + nurse aide hours)

Source for reported staffing hours is the Payroll-Based Journal (PBJ) system. These data are submitted quarterly and are **due 45 days after the end of each reporting period**. Only data submitted and accepted by the deadline are used by CMS for staffing calculations and in the Five-Star Rating System.

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## STAFFING RATING COMPONENTS

### STAFFING RATING COMPONENTS

- ☐ **Reported Hours based on PBJ Hours** – every Quarter
- ☐ **Census: Average MDS-Based Census**
- ☐ **Case Mix Hours** = Calculated based on resident acuity from MDS's using RUG-IV (v. 66) Categories (CASE-MIX ADJUSTED) - quarter covered by PBJ reported staffing
- ☐ **National Average:** Hours for a given staff type represent the **national mean of case-mix hours across all facilities active on the last day of the quarter that submitted valid nurse staffing data for the quarter**. Updated every quarter and will be available in the State US Averages table in the Provider Data Catalog on <https://data.cms.gov/provider-data/>

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## REPORTED HOURS

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### PBJ CODES USED IN STAFFING CALCULATIONS

- ❑ **RN HOURS:** Includes RN Director of Nursing (Job Code 5), Registered Nurses with Administrative Duties (Job Code 6), & Registered Nurses (Job Code 7).
- ❑ **LPN HOURS:** Includes Licensed Practical/Licensed Vocational Nurses with Administrative Duties (Job Code 8) and Licensed Practical/Vocational Nurses (Job Code 9)
- ❑ **NURSE AIDE HOURS:** Includes Certified Nurse Aides (Job Code 10), Aides in Training (Job Code 11), and Medication Aides/Technicians (Job Code 12)

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### PBJ CODES USED IN STAFFING CALCULATIONS

- ❑ PBJ staffing data include both facility employees (full-time and part-time) and individuals under an organization (agency) contract or an individual contract.
- ❑ The PBJ staffing data do not include “private duty” nursing staff reimbursed by a resident or his/her family. Also not included are hospice staff and feeding assistants.

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## DAILY RESIDENT CENSUS

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### DAILY RESIDENT CENSUS

The **daily resident census**, used in the denominator of the reported nurse staffing ratios, is **derived from MDS resident assessments** and is calculated as follows:

- 1) Identify the reporting period (quarter) for which the census will be calculated (e.g., CY 2021 Q2: April 1–June 30, 2021).
- 2) Extract MDS assessment data for all residents of a facility beginning one year prior to the reporting period to identify all residents that may reside in the facility (i.e., any resident with an MDS assessment may still reside in the facility). For example, for the CY 2021 Q2 reporting period, extract MDS data from April 1, 2020 through June 30, 2021.

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### DAILY RESIDENT CENSUS

3) Identify discharged residents using the following criteria:

- ❑ If a resident has an MDS Discharge assessment or Death in Facility tracking record, use the date reported on that assessment and assume that the resident no longer resides in the facility as of the date of discharge/death on the last assessment.
- ❑ In the case of discharges, if there is a subsequent admission assessment, then assume that the resident re-entered the nursing home on the entry date indicated on the entry assessment.

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### DAILY RESIDENT CENSUS

- ❑ For any resident with an interval of 150 days or more with no assessments, assume the resident no longer resides in the facility as of the 150th day from the last assessment. (This assumption is based on the requirement for facilities to complete MDS assessments on all residents at least quarterly). If no assessment is present, assume the resident was discharged, but the facility did not transmit a Discharge assessment.
- ❑ For any particular date, residents whose assessments do not meet the criteria in #3 above prior to that date are assumed to reside in the facility.
- ❑ The count of these residents is the census for that particular day. (CENSUS)

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### DAILY RESIDENT CENSUS

- ❑ MDS assessments for a given resident are linked using the Resident Internal ID. The combination of state and Resident Internal ID uniquely identifies a resident in the national repository.
  - Social Security Number (SSN)
  - Last Name
  - First Name
  - Date of Birth
  - Gender
- ❑ Ensure **that MDS items above, are ENTERED correctly on each assessment.**
- ❑ Also carefully monitor the **Final Validation Reports** for any errors.

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### DAILY RESIDENT CENSUS

- ❑ Providers should work with their State RAI Coordinator or State Automation Coordinator to correct any errors that arise during assessment submission.
- ❑ In addition, monitor MDS data using additional Certification and Survey Provider Enhanced Reports (CASPER) Reports.
  - **MDS Census Summary** (returns resident count per day),
  - **MDS Census Detail** (returns list of Resident Internal IDs counted per day), Admissions, Discharges, Duplicate Residents, Errors, and Daily Rosters, among others.

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### EXCLUSION CRITERIA = 1 STAR

Results reported for facilities with improbable PBJ data:

- ❑ **Total nurse staffing (job codes 5-12), aggregated over all days in the quarter = 0 hours per resident per day.**
- ❑ **Total nurse staffing (job codes 5-12), aggregated over all weekend days in the quarter = 0 hours per resident per day**
- ❑ **Total nurse staffing (job codes 5-12), aggregated over all weekend days in the quarter with at least one resident, is excessively high (>12 hours per resident day).**
- ❑ **Nurse aide staffing (job codes 10-12), aggregated over all days in the quarter with at least one resident, is excessively high (>5.25 hours per resident day).**
- ❑ **Nurse aide staffing (job codes 10-12), aggregated over all weekend days in the quarter with at least one resident, is excessively high (>5.25 hours per resident day).**

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## CASE MIX ADJUSTMENT

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### CASE MIX ADJUSTMENT

- ❑ CMS adjusts the **reported staffing ratios for case-mix**, using the RUG-IV case-mix system
- ❑ This is referred to these as **"case-mix" hours**.
- ❑ The CMS Staff Time Resource Intensity Verification (STRIVE) Study measured the average number of RN, LPN, and nurse aide minutes associated with each RUG-IV group (using the 66-group version of RUG-IV).
- ❑ A downloadable file that contains the "case-mix", "reported" and "adjusted" hours used in the staffing calculations is included in the nursing home provider information data table available in the Provider Data Catalog on CMS.gov (<https://data.cms.gov/provider-data/>).

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## STAFFING RATING: CALCULATION

$$\text{Hours Adjusted} = (\text{Hours Reported/Hours Case-Mix}) * \text{Hours National Average}$$

Table 3  
National Star Cut Points for Staffing Measures, Based on Adjusted Hours per Resident Day (updated April 2019)

Staff type	1 star	2 stars	3 stars	4 stars	5 stars
RN	< 0.317	0.317 - 0.507	0.508 - 0.730	0.731 - 1.048	≥ 1.049
Total	< 3.108	3.108 - 3.579	3.580 - 4.037	4.038 - 4.407	≥ 4.408

Note: Adjusted staffing values are rounded to three decimal places before the cut points are applied.

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## STAFFING CUT POINTS

Table 4  
Staffing and Rating (updated April 2019)

RN rating and hours	Total nurse staffing rating and hours (RN, LPN and nurse aide)				
	1	2	3	4	5
	< 3.108	3.108 - 3.579	3.580 - 4.037	4.038 - 4.407	≥ 4.408
1 < 0.317	★	★	★★	★★	★★★
2 0.317 - 0.507	★★	★★	★★	★★★	★★★★
3 0.508 - 0.730	★★	★★★	★★★	★★★★	★★★★★
4 0.731 - 1.048	★★★	★★★★	★★★★	★★★★★	★★★★★
5 ≥ 1.049	★★★★	★★★★★	★★★★★	★★★★★	★★★★★

Note: Adjusted staffing values are rounded to three decimal places before the cut points are applied.

