

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Effective Date: 10/01/10
Section: Nursing Facility	Section: 36.12	
Subject: Case Mix Guidelines	Pages: 37 Cross Reference: Resident Assessment Minimum Data Set (MDS) 36.11	

Note to the Provider: All federal requirements must be met. In addition, sections contained herein may be more stringent and will supersede the federal requirements for the Resident Assessment Instrument. It is the responsibility of the provider to be in compliance with both the federal and State requirements.

One of the primary aims of the Division of Medicaid (DOM) is the provision of an equitable payment system based on consistent data. At the core of this system are the Minimum Data Set (MDS 3.0) resident assessment instrument and its accurate completion.

The RUG-III classification system has seven major classification groups: Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavioral Problems, and Reduced Physical Function. The seven groups are further divided by the intensity of the resident's activities of daily living (ADL) needs and, in the Clinically Complex category, by the presence of depression; and in the Impaired Cognition, Behavioral and Physical Functioning categories, by the provision of restorative nursing services.

A calculation worksheet was developed in order to provide clinical staff with a better understanding of how the RUG-III classification system works. The worksheet translates the software programming into plain language to assist staff in understanding the logic behind the classification system. A copy of the calculation worksheet for the Mississippi RUG-III Classification system for nursing facilities can be found at the end of this section.

SEVEN MAJOR M³PI RUG-III CLASSIFICATION GROUPS	
MAJOR RUG-III GROUP	CHARACTERISTICS ASSOCIATED WITH MAJOR RUG-III GROUP
Rehabilitation	Residents receiving physical, speech or occupational therapy.
Extensive Services	Residents receiving complex clinical care or with complex clinical needs such as IV feeding or medications, suctioning, tracheostomy care, ventilator/respirator and co morbidities that make the resident eligible for other RUG categories.
Special Care	Residents receiving complex clinical care or with serious medical conditions such as multiple sclerosis, quadriplegia, cerebral palsy, respiratory therapy, multiple ulcers, stage 3 or 4 pressure ulcers, radiation, surgical wounds or open lesions, tube feeding and aphasia, fever with dehydration, pneumonia, vomiting, weight loss or tube feeding.
Clinically Complex	Residents receiving complex clinical care or with conditions requiring skilled nursing management and interventions for conditions and treatments such as burns, coma, septicemia, pneumonia, foot problems/wounds, internal bleeding, dehydration, tube feeding, oxygen, transfusions, hemiplegia, chemotherapy, dialysis, physician visits/order changes.

Impaired Cognition	Residents having cognitive impairment in decision-making, temporal orientation, recall and short-term memory.
Behavioral Problems	Residents who experience hallucinations or delusions, display physical, verbal or other behavioral symptoms, wandering and/or rejection of care.
Reduced Physical Function	Residents whose needs are primarily for activities of daily living and general supervision.

M³PI-Mississippi Case Mix Categories (5.20)

Major Categories

MDS 3.0 Item

Extensive Care (One or More) ADL Score >6 (See ADL Index)

Parenteral/IV Feeding	K0500A
Suctioning	O0100D2
Tracheostomy Care	O0100E2
Ventilator or Respirator	O0100F2
IV Medications	O0100H2

Rehabilitation (One or More) ADL Score 4-18

Speech, Occupational and/or Physical	O0400A1, 2, 3 & 4; O0400B1, 2, 3 & 4; O0400C1, 2, 3 & 4;
A. Received 150 minutes or more per week At least 5 days of therapy per week (Any combination of the three disciplines)	
or	
B. Received 45 minutes or more per week At least 3 days of any combination of the 3 therapies per week With 2 or more Nursing Rehabilitation/Restorative care practices, each for at least 15 minutes, each for at least 6 days	

Special Care (One or More) ADL Score > 6 (See ADL index)

Ulcers; 2 or more of ANY type ulcer with Selected Skin Care Treatment (2 or more)	M0300A, B1-F1≥ 1 M1030≥1 M1200A-E, G-H=1
or	
Stage 3 or 4 Pressure Ulcer with Selected Skin Care Treatment (2 or More)	M0300C1, D1, F1≥1 M1200A-E, G-H=1
or	
Feeding Tube and Aphasia	K0500B=1 I4300=1

and Parenteral/Enteral Intake* (K0700A=3) or (K0700A=2 and K0700B=2)	K0700A=2,3 K0700B=2
or Surgical Wounds	M1040E=1
and Surgical Wound Care	M1200F=1
or Application of non-surgical dressings (with or without medications) other than to feet	M1200G=1
or Application of Ointments	M1200H=1
or Open Lesions (other than ulcers, rashes and/or cuts)	M1040D=1
and Surgical Wound Care	M1200F=1
or Application of non-surgical dressings(with or without medications) other than to feet	M1200G=1
or Application of Ointments	M1200H=1
or Respiratory Therapy x 7 days	O0400D2=7
or Cerebral Palsy with ADL >9	I4400=1
or Fever	J1550A=1
and Vomiting	J1550B=1
or Weight Loss	K0300=1,2
or Pneumonia	I2000=1
or Dehydration	J1550C=1
or Feeding Tube	K0500B=1
and Parenteral/Enteral Intake* (K0700A=3) or (K0700A=2 and K0700B=2)	K0700A=2,3 K0700B=2
or Multiple Sclerosis with ADL >9	I5200=1
or Quadriplegia with ADL >9	I5100=1
or Radiation Therapy	O0100B2=1

