

**MDS 3.0 Version 1.17.1**  
**October 2019**  
**Item Sets Version 1.17.2**  
**October 2020**

Janet Brooks, RN  
RAI Education Coordinator  
for the Division of Health Service Regulation  
North Carolina Department of Health and Human Services

# Objectives

Participants will be able to :

- Recognize the impact of coding inaccuracies
- Define the key components of the Resident Assessment Instrument
- Review the Item Sets Version 1.17.2 effective October 1, 2020

# The Importance of Accuracy

- The importance of accurately completing and submitting the MDS cannot be over- emphasized. The MDS is the basis for:
  - The development of an individualized care plan
  - The Medicare Prospective Payment System
  - Medicaid reimbursement programs
  - The data-driven survey and certification process
  - Quality monitoring activities, such as the quality measure reports
  - The quality measures used for public reporting
  - Research and policy development

# Layout of the RAI Manual

- The layout of the RAI manual is as follows:
- Chapter 1: Resident Assessment Instrument (RAI)
- Chapter 2: Assessments for the Resident Assessment Instrument (RAI)
- Chapter 3: Coding Conventions, 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)

# Layout of the 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

# MDS RAI Manual Version 1.17.1

## effective October 2019

- The RAI Manual is updated every year and posted to the CMS website by September: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>
- Final Rule: <https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities>

# Find the new MDS 3.0 Item Details

- SNF QRP Information webpage- contains the final MDS 3.0 v1.17.2 item set and change tables: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation>
- MDS 3.0 Technical Information: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation>
- Additional information about CMS specification of the RAI and variations in format can be found in Sections 4145.1–4145.7 of the CMS State Operations Manual (SOM) which can be found here: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c04.pdf>
- Data submission specifications: <https://www.cms.gov/files/document/mds-30-data-specs-errata-v3004-final-04-30-2020.pdf>

# Helpful Resource for Documentation

- Medicare Benefit Policy Chapter 8 Coverage of SNF Services:  
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08pdf.pdf>
- NC Medicaid, Nursing Facility Services Clinical Coverage Policy:  
<https://files.nc.gov/ncdma/documents/files/2B-1.pdf>
- Myers and Stauffer:  
<https://www.mslc.com/NorthCarolina/Resources.aspx>



# Spotlights and Announcements for the newest information for SNFs



**CMS.gov**  
Centers for Medicare & Medicaid Services

Search

Medicare Medicaid/CHIP Medicare-Medicaid Coordination Private Insurance Innovation Center Regulations & Guidance Research, Statistics, Data & Systems Outreach & Education

Home > Medicare > Nursing Home Quality Initiative > SNF Quality Reporting Program (IMPACT Act 2014) > SNF Quality Reporting Archives

## SNF Quality Reporting Program (IMPACT Act 2014)

[SNF Quality Reporting Program Spotlights and Announcements](#)

[Skilled Nursing Facility \(SNF\) Quality Reporting Program Measures and Technical Information](#)

[SNF Quality Reporting Program Training](#)

[SNF Quality Reporting Program Public Reporting](#)

[MDS 3.0 RAI Manual](#)

[SNF Quality Reporting Program FAQs](#)

[SNF Quality Reporting Program Data Submission Deadlines](#)

[SNF Quality Reporting Reconsideration and Exception & Extension](#)

## SNF Quality Reporting Archives

**SNF ARCHIVED MATERIALS**

This page is for postings and downloads that appeared on the SNF Quality Reporting section in the past but are not currently applicable. Items are archived for historical reference .CMS provides the following materials for the public to access.

### Downloads

- [SNF ODF FINAL PowerPoint \(ZIP\)](#)
- [Skilled Nursing Facility Quality Reporting Program - Quality Measure Specifications for FY 2016 Notice of Proposed Rule Making report \(PDF\)](#)
- [MDS 3.0 SECTIONS A AND GG DOCUMENT \(PDF\)](#)
- [Draft of the new MDS 3.0 PPS Part A Discharge \(End of Stay\) \(NPE/SPE\) Version 1.14.0 \(PDF\)](#)
- [SNF ODF FINAL RULE 8-2015 \(PDF\)](#)
- [Proposed Item Set Specifications for FY17 SNF QRP NPRM \(PDF\)](#)
- [2016 SNF QRP Spotlights and Announcements.zip \(ZIP\)](#)
- [SNF QRP Requirements for FY18 Reporting Year Fact Sheet\\_updated.pdf \(PDF\)](#)
- [Copy of 2016 04 06 mspb pac snf service exclusions \(XLSX\)](#)

# Code of Federal Regulations (CFR)

- State Operations Manual Appendix PP revised 11/22/17:  
[https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_pp\\_guidelines\\_ltcf.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf)
- Resident Assessment
  - Regulations F635-F646
- Comprehensive Resident Centered Care Plans
  - Regulations F655-F661

# CFR 483.20 Resident Assessments

- F635 Admission Physician Orders for Immediate Care
- F636 Comprehensive Assessments & Timing
- F637 Comprehensive Assessment After Significant Change
- F638 Quarterly Assessment At Least Every 3 Months
- F639 Maintain 15 Months of Resident Assessments
- F640 Encoding/Transmitting Resident Assessment
- F641 Accuracy of Assessments
- F642 Coordination/Certification of Assessment
- F644 Coordination of PASARR and Assessments
- F645 PASARR Screening for MD & ID
- F646 MD/ID Significant Change Notification

# CFR 483.21 Comprehensive Resident Centered Care Plans

- F655 Baseline Care Plan
- F656 Develop/Implement Comprehensive Care Plan
- F657 Care Plan Timing and Revision
- F658 Services Provided Meet Professional Standards
- F659 Qualified Persons
- F660 Discharge Planning Process
- F661 Discharge Summary

# Regulation F636

## Comprehensive Assessments & Timing

- *Resident Assessment: The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.*
- *Comprehensive Assessments: Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS.*

# Regulation F636

## Comprehensive Assessments & Timing (continued)

- The assessment must include at least the following:
  - (i) Identification and demographic information
  - (ii) Customary routine
  - (iii) Cognitive patterns
  - (iv) Communication.
  - (v) Vision.
  - (vi) Mood and behavior patterns.
  - (vii) Psychological well-being.

# Regulation F636

## Comprehensive Assessments & Timing (continued)

- (viii) Physical functioning and structural problems.
- (ix) Continence.
- (x) Disease diagnosis and health conditions.
- (xi) Dental and nutritional status.
- (xii) Skin Conditions.
- (xiii) Activity pursuit.
- (xiv) Medications.
- (xv) Special treatments and procedures

# Regulation F636

## Comprehensive Assessments & Timing (continued)

- (xvi) Discharge planning.
- (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
- (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.
- Not less than once every 12 months.



# F636 Intent

- *INTENT: To ensure that the Resident Assessment Instrument (RAI) is used, in accordance with specified format and timeframes, in conducting comprehensive assessments as part of an ongoing process through which the facility identifies each resident's preferences and goals of care, functional and health status, strengths and needs, as well as offering guidance for further assessment once problems have been identified.*

# F636 Guidance

- The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or CAAs. The scope of the RAI does not limit the facility's responsibility to assess and address all care needed by the resident.
- The facility is expected to use resident observation and communication as the primary source of information when completing the RAI. In addition to record review, direct observation and communication with the resident, the facility must use a variety of other sources, including communication with licensed and non-licensed staff members on all shifts and may include discussions with the resident's physician, the resident's representative, family members, or outside consultants.

# F636 Guidance (continued)

- At a minimum, facilities are required to complete a comprehensive assessment of each resident within 14 calendar days after admission to the facility, when there is a significant change in the resident's status and not less than once every 12 months while a resident. For the purpose of this guidance, not less than once every 12 months means within 366 days.
- The facility must use the RAI process to develop a comprehensive care plan, to provide the appropriate care and services for each resident, and to modify the care plan and care/services based on the resident's status.

# Regulation F641

## Accuracy of Assessments

- *Accuracy of Assessments: The assessment must accurately reflect the resident's status.*
- *INTENT: To assure that each resident receives an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline.*

# F641 Guidance

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

# Regulation F655 Baseline Care Plans

- The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.
- The baseline care plan must be developed within 48 hours of a resident's admission and include the minimum healthcare information necessary to properly care for a resident including, but not limited to:
  - (A) Initial goals based on admission orders. (B) Physician orders.
  - (C) Dietary orders. (D) Therapy services.
  - (E) Social services. (F) PASARR recommendation, if applicable.

# F655 Intent

- Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan.

# Regulation F656 Develop/Implement Comprehensive Care Plan

- *Comprehensive Care Plans: The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.*
- *The comprehensive care plan must describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.*
- *Any services that would otherwise be required but are not provided due to the resident's exercise of rights, including the right to refuse treatment under §483.10(c)(6).*



# Regulation F656 (continued)

- *Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.*
- *In consultation with the resident and the resident's representative(s)— (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate.*

# F656 Intent

- *INTENT: Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs.*

# F656 Guidance

- GUIDANCE: Through the care planning process, facility staff must work with the resident and his/her representative, if applicable, to understand and meet the resident's preferences, choices and goals during their stay at the facility. The facility must establish, document and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of life. Care planning drives the type of care and services that a resident receives. If care planning is not complete, or is inadequate, the consequences may negatively impact the resident's quality of life, as well as the quality of care and services received.

# Regulation F657

## Care Plan Timing and Revision

- *A comprehensive care plan must be—*
- *Developed within 7 days after completion of the comprehensive assessment.*
- *Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.*
- *Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.*

# F657 Intent

- *Intent: To ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care.*

# F657 Guidance

- GUIDANCE: Facility staff must develop the comprehensive care plan within seven days of the completion of the comprehensive assessment (Admission, Annual or Significant Change in Status) and review and revise the care plan after each assessment. “After each assessment” means after each assessment known as the Resident Assessment Instrument (RAI) or Minimum Data Set (MDS), except discharge assessments.
- For newly admitted residents, the comprehensive care plan must be completed within seven days of the completion of the comprehensive assessment and no more than 21 days after admission.

# Use of Dashes

- Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to the MDS QIES ASAP system.
- A dash value indicates that an item was not assessed. This most often occurs when a resident is discharged before the item could be assessed.
- Dash values allow a partial assessment to be submitted when an assessment is required for payment purposes.
- There are four date items (A2400C, O0400A6, O0400B6, and O0400C6) that use a dash-filled value to indicate that the event has not yet occurred. For example, if there is an ongoing Medicare stay, then the end date for that Medicare stay (A2400C) has not occurred, therefore, this item would be dash-filled.
- QMs cannot be calculated, for example, when the use of a dash (-) indicates the SNF was unable to perform a pressure ulcer assessment. Left blank, it also means no assessment was done for that item.
- Coding Conventions Page 3-3 through 3-6

# Interim Payment Assessment (IPA)

- Optional
- Sets payment for remainder of the stay beginning on the ARD
- Too many IPAs may appear to CMS as you trying to manipulate the system
- Should have a plan to help determine when an IPA should be completed



# IPA Continued

- Look back period is 7 days unless otherwise indicated.
  - D0200 with a 14 day look back
  - GG0130 and GG0170 with 3 day look back
  - K0300 with 6 month look back
  - O0100 with a 14 day look back
- Interim Performance (Optional): The Interim Payment Assessment (IPA) is an optional assessment that may be completed by providers in order to report a change in the resident's PDPM classification.

## IPA (continued)

- The ARD for the IPA is determined by the provider, and the assessment period is the last 3 days (i.e., the ARD and the 2 calendar days prior).
- It is important to note that the IPA changes payment beginning on the ARD and continues until the end of the Medicare Part A stay or until another IPA is completed.
- The IPA does not affect the variable per diem schedule.

# Interviews

- Interview status should not be based on B0700, Makes Self Understood, rather, B0700 should be evaluated after all interviews have been attempted and coded.
- B0700 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 resident's ability to make self understood during the entire 7-day look-back.
- While B0700 and resident interview items are not directly dependent on each other, inconsistencies should be evaluated.

# Interviews (continued)

- Use the resident's preferred language or method of communication.
- All residents capable of any communication should be asked about what is important in their care.
- DO NOT complete the staff interview if the resident interview should have been attempted and was not.

# Interviews (continued)

- Basic approaches to make the interviews effective:
  - Introduce yourself and find a quiet, private area
  - Be sure the resident can hear you
  - Is an interpreter needed?
  - Sit where the resident can see you clearly
- See Appendix D for more techniques and tools.