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## SAMPLE PBJ HOURS

RN'S		LPN'S & C.N.A.'S		ALL NURSING STAFF	
448	DON	5441.75	LPN'S		
592	RN'S with ADM		LPN'S WITH ADM		
119.5	RN'S	16611.5	CNA'S	2239.5	RN HOURS
				22053.5	LPN'S & CNAS
2239.5 HOURS		22053.5 HOURS		2492.75 HOURS	

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## RN HOURS

$$2239.5 \text{ HOURS} \div 91 \div 83 = 0.88359745$$

$$0.88359745 \div 0.33798$$

$$\text{Multiplied by } 0.41088 = 0.3605$$

**2 STARS FOR RN'S**

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## ALL NURSING STAFF

$$2239.5 \text{ HOURS} \div 91 \div 83 = 3.2163$$

$$3.2163 \div 2.75146$$

$$\text{Multiplied by } 3.21231 = 3.7550$$

**3 STARS FOR ALL NURSING STAFF**

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**RN ADJUSTED HOURS = 0.3605**  
**TOTAL NURSING HOURS = 3.7550**

Table 4  
Staffing and Rating (updated April 2019)

RN rating and hours	Total nurse staffing rating and hours (RN, LPN and nurse aide)				
	1	2	3	4	5
	< 3.108	3.108 - 3.579	3.580 - 4.037	4.038 - 4.407	≥ 4.408
1 < 0.317	★	★	★★	★★	★★★
2 0.317 - 0.507	★★	★★	★★	★★★	★★★★
3 0.508 - 0.730	★★	★★★	★★★	★★★★	★★★★★
4 0.731 - 1.048	★★★	★★★★	★★★★	★★★★★	★★★★★
5 ≥ 1.049	★★★★	★★★★★	★★★★★	★★★★★	★★★★★

Note: Adjusted staffing values are rounded to three decimal places before the cut points are applied.

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### SCORING EXCEPTIONS

- ☐ Providers that fail to submit any staffing data by the required deadline will receive a one-star rating for overall staffing and RN staffing for the quarter.
- ☐ Providers that submit staffing data indicating that there were four or more days in the quarter with no RN staffing hours (Job Codes 5-7) will receive a One Star Rating for Overall Staffing and RN Staffing for the quarter.

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### SCORING EXCEPTIONS

- ☐ CMS conducts audits of nursing homes to verify the data submitted and to ensure accuracy. Facilities that fail to respond to these audits and those for which the audit identifies significant discrepancies between the hours reported and the hours verified will receive a one-star rating for overall staffing and RN staffing for three months from the time at which the deadline to respond to audit requests passes or discrepancies are identified.

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### TIPS FOR PBJ SUCCESS

#### Verify competency of staff responsible for PBJ submission

- ☐ Understands how to validate submission & data acceptance
- ☐ Understands facility-specific mapping of PBJ job title codes
- ☐ Documentation is in writing
- ☐ Knows how to utilize CASPER reports to identify potential errors
- ☐ Understands how to pull documents if necessary for audit

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### TIPS FOR PBJ SUCCESS

#### Establish process for verifying accuracy of your data

- ☐ Submit early – Don't wait until last minute
- ☐ Submit at least 10 days before quarterly deadline
- ☐ Utilize CASPER reports to identify potential errors
  - Staffing Summary Report
  - Identify missing hours by category
  - Compare with previous quarter to see variances which were not attributed to change in total days

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## QM'S FOR 5-STAR RATING

### 15 QUALITY MEASURES AFFECT 5-STAR RATING

- ☐ QM ratings are based on performance on **10 MDS-based QMs and 5 measures that are created using Medicare claims**
- ☐ **9 LONG-STAY QM'S (7 MDS-BASED & 2 CLAIMS-BASED)**
- ☐ **6 SHORT-STAY QM'S (3 MDS-BASED & 3 CLAIMS-BASED)**
- ☐ Cut points have been recalculated- Deciles and Quintiles (15 or 20 point per level)

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### LONG-STAY QUALITY MEASURES

- 1) % residents whose need for help with ADLs has increased
- 2) Percent of residents whose ability to move independently worsened
- 3) Percent of high-risk residents with pressure ulcers
- 4) Percent of residents who have/had a catheter
- 5) Percent of residents with a urinary tract infection
- 6) Percent of residents experiencing one or more falls with major injury
- 7) Percent of residents who received an antipsychotic medication
- 8) Number of Hospitalizations per 1,000 Long-Stay Resident Days\* (CLAIMS-BASED)
- 9) Number of Outpatient Emergency Department (ED) Visits per 1,000 Long-Stay Resident Days\* (CLAIMS-BASED)

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### SHORT-STAY QUALITY MEASURES

- 1) % of short-stay residents who improved in their ability to move around on their own
  - 2) % of SNF residents with pressure ulcers/pressure injuries that are new or worsened
  - 3) % of short-stay residents who got antipsychotic medication for the first time
  - 4) % of short-stay residents who were re-hospitalized after a nursing home admission\*
  - 5) % of short-stay residents who have had an outpatient emergency department (ED) visit\*
  - 6) Rate of successful return to home & community from a SNF\*
- \*Claims-Based Measures are risk-adjusted\*

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### COMPUTATION OF ADJUSTED 4 Q MDS-BASED QM'S (Except for Short-Stay P/U QM)

$$\begin{aligned} & \text{QM}(4\text{Quarter}) \\ & = \\ & [(QM_{Q1} * D_{Q1}) + (QM_{Q2} * D_{Q2}) + \\ & (QM_{Q3} * D_{Q3}) + (QM_{Q4} * D_{Q4})] \\ & \text{divided by} \\ & D_{Q1} + D_{Q2} + D_{Q3} + D_{Q4} \end{aligned}$$

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### RISK ADJUSTMENT

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### RISK ADJUSTMENT

- ❑ Values for four of the MDS-based QMs (mobility decline, catheter, short-stay functional improvement, and short-stay pressure ulcers) are risk adjusted, using resident-level covariates that adjust for resident factors associated with differences in the performance on the QM.
- ❑ All of the claims-based measures are risk adjusted.
- ❑ Risk-adjustment for the hospitalization and ED visit measures incorporates items from Medicare enrollment data and Part A claims and information from the first MDS assessment associated with the nursing home stay.

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### RISK ADJUSTMENT

- ❑ Risk adjustment for the rate of successful return to home and community from a SNF measure uses data derived from Medicare enrollment data and Part A claims.
- ❑ CMS calculates ratings for the QM domain using the four most recent quarters for which data are available (except the rate of successful return to home and community from a SNF that uses a two-year period).
- ❑ Values for the claims-based measures and the short-stay pressure ulcer/pressure injury measure are calculated in a similar manner, except that the data used to calculate the measures use a full year (or two years) of data rather than being broken out separately by quarter.

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### Scoring Rules for the Individual QM's

- ❑ 2 different sets of weights are used for assigning QM points to individual QMs.
- ❑ Some measures have a maximum score of 150 points while the maximum number of points for other measures is 100.
- ❑ The weight for each measure was determined based on the opportunity for nursing homes to improve on the measure and the clinical significance of the measure **based on expert feedback.**

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### Scoring Rules for the Individual QM's

- ❑ For measures that have a maximum score of 150 points, the points are determined based on deciles.
- ❑ Quintiles are used for measures that have a maximum score of 100 points.
- ❑ For all measures, points are calculated based on performance relative to the national distribution of the measure.
- ❑ Points are assigned after any needed imputation of individual QM values, with the points determined using this methodology: (Refer to next slides)

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### Scoring Rules for the Individual QM's

	POINTS
<b>Long-stay</b>	
❑ % of residents whose need for help with daily activities increased	150
❑ % of residents who received an antipsychotic medication	135
❑ % of residents whose ability to move independently worsened	120
❑ Number of hospitalizations per 1,000 resident days	105
❑ Number of outpatient emergency department (ED) visits per 1,000 resident days	90
<b>Short-stay</b>	
❑ Percentage of residents who improved in their ability to move around on their own	75
❑ Rate of successful return to home and community from a SNF	60
❑ Percentage of short-stay residents who were re-hospitalized after a nursing home admission	45
❑ Percentage of short-stay residents who have had an outpatient emergency department (ED)	30
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### Scoring Rules for the Individual QM's

	POINTS
<b>Long-stay</b>	
❑ Percentage of residents experiencing one or more falls with major injury	100
❑ Percentage of high-risk residents with pressure ulcers	80
❑ Percentage of residents with a urinary tract infection	
❑ Percentage of residents who have or had a catheter inserted and left in their bladder	60
<b>Short-stay</b>	
❑ Percentage of residents who got an antipsychotic medication for the first time	40
❑ Percentage of SNF residents with pressure ulcers/pressure injuries that are new or worsened	20

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### Scoring Rules for QM SCORE

- ❑ After any needed imputation for individual QMs:
  - Sum Up All Long-Stay QM Scores = 155 - 1,150
  - Sum Up All Short-Stay QM Scores = 100 - 800 points (Unadjusted QM Score) – Needs Adjustment Factor to ensure equal weights for both LS Score & SS Scores adjustment factor of 1,150/800 is applied to the unadjusted total short-stay score.
- ❑ After applying this adjustment, the adjusted short-stay score ranges from 144 to 1,150. The total overall QM score, which sums the total long-stay score and the total adjusted short-stay score, ranges between 299 and 2,300.