***51% + calories or 26%+ calories and 501+cc per day intake**

Clinically Complex (One or More)

Residents who meet the criteria for Extensive or Special Care category
and an ADL score of 6 or less.

or Dehydration	J1550C=1
or Hemiplegia/Hemiparesis and ADL>9	I4900=1
or Internal Bleeding	J1550D=1

or Pneumonia	I2000=1
or Chemotherapy	O0100A2=1
or Dialysis	O0100J2=1
or Transfusions	O0100I2=1
or Oxygen Therapy	O0100C2=1
or Physician Order changes on 4 or more days and Physician Examinations on 1 or more days	O0700=4-14 O0600=1-14
or Physician Order changes on 2 or more days and Physician Examinations on 2 or more days	O0700=2-14 O0600=2-14
or Diabetes and Injections on 7 Days and Physician Order changes on 2 or more days	I2900=1 N0300=7 O0700=2-14
or Feeding Tube and Parenteral/Enteral Intake* (K0700A=3) or (K0700A=2 and K0700B=2)	K0500B=1 K0700A=2,3 K0700B=2
*51%+ calories or 26%+ calories and 501+ cc per day intake	
or Comatose/Persistent Vegetative State and Totally Dependent in Bed Mobility and Totally Dependent in Transferring and Totally Dependent in Eating and Totally Dependent in Toilet Use	B0100=1 G0110A1=4,8 G0110B1=4,8 G0110H1=4,8 G0110I1 =4,8
or Septicemia	I2100=1
or Burns (Second or Third Degree)	M1040F=1
or Infection of Foot and Foot Dressing	M1040A=1 M1200I=1
or Diabetic Foot Ulcer and Foot Dressing	M1040B=1 M1200I=1
or	

Open Lesion on Foot and Foot Dressing	M1040C=1 M1200I=1
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Impaired Cognition (ADL sum of 10 or less)

Combination of the Following Items:

Short Term Memory Problem	C0700=1
Cognitive Skills for Daily Decision Making	C1000=1,2,3
Making Self Understood	B0700=1,2,3

Combinations include;

- C0700=1 and C1000=1 and B0700=2
- C0700=1 and C1000=1 and B0700=3
- C0700=1 and C1000=2
- C0700=1 and B0700=2
- C0700=1 and B0700=3
- C1000=1 and B0700=2
- C1000=1 and B0700=3
- C1000=2 and B0700=1
- C1000=2 and B0700=2
- C1000=2 and B0700=3
- C1000=3

or

Brief Interview for Mental Status (BIMS) Summary Score	C0500 ≤9
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BIMS Summary Score is derived from the values of the following items:

- C0200 Repetition of Three Words
- C0300A Able to report correct year
- C0300B Able to report correct month
- C0300C Able to report correct day of week
- C0400A Able to recall "sock"
- C0400B Able to recall "blue"
- C0400C Able to recall "bed"

Behavioral Problems (one or more) ADL sum of 10 or less

Hallucinations	E0100A=1
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or

Delusions	E0100B=1
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or

Physical Behavior on 4 or more days	E0200A≥2
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or

Verbal Behavior on 4 or more days	E0200B≥2
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or

Other Behavior on 4 or more days	E0200C≥2
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or

Rejection of Care 4 or more days	E0800≥2
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or
Wandering on 4 or more days

E0900≥2

Physical Functioning (reduced function) ADL sum of 4-18

Residents who do not meet the criteria for any of the categories previously described shall be classified in the Physical Functioning categories. Additional splits are established for residents receiving Nursing Rehabilitation/Restorative care practices. ADL scores determine final category.

Extensive Category Splits

Once the resident qualifies for Extensive by having O0100D2 or O0100H2 or O0100E2 or O0100F2 or K0500A and an ADL score equal to or greater than 7, the following counter is used to determine the splits:

Start the counter at zero	0
If the resident qualifies for Special Care	Add 1
If the resident qualifies for Clinically Complex	Add 1
If the resident qualifies for Impaired Cognition	Add 1
If the resident has Parenteral/IV Feeding (K0500A=1)	Add 1
If the resident has IV Medications (O0100H2=1)	Add 1

The counter can be zero (0) to five (5).
A count of zero (0) or one (1) puts the resident in SE1.
A count of two (2) or three (3) puts the resident in SE2.
A count of four (4) or five (5) puts the resident in SE3.

Please note that O0100D2, O0100E2 and O0100F2 will qualify the resident for Extensive but none of these items add to the counter for the splits. Also, if the ADL score is 4-6, then resident falls to Special Care (this is the only case where a resident with an ADL of 4-6 will qualify for the Special Care category.)

Depression Criteria

Resident Mood Interview (PHQ-9[®] *)

PHQ-9[®] Total Severity Score D0300≥9.5

PHQ-9[®] Total Severity Score is derived from the values of the following items:

- D0200A2 Little interest or pleasure in doing things.
- D0200B2 Feeling down, depressed, or hopeless.
- D0200C2 Trouble falling or staying asleep or sleeping too much.
- D0200D2 Feeling tired or having little energy.
- D0200E2 Poor appetite or overeating.
- D0200F2 Feeling bad about yourself-or that you are a failure or have let yourself your family down.
- D0200G2 Trouble concentrating on things, such as reading the newspaper watching television.
- D0200H2 Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.
- D0200I2 Thoughts that you would be better off dead, or of hurting yourself in some way.

or

Staff Assessment of Resident Mood (PHQ-9-OV^{®*})