# Significant Change in Status Assessment

A SCSA is appropriate when:

- It is determined there has been a significant change (improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and
- The resident's condition is not expected to return to baseline within two weeks.

# Hospice Services

- Electing Hospice or palliative care from an outside agency requires a SCSA to coordinate care and care plans.
- In-house palliative care services are not indicated on the MDS, a SCSA is not required but the resident should be evaluated for a SCSA and the care plans need to be updated to reflect palliative care.
- CMS does not differentiate between levels of Hospice services, only that they are received.
- O0100K indicates Hospice services for terminally ill persons. If a resident is receiving outside palliative services through a Hospice provider and is terminally ill, it should be counted here.
- J1400 should be marked when a resident has a life expectancy of 6 months or less and/or is receiving Hospice services marked at O0100K.
- Residents with non-terminal conditions receiving palliation services from a Hospice provider should not be marked.

# Hospice then discharges to Hospital

Example: A resident receiving hospice services was sent out and admitted to the hospital. The facility completed a Discharge return-anticipated and transmitted it.

If, upon return to the facility, the resident re-enrolls in hospice services, then a SCSA is required, whether or not it is the same hospice provider. This is to ensure a coordinated plan of care between the hospice and nursing home is in place.



# Section A: Identification Information

- 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.
- Please communicate with your business office regarding any changes to the residents' demographic information.

# Section A

- A0300: Optional State Assessment has been added, NC still to determine use.
- A0310A: OBRA assessments unchanged.
- A0310B: PPS Assessment
  - PPS Scheduled Assessments now only includes
    - 01. 5-day scheduled assessment
  - PPS Unscheduled Assessment now only includes
    - 08. IPA- Interim payment Assessment
- A0310: C (OMRA) and D (Swing Bed) have been deleted.
- A0310G1: Is this a SNF Part A Interrupted Stay?
- A0310H: Is this a SNF Part A PPS Discharge Assessment?

# OBRA Required Assessments – A0310A

- 01. Admission (comprehensive)
- 02. Quarterly
- 03. Annual (comprehensive)
- 04. Significant Change in Status Assess (comprehensive)
- 05. Significant Correction to Prior Comprehensive (comprehensive)
- 06. Significant Correction to Prior Quarterly

# OBRA Required Assessments

- Coding Instructions for A0310A, Federal OBRA Reason for Assessment
- Document the reason for completing the assessment, using the categories of assessment types. For detailed information on the requirements for scheduling and timing of the assessments, see Chapter 2 on assessment schedules.
- Enter the number corresponding to the OBRA reason for assessment. This item contains 2 digits. For codes 01-06, enter “0” in the first box and place the correct number in the second box. If the assessment is not coded 01-06, enter code “99”.
  - 01. Admission assessment (required by day 14)
  - 02. Quarterly review assessment
  - 03. Annual assessment
  - 04. Significant change in status assessment
  - 05. Significant correction to prior comprehensive assessment
  - 06. Significant correction to prior quarterly assessment
  - 99. None of the above

# A0310: OBRA Required Assessments

- Certified beds (Title 18 and/or Title 19): OBRA schedule is required and transmitted regardless of the payer source.
- Licensed only beds are *not* transmitted.
- If you accidentally transmit a record from a licensed only bed, you need to call me. A manual Correction/Deletion Request Form will need to be completed.

# A0310B

## PPS Assessments

- A0310B: PPS Scheduled Assessments now only include:
  - 01. 5-day scheduled assessment
- PPS Unscheduled Assessment now only includes
  - 08. IPA- Interim payment Assessment
- A0310H: PPS Part A Discharge

# PPS 5-day

## Factors Impacting Scheduling

- Resident Transfers, Discharges or Expires Before or On the Eighth Day of SNF Stay:
- If the resident is discharged from the SNF or the Medicare Part A stay ends before or on the eighth day of the covered SNF stay, the provider should prepare a 5-Day assessment as completely as possible and submit the assessment as required.
- If there is not a PPS assessment in the QIES ASAP system, the provider must bill the default rate for any Medicare days. PPS and OBRA discharges and Death in facility Trackers continue to apply.

# PPS 5-day

## Factors Impacting Scheduling (continued)

- If a Medicare Part A resident is admitted to an acute care facility and later returns to the SNF to resume Part A coverage, the resident requires a new 5-Day assessment, unless it is an instance of an interrupted stay. If it is a case of an interrupted stay (i.e., the resident returns to the SNF and resumes Part A services in the same SNF within the 3-day interruption window), then no PPS assessment is required upon reentry, only an Entry tracking form. An IPA may be completed, if deemed appropriate.
- RAI page 2-50



# A0310F/A0310G/A0310G1/A0310H

## Entry/Discharge Reporting Required for all Residents

- A0310F
  - 01. Entry tracking record
  - 10. Discharge assessment- return not anticipated
  - 11. Discharge assessment- return anticipated
  - 12. Death in facility tracking
  - 99. None of the above
- A0310G Type of Discharge
  - 1. Planned, 2. Unplanned
- A0310G1 Is this a SNF Part A Interrupted Stay?
  - 0. No, 1. Yes
- A0310H Is this a SNF Part A PPS Discharge Assessment?
  - 0. No, 1. Yes

# A0310F: Entry/Discharge Reporting

## Entry Record

Completed within 7 days every time a person is **admitted or readmitted** into a nursing home (or swing bed facility)

Submitted no later than the 14th calendar day after the entry (entry + 14 calendar days)

Submit before the next assessment.

Required in addition to the initial Admission assessment or other OBRA or PPS assessments that might be required

Cannot be combined with an assessment

Needs to be completed even if in the facility for a short period of time

## Discharge Assessment and Record

Not associated with the bed hold status or opening and closing of the medical record

# A0310H: SNF PPS Part A Discharge (End of Stay) Assessment

- A Part A PPS Discharge assessment is required when the resident's Medicare Part A stay ends (as documented in A2400C, End Date of Most Recent Medicare Stay) but the resident remains in the facility
- If the End Date of the Most Recent Medicare Stay (A2400C) occurs on the day of or one day before the Discharge Date (A2000), the OBRA Discharge assessment and Part A PPS Discharge assessment are **both required** and may be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD (A2300) must be equal to the Discharge Date (A2000)
- Needs to be completed even if in the facility for a short period of time

# Section A (continued)

## Interrupted Stay

- A0310G1: Is this a SNF Part A Interrupted Stay? Yes or No
- DEFINITIONS:
  - Interrupted Stay is a Medicare Part A SNF stay in which a resident is discharged from SNF care (i.e., the resident is discharged from a Medicare Part A-covered stay) and subsequently resumes SNF care in the same SNF for a Medicare Part A-covered stay during the interruption window.
  - Interruption Window is a 3-day period, starting with the calendar day of discharge and including the 2 immediately following calendar days. In other words, 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. If both conditions are met, the subsequent stay is considered a continuation of the previous Medicare Part A-covered stay for the purposes of both the variable per diem schedule and PPS assessment completion.

# Section A (continued)

- A0500: Legal Name of Resident: this needs to be what Medicare has on file, match the Medicare/Medicaid card, and the common working file.
- A0500 D: Suffix: *Please use!*
- A0800 Gender: What it says on the Medicare card.
- A2400 Medicare Stay: This is for traditional Medicare ONLY

# A1500: Preadmission Screening and Resident Review (PASRR)

- PASRR is a preadmission screening process.
- A positive screen indicates the resident has a mental illness, intellectual disability, or a related condition.
- A1500 documents whether a PASRR Level II determination has been issued.
- Reports on the results of the PASRR process
- Only completed on the OBRA comprehensive MDS assessments

**PASRR Help Desk 888-245-0179, 919-813-5603**

[https://www.ncmust.com/doclib/PASRR\\_Numbers.pdf](https://www.ncmust.com/doclib/PASRR_Numbers.pdf)

# PASRR Level II for Referral

- ***§483.20(e)(2) Refer all level II residents and all residents with newly evident or possible serious mental disorder (MI), intellectual disability (ID), or a related condition for level II resident review upon a significant change in status assessment***
- ***F644, F645, F646***

# A1500: PASRR

- NC MUST (919) 816-3015, (888) 245-0179 or (919) 318-5550, Fax (919) 224-1072
- Not everyone with MI is a Level II PASRR.
- Everyone with ID should be a Level II PASRR.
- All known Level II PASRR residents need to have a referral completed for any significant change in status identified. Do not wait until the SCSA assessment has been completed to make this referral.
- Level I residents who experience a psychiatric episode, have a new psychiatric diagnosis or have been placed on antipsychotic medications should have a Level II PASRR referral made (RAI page 2-28 & 29).



# Section B: Hearing, Speech, and Vision

- B0100 Comatose: needs to be documented by a physician to count.
- B0200 Hearing: should be conducted in a private, quiet spot. The resident may need to use an amplifier. The resident does not need to own the device to use it for the assessment.
- B0600 Speech Clarity: if the resident is “aphasic” but is able to speak 1-2 words clearly, this should be coded as “clear speech”. It is about the clarity of the words, not the content or intended message.
- Section B0600 Speech Clarity and B0700 Makes Self Understood are assessing different things!

# B0700: Makes Self Understood

- 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 resident's ability to make them self understood during the entire 7 day look back.
- This includes the ability to express or communicate requests, needs, opinions and to conduct social conversations in their primary language, whether in speech, writing, sign language, gestures, or a combination of these. Deficits in the ability to make one's self understood can included reduced voice volume and difficulty in producing sounds, finding the right word, making sentences, writing and/or gesturing.
- This should be coded after 11:59 PM of the ARD, taking into account all information.
- While B0700 and resident interview items are not directly dependent on each other, inconsistencies should be evaluated.

# Section C: Cognitive Patterns

- C0100: If the resident is ever understood, the interview needs to be attempted. Use the resident's preferred language or primary method of communication. *DO NOT* consult B0700 to decide to do the interview or not.
- If the interview is not possible, the resident is rarely or never understood, then skip to the staff assessment.
- If the assessment should have been done during the look back period and *WAS NOT*, code C0100 as YES and dash (-) the information.
- C0500: Enter "99" if the resident was unable to complete the interview, do not dash.
- Score: 13- 15 cogitatively intact, 8-12 moderately impaired, 0-7 severely impaired.

## Section C (continued)

- C0600: Staff assessment should only be completed if the resident refuses, has nonsensical responses or is rarely/never understood.
- *DO NOT* complete a staff assessment if the resident interview *should have* been done and was not.
- C1310: Signs and Symptoms of Delirium: This may alert you to a problem. Probe and document what was said, then make a decision about notifying the physician.

## Section C Coding Tips from page C-2

- 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.

# Section D: Mood

- D0100: If the resident is ever understood, the interview needs to be attempted. Use the resident's primary method of communication. DO NOT consult B0700 to decide to do the interview or not.
- If the interview is not possible, the resident is rarely or never understood, then skip to the staff assessment.
- If the resident refuses, make several attempts.
- If the assessment should have been done during the look back period and WAS NOT, code C0100 as YES and dash (-) the information.

## Section D (continued)

- D0200: Symptom presence and frequency may alert you to a problem. Probe and document what was said during the interview. Then make a decision to notify the physician or not.
- D0200 I: Thoughts that would be better off dead- you must ask this question. If yes, find out why. Feeling ready to die is not the same as better off dead.
- D0300 Total Severity Score: 1-4 Minimal depression, 5-9 Mild, 10-14 Moderate, 15-19 Moderately Severe, 20-27 Severe depression.

## Section D (continued)

- D0500: Staff assessment should only be completed if the resident refuses, has nonsensical responses or is rarely/never understood.
- DO NOT complete a staff assessment if the resident interview should have been done and was not.



# Section E: Behavior

- This section is based on observations during the look back period.
- An increase in behaviors should be discussed with the physician, consider PASRR notification, or a possible SCSA.
- Should seek to understand why the behavior is being exhibited: lonely, meaningless, helpless, boredom.

# Section E (continued)

- E800 Rejection of Care: If the resident understands the ramifications of the lack of care, this would not be rejection.
- When surveyors look at ADL care, facial hair, long nails, the rejection of care section of the MDS is also reviewed.
- E0900 and E1000: Wandering. If the resident is out of the building without staff knowledge=elopement.
- Not talking about alert and oriented who have been assessed as safe to go outside. Or confused residents who are allowed to wander into an enclosed, secured area.
- If the resident has exit seeking behaviors, and this was prior knowledge, the facility is liable.