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### Scoring Rules for QM SCORE

- ❑ **ADJUSTED LONG-STAY QM SCORE = 155 - 1,150 Points**
- ❑ **ADJUSTED SHORT-STAY QM SCORE:** Needs Adjustment  

$$[\text{Unadjusted Short-Stay QM Score} \times \text{Adjustment Factor for Short-Stay QM} = (1150/800) = 1.4375]$$
**ADJUSTED SHORT-STAY QM SCORE = 144 - 1,150 Points**
- TOTAL OVERALL QM SCORE = 299 POINTS - 2,300 POINTS**
- [Adjusted Long-Stay QM Score + Adjusted Short-Stay QM Score]**

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## QM CALCULATIONS

- Once the long-stay, short-stay, and overall QM scores are computed for each nursing home, a long-stay QM rating is assigned to nursing homes that have long-stay QM scores; a short-stay QM rating is assigned to nursing homes that have short-stay QM scores, and an overall QM star rating is assigned using the point thresholds.

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Table 6

Point Ranges for the QM Ratings (as of April 2022)

QM Rating	Long-Stay QM Rating Thresholds	Short-Stay QM Rating Thresholds	Overall QM Rating Thresholds
★	155–477	144–488	299–966
★★	478–574	489–585	967–1,160
★★★	575–655	586–674	1,161–1,330
★★★★	656–746	675–762	1,331–1,509
★★★★★	747–1,150	763–1,150	1,510–2,300

Note: the short-stay QM rating thresholds are based on the adjusted scores (after applying the factor of 1,150/800 to the unadjusted scores)

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## OVER-ALL RATING

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## Overall Rating (Composite Measure)

Step 1 Health Inspection Rating	Step 2 Staffing Rating	Step 3 Quality Measures Rating (QMs)
Start with Health Inspection Rating	Add 1 star for 4- or 5- Star Staffing <b>&amp; greater than Survey Rating</b> Subtract 1 star for 1- Star Staffing	Add 1 star for <b>5-Star QMs</b>  Subtract 1 star for 1- Star QMs

=

Overall Rating

If you are 1-Star in Health Inspections, you can only add 1 STAR

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## 5-STAR RATING PREVIEW REPORT

**OVERALL STAR RATING**

**HEALTH INSPECTION DOMAIN**

**QUALITY MEASURES DOMAIN**

**NURSE STAFFING (RN + ALL NURSING) DOMAIN**

Care Compare Five-Star Ratings of Nursing Homes  
Provider Rating Report for November/December 2021

Ratings for Broadway House for Continuing (31534)  
Newark, New Jersey

Overall Quality	Health Inspection	Quality Measures	Staffing	RN Staffing
★★★★★	★★★★★	★★★★★	★★★★★	★★★★★

The Five-Star ratings provided above will be displayed for your nursing home on the Care Compare website on or around December 8, 2021. The health inspection rating incorporates data reported through October 31, 2021. The time periods for each of the quality measures that contribute to the Quality Measure (QM) rating can be found in the QM tables located later in this report. The staffing and RN staffing ratings are based on payroll-based journal (PBJ) staffing data reported for the second calendar quarter of 2021.

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## MDS'S FOR QUALITY MEASURES

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## WHAT ARE QM's?

- Quality measures are tools that help us **measure or quantify** healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are **associated with the ability to provide high-quality health care** and/or that relate to one or more quality goals for health care.

### PURPOSES:

- Information on Quality of Care for placement (**Consumers**)
- Information on Quality of Care for existing residents (**Surveyors**)
- Prompt for discussions with staff to improve care (**Providers**)
- Provide data to assist with quality improvement initiatives (**CMS**)

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## QUALITY MEASURES

- MDS-BASED QM's:** Designed to assess residents' physical & clinical conditions, abilities, preferences & life care wishes
- CLAIMS-BASED QM's:** Developed to provide another source of information for the consumer & the provider related to quality of care. *"Data obtained from claims submitted to Medicare A & B for services rendered to beneficiaries"*
  - Unique Info from UB-04:** Hospital Information, Prior SNF Stays, Treatment History, Routine Charges/Costs, NTA Costs, Physician Information, Managed Care Levels, Benchmarking data (RUG levels, Per diem rate, Episodic Cost, LOS, Types of Assessments, Discharge Status/destinations)

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## HOW QUALITY MEASURES ARE UTILIZED

- For 5-STAR RATING
- For PUBLIC REPORTING
- For SURVEYORS
- For SNF-QRP's
- For VALUE-BASED PURCHASING



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Table A-1: Quality Measures (QMs) by CMS Reporting Module - Short Stay

Quality Measure (QM) Label	CMS ID	NQF ID	Effective Date	CASPER <sup>SM</sup>	NHC	Five-Star	Provider Preview
<b>SHORT STAY QMs</b>							
Changes in Skin Integrity Post-Acute Care: Pressure Ulcer/Injury	0036.02	NA	10/1/20	YES	YES	YES	YES
Percent of Residents Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine	N003.03	0680	10/1/12	NO	YES	NO	YES
Percent of Residents Who Received the Seasonal Influenza Vaccine	N004.03	0680A	10/1/12	NO	NO	NO	YES
Percent of Residents Who Were Offered and Declined the Seasonal Influenza Vaccine	N005.03	0680B	10/1/12	NO	NO	NO	YES
Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Seasonal Influenza Vaccine	N006.03	0680C	10/1/12	NO	NO	NO	YES
Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine	N007.02	0682 (with-drawn)	10/1/12	NO	YES	NO	YES
Percent of Residents Who Received the Pneumococcal Vaccine	N008.02	0682A (with-drawn)	10/1/12	NO	NO	NO	YES

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Quality Measure (QM) Label	CMS ID	NQF ID	Effective Date	CASPER <sup>SM</sup>	NHC	Five-Star	Provider Preview
<b>SHORT STAY QMs</b>							
Percent of Residents Who Were Offered and Declined the Pneumococcal Vaccine	N009.02	0682B (with-drawn)	10/1/12	NO	NO	NO	YES
Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Pneumococcal Vaccine	N010.02	0682C (with-drawn)	10/1/12	NO	NO	NO	YES
Percent of Residents Who Newly Received an Antipsychotic Medication	N011.02	NA	4/1/12	YES	YES	YES	YES
Percentage of Residents Who Made Improvements in Function	N037.03	NA	10/1/16	YES	YES	YES	YES

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Table A-2: Quality Measures (QMs) by CMS Reporting Module - Long Stay

Quality Measure (QM) Label	CMS ID	NQF ID	Effective Date	CASPER <sup>SM</sup>	NHC	Five-Star	Provider Preview
<b>LONG STAY QMs</b>							
Percent of Residents Experiencing One or More Falls with Major Injury	N013.02	0674	10/1/10	YES	YES	YES	YES
Percent of High-Risk Residents with Pressure Ulcers	N015.03	0679	10/1/18	YES	YES	YES	YES
Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine	N016.03	0681	10/1/10	NO	YES	NO	YES
Percent of Residents Who Received the Seasonal Influenza Vaccine	N017.03	0681A	10/1/10	NO	NO	NO	YES
Percent of Residents Who Were Offered and Declined the Seasonal Influenza Vaccine	N018.03	0681B	10/1/10	NO	NO	NO	YES
Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Seasonal Influenza Vaccine	N019.03	0681C	10/1/10	NO	NO	NO	YES
Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine	N020.02	0683 (with-drawn)	10/1/10	NO	YES	NO	YES