PHQ-9-OV[®] Total Severity Score D0600≥9.5

PHQ-9-OV[®] Total Severity Score is derived from the values of the following items:

- D0500A2 Little interest or pleasure in doing things
- D0500B2 Feeling or appearing down, depressed, or hopeless
- D0500C2 Trouble falling or staying asleep, or sleeping too much
- D0500D2 Feeling tired or having little energy
- D0500E2 Poor appetite or overeating
- D0500F2 Indicating that s/he feels bad about self, is a failure, or has let self or family down.
- D0500G2 Trouble concentrating on things, such as reading the newspaper or watching television.
- D0500H2 Moving or speaking so slowly that other people have noticed. Or the opposite- being so fidgety or restless that s/he has been moving around a lot more than usual.
- D0500I2 States that life isn't worth living, wishes for death, or attempts to harm self
- D0500J2 Being short-tempered, easily annoyed

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Rehabilitation/Restorative Nursing Criteria

Techniques/Practices (2 or more provided)

Range of Motion - Passive* O0500A≥6

or

Range of Motion - Active* O0500B≥6

or

Splint or Brace Assistance* O0500C≥6

or

Training/Skill Practice in Bed Mobility* O0500D≥6

or

Training/Skill Practice in Transfers* O0500E≥6

or

Training/Skill Practice in Walking* O0500F≥6

or

Training/Skill Practice in Dressing/Grooming* O0500G≥6

or

Training/Skill Practice in Eating/Swallowing* O0500H≥6

or

Amputation/Prosthesis Care* O0500I≥6

or

Communication* O0500J≥6

or

Toileting Program H0200C=1

or

Bowel Toileting Program H0500=1

***Each provided for at least 15 minutes, at least 6 of the past 7 days.**

ADL Dependency Index

Determining ADL Scores

Bed Mobility Coding	ADL Score
G0110A1=-,0,1,7	1
G0110A1=2	3
G0110A1=3,4,8 AND G0110A2=-,0,1,2	4
G0110A1=3,4,8 AND G0110A2=3,8	5
Transfer Coding	ADL Score
G0110B1=-,0,1,7	1
G0110B1=2	3
G0110B1=3,4,8 AND G0110B2=-,0,1,2	4
G0110B1=3,4,8 AND G0110B2=3,8	5
Toileting Coding	ADL Score
G0110I1=-,0,1,7	1
G0110I1=2	3
G0110I1=3,4,8 AND G0110I2=-,0,1,2	4
G0110I1=3,4,8 AND G0110I2=3,8	5
Eating Coding	ADL Score
G0110H1=-,0,1,7	1
G0110H1=2	2
G0110H1=3,4,8	3
K0500A=1	3
K0500B=1 and (K0700A=3)	3
K0500B=1 and (K0700A=2 and K0700B=2)	3

Scores from each of the four areas are summed for the total ADL score.

Lowest score = 4 (1+1+1+1), Highest score = 18 (5+5+5+3)

Mississippi Case Mix Index for M3PI version 5.20 – 10/01/10			
Group	Description	Regular Index	Access Incentive Index
SE3	Extensive Special Care 3 / ADL>6	2.839	2.896
SE2	Extensive Special Care 2 / ADL>6	2.316	2.362
SE1	Extensive Special Care 1 / ADL>6	1.943	1.982
RAD	Rehab. All Levels / ADL 17-18	2.284	2.330
RAC	Rehab. All Levels / ADL 14-16	1.936	1.975
RAB	Rehab. All Levels / ADL 10-13	1.772	1.807
RAA	Rehab. All Levels / ADL 4-9	1.472	1.501
SSC	Special Care / ADL 17-18	1.877	1.915
SSB	Special Care / ADL 15-16	1.736	1.771
SSA	Special Care / ADL 7-14 (Extensive 4-6)	1.709	1.743
CC2	Clinically Complex w/Depression / ADL 17-18	1.425	1.454
CC1	Clinically Complex / ADL 17-18	1.311	1.337
CB2	Clinically Complex w/Depression / ADL 12-16	1.247	1.272
CB1	Clinically Complex / ADL 12-16	1.154	1.177
CA2	Clinically Complex w/Depression / ADL 4-11	1.043	1.064
CA1	Clinically Complex / ADL 4-11	0.934	0.953
IB2	Cognitively Impaired w/ Nursing Rehab. / ADL 6-10	1.061	1.082
IB1	Cognitively Impaired / ADL 6-10	0.938	0.957
IA2	Cognitively Impaired w/ Nursing Rehab. / ADL 4-5	0.777	0.777
IA1	Cognitively Impaired / ADL 4-5	0.703	0.703
BB2	Behavior Problems w/ Nursing Rehab. / ADL 6-10	1.021	1.041
BB1	Behavior Problems / ADL 6-10	0.866	0.883
BA2	Behavior Problems w/ Nursing Rehab. / ADL 4-5	0.750	0.750
BA1	Behavior Problems / ADL 4-5	0.612	0.612
PE2	Physical Functioning w/ Nursing Rehab. / ADL 16-18	1.188	1.212
PE1	Physical Functioning / ADL 16-18	1.077	1.077
PD2	Physical Functioning w/ Nursing Rehab. / ADL 11-15	1.095	1.117
PD1	Physical Functioning / ADL 11-15	0.990	0.990
PC2	Physical Functioning w/ Nursing Rehab. / ADL 9-10	0.937	0.956
PC1	Physical Functioning / ADL 9-10	0.865	0.865
PB2	Physical Functioning w/ Nursing Rehab. / ADL 6-8	0.824	0.841
PB1	Physical Functioning / ADL 6-8	0.749	0.749
PA2	Physical Functioning w/ Nursing Rehab. / ADL 4-5	0.637	0.637
PA1	Physical Functioning / ADL 4-5	0.575	0.575
BC1	RUG3/M ³ PI not calculated due to errors	0.575	0.575