# Section F: Preferences for Customary Routine and Activities

- F0300: If the resident is ever understood, the interview needs to be attempted. Use the resident's primary method of communication. *DO NOT* consult B0700 to decide to do the interview or not.
- If the interview is not possible, the resident is rarely or never understood, then conduct the interview with the family or significant other. If the interview could not be completed, then skip to the staff assessment.
- Documentation would be expected if the resident or family were not interviewed.
- If the assessment should have been done during the look back period and *WAS NOT*, code F0300 as YES and dash (-) the information.

## Section F (continued)

- Section F is about the quality of their life. These questions are only asked on comprehensive assessments, but it is okay to ask these questions more frequently.
- Please include preferences in the care plan!
- Surveyors ask many of these questions when interviewing residents. Get there before they do!

# Section G:

## Functional Status

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

# Section G

## ADL Assistance Coding Tips

- Observations, record review, and interview all shifts.
- Do not code ADLs based on the resident's potential ability, but on actual performance.
- Include only assistance provided by individuals employed or under contract with the facility (no family, students, visitors or Hospice staff).
- Consider each episode of an activity that occurred during the 7 day look back period.

# Section G

## ADL Assistance Coding Tips

- Self performance may vary from shift to shift in a 24 hours
- Consider the resident's performance while using adaptive equipment.
- Clarify your own understanding and observations about a resident's performance of an ADL activity.

# Coding Tips and Special Populations

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



# Coding Tips and Special Populations

- How a resident turns from side to side, in the bed, during incontinence care, is a component of bed mobility and should not be considered as part of Toileting.
- When a resident is transferred into or out of bed or a chair for incontinent care or to use the bedpan or urinal, the transfer is coded in G0110B, Transfers. How the resident uses the bedpan or urinal is coded in G0110I, Toilet use.

# G0110: ADL Assistance Definitions

- Self performance
- Code 0, Independent: If resident completed activity with no help or oversight every time during the 7-day look-back period and it occurred at least 3 times.
- Code 1, Supervision: If oversight, encouragement, or cueing was provided 3 or more times in the last 7 days.
- Code 2, Limited assistance: If resident was highly involved in activity and received physical help in guided maneuvering of limbs or other non-weight-bearing assistance 3 or more times in the last 7 days.

# G0110: ADL Assistance Definitions (continued)

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

# G0110: ADL Assistance Definitions (continued)

- Code 4, Total dependence: If every time it occurred there was full staff performance of an activity with no participation by resident for any aspect of the ADL activity, and the activity occurred 3 or more times.
- Code 7, Activity only occurred once or twice: If the activity occurred fewer than 3 times in the last 7 days.
- Code 8, Activity did not occur: If the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day look-back period.

# Coding with the Rule of 3

- Staff completing this section must understand the ADL self performance coding level definitions, the components of each ADL, and the steps to the rule of 3.
- In order to properly apply the Rule of 3, the facility must first note which ADL activities occurred, how many times each ADL activity occurred, that type and what level of support was required for each ADL activity over the entire 7 day look-back period.

# Instructions for Rule of 3

- 1. When an activity occurs 3 or more times at any one level, code that level – \*note exceptions for Independent (0) and Total Dependence (4).
- 2. When an activity occurs 3 or more times at multiple levels, code the most dependent level that occurs 3 or more times – \*note exceptions for Independent (0) and Total Dependence (4).
- 3. When an activity occurs 3 or more times and at multiple levels, but NOT 3 times at any one level, apply the following in sequence as listed – stop at the first level that applies: (NOTE: This 3rd rule only applies if there are NOT ANY LEVELS that are 3 or more episodes at any one level. DO NOT proceed to 3a, 3b or 3c unless this criteria is met.) a. Convert episodes of Total Dependence (4) to Extensive Assistance (3). b. When there is a combination of Total Dependence (4) and Extensive Assist (3) that total 3 or more times – code Extensive Assistance (3). c. When there is a combination of Total Dependence (4) and Extensive Assist (3) and/or Limited Assistance (2) that total 3 or more times, code Limited Assistance (2).
- If none of the above are met, code Supervision (1). RAI page G-8

# Exceptions to the Rule of 3

- Code 0- Independent
- Code 4- Total dependence
- Code 8- Activity did not occur
- The definition for these coding levels are finite and cannot be entered on the MDS unless that level occurred every time the ADL occurred.
- Code 7- Activity occurred only once or twice. Coded in the ADL activity occurred fewer than 3 times in the 7-day look-back period.

# Section GG: 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.



# Section GG:

## Functional Abilities and Goals

- Changes in section GG include an update with State Requires Completion with an OBRA Assessment language.
- Completed for PPS 5-day, IPA, PPS Discharge, and OBRA Admission, Quarterly, Annual, SCSA, SCPC and SCPQ assessments.
- This section assesses the need for assistance with self-care and mobility activities at the beginning and end of a SNF PPS stay and OBRA assessments.
- Section GG coding on admission should reflect the person's baseline admission functional status and is based on a clinical assessment that occurs soon after the resident's admission.
- Beginning October 2019, the PPS functional score will be based from section GG.

# Section GG: PPS assessments

- 5-day PPS MDS- Items focus on the resident's self-care/mobility performance at admission. This 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.
- The assessment period is days 1-3 of the SNF PPS stay starting with A2400B.
- Must have at least 1 goal for discharge performance.

# GG0100, GG0110 Prior Functioning:

- GG0100: Everyday Activities
  - Self-Care
  - Indoor Mobility (Ambulation)
  - Stairs
  - Functional Cognition
- GG0110: Prior Device Use
  - Manual wheelchair
  - Motorized wheelchair and/or scooter
  - Mechanical lift
  - Walker
  - Orthotics/prosthetics
  - None of the above

# GG0100 Prior Functioning

- Ask the resident, their family or caregivers about their prior functioning with everyday activities
- Review the resident's medical records describing the resident's prior functioning with everyday activities.

# GG 0100 Coding: Prior Functioning

- Code 3, Independent: if the resident completed the activities by himself or herself, with or without an assistive device, with no assistance from a helper.
- Code 2, Needed Some Help: if the resident needed partial assistance from another person to complete the activities.
- Code 1, Dependent: if the helper completed the activities for the resident, or the assistance of two or more helpers was required for the resident to complete the activities.

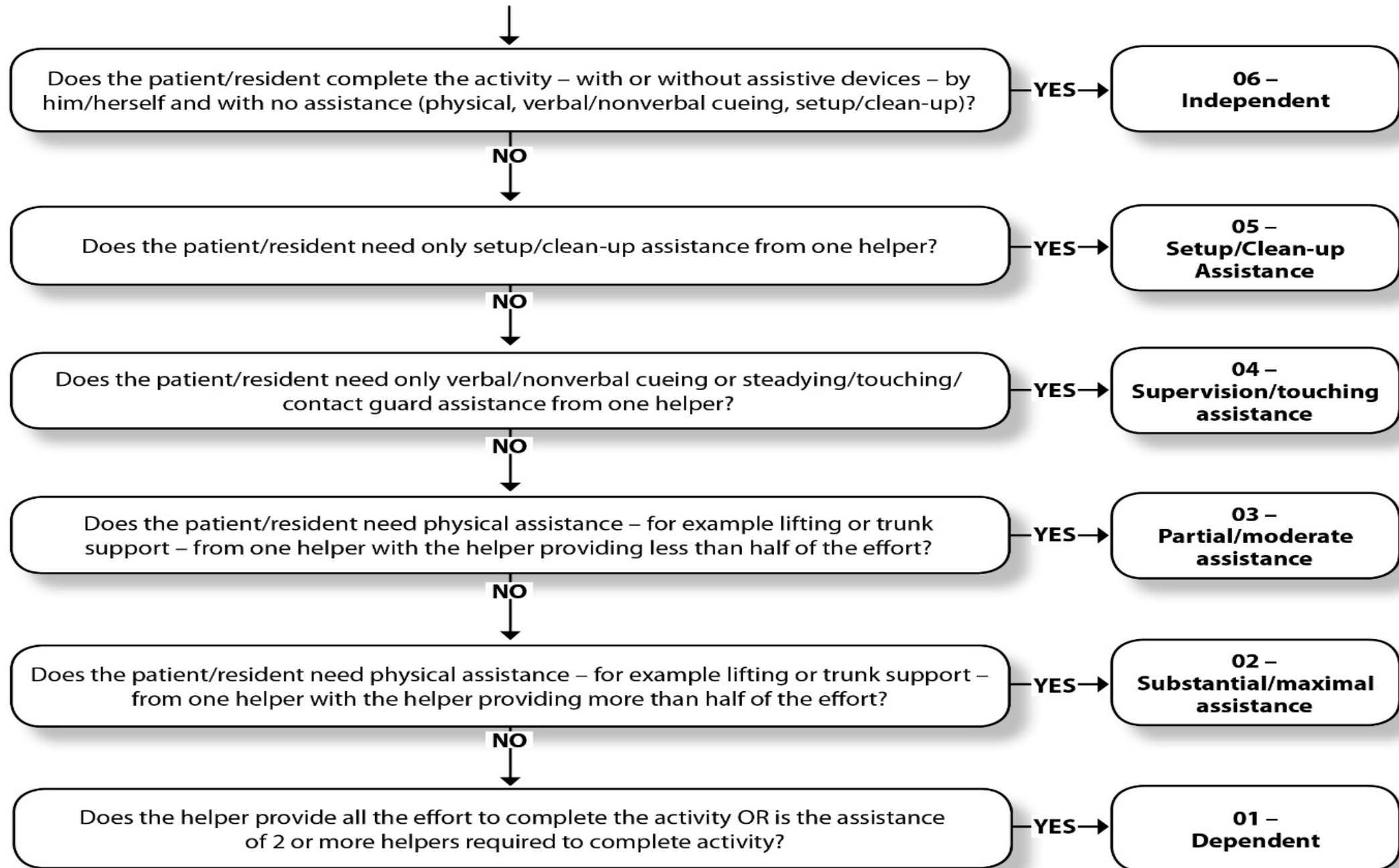
# GG 0100 Coding: Prior Functioning (continued)

- Code 8, Unknown: if the resident's usual ability prior to the current illness, exacerbation, or injury is unknown.
- Code 9, Not Applicable: if the activities were not applicable to the resident prior to the current illness, exacerbation, or injury.

# Decision Tree page GG-12

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

## START DECISION TREE HERE





# GG0130 Self Care and GG0170 Mobility Coding

PPS and OBRA assessments

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

# GG0130 Self Care and GG0170 Mobility Coding

- Code 04, Supervision or touching assistance: if the helper provides verbal cues or touching/steadying/contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. For example, the resident requires verbal cueing, coaxing, or general supervision for safety to complete activity; or resident may require only incidental help such as contact guard or steadying assist during the activity.
- Code 03, Partial/moderate assistance: if the helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.

# GG0130 Self Care and GG0170 Mobility Coding

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

# GG0130 and GG0170 Coding

## Activity was not attempted

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

# GG0130 & GG0170

## Steps for Assessment

- 1. Assess the resident's self-care and mobility performance based on direct observation, the resident's self-report, and reports from clinicians, care staff, or family reports, documented in the resident's medical record during the 3-day assessment period.
- 2. Residents should be allowed to perform activities as independently as possible, as long as they are safe.
- 3. If helper assistance is required because resident's performance is unsafe or of poor quality, score according to the amount of assistance provided.
  - If 2 or more helpers are required for safety, code as 01, Dependent.
- Fastening, buttoning, tying shoes is touching assistance.

# GG: Stand Alone OBRA Assessments

- Admission, Quarterly, Annual, Significant Change in Status, Significant Correction to prior assessment- Comprehensive or Quarterly.
- The look back is the ARD plus the 2 previous days (days 5, 6 and 7).
- Code the resident's usual performance. Use the 6-point scale or activity was not attempted codes.
- Complete only column 1.
- GG information is not required for OBRA Discharge assessments.

# CMS GG Training Videos

- Lesson 1: Importance of Section GG for Post-Acute Care
- Lesson 2: Section GG Assessment and Coding Principles
- Lesson 3: Coding GG0130.Self-Care Items
- Lesson 4: Coding GG0170.Mobility Items
- Coding GG0110. Prior Device Use with Information From Multiple Sources (3:58)
- Decision Tree for Coding Section GG0130. Self-Care and GG0170. Mobility (11:56)
- Coding GG0130B. Oral Hygiene (4:25)
- Coding GG0170C. Lying to Sitting on side of bed (4:33)
- <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Skilled-Nursing-Facility-Quality-Reporting-Program/SNF-Quality-Reporting-Program-Training.html>
- Accessed 3/05/2021

# GG IPA

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



# Section GG

## PPS Discharge

- Part A PPS Discharge
- Completed when the Medicare Stay ends (as documented in A2400C, End of Most Recent Medicare Stay), either as a standalone assessment when the resident's Medicare Part A stay ends, but the resident remains in the facility,
- Or may be combined with an OBRA Discharge if the Medicare Part A stay ends on the day of, or the day before the resident's discharge date (please see Chapter 2 and Section A of the RAI Manual for additional details regarding the Part A PPS Discharge assessment).