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Quality Measure (QM) Label	CMS ID	NQF ID	Effective Date	CASPER*	NHC	Five-Star	Provider Preview
<b>LONG STAY QM:</b>							
Percent of Residents Who Received the Pneumococcal Vaccine	N021.02	0683A (with-drawn)	10/1/10	NO	NO	NO	YES
Percent of Residents Who Were Offered and Declined the Pneumococcal Vaccine	N022.02	0683B (with-drawn)	10/1/10	NO	NO	NO	YES
Percent of Residents Who Did Not Receive, Due to Medical Contraindication, the Pneumococcal Vaccine	N023.02	0683C (with-drawn)	10/1/10	NO	NO	NO	YES
Percent of Residents with a Urinary Tract Infection	N024.02	0684	10/1/10	YES	YES	YES	YES
Percent of Low Risk Residents Who Lose Control of Their Bowels or Bladder	N025.02	0685 (with-drawn)	10/1/10	YES	YES	NO	YES
Percent of Residents Who Have Had a Catheter Inserted and Left in Their Bladder	N026.03	0686	10/1/10	YES	YES	YES	YES
Percent of Residents Who Were Physically Restrainted	N027.02	0687	10/1/10	YES	YES	NO	YES
Percent of Residents Whose Need for Help with Activities of Daily Living Has Increased	N028.02	0688	10/1/10	YES	YES	YES	YES
Percent of Residents Who Lose Too Much Weight	N029.02	0689	10/1/10	YES	YES	NO	YES

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Quality Measure (QM) Label	CMS ID	NQF ID	Effective Date	CASPER*	NHC	Five-Star	Provider Preview
<b>LONG STAY QM:</b>							
Percent of Residents Who Have Depressive Symptoms	N030.02	0690 (with-drawn)	10/1/10	YES	YES	NO	YES
Percent of Residents Who Received an Antipsychotic Medication	N031.03	NA	4/1/12	YES	YES	YES	YES
Percent of Residents Who Have Had a Fall	N032.02	NA	10/1/10	YES	NO	NO	NO
Percent of residents who used Antianxiety or Hypnotic Medication without a Psychotic or Related Condition	N033.02	NA	10/1/10	YES	NO	NO	NO
Percent of Residents Who Have Behavior Symptoms Affecting Others	N034.02	NA	10/1/10	YES	NO	NO	NO
Percent of Residents Whose Ability to Move Independently Worsened	N035.03	NA	10/1/16	YES	YES	YES	YES
Percent of Residents Who Used Antianxiety or Hypnotic Medication	N036.02	NA	4/27/16	YES	YES	NO	YES

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**Skilled Nursing Facility Quality Reporting Program (SNF QRP)**

**COMPLIANCE WITH SNF-QRP TO AVOID THE 2% PENALTY:**

- ☐ If you are not in compliance, you would have received a letter, notifying you that you have not reached the threshold for compliance.
- ☐ This is an MDS Completion and Submission Issue, so you need have at least 80% Compliance in the completion and submission of MDS's that trigger all of the SNF-QRP's.

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To be sure, please also go to CASPER and follow these Steps to generate QRP Reports:

1. Login to QIES system
2. Enter username and password
3. Select CASPER Reporting
4. Enter username and password
5. Select Reports
6. Select SNF Quality Reporting Program
7. Select the following:
  - SNF Facility Level QM report
  - SNF Provider Threshold Report (Choose FY 2022)
  - SNF Resident Level QM Report
  - SNF Review and Correct Report
  - Reports generated can be found under Folders (Facility Inbox)

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**Skilled Nursing Facility Quality Reporting Program (SNF QRP) update**

SNF QRP

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Measures-and-Technical-Information>

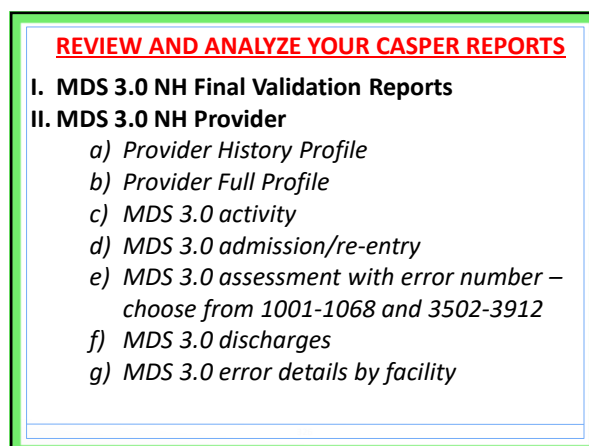
HAI Technical Specifications

<https://www.cms.gov/files/document/development-skilled-nursing-facility-snf-healthcare-associated-infections-hais-requiring.pdf>

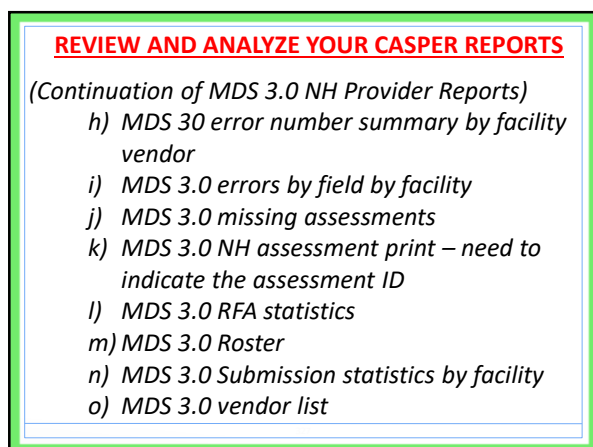
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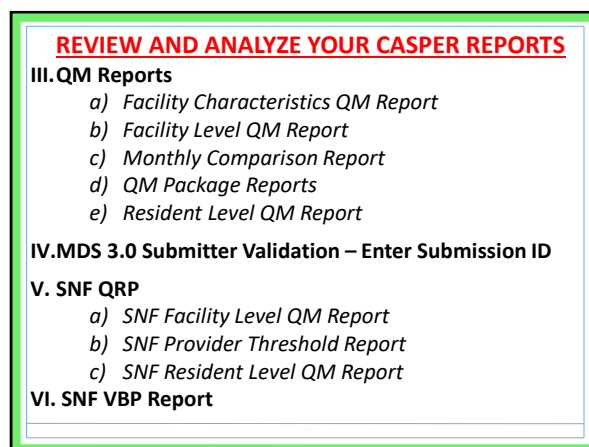
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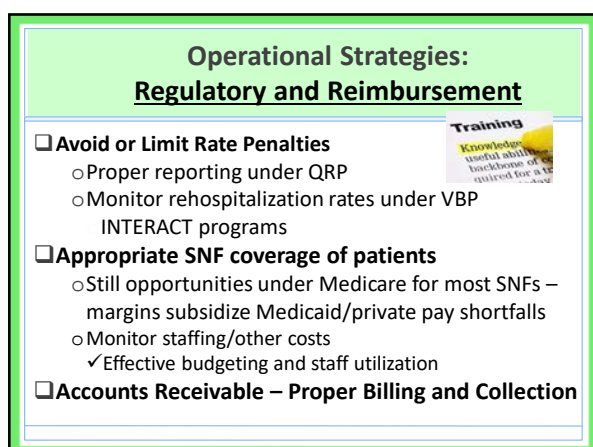
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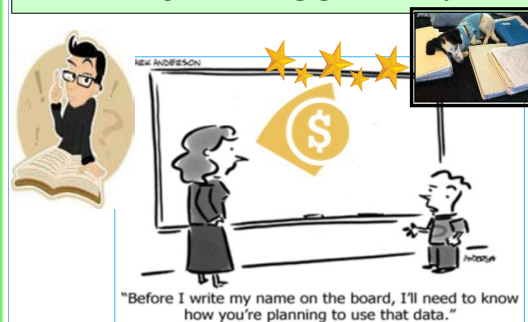
330

### Operational Strategies: QUALITY

- ❑ MDS personnel must accurately complete all sections of the MDS. Utilize Clinical Judgment & Critical Thinking Skills.
  - Will remain a key factor with PDPM implementation
  - Management team routinely review ALL CASPER reports
  - It is the submission of quality data, not performance on the QMs that determines compliance with the QRP.
  - Take advantage of the "Review and Correction" periods and pay attention to deadlines for payment determination.
- ❑ QAPI program includes Performance Improvement Plan (PIP) to improve accuracy of MDS coding & compliance with billing Medicare claims.
- ❑ QAPI program includes PIP for each Quality Measure determined to be above or below threshold.

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### IT'S ALL ABOUT DATA!