Documentation Guidelines

<p>B0100</p>	<p>Comatose/ Persistent Vegetative State</p>	<p>This item is coded to record whether the resident’s clinical record includes a documented neurological diagnosis of coma or persistent vegetative state.</p> <p>COMATOSE (coma): A pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; he/she does not open his/her eyes, does not speak and does not move his/her extremities on command or in response to noxious stimuli (e.g., pain).</p> <p>PERSISTENT VEGETATIVE STATE: Sometimes residents, who were comatose after an anoxic-ischemic injury (i.e., not enough oxygen to the brain) from a cardiac arrest, head trauma, or massive stroke, regain wakefulness but do not evidence any purposeful behavior or cognition. Their eyes are open, and they may grunt, yawn, pick with their fingers, and have random body movements. Neurological exam shows extensive damage to both cerebral hemispheres.</p> <p>Documentation in the clinical record, within the observation period, must:</p> <ul style="list-style-type: none"> • Indicate that a physician, nurse practitioner or clinical nurse specialist has a documented physician’s diagnosis of coma or persistent vegetative state that is applicable during the observation period. • Have a relationship to the resident’s current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. • Be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.
<p>B0700</p>	<p>Makes Self Understood</p>	<p>This item is coded to record the ability to express or communicate requests, needs, and opinions and to conduct social conversation in his or her primary language, whether in speech, writing, sign language, gestures or a combination of these.</p> <p>Documentation in the clinical record, within the observation period, must:</p> <ul style="list-style-type: none"> • Include a description of the resident’s ability to make self understood • Be consistent with physician and interdisciplinary notes, interventions and the plan of care.

<p>C0100</p> <p>C0200</p> <p>C0300</p> <p>C0400</p> <p>C0500</p>	<p>Brief Interview for Mental Status (BIMS)</p> <p>Repetition of Three Words</p> <p>Temporal Orientation</p> <p>Recall</p> <p>Summary Score</p>	<p>This item is coded to determine the ability to remember both recent and long-past events (i.e.; short-term and long-term memory) and to think coherently.</p> <p>Documentation in the clinical record, within the observation period, must:</p> <ul style="list-style-type: none"> • Include an exact description of the resident’s responses. • Be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care. <p>Record the maximum number of words that the resident correctly repeated on the first attempt. This will be any number between 0 and 3.</p> <p>Record the resident’s response to year, month and day of the week.</p> <p>Record the resident’s ability to recall the three words that were initially presented.</p> <p>Record the total score for questions C0200—C0400. Enter 99 if unable to complete the interview.</p> <p>Total score reflects cognitive status:</p> <ul style="list-style-type: none"> • 13—15 Cognitively intact • 08—12 Moderately impaired • 00—07 Severe impairment
<p>C0700</p>	<p>Short Term Memory</p>	<p>This item is coded to determine the functional capacity to remember recent events and assess the mental state of residents who cannot be interviewed.</p> <p>Documentation in the clinical record, within the observation period, must:</p> <ul style="list-style-type: none"> • Include an exact description of the resident’s responses • Be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.



C1000	Cognitive Skills for Daily Decision Making	<p>This item is coded to record the actual performance in making everyday decisions about tasks or activities of daily living.</p> <p>Documentation in the clinical record, within the observation period, must include:</p> <ul style="list-style-type: none">• A description of the resident's ability to make everyday decisions about the tasks or activities of daily living.• The supervision or assistance required to make decisions.• The frequency of the impaired decision making process.• The resident's documented performance must also be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.
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D0200	Resident Mood Interview (PHQ-9®) Copyright © Pfizer Inc. All rights reserved.	Items contained in this section are coded to record the presence and frequency of symptoms of depression. The PHQ-9® provides a standardized severity score and a rating for evidence of a depressive disorder. Documentation in the clinical record, within the observation period, must: <ul style="list-style-type: none"> • Have an exact description of the resident’s responses and symptom frequency. • Be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and mood/ behavior records. • Have a plan of care in place for each mood coded with specific interventions addressing each symptom(s).
D02001	Symptom Presence	This item is coded to record the resident’s response to the presence of the mood symptoms (D0200A—D0200I).
D02002	Symptom Frequency	This item is coded to record the resident’s response to the frequency for the occurrence of the mood symptoms (D0200A—D0200I).
D0200A-D0200I	Symptom(s)	A. Little interest or pleasure in doing things. B. Feeling down, depressed, or hopeless. C. Trouble falling or staying asleep or sleeping too much. D. Feeling tired or having little energy. E. Poor appetite or overeating. F. Feeling bad about yourself-or that you are a failure or have let yourself or your family down. G. Trouble concentrating on things, such as reading the newspaper or watching television. H. Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual. I. Thoughts that you would be better off dead, or of hurting yourself in some way.
D0300	Total Severity Score	Records the total frequency score for questions D0200A2—D0200I2. Enter 99 if unable to complete the interview. Responses to PHQ-9® can indicate possible depression. The Total Severity Score can be interpreted as follows: <ul style="list-style-type: none"> A. 01—04 Minimal depression B. 05—09 Mild depression C. 10—14 Moderate depression D. 15—19 Moderately severe depression E. 20—27 Severe depression