# PPS 5-day, IPA or Discharge Performance and OBRA Admission, Quarterly, Annual, SCSA, SCPC, SCPQ

- Code the resident's usual performance for each activity using the 6-point scale.
- Start with the least assistance provided, then step through the levels until you reach one that matches the resident's usual performance.
- If the activity was not attempted during the entire 3-day assessment period, indicate the reason. DO NOT DASH!
- Coding a dash (-) indicates "No information"
- Use of dashes in the Discharge Goals is allowed and does not affect the Annual Payment Update (APU), however, at least one discharge goal should be entered.
- 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.

# Section H: Bladder and Bowel

- H0100A: Indwelling Catheter: may code even if in only a brief time during the look back period.
- H0300 and H0400 Urinary and Bowel Continence: If a resident has a change from occasional incontinent to frequently incontinent, this is a significant difference and needs to be investigated.
  - Incontinence: any urine touching the skin, willful or not. Peeing in a brief is not continence.

# Toileting Programs

- Toileting programs must include:
- Evidence it was used during the look back period.
- Must be individualized, resident specific, based on an assessment.
- Evidence it had been communicated to the staff and the resident.
- Would expect to see flow records, a care plan and written evaluations of the resident response.
- This would include toileting trials.
- Guidance found in Appendix C.

# Section I: Active Diagnoses

- The items in this section are intended to code diseases and conditions that have a relationship to current function, cognition, moods, behaviors, medical treatment, 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.
- This section identifies active diseases and infections that drive the current care plan.
- Diagnoses need to have been noted by the physician within the past 60 days, and then narrow to the last 7 days if active (labs, monitoring, medications, therapy).

# I0020 Indicate the Resident's Primary Medical Condition Category PPS 5-day

- The *primary reason* for admission will determine the clinical grouping for each resident.
- Many previously used diagnoses have been determined to be too vague to single out a clinical grouping. This may result in a “return to provider” claim status with the claim being sent back to the provider for proper coding and resubmission.
  - Examples include muscle weakness, dysphagia, difficulty walking, unsteadiness on feet, abnormalities of gait and mobility, unspecified convulsions, history of falls, hypotension, and other codes with unspecified sites, or unspecified diseases.
- Examples start on page I-3

# I0020 Indicate the Resident's Primary Medical Condition Category OBRA Assessments

- I0020: Indicate the resident's primary medical condition category is coded when A0310A= 01, 02, 03, 04, 05, 06
- Indicate the resident's primary medical condition category that best describes the primary reason for the stay; then proceed to I0020B and enter the International Classification of Diseases (ICD) code for that condition, including the decimal.
- Include the primary medical condition coded in this item in Section I: Active Diagnoses in the last 7 days.
- This is an active diagnosis indicating the primary reason for the SNF stay.

# I0020 (continued)

- Code 01, Stroke, if the resident's primary medical condition category is due to stroke. Examples include ischemic stroke, subarachnoid hemorrhage, cerebral vascular accident (CVA), and other cerebrovascular disease.
- Code 02, Non-Traumatic Brain Dysfunction, if the resident's primary medical condition category is non-traumatic brain dysfunction. Examples include Alzheimer's disease, dementia with or without behavioral disturbance, malignant neoplasm of brain, and anoxic brain damage.



# I0020 (continued)

- Code 03, Traumatic Brain Dysfunction, if the resident's primary medical condition category is traumatic brain dysfunction. Examples include traumatic brain injury, severe concussion, and cerebral laceration and contusion.
- Code 04, Non-Traumatic Spinal Cord Dysfunction, if the resident's primary medical condition category is non-traumatic spinal cord injury. Examples include spondylosis with myelopathy, transverse myelitis, spinal cord lesion due to spinal stenosis, and spinal cord lesion due to dissection of aorta.

# I0020 (continued)

- Code 05, Traumatic Spinal Cord Dysfunction, if the resident's primary medical condition category is due to traumatic spinal cord dysfunction. Examples include paraplegia and quadriplegia following trauma.
- Code 06, Progressive Neurological Conditions, if the resident's primary medical condition category is a progressive neurological condition. Examples include multiple sclerosis and Parkinson's disease.

## I0020 (continued)

- Code 07, Other Neurological Conditions, if the resident's primary medical condition category is other neurological condition. Examples include cerebral palsy, polyneuropathy, and myasthenia gravis.
- Code 08, Amputation, if the resident's primary medical condition category is an amputation. An example is acquired absence of limb.

## I0020 (continued)

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

# I0020 (continued)

- Code 11, Other Orthopedic Conditions, if the resident's primary medical condition category is other orthopedic condition. An example is unspecified disorders of joint.
- Code 12, Debility, Cardiorespiratory Conditions, if the resident's primary medical condition category is debility or a cardiorespiratory condition. Examples include chronic obstructive pulmonary disease (COPD), asthma, and other malaise and fatigue. \*Includes cardiac surgery.

# I0020 (continued)

- Code 13, Medically Complex Conditions, if the resident's primary medical condition category is a medically complex condition. Examples include diabetes, pneumonia, chronic kidney disease, open wounds, pressure ulcer/injury, infection, and disorders of fluid, electrolyte, and acid-base balance.

# Section I: Active Diagnoses

- I1700 Multidrug-Resistant Organism (MDRO) includes MRSA, VRE, ESBL. It does not include C-Difficile.
- I2300 Urinary Tract Infection (UTI) (Last 30 Days) includes Item I2300 Urinary tract infection (UTI): Code only if both of the following are met in the last 30 days:
  - 1. It was determined that the resident had a UTI using evidence-based criteria such as McGeer, NHSN, or Loeb in the last 30 days, AND
  - 2. A physician documented UTI diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days.
- If the diagnosis of UTI was made prior to the resident's admission, entry, or reentry into the facility, it is not necessary to obtain or evaluate the evidence-based criteria used to make the diagnosis in the prior setting. A documented physician diagnosis of UTI prior to admission is acceptable.

# Section I: Active Diagnoses

- I5100 Quadriplegia. No functional use of all four limbs. Use only if spinal cord injury. Spinal cord injury must be a primary condition and not a result of another condition. DO NOT code functional quad here. If the resident has dementia or spastic quadriplegia due to cerebral palsy, stroke, contractures, brain disease the primary diagnosis should be coded and not the resulting paralysis or paresis from that condition.
- I8000 Additional active diagnoses. Diagnoses coded here do not trigger anything. Use to be more specific with diagnoses listed in the active diagnoses list (hypothyroid, glaucoma).



# Section J: Health Conditions

- The intent of the items in this section is to document a number of health conditions that impact the resident's functional status and quality of life. The items include an assessment of pain which uses an interview with the resident or staff if the resident is unable to participate. The pain items assess the presence of pain, pain frequency, effect on function, intensity, management and control. Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, falls, prior surgery, and surgery requiring active SNF care.
- Item J2100 Recent Surgery Requiring Active SNF Care- completed for 5-day PPS and OBRA assessments.
- J2300 – J5000 Surgical Procedures- complete only if J2100= Yes.
- Documentation is needed to justify answers.

# J0100: Pain Management: Scheduled and PRN Pain Medication, Non-pharmacological Pain Interventions

- 5-day look back period
- Data to answer the 3 questions in this item come from the medical record review and interviews
- Interventions are included as part of a care plan
- There must be documentation that the intervention(s) were received and results assessed
- Interventions do not have to be successful to be counted
- F697 in SOM Appendix PP, Pain Management

# Non-Medication Pain Interventions

- Scheduled and implemented non-pharmacological interventions include, but are not limited to, biofeedback, application of heat/cold, massage, physical therapy, nerve block, stretching and strengthening exercises, chiropractic, electrical stimulation, radiotherapy, ultrasound and acupuncture.
- Herbal or alternative medicine products are not included in this category.
- Alternatives need to be carefully planned and evaluated for effectiveness.

# J0300-J0600: Resident Pain Interview

- The look-back period on these items is 5 days. Because this item asks the resident to recall pain during the past 5 days, this assessment should be conducted close to the end of the 5- day look-back period; preferably on the day before, or the day of the ARD. This should more accurately capture pain episodes that occur during the 5-day look-back period.
- Attempt to conduct the interview with all residents
- The Pain Interview is not contingent upon B0700.
- Use the resident's preferred language. If not verbal, offer writing, sign or cue cards.
- Use the resident's terminology for pain-such as hurting, aching, burning.
- Code for the presence or absence of pain regardless of main management efforts.
- The resident's reported pain scale is independent of the medication received during the look-back.

# J0800-J0850: Staff Assessment for pain

- Do not complete the Staff Interview if the resident interview should have been attempted- and it was not attempted.

# J1100: Shortness of Breath

- **Item Rationale**

- Shortness of breath can be an extremely distressing symptom to residents and lead to decreased interaction and quality of life.
- Some residents compensate for shortness of breath by limiting activity. They sometimes compensate for shortness of breath when lying flat by elevating the head of the bed and do not alert caregivers to the problem.
- Shortness of breath can be an indication of a change in condition requiring further assessment and should be explored.
- The care plan should address underlying illnesses that may exacerbate symptoms of shortness of breath as well as symptomatic treatment for shortness of breath when it is not quickly reversible.

# J1100: Shortness of Breath

- **Steps for Assessment**

- Interview the resident about shortness of breath.
- If the resident is not experiencing shortness of breath or trouble breathing during the interview, ask the resident if shortness of breath occurs when he or she engages in certain activities.
- Review the medical record for staff documentation of the presence of shortness of breath or trouble breathing.
- Observe the resident for shortness of breath or trouble breathing.
- If shortness of breath or trouble breathing is observed, note whether it occurs with certain positions or activities.

# J1300: Current Tobacco Use

- **Includes tobacco used in any form**
  - Does not include vaping, nicotine patches
- **Planning for Care**
  - This item opens the door to negotiation of a plan of care with the resident that includes support for smoking cessation.
  - If cessation is declined, a care plan that allows safe and environmental accommodation of resident preferences is needed.



# J1400: Prognosis

- Coding Instructions
  - Code 0, no: if the medical record does not contain physician documentation that the resident is terminally ill and the resident is not receiving hospice services.
  - Code 1, yes: if the medical record includes physician documentation:
    - that the resident is terminally ill; or
    - the resident is receiving hospice services.

# J1700: Fall History on Admission or Reentry

- Falls, especially a recent fall, recurrent falls, and falls with significant injury are the most important predictors of risk for future falls,
- Ask the resident and family/significant other about falls in the last 6 months.
- Review inter-facility transfer information.
- Review all relevant medical records for evidence of one or more falls in the previous 6 months.

# J1800 Falls Since Admission/Entry or Prior Assessment (OBRA or Scheduled PPS)

- If this is the first assessment/entry or reentry (A0310E = 1), review the medical record for the time period from the admission date to the ARD.
- If this is not the first assessment/entry or reentry (A0310E = 0), the review period is from the day after the ARD of the last MDS assessment to the current ARD.
- Any fall since the last MDS, even if it occurred while out in the community, in an acute hospital, or in the nursing home.
- Review incident reports, fall logs and the medical record.
- Ask the resident and family about falls during the look-back period even if not documented in the medical record.

# What are you calling a fall?

- An unintentional change in position coming to rest on the ground, floor or onto the next lower surface.
- Falls are not a result of an overwhelming external force.
- An intercepted fall occurs is still considered a fall.
- A resident found of the floor or ground without knowledge of how they got there, is a fall.
- CMS understands that challenging a resident's balance and training him/her to recover from a loss of balance is an intentional therapeutic intervention and does not consider anticipated losses of balance that occur during supervised therapeutic interventions as intercepted falls.

# J1900: Falls Since Admission or Most Recent MDS-Without or With Injury

- J1900A-No injury
  - No evidence of injury seen; no c/o pain or injury, no change in resident behavior after the fall.
- J1900B-Injury (except major)
  - Skin tears, abrasions, lacerations, superficial bruises, hematomas, and sprains; or any fall-related injury that causes the resident to complain of pain.
- J1900C-Major Injury
  - Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma.