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## MDS 3.0 FOR PDPM

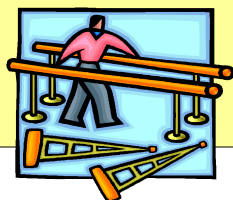
333

### PDPM SNAPSHOT

PT	PT Base Rate	PT CMI	VPD Adjustment Factor
OT	OT Base Rate	OT CMI	VPD Adjustment Factor
SLP	SLP Base Rate	SLP CMI	
NTA	NTA Base Rate	NTA CMI	VPD Adjustment Factor
Nursing	Nursing Base Rate	Nursing CMI	18% Nursing Adjustment Factor (Only for Patients with AIDS)
Non-Case-Mix	Non-Case-Mix Base Rate		

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## PHYSICAL THERAPY & OCCUPATIONAL THERAPY COMPONENTS



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### PT AND OT COMPONENT CRITERIA

#### Components 1 & 2: PT & OT

#### ❑ 16 RUG Categories Based on:

##### A. Clinical Category – Based on the following:

- ① Clinical Reason for the SNF Stay (Section 10020B) – Diagnosis Code that justifies the **REASON FOR ACTIVE SNF STAY (Supports Medical Necessity of Skilled Services provided in a SNF)**
- ② Recent Surgery Requiring Active SNF Care, if applicable (**Section J2100; J2300-J5000**)

##### B. Functional Score (**SECTION GG**)

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PT & OT Clinical Categories	
<input type="checkbox"/> Based on data showing similar costs among certain clinical categories, the PT & OT components use four collapsed clinical categories for patient classification.	
PDPM Clinical Categories	4 PT & OT Clinical Categories
Major Joint Replacement or Spinal Surgery	Major Joint Replacement or Spinal Surgery
Acute Neurologic	Non-Orthopedic Surgery & Acute Neurologic
Non-Orthopedic Surgery	
Non-Surgical Orthopedic/Musculoskeletal	Other Orthopedic
Orthopedic Surgery (Except Major Joint Replacement or Spinal Surgery)	
Medical Management	Medical Management
Cancer	
Pulmonary	
Cardiovascular & Coagulations	
Acute Infections	

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I0020B. Resident's Primary Medical Condition Category	
<b>Item I0020B:</b> Enter the code that represents the primary medical condition that resulted in the resident's SNF admission. Include the <u>primary medical condition coded in this item in Section I: Active Diagnoses in last 7 days.</u>	
<b>Section I Active Diagnoses</b> I0020. Indicate the resident's primary medical condition category. Complete only if A0110B = 01 or 08. 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 Disability, Cardiorespiratory Conditions 13 Medically Complex Conditions	FOR SNF QRP  FOR PDPM \$\$\$\$\$\$\$\$

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Section GG (PT & OT COMPONENTS) – Must be supported by Clinical Documentation (3-Day Look back): Collaboration between Therapy & Nursing
<b>SELF-CARE ITEMS:</b> 1) Self Care: EATING 2) Self Care ORAL HYGIENE 3) Self Care: TOILETING HYGIENE
<b>MOBILITY ITEMS:</b> 4) BED MOBILITY - Sit to lying BED MOBILITY - Lying to sitting on side of bed 5) TRANSFER - Sit to stand TRANSFER - Chair/bed transfer TRANSFER - Toilet Transfer 6) AMBULATION - Walk 50 feet w/ 2 turns AMBULATION - Walk 150 feet

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SAMPLE: FOR ILLUSTRATION PURPOSES					
WAGE INDEX = 1.2639 PT/OT					
Clinical Categ	GG Score	RUG	PT RATE	OT RATE	TOTAL RATE
Maj Jt Repl or Spinal Surg	0-5	TA	\$111.06	\$100.67	\$211.73
	6-9	TB	\$123.40	\$110.13	\$233.53
	10-23	TC	\$136.46	\$114.19	\$250.65
	24	TD	\$139.37	\$103.38	\$242.74
Other Orthoped	0-5	TE	\$103.07	\$95.27	\$198.34
	6-9	TF	\$116.87	\$108.11	\$224.97
	10-23	TG	\$121.22	\$110.81	\$232.03
	24	TH	\$84.20	\$77.70	\$161.90
Medical Management	0-5	TI	\$82.02	\$79.73	\$161.75
	6-9	TJ	\$103.07	\$97.97	\$201.05
	10-23	TK	\$110.33	\$104.05	\$214.39
	24	TL	\$79.12	\$75.00	\$154.12
NonOrthop Surg & Acute Neurologic	0-5	TM	\$92.19	\$87.84	\$180.02
	6-9	TN	\$107.43	\$101.35	\$208.78
	10-23	TO	\$112.51	\$104.73	\$217.24
	24	TP	\$78.39	\$73.65	\$152.04

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SLP Component
<input type="checkbox"/> For the SLP component, PDPM uses a number of different patient characteristics that were predictive of increased SLP costs:
<b>STEP 1:</b> a) Acute Neurologic Clinical Classification b) Certain SLP-related Comorbidities c) Presence of Cognitive Impairment
<b>STEP 2:</b> a) Use of a Mechanically-Altered Diet b) Presence of Swallowing Disorder

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**SAMPLE: FOR ILLUSTRATION PURPOSES ONLY**

WAGE INDEX = 1.2639

SLP			
Acute Neuro, SLP Comorb, Cog Impairm	Mech diet OR Swall disord	RUG	RATE
None	Neither	SA	\$18.42
None	Either	SB	\$49.31
None	Both	SC	\$72.35
Any One	Neither	SD	\$39.56
Any One	Either	SE	\$63.40
Any One	Both	SF	\$80.74
Any Two	Neither	SG	\$55.27
Any Two	Either	SH	\$77.49
Any Two	Both	SI	\$95.65
All Three	Neither	SJ	\$81.02
All Three	Either	SK	\$100.25
All Three	Both	SL	\$114.07

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NURSING COMPONENT
<b>1. SECTION GG DOCUMENTATION – COLLABORATION BETWEEN NURSING AND REHAB (3-DAY LOOK BACK)</b> <input type="checkbox"/> Please note that if the Functional Score is 15 or 16, the any Extensive Service or Special Care High or Special Care Low Category will drop to a CA1. For these categories, Functional Score from Section GG (Late Loss ADL's) must be from 0 to 14.

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Nursing Functional Score: GG Items	
Section GG items included in the Nursing functional score	
Section GG Item	Functional Score Range
GG0130A1 – Self-care: Eating	0 – 4
GG0130C1 – Self-care: Toileting Hygiene	0 – 4
GG0170B1 – Mobility: Sit to Lying	0 – 4 (average of 2 items)
GG0170C1 – Mobility: Lying to Sitting on side of bed	
GG0170D1 – Mobility: Sit to Stand	0 – 4 (average of 3 items)
GG0170E1 – Mobility: Chair/bed-to-chair transfer	
GG0170F1 – Mobility: Toilet Transfer	

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NURSING COMPONENT
<b>2. CHECKLIST WITH ALL QUALIFIERS</b> a) EXTENSIVE SERVICES b) SPECIAL CARE HIGH – PHQ9 c) SPECIAL CARE LOW – PHQ9 d) CLINICALLY COMPLEX – PHQ9 e) BEHAVIOR – RNP f) IMPAIRED COGNITION - RNP g) PHYSICAL REDUCED – RNP

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NURSING CASE MIX CATEGORIES				
NURSING COMPONENT	POINTS OR END-SPLITS	ADL SCORE	NURSING CASE MIX GROUP	CMI
EXTENSIVE SERVICES	TRACHEOSTOMY & VENTILATOR (3)	0-14	ES3	4.04
	TRACHEOSTOMY OR VENTILATOR (2)	0-14	ES2	3.06
	INFECTION ISOLATION (1)	0-14	ES1	2.91
SPECIAL CARE HIGH	DEPRESSED (2)	0-5	HDE2	2.39
	DEPRESSED (2)	6-14	HBC2	2.23
	NOT DEPRESSED (1)	0-5	HDE1	1.99
	NOT DEPRESSED (1)	6-14	HBC1	1.85
SPECIAL CARE LOW	DEPRESSED (2)	0-5	LDE2	2.07
	DEPRESSED (2)	6-14	LBC2	1.71
	NOT DEPRESSED (1)	0-5	LDE1	1.72
	NOT DEPRESSED (1)	6-14	LBC1	1.43