D0500	Staff Assessment of Resident Mood (PHQ-9-OV®) Copyright © Pfizer Inc. All rights reserved.	The PHQ-9-OV® Staff Assessment of Mood is completed so that any behaviors, signs, or symptoms of mood distress are identified and treated. Documentation in the clinical record, within the observation period, must: <ul style="list-style-type: none"> • Have an exact description of the resident's responses, staff observations and symptom frequency. • Be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and mood/ behavior records. • Have a plan of care in place for each mood coded with specific interventions addressing each symptom(s).
D05001	Symptom Presence	This item is coded to record the staff's assessment of the resident for the presence of mood symptoms (D0500A—D0500J).
D05002	Symptom Frequency	This item is coded to record the staff's assessment for the frequency of occurrence of the resident's mood symptoms (D0500A—D0500J).
D0500A-D0500J	Symptom(s)	A. Little interest or pleasure in doing things. B. Feeling or appearing down, depressed, or hopeless. C. Trouble falling or staying asleep, or sleeping too much. D. Feeling tired or having little energy. E. Poor appetite or overeating. F. Indicating that s/he feels bad about self, is a failure, or has let self or family down. G. Trouble concentrating on things, such as reading the newspaper or watching television. H. Moving or speaking so slowly that other people have noticed; or the opposite- being so fidgety or restless that s/he has been moving around a lot more than usual. I. States that life isn't worth living, wishes for death, or attempts to harm self. J. Being short-tempered, easily annoyed.
D0600	Total Severity Score	Records the total frequency score for questions D0500A2—D0500J2. Responses to PHQ-9-OV® can indicate possible depression. The Total Severity Score can be interpreted as follows: <ul style="list-style-type: none"> A. 01—04 Minimal depression B. 05—09 Mild depression C. 10—14 Moderate depression D. 15—19 Moderately severe depression E. 20—30 Severe depression

Section E	Psychosis and Behavioral Symptoms	<p>These items are coded to identify behavioral symptoms in the last seven days that cause distress to the resident, or are distressing or disruptive to facility residents, staff members or the care environment. This section focuses on the resident's actions, not the intent of his or her behavior.</p> <p>These documentation requirements apply to items E0100A—E0900.</p> <p>Documentation in the clinical record, within the observation period, must include:</p> <ul style="list-style-type: none"> • A specific description, frequency and impact of the hallucination/delusion experienced by the resident. • Follow-up evaluation and care plan interventions developed to improve behavioral symptoms and/or reduce their impact. • Documentation must also be consistent with physician orders, progress notes, interdisciplinary notes, treatment records, mood/ behavior records and the plan of care.
E0100A	Hallucinations	The perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch.
E0100B	Delusions	A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary.
E0200A	Physical behavioral symptoms directed toward others	This includes, but not limited to: hitting, kicking, pushing, scratching, grabbing, and/or abusing others sexually.
E0200B	Verbal behavioral symptoms directed toward others	This includes, but not limited to: threatening, screaming and/or cursing at others.
E0200C	Other behavioral symptoms not directed toward others	This includes, but not limited to: physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, verbal/vocal symptoms like screaming, and/or disruptive sounds.
E0800	Rejection of care— Presence & Frequency	<p>This includes potential behavioral problems that interrupts or interferes with the delivery or receipt of care by disrupting the usual routines or processes by which care is given, or by exceeding the level or intensity of resources that are usually available for the provision of care.</p> <ul style="list-style-type: none"> • Does not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and/or determined to be consistent with resident values, preferences, or goals.

E0900	Wandering—Presence & Frequency	<p>Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place without a specified course or known direction.</p> <ul style="list-style-type: none"> • Wandering may be aimless. The wandering resident may be oblivious to his or her physical or safety needs. Alternatively, the resident may have a purpose such as searching to find something, but he or she persists without knowing the exact direction or location of the object, person or place. The behavior may or may not be driven by confused thoughts or delusional ideas (e.g., when a resident believes she must find her mother, who staff knows is deceased). • Does not include pacing.
G01101	ADL Self-Performance	<p>These items are coded to record the resident's self-care performance for bed mobility, transfers, eating, and toileting activities of daily living during the last seven days. This is a measure of what the resident actually did, not what he or she might be capable of doing.</p> <ul style="list-style-type: none"> • Code for resident's performance over all shifts. • A description of each ADL aspect, as applicable to the individual resident, must be documented in the clinical record within the observation period. • The resident's participation in any ADL aspects, as applicable to the individual resident, must be documented. • Although it is not necessary to document the actual number of times the activity occurred, it is necessary to document whether or not the activity occurred three or more times within the last 7 days. • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.
G01102	ADL Support	<p>These items are coded to measure the type and highest level of support, provided by staff, for bed mobility, transfers, eating, and toileting activities of daily living over the last seven days, even if that level of support only occurred once.</p> <ul style="list-style-type: none"> • Code for the most support provided over all shifts. • A description of the support provided (no help, set-up help, one person physical assist, two+ persons physical assist and/or did not occur) for each of the ADL aspects, as applicable to the individual resident, must be documented in the clinical record within the observation period. • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.