# Language at J1900

- It is important to ensure the accuracy of the level of injury resulting from a fall. Since injuries can present themselves later than the time of the fall, the assessor may need to look beyond the ARD to obtain the accurate information for the complete picture of the fall that occurs in the look back of the MDS.
- Review any follow-up medical information received pertaining to the fall, even if this information is received after the ARD (e.g., emergency room x-ray, MRI, CT scan results), and ensure that this information is used to code the assessment.
- If the level of injury directly related to a fall that occurred during the look-back period is identified after the ARD and is at a different injury level than what was originally coded on an assessment that was submitted to the QIES ASAP, the assessment must be modified to update the level of injury that occurred with that fall.

# J2000-5000: Prior Surgery, Recent Surgery, and Surgical Procedures

- J2000: Only completed for 5-day PPS assessments
  - Generally, major surgery for item J2000 refers to a procedure that meets the following criteria:
    - 1. the resident was an inpatient in an acute care hospital for at least one day in the 100 days prior to admission to the SNF
    - 2. the surgery carried some degree of risk to the resident's life or the potential for severe disability.
- J2100: Recent Surgery Requiring Active SNF Care completed on PPS 5-day and OBRA assessments.
- Need to determine if this surgery requires active care during this stay.
- J2300 through J5000 Surgical Procedures, completed only if J2100= 1 (Yes). Documentation in the medical record is required to justify answers.

# Section J: J2100

## Recent Surgery Requiring Active SNF Care

- Complete only for PPS 5-day or OBRA assessments.
- For PPS: Review the resident's medical record to determine whether the resident had major surgery during the inpatient hospital stay that immediately preceded the resident's Part A admission. Did that surgery require active care?
- For OBRA: Was the resident an inpatient in an acute care hospital for at least one day, and the surgery carried some degree of risk to the resident's life or the potential for severe disability within 30 days of the ARD. Did that surgery require active care? RAI page J-38
- Documentation is needed to justify answers.
- If 1. Yes, proceed to J2300-J5000.



# Section K: Swallowing/Nutritional Status

- 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.

# Section K:

## Swallowing/Nutritional Status

- K0100 Swallowing Disorder: need to observe the resident and ask staff who work with the resident if any of these signs and symptoms were present during the look back period.
- K0200B Weight: Record the weight, on the most recent measure in the last 30 days, *closest* to the ARD.
- K0300 Weight Loss: Since this looks back 6 months, it may not capture weight loss from 3 months ago.
  - This item does not consider weight fluctuation outside of these two time points, although the resident's weight should be monitored on a continual basis and weight loss assessed and addressed on the care plan as necessary.

# Section K (continued)

- K0510 Nutritional Approaches:
  - Column 1, items A, B and Z are required information in North Carolina.
- K0510 A Parenteral/IV feeding: Needs documentation that reflects the need for additional fluids to address nutrition, hydration or prevention.
- K0510B Feeding tube: Only mark this if used for nutrition or hydration.

# K0300: Weight Loss

- 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.
- To code K0300 as 1, yes, the expressed goal of the weight loss diet or the expected weight loss of edema through the use of diuretics must be documented.

# K0510A: Parenteral/IV Feeding

- Include only if given for nutrition or hydration and when there is documentation addressing the need.
  - IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently
  - IV fluids running at KVO (Keep Vein Open)
  - IV fluids contained in IV Piggybacks
  - Hypodermoclysis and subcutaneous ports in hydration therapy

# Section L:

## Oral/Dental Status

- L0200B: No natural teeth or tooth fragments (edentulous). This means complete tooth loss.
- Dentures are not natural teeth.
- Implants are permanently affixed hardware and are considered natural teeth as they are not removable.

## Section L (continued)

- Residents who have some, but not all of their natural teeth, that do not appear damaged, broken, loose, or with obvious or likely cavity and do not have any other conditions in L0200 A-G should be coded at L0200Z, a none of the above.
- Many residents have dentures or partials that fit well and work properly. For individualized care planning purposes, consideration should be taken to make sure residents are in possession of their dentures or partials and that they are being utilized properly for meals, snack , med pass and social activities. Also, the dentures or partials should be properly cared for with regular cleaning and by assuring that they continue to fit properly throughout the resident's stay.

# Section M:

## Skin Conditions

- If a pressure ulcer heals on or before the ARD, it is not captured.
- Wounds do not heal in reverse. Page M-7 discusses back staging.
- M0300E Unstageable-Non-removable dressing/device: Known but not stageable due to non-removable dressing/device. Only code with supporting documentation in the record.
- If a wound was present upon admission, then becomes unstageable, or at a higher stage, then new category was NOT present upon admission.



## Section M (continued)

- M1040 D Open lesion (s) other than ulcers, rashes, cuts: that are not coded elsewhere and develop as a result of a disease process should be coded here.
- Cuts, lacerations, and abrasions are not coded on the MDS.
- M1040 H Moisture Associated Skin Damage (MASD):  
Superficial skin damage. If MASD is present with a PU, only code the pressure ulcer. If the tissue damage extends into the subcutaneous tissues, then code as a pressure ulcer.

## Section M (continued)

### M1200: Skin and Ulcer/Injury Treatments

- M1200 H Applications of ointments/medications other than to feet: Includes barrier creams and skin prep.
- Skin prep to the heel for prevention is not captured on the MDS.
- If skin prep is being used on the heel to treat a DTI, code at M1200 E, Pressure ulcer/injury care.
- Band aids are not coded as dressings.

# Section N: Medications

- Look back period is 7 days or since admission if less than 7 days. The look back does not extend into the preadmission period.
- N0410 Medications Received: Code according to how the medication is classified and not how it is used.
- Examples: Compazine- is an antipsychotic and often used to treat nausea and vomiting.
- Symbyax is a combination medication- fluoxetine (antidepressant) and olanzapine (antipsychotic). Code both medication categories.
- Benzodiazepines: some are classified as anxiolytic and some as hypnotic. Be sure to know which one should be counted where.
- Watch for combination medications like Zestoretic which has HCTZ.

# N0450: Antipsychotic Medication Review Gradual Dose Reduction (GDR)

- Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated. See F758.

# Antipsychotic Medication Review

- N0450A- Did the resident receive antipsychotic medications since admission/entry or the prior OBRA assessment, whichever is more recent?
  - 0. No, not received
  - 1. Yes, received on a routine basis only
  - 2. Yes, received on a PRN basis only
  - 3. Yes, antipsychotics were received on a routine and PRN basis

# N0450: Antipsychotic Medication Review (continued)

- N0450B: Do not include GDRs completed prior to admission.
- Do not count as a GDR an antipsychotic medication reduction performed for the purpose of switching from one antipsychotic to another.
- Discontinuation of an antipsychotic, even without a GDR process, should be coded in N0450B
- The date of the GDR in N0450C is the first day of the dose reduction attempt.

# N0450: Antipsychotic Medication Review (continued)

- N0450B- Has a gradual dose reduction (GDR) been attempted?
- 0. No- skip to physician documented GDR as clinically contraindicated
- 1. Yes- continue to date of last attempted GDR
- N0450C- Date of last attempted GDR

# N0450: Antipsychotic Medication Review (continued)

- N0450D Physician documented GDR as clinically contraindicated
  - 0. No- GDR has no been documented by a physician as clinically contraindicated.
  - 1. Yes- GDR has been documented by a physician as clinically contraindicated, continue to date physician documented GDR as clinically contraindicated
- N0450E- Date physician documented GDR as clinically contraindicated



# Section N

## N2001-2005

- N2001 Drug Regimen Review: Only on the 5-day PPS. Were there any medication issues identified?
- N2003 Medication Follow-up: Only on the 5-day PPS. If any medication issues were identified, was the physician contacted and were actions to correct this issue completed by the next day?
- N2005 Medication Intervention: Only on the PPS discharge. Had any medication issues been identified, the physician contacted, and an action taken since the admission?
- Clinically Significant: wrong medication, dose, time, omission, interactions, duplicate therapy, known allergy, ineffective therapy.

# Section N Resources

- The following resources and tools provide information on medication classifications. Providers are responsible for coding each medication's pharmacological/therapeutic classification accurately.  
From RAI page N-11:
- GlobalRPh Drug Reference, <http://globalrph.com/drug-A.htm>
- USP Pharmacological Classification of Drugs, <http://www.usp.org/usp-healthcareprofessionals/usp-medicare-model-guidelines/medicare-model-guidelines-v50v40#Guidelines6>.
  - Directions: Scroll to the bottom of this webpage and click on the pdf download for “USP Medicare Model Guidelines (With Example Part D Drugs)”
- Medline Plus, <https://www.nlm.nih.gov/medlineplus/druginformation.html>

# Section O: Special Treatments, Procedures, and Programs

- 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.

# 00100: Coding Tips

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

# 00100A: Chemotherapy

- Code any type of chemotherapy agent administered as an antineoplastic given by any route in this item.
- Each medication should be evaluated to determine its reason for use before coding it here. Medications coded here are those actually used for cancer treatment.
  - For example, megestrol acetate is classified as an antineoplastic drug. If megestrol acetate is being given only for appetite stimulation, do not code it as chemotherapy in this item.
  - 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.
- IVs, IV medication, and blood transfusions administered during chemotherapy are not recorded under items K0510A (Parenteral/IV), 00100H (IV Medications), or 00100I (Transfusions).

# 00100 Coding Tips

- B. Radiation: Includes intermittent radiation therapy, as well as radiation administered via radiation implant.
- C. Oxygen therapy: Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia. 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.
- D. 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.
- E. Tracheostomy care: Code cleansing of the stoma, tracheostomy and/or cannula in this item. This item may be coded if the resident performs his/her own tracheostomy care.

# 00100F: 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 unable to support his or her own respiration in this item. During invasive mechanical ventilation the resident's breathing is controlled by the ventilator.
- A resident who has been weaned off of a respirator or ventilator in the last 14 days or is currently being weaned off a respirator or ventilator, should also be coded here.
- Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.

# 00100G: Non-Invasive Mechanical Ventilator (BiPAP/CPAP)

- Code any type of CPAP or BiPAP respiratory support devices that prevent airways from closing by delivering slightly pressurized air through a mask or other device continuously or via electronic cycling throughout the breathing cycle. The BiPAP/CPAP mask/device enables the individual to support his or her own spontaneous respiration by providing enough pressure when the individual inhales to keep his or her airways open, unlike ventilators that “breathe” for the individual.
- If a ventilator or respirator is being used as a substitute for BiPAP/CPAP, code here. This item may be coded if the resident places or removes his/her own BiPAP/CPAP mask/device.



# 00100H: IV Medications

- Code any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item.
- 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.
- Do not code flushes to keep an IV access port patent, or IV fluids without medication here. 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.

# 00100 Coding Tips (continued)

- I. 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.
- J. Dialysis: Code peritoneal or renal dialysis which occurs at the nursing home or at another facility.
- K. Hospice Care: Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.

# 00100M: Isolation or Quarantine for Active Infectious Disease

- Code only when the resident requires transmission-based precautions
  - Is alone in a separate room
  - Has an active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage)
  - Highly transmissible or significant pathogens that have been acquired by physical contact, airborne, or droplet transmission.
- Do not code this item if the resident only has a history of infectious disease (e.g., s/p MRSA or s/p C-Diff - no active symptoms).
- Do not code this item if the precautions are standard precautions, because these types of precautions apply to everyone.

# Code for “single room isolation” only when all of the following conditions are met:

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

# 00250: Influenza Vaccine

- Once the influenza vaccination has been administered to a resident for the current influenza season, this value is carried forward until the new influenza season begins.
- Influenza can occur at any time, but most influenza occurs from October through May. However, residents should be immunized as soon as the vaccine becomes available and continue until influenza is no longer circulating in your geographic area.
- Information about the current influenza season can be obtained by accessing the CDC Seasonal Influenza (Flu) website. This website provides information on influenza activity and has an interactive map that shows geographic spread of influenza: <http://www.cdc.gov/flu/weekly/fluactivitysurv.htm>, <http://www.cdc.gov/flu/weekly/usmap.htm>.
- Facilities can also contact their local health department website for local influenza surveillance information.