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NURSING COMPONENT	POINTS OR END-SPLITS	ADL SCORE	NURSING CASE MIX GROUP	CMI
CLINICALLY COMPLEX	DEPRESSED (2)	0-5	CDE2	1.86
	DEPRESSED (2)	6-14	CBC2	1.54
	DEPRESSED (2)	15-16	CA2	1.08
	NOT DEPRESSED (1)	0-5	CDE1	1.62
	NOT DEPRESSED (1)	6-14	CBC1	1.34
BEHAVIOR SYMPTOMS COGNITION	NOT DEPRESSED (1)	15-16	CA1	0.94
	NURSING REHAB (2)	11-16	BAB2	1.04
	NO NURSING REHAB (1)	11-16	BAB1	0.99
REDUCED PHYSICAL FUNCTION	NURSING REHAB (2)	0-5	PDE2	1.57
	NURSING REHAB (2)	6-14	PBC2	1.21
	NURSING REHAB (2)	15-16	PA2	0.70
	NO NURSING REHAB (1)	0-5	PDE1	1.47
	NO NURSING REHAB (1)	6-14	PBC1	1.13
	NO NURSING REHAB (1)	15-16	PA1	0.66

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SAMPLE: FOR ILLUSTRATION PURPOSES WAGE INDEX = 1.2639			
NURSING			
RUG	GG Score	End Split	RATE
ES3	0-14	Vent & Trach	\$513.85
ES2	0-14	Vent or Trach	\$388.55
ES1	0-14	Isolation	\$370.83
HDE2	0-5	s/s Depress	\$303.76
HDE1	0-5		\$251.86
HBC2	6-14	s/s Depress	\$283.51
HBC1	6-14		\$235.41
LDE2	0-5	s/s Depress	\$263.25
LDE1	0-5		\$218.96
LBC2	6-14	s/s Depress	\$217.69
LBC1	6-14		\$180.99

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SAMPLE: FOR ILLUSTRATION PURPOSES WAGE INDEX = 1.2639			
CDE2	0-5	s/s Depress	\$236.68
CDE1	0-5		\$205.03
CBC2	6-14	s/s Depress	\$196.18
CA2	15-16	s/s Depress	\$137.96
CBC1	6-14		\$169.60
CA1	15-16		\$118.97
BAB2	11-16	RNP	\$131.63
BAB1	11-16		\$125.30
PDE2	0-5	RNP	\$198.71
PDE1	0-5		\$186.05
PBC2	6-14	RNP	\$154.41
PA2	15-16	RNP	\$89.86
PBC1	6-14		\$143.02
PA1	15-16		\$83.53

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## NON-THERAPY ANCILLARY COMPONENT



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### NTA – Non-Therapy Ancillary

- ☐ **6 RUG Categories Based on:**
  - o Diagnoses, conditions, and services, etc.
- ☐ CMS has a list of conditions and assigned points to each condition (see list)
- ☐ Patients get points for each condition they have
- ☐ The higher the points, the higher the CMI, and the higher the rate

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### NTA Component: Comorbidity Coding

- ☐ 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/SNFPSPDPDM.html>
- ☐ One comorbidity (HIV/AIDS) is reported on the SNF claim, in the same manner as under RUG-IV
  - o The patient's NTA classification will be adjusted by the appropriate number of points for this condition by the CMS PRICER for patients with HIV/AIDS

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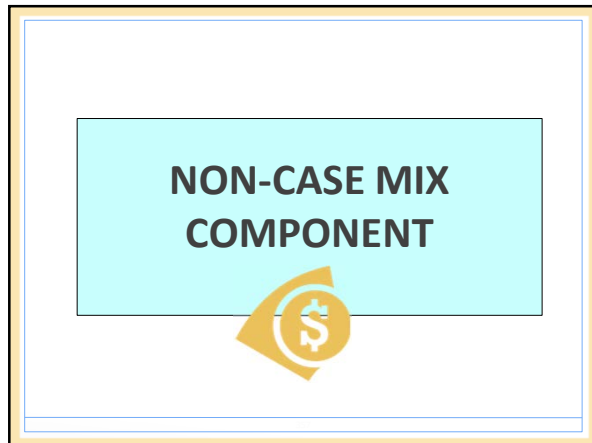
NTA Points	CMG	HIPPS	CMI
12+	NA	A	3.24
9-11	NB	B	2.53
6-8	NC	C	1.84
3-5	ND	D	1.33
1-2	NE	E	0.98
0	NF	F	0.72

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SAMPLE: FOR ILLUSTRATION PURPOSES  
WAGE INDEX = 1.2639

NTA		
Points	RUG	RATE
12+	NA	\$309.36
9-11	NB	\$241.57
6-8	NC	\$175.69
3-5	ND	\$126.99
1-2	NE	\$91.66
0	NF	\$68.75

356

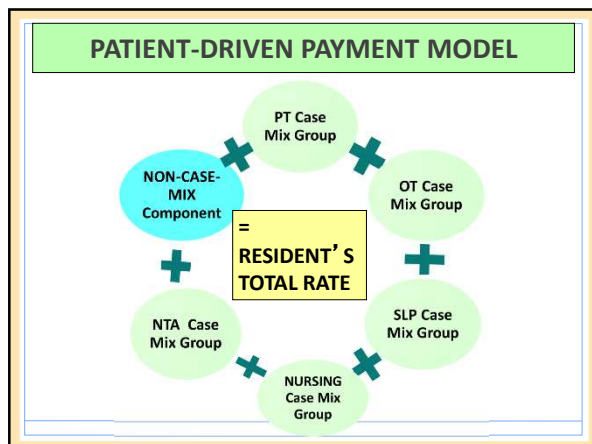


357

**Non- Case Mix**

- ☐ Fixed rate for all patients
- ☐ Is not affected by patient characteristics – same rate for all patients
- ☐ Accounts for overhead, administrative costs, etc.

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**Variable Per Diem Adjustment**

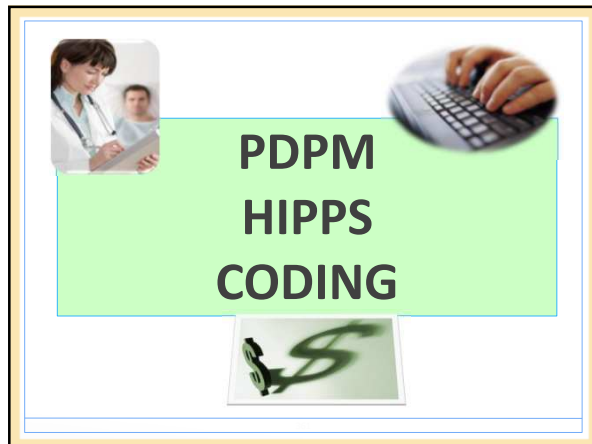
**PT & OT Components**

Day in Stay	Adjustment Factor	Day in Stay	Adjustment Factor
1-20	1.00	63-69	0.86
21-27	0.98	70-76	0.84
28-34	0.96	77-83	0.82
35-41	0.94	84-90	0.80
42-48	0.92	91-97	0.78
49-55	0.90	98-100	0.76
56-62	0.88		

**NTA Component**

Day in Stay	Adjustment Factor
1-3	3.00
4-100	1.00

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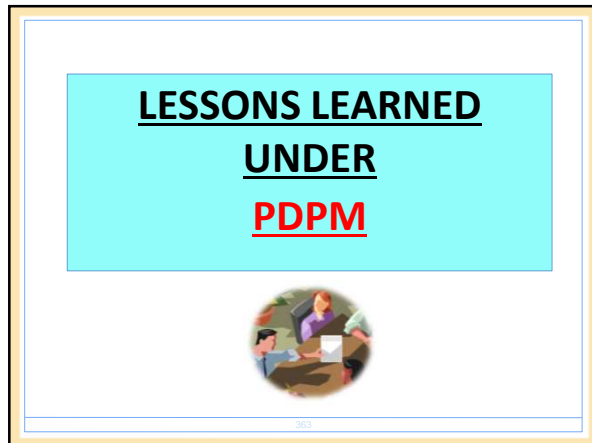


361

### PDPM HIPPS Coding

- ❑ Based on responses on the MDS, patients are classified into payment groups, which are billed using a 5-character Health Insurance Prospective Payment System (HIPPS) code.
- ❑ In order to accommodate the new payment groups, the **PDPM HIPPS algorithm** is revised as follows:
  - ❑ Character 1: PT/OT Payment Group
  - ❑ Character 2: SLP Payment Group
  - ❑ Character 3: NURSING Payment Group
  - ❑ Character 4: NTA Payment Group
  - ❑ Character 5: Assessment Indicator

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### CHANGES IN SNF MEDICARE CLINICAL REIMBURSEMENT

- ❑ Centers for Medicare & Medicaid Services (CMS):  
"PDPM represents a move toward Value-Based Care".  
*CMS wants to recognize that some patients are sicker than others and acknowledge the increased complexity by compensating centers for providing care and rehabilitation to the more ill, complex population.*  
 Whereas the RUG-IV rates were primarily determined by therapy minutes, a majority of the rates under PDPM will hinge on medical diagnoses and comorbidities, as determined by ICD-10 codes.