H0200C	Current toileting program or trial	<p>This item is coded to gather information on the use of and response to urinary training programs. “Program” refers to a specific approach that is organized, planned, documented, monitored and evaluated and is consistent with the nursing homes’ policies and procedures and current standards of practice.</p> <p>Documentation in the clinical record must include:</p> <ul style="list-style-type: none"> • Implementation of an individualized, resident-specific toileting program that is based on an assessment of the resident’s unique voiding pattern; and • Evidence that the individualized program is communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report; and • Notation of the resident’s response to the toileting program and subsequent evaluations as needed. <p>Toileting program (or trial toileting) does not refer to:</p> <ul style="list-style-type: none"> • Simply tracking continence status. • Changing the resident’s pads or wet garments. • Random assistance with toileting or hygiene.
H0500	Bowel Toileting Program	<p>This item is coded to gather information on the use of and response to a bowel toileting program. “Program” refers to a specific approach that is organized, planned, documented, monitored and evaluated and is consistent with the nursing homes’ policies and procedures and current standards of practice.</p> <p>Documentation in the clinical record must include:</p> <ul style="list-style-type: none"> • Implementation of an individualized, resident-specific toileting program that is based on an assessment of the resident’s unique bowel function pattern; and • Evidence that the individualized program is communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report; and • Notation of the resident’s response to the toileting program and subsequent evaluations as needed. <p>Toileting program does not refer to:</p> <ul style="list-style-type: none"> • Simply tracking continence status. • Changing the resident’s pads or soiled garments. • Random assistance with toileting or hygiene.
Section I	Active Diagnoses	<p>Diagnoses that have a direct relationship to the resident’s functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the observation period.</p> <p>These documentation requirements apply to items I2000—I5200.</p> <p>Documentation in the clinical record must include:</p> <ul style="list-style-type: none"> • A current physician diagnosis. • Signs and symptoms specific to the diagnosis and/or problem. • Treatment and interventions • Documentation must also be consistent with radiological reports, laboratory reports, positive study, tests or procedures, physician orders, progress notes, interdisciplinary notes, treatment records, mood/ behavior records and the plan of care.

I2000	Pneumonia	A disease of the lungs characterized by inflammation and consolidation followed by resolution and caused by infection or irritants.
I2100	Septicemia	Invasion of the bloodstream by virulent microorganisms from a focus of infection that is accompanied by chills, fever, and prostration and often by the formation of secondary abscesses in various organs.
I2900	Diabetes Mellitus	A variable disorder of carbohydrate metabolism caused by a combination of hereditary and environmental factors and usually characterized by inadequate secretion or utilization of insulin, by excessive urine production, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight.
I4300	Aphasia	Loss or impairment of the power to use or comprehend words usually resulting from brain damage.
I4400	Cerebral Palsy	A disability resulting from damage to the brain before, during, or shortly after birth and outwardly manifested by muscular incoordination and speech disturbances.
I4900	Hemiplegia or Hemiparesis	Total or partial paralysis of one side of the body that results from disease of or injury to the motor centers of the brain.
I5100	Quadriplegia	An abnormal condition characterized by paralysis of both arms and legs and the trunk of the body below the level of the associated injury to the spinal cord. This disorder is usually caused by a spinal cord injury in the area of the fifth to seventh cervical vertebrae. Automobile accidents and sporting mishaps are common causes.
I5200	Multiple Sclerosis	A demyelinating disease marked by patches of hardened tissue in the brain or the spinal cord and associated especially with partial or complete paralysis and jerking muscle tremor.
	Diagnoses Reference:	Merriam Webster Medical Dictionary website http://www.intelihealth.com/IH/ihtIH/WSIH/9276/9276.html

J1550A	Fever	<p>This item is coded to record a fever which is defined as a temperature of 2.4 degrees F higher than the baseline. The resident's baseline temperature should be established prior to the Assessment Reference Date.</p> <ul style="list-style-type: none"> • Documented temperatures must be utilized when identifying a baseline temperature. • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.
J1550B	Vomiting	<p>This item is coded to record the regurgitation of stomach contents; may be caused by many factors (e.g., drug toxicity, infection, psychogenic).</p> <ul style="list-style-type: none"> • Frequency of episodes and accompanying symptoms must be documented. • Description of the vomitus must be documented. • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.
J1550C	Dehydration	<p>This is a condition that occurs when fluid output exceeds fluid intake. Code this item if the resident has two or more of the following indicators over the last 7 days.</p> <ul style="list-style-type: none"> • Resident usually takes in less than the recommended 1,500 ml. of fluids daily (water or liquids in beverages and water in high fluid content foods such as gelatin and soups). • Resident has one or more clinical signs of dehydration, including but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset of confusion, fever, or abnormal laboratory values (e.g. elevated hemoglobin and hematocrit, potassium chloride, sodium, albumin, blood urea nitrogen, or urine specific gravity). • Resident's fluid loss exceeds the amount of fluids he/she takes in (e.g. loss from vomiting, fever, diarrhea that exceeds fluid replacement). <p>Documentation in the clinical record, within the observation period, must include:</p> <ul style="list-style-type: none"> • Clinical signs and symptoms of the illness. • Interventions and treatments. • Documentation must also be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.