# O0300: Pneumococcal Vaccine

- Specific guidance about pneumococcal vaccine recommendations and timing for adults can be found at <https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccinetiming.pdf>.
- “Up to date” in item O0300A means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations. For up-to-date information on timing and intervals between vaccines, please refer to ACIP vaccine recommendations available at <https://www.cdc.gov/vaccines/schedules/hcp/index.html>  
<http://www.cdc.gov/vaccines/hcp/acip-recs/index.html>  
<https://www.cdc.gov/pneumococcal/vaccination.html>

# Pneumococcal Vaccine continued

- If a resident has received one or more pneumococcal vaccinations and is indicated to get an additional pneumococcal vaccination but is not yet eligible for the next vaccination because the recommended time interval between vaccines has not lapsed, O0300A is coded 1, yes, indicating the resident's pneumococcal vaccination is up to date.
- Advisory Committee on Immunization Practices (ACIP)  
Vaccine Recommendations and Guidelines  
<https://www.cdc.gov/vaccines/hcp/acip-recs/index.html>

# 00400 Therapies Coding Tips

- Code only medically necessary therapies that occurred after admission/readmission to the nursing home that were:
  - Ordered by a physician (or an approved extender) based on a qualified therapist's assessment and treatment plan
  - Documented in the resident's medical record, and
  - Care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective.
- Therapy can occur inside or outside the facility



# 00400D: Respiratory Therapy

- Respiratory Therapy: Services that are provided by a qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function.

# 00400D: Respiratory Therapy continued

- Respiratory therapy services include coughing, deep breathing, nebulizer treatments, assessing breath sounds and mechanical ventilation, etc., which must be provided by a respiratory therapist or trained respiratory nurse. A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under the state Nurse Practice Act and under applicable state laws.

# 00400E: Psychological Therapy

- Psychological Therapy: The treatment of mental and emotional disorders through the use of psychological techniques designed to encourage communication of conflicts and insight into problems, with the goal being relief of symptoms, changes in behavior leading to improved social and vocational functioning, and personality growth. Psychological therapy may be provided by a psychiatrist, psychologist, clinical social worker, or clinical nurse specialist in mental health as allowable under applicable state laws.

# 00425: Part A Therapies

- Only completed for PPS Discharge
- Code only medically necessary therapies that occurred after admission/readmission to the nursing home that were:
  - Ordered by a physician (or an approved extender) based on a qualified therapist's assessment and treatment plan
  - Documented in the resident's medical record, and
  - Care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective.
- Therapy can occur inside or outside the facility

# 00500: Restorative Nursing Programs

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

# O0500: Restorative Nursing Programs

- Must meet specific criteria prior to coding
  - Measurable objectives and interventions documented in the care plan and medical record
  - Periodic evaluation by licensed nurse in medical record
  - Nursing assistants/aides/other staff/volunteers must be trained in the techniques that promote resident involvement
  - A nurse must supervise the activities in a nursing restorative program
  - Groups no larger than 4 residents per staff
  - Cannot claim techniques that therapists claim under O0400 A,B or C

# 00600: Physician Exams and 00700: Physician Orders

- CMS does not require completion of this item; however, North Carolina continues to require its completion.
- Do not include exams prior to admission, ER visits, medicine men, or psychologists (O0400E)
- Examinations (full or partial) can occur in the facility or in the physician's office.
- Psychological therapy visits by a licensed psychologist (PhD) should be recorded in O0400E, Psychological Therapy, and should not be included as a physician visit in this section.

# Section P: Restraints and Alarms

- Intent: The intent of this section is to record the frequency that the resident was restrained by any of the listed devices or an alarm was used, at any time during the day or night, during the 7day 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.
- ***DEFINITION PHYSICAL RESTRAINTS:*** Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body (State Operations Manual, Appendix PP).



# Restraints and Alarms

- Any manual method or physical or mechanical device should be classified as a restraint only when it meets the criteria of the physical restraint definition.
  - This can only be determined on a case-by-case basis by individually assessing each and every method or device, attached or adjacent to the resident's body, and the effect it has on the resident.
- Any manual method or physical or mechanical device, material, or equipment that meets the definition of a physical restraint must have:
  - physician documentation of a medical symptom that supports the use of the restraint
  - a physician's order for the type of restraint and parameters of use
  - a care plan and a process in place for systematic and gradual restraint reduction (and/or elimination, if possible), as appropriate.

# Restraints and Alarms (continued)

- A clear link must exist between physical restraint use and how it benefits the resident by addressing the specific medical symptom.
- If it is determined, after thorough evaluation and attempts at using alternative treatments and less restrictive methods, that a physical restraint must still be employed, the medical symptoms that support the use of the restraint must be documented in the resident's medical record, ongoing assessments, and care plans.
- There also must be a physician's order reflecting the use of the physical restraint and the specific medical symptom being treated by its use. The physician's order alone is not sufficient to employ the use of a physical restraint.

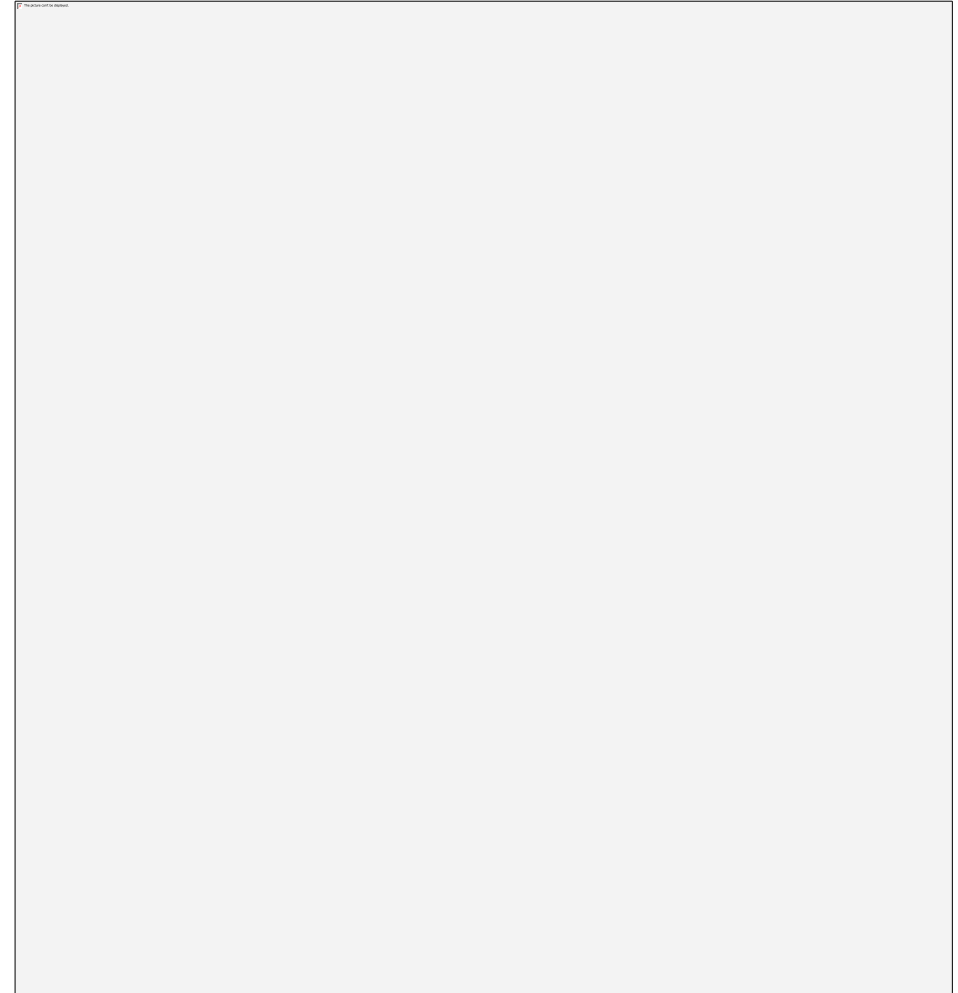
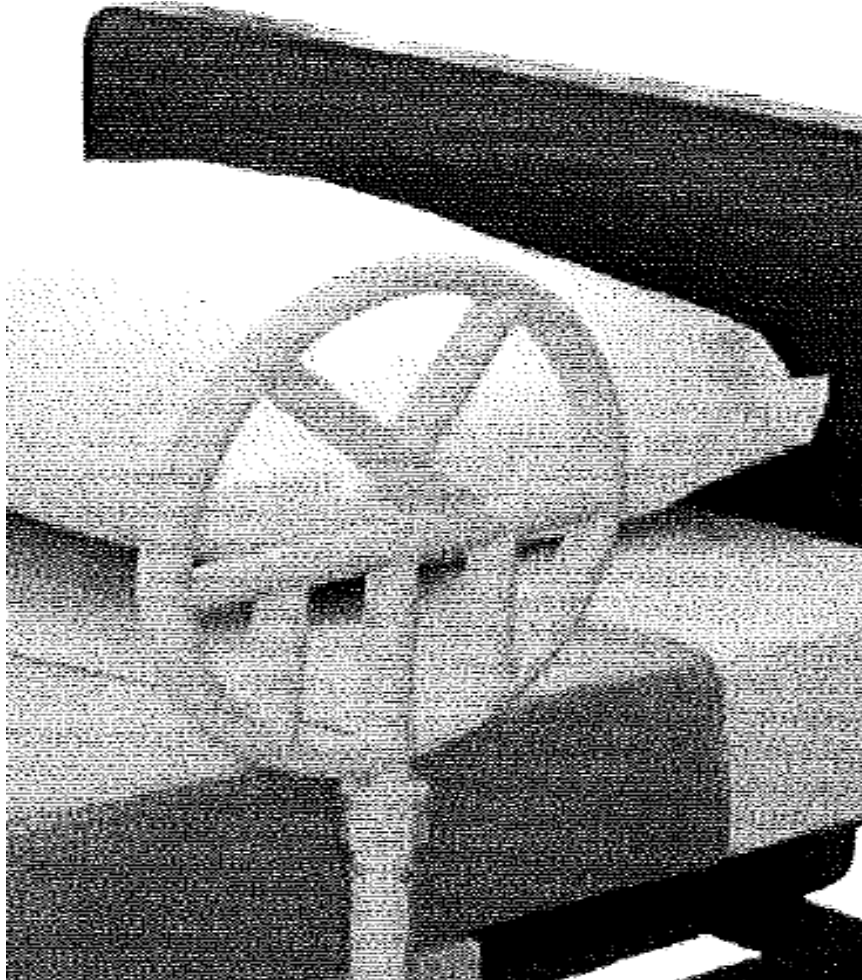
# Bed Rails

- Bed rails include any combination of partial or full rails.
- Bed rails used as positioning devices: If the use of bed rails meet the definition of a physical restraint even though they may improve the resident's mobility in bed, the nursing home must code their use as a restraint.
- Bed rails used with residents who are immobile: If the resident is immobile and cannot voluntarily get out of bed because of a physical limitation, the bed rails do not meet the definition of a physical restraint.
- For residents who have no voluntary movement: Staff need to determine if there is an appropriate use of bed rails. Bed rails may create a visual barrier and deter physical contact from others.

# Bed Rails (continued)

- Some residents have no ability to carry out voluntary movements, yet they exhibit involuntary movements. Involuntary movements, resident weight, and gravity's effects may lead to the resident's body shifting toward the edge of the bed.
  - When bed rails are used in these cases, the resident could be at risk for entrapment. For this type of resident, clinical evaluation of alternatives (e.g., a concave mattress to keep the resident from going over the edge of the bed), coupled with frequent monitoring of the resident's position, should be considered.
- While the bed rails may not constitute a physical restraint, they may affect the resident's quality of life and create an accident hazard.

# Even These Have Caused Injury or Death



# Restraints (continued)

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

# Alarms

- An alarm is any physical or electronic device that monitors resident movement and alerts the staff, by either audible or inaudible means, when movement is detected, and may include bed, chair and floor sensor pads, cords that clip to the resident's clothing, motion sensors, door alarms, or elopement/wandering devices.
- While often used as an intervention in a resident's fall prevention strategy, the efficacy of alarms to prevent falls has not been proven; therefore, alarm use must not be the primary or sole intervention in the plan.
- The use of an alarm as part of the resident's plan of care does not eliminate the need for adequate supervision, nor does the alarm replace individualized, person-centered care planning.
- Adverse consequences of alarm use include, but are not limited to, fear, anxiety, or agitation related to the alarm sound; decreased mobility; sleep disturbances; and infringement on freedom of movement, dignity, and privacy.

# Alarms (continued)

- Steps for Assessment
  - Review the resident's medical record (e.g., physician orders, nurses' notes, nursing assistant documentation) to determine if alarms were used during the 7-day look-back period.
  - Consult the nursing staff to determine the resident's cognitive and physical status/limitations.
  - Evaluate whether the alarm affects the resident's freedom of movement when the alarm/device is in place. For example, does the resident avoid standing up or repositioning himself/herself due to fear of setting off the alarm?
- If an alarm meets the criteria as a restraint, code the alarm use in both P0100, Physical Restraints, and P0200, Alarms.