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### TRANSITIONS OF CARE; IDCP COMMUNICATION; MD DOCUMENTATION

- ❑ Interdisciplinary Communication and Physician Documentation of each patient's active diagnoses, chronic conditions, treatments, functional status, cognitive status, communication status, etc. across the healthcare spectrum IS A MUST!
- ❑ Documentation Must be completed during the Look-back Period
- ❑ EFFICIENT AND EFFECTIVE TRANSITIONS OF CARE

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### PARTNERSHIP BETWEEN MDS, NURSING & REHAB

- ❑ Encourage the Team (MDS Coordinator, Nursing and REHAB) to dig thru the Hospital Records.
- ❑ WE need to find a MEDICAL condition that was treated in the hospital stay and relate it to the "Reason for Daily Skilled Services" and required the patient to be in a SNF - this is a "MUST" for Rehab since the Principal Diagnosis Code will be the "subject of scrutiny for PDPM AUDITS related to the PT, OT and part of the SLP Component."

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**PARTNERSHIP BETWEEN MDS, NURSING & REHAB**

- ☐ While looking through the hospital records, copy all pages that include "any decline, PT/OT/SLP Evals or Treatments, etc.)."
- ☐ This will help support claim and will help stand up to any audits in the future.
- ☐ Also pull out copies of any diagnoses/conditions/ treatments/etc. that may contribute to the NTA POINTS. Note that the NTA points significantly affects the Medicare Revenue.

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**PICKING THE PRINCIPAL DIAGNOSIS CODE FOR I0020B AND FIELD 67 IN THE UB-04**

- ☐ USE THE MOST CURRENT "ICD-10-CM" BOOK to ensure that you are following ALL ICD-10-CM Coding Conventions and Guidelines. (In my humble opinion, this will be an area of potential "MAJOR RISK" for Denials/Recoveries in PDPM Audits).
- ☐ A principal DIAGNOSIS (that is picked for I0020B and the Claim) because it is not "RTP" (Return to provider) does NOT mean that it is the appropriate and proper PRINCIPAL DIAGNOSIS CODE.

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**PICKING THE PRINCIPAL DIAGNOSIS CODE FOR I0020B AND FIELD 67 IN THE UB-04**

- ☐ The Principal Diagnosis Code is the REASON for DAILY SKILLED NURSING AND REHAB SERVICES IN A SNF that is related to a condition that was treated in the Qualifying Hospital Stay or arose during the Medicare Stay that is related to a condition that was treated in the hospital Stay).
- ☐ Use Physician QUERY tools and call the MD for further clarification if need be and document via a "Telephone Order" so you can capture the diagnosis during the look back period. This also applies for NTA's (Malnutrition or At Risk for Malnutrition, Morbid Obesity, etc.)

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**CODING VULNERABILITIES**

- 1) ICD-10-CM CODING: Adherence to ICD-10-CM Coding Conventions and Guidelines
- 2) MDS 3.0 CODING: Documentation to support Coding of MDS 3.0 Items (Except Resident Interviews)
  - ☐ Documentation to Support Principal ICD-10-CM Diagnosis Code
  - ☐ Documentation to Support Coding of Active DIAGNOSIS CODES

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**SECTION GG DOCUMENTATION**

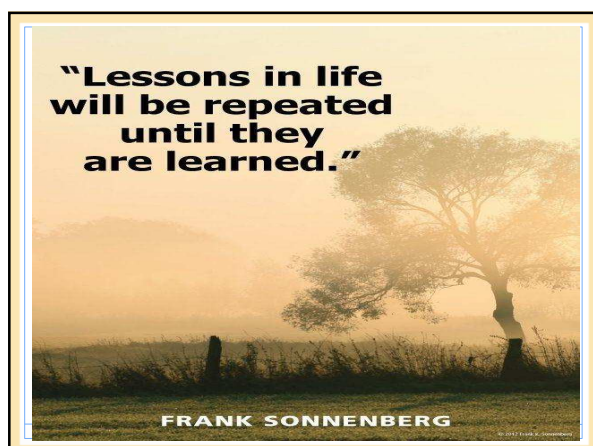
- ☐ Documentation MUST support coding of payment drivers in Section GG - to show assessments performed by Clinicians and a "collaboration" between Rehab and Nursing (during the look back period) in order to establish resident's "Baseline Functional Status."
- ☐ The various departments can no longer function in "SILO" - An INTERDISCIPLINARY APPROACH is a "MUST".

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**TRIPLE CHECK PROCESS**

- ☐ **PROPER TRIPLE CHECK is CRITICAL!** Compare the MDS & Claim and Medical Records (CODING IN BOTH the MDS and Claim) **MUST BE SUPPORTED** by the Medical Records (including MD Documentation, Hospital Records, Rehab, Nursing, Social Services, etc.). **REHAB - You must MATCH the HIPPS Codes in the MDS and UB-04.**
- ☐ Establish a Plan of care for all patients in accordance with their individual characteristics, conditions, comorbidities, etc.
- ☐ If you do the **RIGHT** thing, everything else follows.....

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### MEDICAL REVIEW AUDITS

- ❑ Healthcare made up 85% of FALSE CLAIMS ACT recoveries in 2020 and that trend is likely to continue through both standard channels and a focus on new risk areas such as telehealth billing fraud.
- ❑ Recovery Audit Contractors are now authorized to review for Medical Necessity and Documentation Requirements specific to the Patient Driven Payment Model (PDPM)
- ❑ OIG has added new focus to the Work Plan to identify program integrity risks associated with Medicare telehealth services during the pandemic.

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### Medicare Improper Payments: Measuring, Correcting, & Preventing Overpayments and Underpayments

- ❑ Addressing improper payments in the Medicare fee-for service (FFS) program and promoting compliance with Medicare coverage and coding rules is a top priority for the CMS.
- ❑ The CMS contracts with various types of contractors in its effort to fight improper payments and promote provider compliance in the Medicare FFS program:
  - ❑ CERT contractors;
  - ❑ MACs;
  - ❑ Recovery auditors
  - ❑ SMRC
  - ❑ UPIC

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### REASONS FOR DENIAL: MEDICARE FFS PART A

LACK OF SUPPORTING DOCUMENTATION TO SUPPORT THE FOLLOWING (In accordance with the RAI MDS 3.0 Manual; ICD-10-CM Coding Conventions & Guidelines; and Medicare Benefits Policy Manual Chapter 8)

- ❑ Principal Diagnosis
- ❑ Section GG
- ❑ Active Diagnosis (CVA; HEMI; MALNUTRITION or AT RISK FOR MALNUTRITION)
- ❑ Respiratory Therapy;
- ❑ NTA & SLP Comorbidities (ICD-10 Coding & Cross-Mapping)
- ❑ BIMS & PHQ-9 (Not Completed & Dated on or before ARD during the Look Back Period)

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### ICD-10 DIAGNOSIS CODING & YOUR FISCAL SURVIVAL *(This explains it ALL!)*