J1550D	Internal Bleeding	<p>This item is coded to record bleeding that may appear as frank (such as bright red blood) or occult (such as guaiac positive stools). Clinical indicators include black, tarry stools, vomiting “coffee grounds”, hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed) that requires packing. However, nose bleeds that are easily controlled should not be coded in internal bleeding.</p> <p>Documentation in the clinical record, within the observation period, must include:</p> <ul style="list-style-type: none"> • The source and characteristics/description of the bleeding. • Treatment and interventions. • Documentation must also be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.
K0300	Weight Loss	<p>This item is coded to record a 5% or more weight loss in the past 30 days or a 10% or more weight loss in the past 180 days.</p> <ul style="list-style-type: none"> • Weight loss should be monitored and recorded at least monthly. • Percentages of weight loss during the past 30 and past 180 days must be documented. • Weight loss should be assessed and care planned at the time of detection and not delayed until the next MDS assessment. • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.
K0500A	Parenteral/IV Feeding	<p>This item is coded to record the introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous) during the last 7 days.</p> <ul style="list-style-type: none"> • Includes only substances administered for nutrition or hydration. • Documentation in the clinical record must include physician’s order, time, type, amount, and rate of administration. • Do not include fluids administered solely as flushes or for the reconstitution of medications for IV administration unless there is a documented need for additional fluid intake for nutrition and/or hydration. • Do not include fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay. • Do not include fluids administered in conjunction with chemotherapy or dialysis. • Do not include additives, such as electrolytes and insulin that are added to TPN or IV fluids. • Documentation in the clinical record must reflect that alternative nutritional approaches are monitored to validate effectiveness. • Care planning must include periodic reevaluation of the appropriateness of the approach.

K0500B	Feeding Tube	<p>This item is coded to record the presence of any type of tube that can deliver food, nutritional substances, fluids, medications directly into the gastrointestinal system during the last 7 days.</p> <p>Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, and percutaneous endoscopic gastrostomy (PEG) tubes.</p> <ul style="list-style-type: none"> • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care. • Documentation in the clinical record must include time, type, amount, and rate of administration. • Documentation in the clinical record must reflect that alternative nutritional approaches are monitored to validate effectiveness. • Care planning must include periodic reevaluation of the appropriateness of the approach.
K0700A	Percent Intake by Artificial Route—Calories	<p>This item is coded to record the proportion of total calories the resident received through parenteral or tube feeding during the last 7 days.</p> <ul style="list-style-type: none"> • Documentation in the clinical record must include intake records to determine actual caloric intake through parenteral or tube feeding routes. • Proportion of calories received through artificial routes should be monitored with periodic reassessment to ensure adequate nutrition and hydration. • Oral intake must be documented. • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.
K0700B	Percent Intake by Artificial Route—Fluids	<p>This item is coded to record the average fluid intake the resident received through parenteral or tube feeding during the last 7 days.</p> <ul style="list-style-type: none"> • Documentation in the clinical record must include intake records to determine actual fluid intake through parenteral or tube feeding routes. • Fluid intake received through artificial routes should be monitored with periodic reassessment to ensure adequate nutrition and/or hydration. • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.

M0300	Unhealed Pressure Ulcers	<p>A pressure ulcer is defined as a lesion(s) caused by unrelieved pressure that result(s) in damage to the underlying tissues. Pressure ulcers occur when tissue is compressed between a bony prominence and an external surface.</p> <p>These documentation requirements apply to items M0300A—M0300F1:</p> <ul style="list-style-type: none"> • Ulcer staging should be based on the ulcer’s deepest visible anatomical level. Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a deeper stage than what is observed now, it should continue to be classified at the deeper stage. A detailed historical description (length, depth, width, stage) of the ulcer at the deeper stage must be included in the clinical record. • A detailed current description that includes, but is not limited to, the size (length, width, and depth), stage and the location must be documented in the clinical record within the observation period. • The care plan should include individualized interventions and evidence that the interventions have been monitored and modified as appropriate. • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care. • Facility wound reports that are not part of the resident’s clinical record are not acceptable for reimbursement.
M0300A	Number of Stage 1 Pressure Ulcers	This item is coded to record the number of unhealed stage 1 pressure ulcers. A stage 1 ulcer is defined as: intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.
M0300B1	Number of Stage 2 Pressure Ulcers	This item is coded to record the number of unhealed stage 2 pressure ulcers. A stage 2 ulcer is defined as: partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or opened/ruptured blister.
M0300C1	Number of Stage 3 Pressure Ulcers	This item is coded to record the number of unhealed stage 3 pressure ulcers. A stage 3 ulcer is defined as: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
M0300D1	Number of Stage 4 Pressure Ulcers	This item is coded to record the number of unhealed stage 4 pressure ulcers. A stage 4 ulcer is defined as: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may present on some parts of the wound bed. Often includes undermining and tunneling.

M0300F1	Number of Unstageable Pressure Ulcers— Slough and/or Eschar	<p>This item is coded to record the number of known pressure ulcers that are not stageable due to coverage of wound bed by slough and/or eschar.</p> <p>Staging should be determined once enough slough and/or eschar is removed to expose the base of the wound and the true depth/stage.</p>
M1030	Number of Venous and Arterial Ulcers	<p>This item is coded to record the number of venous and arterial ulcers.</p> <p>Venous ulcers are caused by peripheral venous disease, which most often commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg.</p> <p>Arterial ulcers are caused by peripheral arterial disease, which commonly occur on the tips of toes, top of the foot, or distal to the medial malleolus.</p> <p>The wound does not typically occur over a bony prominence, and pressure forces play virtually no role in the development of these ulcers. Lower extremity and foot pulses may be diminished or absent.</p> <p>Documentation in the clinical record, within the observation period, must include:</p> <ul style="list-style-type: none"> • A detailed description that includes, but is not limited to, the stage of the ulcer, the size (length, width, and depth), and the location. • A care plan with individualized interventions and evidence that the interventions have been monitored and modified as appropriate. • Documentation must also be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care. • Facility wound reports that are not part of the resident's clinical record are not acceptable for reimbursement.
M1040	Other Ulcers, Wounds and Skin Problems	<p>These items are coded to record other ulcers, wounds and skin problems present during the last 7 days. (Pressure ulcers coded in M0200 through M0900 should not be coded here.)</p> <p>These documentation requirements apply to items M1040A—M1040F.</p> <p>Documentation in the clinical record, within the observation period, must include:</p> <ul style="list-style-type: none"> • A detailed description of the skin impairment (infection, ulcer, surgical wound, lesion or burn) that includes, but is not limited to, the type, location, size, depth, appearance, etc. • A care plan with individualized interventions and evidence that the interventions have been monitored and modified as appropriate. • Documentation must also be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care. • Facility wound reports that are not part of the resident's clinical record are not acceptable for reimbursement.