# Alarms (continued)

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

# Restraints

## Federal Tags

- F604: Right to be free from Physical Restraints. Without medical justification/staff convenience.
- F605: Right to be free from Chemical Restraints
- F700: Bedrails: Accidents hazards, bedrail entrapment issues.

# Section Q: Participation in Assessment and Goal Setting

- Intent: The items in this section are intended to record the participation and expectations of the resident, family members, or significant other(s) in the assessment, and to understand the resident's overall goals.
- Section Q ensures 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.

# Section Q: Participation in Assessment and Goal Setting

- Language for Section Q
- Puts emphasis on the resident's....
  - Civil rights
  - Right to request and receive information on community-based services
  - Request to learn about home and community-based services is not a request for discharge
  - Family support is not always necessary
- Section 504 of the Rehabilitation Act prohibits discrimination based on disability

# Office of Civil Rights-

## May 2016 Guidance to SNFs

- When coding Q0300 Resident's Overall Expectation, the response selected must reflect the resident's perspective if they are able to express it, even if the opinion of family member/significant other or guardian/legally authorized representative differs.
- Coding other than the resident's stated expectation is a violation of the resident's civil rights.
- Unjustified segregation can include nursing home placement when a resident could live in a more integrated setting.

# Discharge Planning Collaboration

- Nursing home staff expected to contact Local Contact Agencies for those residents who express a desire to learn about possible transition back to the community and what care options and supports are available.
- Local Contact Agencies expected to respond to nursing home staff referrals by providing information to residents about available community-based, long-term care supports and services.
- Nursing home staff and Local Contact Agencies expected to meaningfully engage residents in their discharge and transition plan, and collaboratively work to arrange for all of the necessary community-based, long-term care services.

# Q0400: Discharge Plan

- Is active discharge planning already occurring for the resident to return to the community?
- The current care plan has goals specific to discharge
- DC is in the near future (within 3 months)
- Staff are taking active steps to accomplish discharge
- If special equipment, money, etc. is needed then a referral may still be necessary
- Or
- Skip pattern if the is an uncomplicated/expected discharge

# Q0500: Return to Community

Do you want to talk to someone?

- Intent: Provide an opportunity for the resident to get more information and explore the possibility of different settings for receiving care.
- 0. No= Nothing in the chart about Q0500 preference.
- 1. Yes= There is documentation in the record so don't ask again about Return to Community until the next comprehensive > skip to Q0600, Referral



# Q0600: Referral

- Has a referral been made to the Local Contact Agency (LCA)?
- For additional guidance, see CMS' Planning for Your Discharge: A checklist for patients and caregivers preparing to leave a hospital, nursing home, or other health care setting.
- Available at: <https://www.medicare.gov/pubs/pdf/11376-discharge-planning-checklist.pdf>

# The Office of Civil Rights Recommends...

- Review/Revise/Develop policies/procedures on Discharge Planning, MDS administration, and LCA referral process
- Train all members of the IDT on Section Q, and what the area LCA has to offer
- Invite the LCA and community-based service systems in to provide training

# For NC statewide LCA questions:

Steve Strom

- [steve.strom@dhhs.nc.gov](mailto:steve.strom@dhhs.nc.gov)

or

- call 1-855-761-9030

To make a referral

- Care Link at 1-866-271-4894

# Discharge Planning Process should...

- Identify the needs and goals of ***this*** resident
- Include the resident as an active partner
- Emphasize value in moving back to the community
- Ensure a referral is made to the LCA if the resident indicates interest
- Include documentation if discharge to the community is not feasible
- ***Who decided and why***
- Be re-evaluated and updated as necessary

# Section V: Care Area Assessments (CAA)

- Intent: 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.
- Documentation supports your decision.

# CAAs

- A risk factor increases the chances of having a negative outcome or complication. Recognizing the connection among these symptoms and treating the underlying cause(s) to the extent possible, can help address complications and improve the resident's outcome.
- Conversely, failing to recognize the links and instead trying to address the triggers or MDS findings in isolation may have little if any benefit for the resident with complex or mixed causes of impaired behavior, cognition and mood.
- Not all triggers identify deficits or problems. Some triggers indicate areas of resident strengths, and possible approaches to improve function or minimize decline.

# The CAA Process Should...

- Consider each resident as a whole, with unique characteristics and strengths that affect his or her capacity to function
- Identify areas that may warrant interventions
- Help develop interventions to improve, stabilize, or prevent decline in physical, functional, and psychosocial well-being, choices, and preferences for interventions

# Each Triggered CAA Should Describe...

- The issue/problem for this resident and why is it a problem
  - Complications affecting or caused by the care area
  - Risk factors related to the presence of the condition
  - Factors to be considered in developing individualized care plan interventions
  - The need for additional evaluation as appropriate
  - The resource(s), or assessment tool(s) used for decision-making, and conclusions that arose from performing the CAA
- 
- See Appendix C for CAA Triggers



# CAAs

- Step 1: For any triggered care area, assess the resident using the care area-specific resources.
- Step 2: Check the box in the left column if the item is present for this resident. ***Some of this information will be on the MDS - some will not.***
- Step 3: In the right column you can provide a summary of supporting documentation regarding the basis or reason for checking a particular item or items. This could include the location and date of that information, symptoms, possible causal and contributing factor for item checked, etc.

# CAAs

Step 4: Get input from resident and/or family regarding the care area.

Step 5: Analyze the findings for this care area in the context of this resident as an individual. Draw conclusions about the causal/contributing factors and effect(s) on the resident and document these conclusions in the Analysis of Findings section.

# CAAs

Step 6: Decide whether referral to other disciplines is warranted and document this decision.

Step 7: Document the Care Planning Decision

Step 8: Use the “Location and Date of CAA Documentation” (at V0200 A) to note where the CAA summary can be found

# CAAs

## **For each triggered CAA describe:**

1. Identified nature of the condition and why it's a problem
2. Complications caused by the care area for this person
3. Risk factors related to the condition that affect the decision to care plan/or not to care plan
4. Factors to consider in developing *individualized* care plan interventions, including decision to care plan or not to care plan
5. The need additional evaluation by the physician and other health professionals, as appropriate;
6. The resource(s), or assessment tool(s) used for decision-making

# CAA Documentation

- CAA documentation helps to explain the basis for the care plan by showing how the IDT determined that the underlying causes, contributing factors, and risk factors were related to the care area condition for a specific resident; for example, the documentation should indicate the basis for these decisions, why the finding(s) require(s) an intervention, and the rationale(s) for selecting specific interventions.
- Based on the review of the comprehensive assessment, the IDT and the resident and/or the resident's representative determine the areas that require care plan intervention(s) and develop, revise, or continue the individualized care plan. F553

# CAA Documentation

- Relevant documentation for each triggered CAA describes:
- Causes and contributing factors;
- The nature of the issue or condition (may include presence or lack of objective data and subjective complaints). In other words, what exactly is the issue/problem for this resident and why is it a problem;
- Complications affecting or caused by the care area for this resident;
- Risk factors related to the presence of the condition that affects the staff's decision to proceed to care planning;

# CAA Documentation

- Factors that must be considered in developing individualized care plan interventions, including the decision to care plan or not to care plan various findings for the individual resident;
- The need for additional evaluation by the attending physician and other health professionals, as appropriate;
- The resource(s), or assessment tool(s) used for decision-making, and conclusions that arose from performing the CAA;
- Completion of Section V (CAA Summary; see Chapter 3 for coding instructions) of the MDS.

# A Smooth Transition to the Care Plan



- **A good assessment is the starting point for good clinical problem solving and decision making and ultimately for the creation of a sound care plan.**

**The CAAs provide a link between the MDS and care planning. The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving.**



# Care Area Assessments (CAAs)

- The CAA process provides a framework for guiding the review of triggered areas, and clarification of a resident's functional status and related causes of impairments.

It also provides a basis for additional assessment of potential issues, including related risk factors.

The assessment of the causes and contributing factors gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care.

# Care Planning

- No required format or structure
- Must have measurable goals and timetables
  - Goals should have a subject, verb, modifier, time frame and goal
- Approaches should identify what staff are to do and when to do it and when it will be evaluated by the nurse for possible changes

<i><b>Subject</b></i>	<i><b>Verb</b></i>	<i><b>Modifiers</b></i>	<i><b>Time frame</b></i>	<i><b>Goal</b></i>
Mr. Jones <b>OR I</b>	will walk	fifty feet daily with the help of one nursing assistant	the next 30 days	in order to maintain continence and eat in the dining area

# The Overall CP Should Be Oriented Toward:

1. Preventing avoidable declines in functioning or clarifying why another goal takes precedence (e.g. palliative care for end of life).
2. Managing risk factors or indicating the limits of such interventions.
3. Ways to try to preserve and build upon resident strengths.
4. Applying current standards of practice in care planning.
5. Evaluating measurable objectives, timetables and outcomes.
6. Respecting the resident's right to decline treatment.
7. Offering alternative treatments, as applicable.

## (cont.) CP Should Be Oriented Toward:

8. Using an appropriate interdisciplinary approach to care plan development to improve the resident's functional abilities.
9. Involving resident, resident's family and other resident representatives as appropriate.
10. Assessing and planning for care to meet the resident's medical, nursing, mental and psychosocial needs.
11. Involving the direct care staff with the care planning process relating to the resident's expected outcomes.
12. Addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting.

# Step/Objective

# Key Tasks

## **Recognition / Assessment**

*Gather essential information about the individual*

- Identify and collect information that is needed to identify an individual's conditions that enables proper definition of their conditions, strengths, needs, risks, problems, and prognosis
- Obtain a personal and medical history
- Perform a physical assessment

## **Problem definition**

*Define the individual's problems, risks, and issues*

- Identify any current consequences and complications of the individual's situation, underlying condition and illnesses, etc.
- Clearly state the individual's issues and physical, functional, and psychosocial strengths, problems, needs, deficits, and concerns
- Define significant risk factors

# Step/Objective

# Key Tasks

## **Diagnosis / Cause-and-effect analysis**

*Identify physical, functional, and psychosocial causes of risks, problems, and other issues, and relate to one another and to their consequences*

- Identify causes of, and factors contributing to, the individual's current dysfunctions, disabilities, impairments, and risks
- Identify pertinent evaluations and diagnostic tests
- Identify how existing symptoms, signs, diagnoses, test results, dysfunctions, impairments, disabilities, and other findings relate to one another
- Identify how addressing those causes is likely to affect consequences

## **Identifying goals and objectives of care**

*Clarify purpose of providing care and of specific interventions, and the criteria that will be used to determine whether the objectives are being met*

- Clarify prognosis
- Define overall goals for the individual
- Identify criteria for meeting goals

# Step/Objective

# Key Tasks

## **Selecting interventions / planning care**

*Identify and implement interventions and treatments to address the individual's physical, functional, and psychosocial needs, concerns, problems, and risks*

- Identify specific symptomatic and cause-specific interventions (physical, functional, and psychosocial)
- Identify how current and proposed treatments and services are expected to address causes, consequences, and risk factors, and help attain overall goals for the individual
- Define anticipated benefits and risks of various interventions
- Clarify how specific treatments and services will be evaluated for their effectiveness and possible adverse consequences

## **Monitoring of progress**

*Review individual's progress towards goals and modify approaches as needed*

- Identify the individual's response to interventions and treatments
- Identify factors that are affecting progress towards achieving goals
- Define or refine the prognosis
- Define or refine when to stop or modify interventions
- Review effectiveness and adverse consequences related to treatments
- Adjust interventions as needed
- Identify when care objectives have been achieved sufficiently to allow for discharge, transfer, or change in level of care

# Summary: Decision Making / Documentation

- Formulate clear picture of the resident
- Create a resident-centered care plan
  - Based on conclusions from clinical problem solving and decision-making process AND
  - Resident preferences, personal goals
- Document basis for conclusions
  - Not just conclusions



# Section X: Correction Request

- Intent: The purpose of Section X is to identify an MDS record to be modified or inactivated. 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 Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system.
- Corrections/modifications should be made within 14 days of discovery and submitted within 14 days of the attestation date.

# Section X (continued)

## Major vs Minor Errors

- **Check your validation reports.**
- Significant Error is an error in an assessment where:
  - 1. the resident's overall clinical status is not accurately represented and
  - 2. the error has not been corrected via submission of a more recent assessment.
- Minor errors are all other errors related to coding the MDS.