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<b>OVERPAYMENT = \$5,592.08</b>	
<b>BILLED = KCGD1</b> <b>X 20 Days</b>	<b>VALIDATED = PBQF1</b> <b>X 20 Days</b>
<input type="checkbox"/> TK = \$215.99	<input type="checkbox"/> TP = \$153.18
<input type="checkbox"/> SC = \$72.89	<input type="checkbox"/> SB = \$49.69
<input type="checkbox"/> G = \$237.16	<input type="checkbox"/> Q = \$119.85
<input type="checkbox"/> ND = \$127.94	<input type="checkbox"/> NF = \$69.26
(\$383.82VPDA)	(\$207.78VPDA)
<input type="checkbox"/> NON-CASEMIX = \$114.17	<input type="checkbox"/> NON-CASEMIX = \$114.17
\$1,024.03 x 3 = \$3,072.09	\$664.67 X 3 = \$1,934.01
\$768.15 x 17 = \$13,058.55	\$506.15 X 17 = \$8,604.55
<b>TOTAL = \$16,130.64</b>	<b>TOTAL = \$10,538.56</b>

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<b>REASONS FOR DENIAL</b>	
<b>Billed = OICD1</b>	<b>Validated = KEPE1</b>
5-day assessment, ARD 09/7/2020, paying for 9/1/2020 – 9/30/2020, 10/1/20 – 10/31/20, 11/1/20 – 11/30/20, 12/1/20-12/9/2020. CMS's RAI manual requires clinical documentation to support the PDPM HIPPS code billed. <b>No documentation received to support coding of the Primary Diagnosis of I69.351 in I0020B. Clinical documentation does not support coding of swallow disorders:</b> Complaints of difficulty or pain when swallowing on the MDS during the assessment reference period. Clinical documentation does not support the Nursing CMG level billed. Clinical documentation <b>does not support coding of Isolation.</b> Documentation does not support <b>NTA CMG level billed. Clinical documentation does not support coding of Isolation as valid</b>	

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<b>REASONS FOR DENIAL</b>
<b>Billed AND PAID = OICD1</b>
<b>TOTAL FOR THE DOS WITH VPDA =</b>
<b>\$57,451.26</b>
<b>Validated = KEPE1</b>
<b>TOTAL FOR THE DOS WITH VPDA =</b>
<b>\$82,456.55</b>
<b>TOTAL OVERPAYMENT = \$25,005.29</b>

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<b>REASONS FOR DENIAL</b>
Units : 12.00 for Revenue code: '022', HCPC Code: 'FFKE1', RUG Score: FFKF1,Comments: 'Payment information for claim 820202210131611. Billed HIPPS Code: FFKF1 X 12 Days. Validated HIPPS Code: FFKF1 X 12 Days. The 5 day Minimum Data Set (MDS), Assessment Reference Date (ARD) 6/23/20 paying from 7/1/20-7/13/20. The Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual requires clinical documentation to support the Health Insurance Prospective Payment System (HIPPS) code billed. The documentation provided does not appear to support the Non-Therapy Ancillary Case (NTA) Case Mix Grouper as follows: The documentation provided does not appear to support the Non-Therapy Ancillary Case (NTA) Case Mix Grouper as follows: There was no physician supported diagnosis to support the coding of I5600 (malnutrition) on the MDS.'
<b>NO PHYSICIAN SUPPORTED DIAGNOSIS TO SUPPORT THE CODING OF I5600 (MALNUTRITION) ON THE MDS.</b>

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<b>REMINDERS</b>
<u>CMS has implemented unprecedented TECHNOLOGICAL UPGRADES in Claims Processing &amp; Management:</u>
<input type="checkbox"/> <b>Automatic Denials</b> due to increase in "EDITS" (NCCI Edits; Medically Unlikely Edits; MAC Medical Review Edits)
<input type="checkbox"/> <b>Enhanced Coordination of Benefits:</b> To detect overlapping of claims (sequencing), avoid duplication of services, follow the beneficiary across care settings
<input type="checkbox"/> Determine <b>compliance with Medicare regulations</b> via "data (e.g., Dates, Codes, Modifiers) in the UB-04 (electronic claims submitted as reflected in FISS)

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<b>1135 WAIVERS</b>
<b>Use of Waivers</b>
<input type="checkbox"/> Waivers must be used appropriately
<input type="checkbox"/> Medicare skilling criteria did not change – the level of care requirements for skilled services must be met – documentation must support the skilled level of care
<input type="checkbox"/> Documentation supports the use of the waivers as appropriate
<b>Risk of Noncompliance</b>
<input type="checkbox"/> Failure to meet the Medicare guidelines for a skilled level of care can result in medical reviews and identification of overpayments

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## PRACTICAL STRATEGIES

- 1) Evaluate Current Processes:
  - ☐ Review your Pre-admission & Admission Process
    - o Who ensures that appropriate Hospital Records are obtained?
    - o How soon does MD come in to do a Comprehensive H&P? Discuss establishment of a system with your Medical Director and MD's.
  - ☐ Evaluate your systems (including tools and forms) on how you obtain the necessary documentation to support MDS Coding.
  - ☐ Review efficiency and productivity of your Morning Meetings, IDCP Meetings, UR Meetings and Triple Check Meetings

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## PRACTICAL STRATEGIES

- 2) Review your Current Work Flow on MD Documentation and Diagnosis Coding.
  - o Clean up all your Diagnosis codes in your systems (upon admission and throughout the stay).
  - o Have MD review, verify and clarify appropriate DX Codes (especially the payment drivers).
  - o How will your team work with MD's/NPP's to collect necessary diagnosis data if not originally provided?
  - o Include discussion of the most appropriate ICD-10-CM codes for each resident in the UR meeting (Remember: You are justifying medical necessity and/or continued stay in a SNF).

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## PRACTICAL STRATEGIES

- 3) Generate Diagnosis Worksheets for each Medicare beneficiary & keep them up-to-date
- 4) Discuss Training Plan around new MDS changes and MDS items that will drive payment areas.
  - o Identify areas for improvement and establish a Plan of Action. Start by doing random audits on MDS Coding accuracy. Include review of Resident Interviews
  - o Review your forms and tools; Modify as necessary
  - o Review your Restorative Nursing Program

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## PRACTICAL STRATEGIES

- 5) Review your Triple Check Process to ensure accurate and documented MDS and Claims Coding. Make necessary changes if needed.
- 6) Ensure compliance with Official ICD-10-CM Coding and RAI Manual Guidelines
- 7) Collaboration is a "Must". WE ARE A TEAM! Start with how Section GG is supported by Documentation.
- 8) It is a "confusing world." Therefore, the key is to always go back to CMS's "Intent" behind the regulations.

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With integrity, you have nothing to fear, since you have nothing to hide. With integrity, you will do the right thing, so you will have no guilt.

*Zig Ziglar*

101 Quotes

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***"Most of the important things in the world have been accomplished by people who have kept on trying when there seemed to be no hope at all."***

— Dale Carnegie, American writer

**MY DAILY PRAYER**

***"Let me dedicate my life today to the care of those who come my way.  
Let me touch each one with a healing hand and the gentle art for which I stand.  
And then tonight when the day is done, let me rest in peace if I've helped just one."***  
- Unknown

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## RESOURCES

- ☐ [www.cms.gov](http://www.cms.gov)
- ☐ [www.ahca.org](http://www.ahca.org)
- ☐ [www.hcanj.org](http://www.hcanj.org)
- ☐ [www.aanac.org](http://www.aanac.org)
- ☐ [www.oig.hhs.gov](http://www.oig.hhs.gov)
- ☐ [www.novitas-solutions.com](http://www.novitas-solutions.com)
- ☐ [www.ngsmedicare.com](http://www.ngsmedicare.com)
- ☐ [www.noridian.com](http://www.noridian.com)
- ☐ [www.wps.com](http://www.wps.com)
- ☐ Medicare Benefits Policy Manual Chapter 8
- ☐ Medicare Claims Processing Manual Chapter 6
- ☐ Medicare Program Integrity Manual Chapter 3
- ☐ Medicare Program Integrity Manual Chapter 6
- ☐ MDS 3.0 RAI Manual version 1.17.1
- ☐ [www.mcknights.com](http://www.mcknights.com)



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## RESOURCES

- ☐ Specifications for all CMS ID quality measures are contained in the MDS 3.0 QM User's Manual V15.0 available at:  
<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html>
- ☐ Provider Preview: Facility and Resident Quality Measure Preview Reports  
<https://www.qtso.com/providernh.html>

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## RESOURCES

- ☐ CASPER: Certification and Survey Provider Enhanced Reports (CASPER) Quality Measure Reports  
<https://qtso.cms.gov/providers/nursing-home-mdsswing-bed-providers/reference-manuals>



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**THANK YOU!  
QUESTIONS???**



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