# Section X (continued)

## Correcting Significant Errors

- When any significant error is discovered in an OBRA comprehensive or Quarterly assessment in the QIES/ASAP system, the nursing home must take the following actions to correct the OBRA assessment:
- Create a corrected record with all items included, not just the items in error.
- Complete the required correction request section X items and include with the corrected record. Item A0050 should have a value of 2, indicating a modification request.
- Submit this modification request record.
- Perform a new Significant Correction to Prior Assessment (SCPA) or Significant Change in Status Assessment (SCSA) and update the care plan as necessary.

# Section X (continued)

## A0050: Modifications

- Create a corrected MDS record with all item included, not just the items in error.
- Complete Section X (correction request) to identify the record that needs to be modified, and include with the corrected record.
- Submit both the Section X and the corrected record to QIES ASAP.
- A hard copy of the Section X must be kept with corrected paper copies of the MDS record in the clinical file to track changes. A hard copy of Section X should also be kept with any inactivated record.

# Inactivation vs. Modification

- Modification can be used for most items
- Entry and discharge dates, ARD when it was a typographical error and when type of assessment does not change the item set.
- Inactivation needs to be followed by a new record with a new ARD.
- Correction/Deletion request is required to correct: Unit Certification or Licensure Designation (A0410).
- Accidental transmission of a resident who never entered the facility.
- The facility must submit a written request to the state MDS Coordinator to have these problems fixed. See chapter 5 pages 13-14 for more information.

# Section Z: Assessment Administration

- The intent of the items in this section is to provide billing information and signatures of persons completing the assessment.
- Rational: Used to capture the Patient Driven Payment Model (PDPM) case mix version code followed by Health Insurance Prospective Payment System (HIPPS) modifier based on type of assessment.

# HIPPS Codes

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

# HIPPS Codes

- 1st Character: PT/OT Payment Group
- 2nd Character: SLP Payment Group
- 3rd Character: Nursing Payment Group
- 4th Character: NTA Payment Group
- 5th Character: Assessment Indicator Code
- See RAI Chapter 6: MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM (SNF PPS)
- <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPayment/PDPM.html>



# Section Z: Assessment Administration

- Z0400: Signatures 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.
  - Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident's status. Penalties may be applied for submitting false information.

# Assessment Administration continued

- Z0500: Signature of the RN Assessment Coordinator
  - 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.

# Signature Date

- Signature Date:
  - Gathering information from staff, family or significant others about the resident's status should be done after the observation period ends so as to capture information from the entire look back period.
  - All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed.
  - If a staff member cannot sign Z0400 on the same day that they completed a section or portion of a section, when the staff member signs, use the date the item originally was completed.

# Transmitting MDS Data

- From RAI page 5-1:
- Assessments that are completed for purposes other than OBRA and SNF PPS reasons are not to be submitted, e.g., private insurance, including but not limited to Medicare Advantage Plans.

# Validation Reports

- *Please* review your transmission validation reports regularly.
  - Reviewing will help you identify and correct errors
  - Reviewing will help prevent “missing assessments” and duplicate folders in the CMS data base
  - Reviewing will help ensure the facility will be paid

# Validation Report References

- **CASPER Reporting User's Guide For MDS Providers** is available at:  
<https://qtso.cms.gov/reference-and-manuals/casper-reporting-users-guide-mds-providers>
- **MDS 3.0 Provider User's Guide** is available at:  
<https://qtso.cms.gov/reference-and-manuals/mds-30-provider-users-guide>

**This was one facility with inconsistencies resulting in 3 accounts in the CMS database**

## **1. Entry Tracker**

**Record:** Accepted  
**Res\_Int\_ID:** 5---2  
**A0300A:** 0 **A0300B:**  
**A0310A:** 99 **A0310B:** 99  
**A0310C:** **A0310D:**  
**A0310E:** 0 **A0310F:** 01  
**A0310G:** ^ **A0310H:** 0  
**Name:** A  
**A0050:** NEW RECORD  
**Target Date:** 02/17

## **2. Admission Assessment**

**Record:** Accepted  
**Res\_Int\_ID:** 5---43  
**A0300A:** 0 **A0300B:**  
**A0310A:** 01 **A0310B:** 99  
**A0310C:** **A0310D:**  
**A0310E:** 1 **A0310F:** 99  
**A0310G:** ^ **A0310H:** 0  
**Name:** A  
**A0050:** NEW RECORD  
**Target Date:** 02/24  
**MDS 3.0 Item(s):** Current Record Type, Prior Record: A0310A, A0310B, A0310F  
**Item Values:** OBRA Admission, MDS 3.0: , ,  
**Message Number:** -1018 WARNING  
**Message:** Inconsistent Record Sequence: Under CMS sequencing guidelines, the type of assessment in this record does not logically follow the type of assessment in the record received prior to this one.

**This was one facility with inconsistencies resulting in 3 accounts in the CMS database**

### **3. Discharge Return Not Anticipated**

### **Result:**

**Record:** Accepted  
**Res\_Int\_ID:** 5---93  
**A0300A:** 0 **A0300B:**  
**A0310A:** 99 **A0310B:** 99  
**A0310C:** **A0310D:**  
**A0310E:** 0 **A0310F:** 10  
**A0310G:** 1 **A0310H:** 0  
**Name:** A  
**A0050:** NEW RECORD  
**Target Date:** 03/18  
**MDS 3.0 Item(s):** Current Record Type, Prior Record:  
A0310A, A0310B, A0310F  
**Item Values:** OBRA Discharge, MDS 3.0: , ,  
**Message Number:** -1018 WARNING  
**Message:** Inconsistent Record Sequence: Under CMS sequencing guidelines, the type of assessment in this record does not logically follow the type of assessment in the record received prior to this one.

Same person, all assessments with different dates of birth



5-day PPS, First assessment, DCRA, unplanned, PPS DC

**Record:** Accepted

**A0310A:** 99 **A0310B:** 01

**A0310C:** **A0310D:**

**A0310E:** 1 **A0310F:** 11

**A0310G:** 2 **A0310H:** 1

**Name:** B

**A0050:** NEW RECORD

**Target Date:** 10/10

**MDS 3.0 Item(s):** K0200B

**Item Values:** -

**Message Number:** -3897 WARNING

**Message:** Payment Reduction Warning: If A0310B equals 01 or 08, then a dash (-) submitted in this quality measure item may result in a payment reduction for your facility of two percentage points for the affected payment determination.

Weight dashed

# Entry Tracker

**Record:** Accepted

**A0300A:** 0 **A0300B:**

**A0310A:** 99 **A0310B:** 99

**A0310C:** **A0310D:**

**A0310E:** 0 **A0310F:** 01

**A0310G:** ^ **A0310H:** 0

**Name:** C

**A0050:** NEW RECORD

**Target Date:** 10/2

**MDS 3.0 Item(s):** A0600A (SSN)

**Item Values:** Old: 4---4 New: 4---2

**Message Number:** -1031 WARNING

**Message:** Resident Information Mismatch: Submitted value(s) for the item(s) listed do not match the values in the QIES ASAP database. If the record was accepted, the resident information in the database was updated. Verify that the new information is correct.

**MDS 3.0 Item(s):** Facility ID (FAC\_ID)

**Item Values:** New: 9--3

**Message Number:** -1032 WARNING

**Message:** Resident Provider Updated: Our records indicated that a different provider previously cared for this resident. The provider associated with this resident was updated. Please verify.

# Entry Tracker

**Record:** Rejected

**A0300A:** 0 **A0300B:**

**A0310A:** 99 **A0310B:** 99

**A0310C:** **A0310D:**

**A0310E:** 0 **A0310F:** 01

**A0310G:** ^ **A0310H:** 0

**Name:** D

**A0050:** NEW RECORD

**Target Date:** 10/9

**MDS 3.0 Item(s):** A0600B (Medicare Beneficiary Number)

**Item Values:** xxx

**Message Number:** -3913 FATAL

**Message:** Incorrect Medicare Beneficiary Identifier (MBI): The MBI or Medicare Number format is invalid.

-  
SSN was in MBI

DCRA, Unplanned

**Record:** Accepted

**A0300A:** 0 **A0300B:**

**A0310A:** 99 **A0310B:** 99

**A0310C:** **A0310D:**

**A0310E:** 0 **A0310F:** 11

**A0310G:** 2 **A0310H:** 0

**Name:** E

**A0050:** NEW RECORD

**Target Date:** 12/14

**MDS 3.0 Item(s):** Z0500B, A2300

**Item Values:** 01/06, 12/14

**Message Number:** -3749a WARNING

**Message:** Assessment Completed Late: Z0500B (assessment completion date) is more than 14 days after A2300 (assessment reference date).

# Admission Assessment, First Assessment

**Record:** Accepted

**A0300A:** 0 **A0300B:**

**A0310A:** 01 **A0310B:** 99

**A0310C:** **A0310D:**

**A0310E:** 1 **A0310F:** 99

**A0310G:** ^ **A0310H:** 0

**Name:** F

**A0050:** NEW RECORD

**Target Date:** 12/25/2020

**MDS 3.0 Item(s):**

A0310A (admission),

V0200B2 (RN signature date),

A1600 (entry date)

5-dayPPS, CAA signature date,  
Entry date

**Item Values:** 01,

01/07/2021, 12/18/2020

**Message:** Care Plan Completed Late: For this Admission assessment (A0310A equals 01), V0200B2 (CAA process signature date) is more than 13 days after A1600 (entry date).

**MDS 3.0 Item(s):** A0310A, Z0500B, A1600

**Item Values:** 01, 01/04/2021, 12/18/2020

**Message Number:** -3749d WARNING

**Message:** Assessment Completed Late: For this Admission assessment (A0310A equals 01), Z0500B (completion date) is more than 13 days after A1600 (entry date).

**MDS 3.0 Item(s):** Z0100B, RECALCULATED Z0100B

**Item Values:** 1.0008, 1.0009

**Message Number:** -3935b WARNING

**Message:** Incorrect RUG/PDPM Version: The submitted value of the RUG/PDPM version code does not match the value calculated by the QIES ASAP System.

# 5-day PPS, first assessment, modification of previous assessment

**Record:** Accepted

**A0300A:** 0 **A0300B:**

**A0310A:** 99 **A0310B:** 01

**A0310C:** **A0310D:**

**A0310E:** 1 **A0310F:** 99

**A0310G:** ^ **A0310H:** 0

**Name:** G

**A0050:** MODIFICATION

**Target Date:** 12/25

**Attestation Date (X1100E):**  
01/12

**MDS 3.0 Item(s):** Target Date, A0300A, A0310A, A0310B, A0310F, A0310H, O0400A6

**Item Values:** Previous: 12/26/2020, 0, 99, 01, 11, 1, 20201226 (ARD, 5-day, DCRA, PPS-DC, Therapy end date)  
New: 12/25/2020, 0, 99, 01, 99, 0, ----- (ARD change, 5-day, DCRA-removed, PPS-DC removed, Therapy end date)

**Message Number:** -1061 WARNING

**Message:** A change in the target date and/or RFA in combination with a change in the clinical item listed may indicate improper coding. Other clinical items may also have changed.

**MDS 3.0 Item(s):** **Item Values:** 1.0008, 1.0009Z0100B,  
RECALCULATED Z0100B

**Message Number:** -3935b WARNING

**Message:** Incorrect RUG/PDPM Version: The submitted value of the RUG/PDPM version code does not match the value calculated by the QIES ASAP System

# Admission, 5-day PPS, first assessment

Record: Rejected

A0200: 1 A0300A: 0 A0300B: A0310A: 01 A0310B: 01 A0310C: A0310D:  
A0310E: 1 A0310F: 99 A0310G: ^ A0310H: 0

Name: H

A0050: NEW RECORD Target Date: 10/26

Message Number: -1007 FATAL

Message: Duplicate Assessment: The submitted record is a duplicate of a previously accepted record.

# Contact Information

- Janet Brooks, RAI Education Coordinator
  - 919-909-9256
  - [janet.brooks@dhhs.nc.gov](mailto:janet.brooks@dhhs.nc.gov)
- 
- Sandra McLamb, IT Automation Coordinator
  - 919-855-3352
  - [sandra.mclamb@dhhs.nc.gov](mailto:sandra.mclamb@dhhs.nc.gov)



# Thank you!

- Thank you for all of the work you do to ensure the care, comfort and safety of our most vulnerable in society. This is not an easy job you do, and it must come from the heart. Weariness and frustration can easily become your best friends, but don't let them take over! Know that you are not alone in your work. Reach out, make friends and contacts who will encourage your soul. Please know that you are welcome to call or email me anytime. Sincerely, Janet