M1040A	Infection of the foot	Includes but is not limited to cellulitis and/or purulent drainage. <ul style="list-style-type: none"> Do not code infections located on the ankle. The ankle is not part of the foot.
M1040B	Diabetic foot ulcer	Diabetic foot ulcers are caused by the neuropathic and small blood vessel complications of diabetes. These ulcers typically occur over the planter (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudates, and callused wound edges. <ul style="list-style-type: none"> Do not code ulcers located on the ankle. The ankle is not part of the foot.
M1040C	Other open lesion(s) on the foot	Includes but is not limited to cuts, ulcers and/or fissures. <ul style="list-style-type: none"> Does not include an open lesion on the ankle.
M1040D	Open lesion(s) other than ulcers, rashes and/or cuts	Typically skin ulcers that develop as a result of diseases and conditions such as syphilis and cancer. <ul style="list-style-type: none"> Does not include pressure ulcers, diabetic foot ulcers, venous ulcers, arterial ulcers, rashes or cuts.
M1040E	Surgical Wounds	Any healing or non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. <ul style="list-style-type: none"> This category does not include healed surgical sites, stomas or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds. Do not code pressure ulcers that have been surgically debrided as surgical wounds. This coding is appropriate for pressure ulcers that are surgically repaired with grafts and/or flap procedures.
M1040F	Burn(s)	Second or third degree burn(s) are defined as skin and tissue injury caused by heat or chemicals and may be in any stage of healing. <ul style="list-style-type: none"> Type, cause, detailed description and tissue involvement must be documented in the clinical record within the observation period.

M1200	Skin and Ulcer Treatments	<p>These items are coded to record general skin treatment, basic pressure ulcer prevention and skin health interventions that were provided during the last 7 days</p> <p>These documentation requirements apply to items M1200A—M1200I.</p> <p>Documentation in the clinical record, within the observation period, must include:</p> <ul style="list-style-type: none"> • A description and the frequency of the specific care/treatment provided. • A care plan with individualized interventions and evidence that the interventions have been monitored and modified as appropriate. • Documentation must also be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.
M1200A	Pressure Reducing Device for Chair	<p>Equipment that aims to relieve pressure away from areas of high risk. May include foam, air, water gel, or other cushioning placed on a chair, wheelchair or bed.</p> <ul style="list-style-type: none"> • Does not include egg crate cushions of any type. • Do not include doughnut or ring devices in chairs.
M1200B	Pressure Reducing Device for Bed	
M1200C	Turning/ Repositioning Program	<p>A consistent program for changing the resident’s position and realigning the body.</p> <ul style="list-style-type: none"> • “Program” is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident’s needs. • The program should specify the intervention (e.g. reposition on side, pillows between knees) and frequency (e.g. every 2 hours). • Progress notes, assessments and other documentation (as directed by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.
M1200D	Nutrition/ Hydration Interventions	<p>Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions, e.g., wheat free diet to prevent allergic dermatitis, high calorie diet with added supplements to prevent skin breakdown, high protein supplements for wound healing.</p>
M1200E	Ulcer Care	<p>Interventions for treating pressure ulcers.</p> <ul style="list-style-type: none"> • May include the use of topical dressings, chemical or surgical debridement, wound irrigations, wound vacuum assisted closure (VAC), and/or hydrotherapy.

M1200F	Surgical Wound Care	<p>Surgical wound care may include any intervention for treating or protecting any type of surgical wound.</p> <ul style="list-style-type: none"> Includes topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application.
M1200G	Application of non-surgical dressings (with or without medications) other than to feet	<p>Dressings do not have to be applied daily in order to be coded on the MDS assessment. Code any dressing meeting the MDS definitions, if applied even once during the last 7 days.</p> <ul style="list-style-type: none"> Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles. Do not code dressings for pressure ulcers on the foot in this item. Application of a dressing to the ankle should be included in this item.
M1200H	Application of ointments/ Medications (other than to feet)	<p>Ointments or medications used to treat a skin condition.</p> <ul style="list-style-type: none"> Includes topical creams, powders, and liquid sealants used to treat or prevent skin conditions. This does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain).
M1200I	Application of dressings to feet, with or without topical medications	<p>Interventions to treat any foot wound or ulcer other than a pressure ulcer.</p> <ul style="list-style-type: none"> For pressure ulcers on the foot, use Ulcer Care item (M1200E). Do not code application of dressings to the ankle. The ankle is not part of the foot.
N0300	Injections	<p>This item is coded to record the number of days during the last 7 days (or since admission/reentry if less than 7 days) that the resident received any type of medication, antigen, vaccine, etc., by subcutaneous, intramuscular, or intradermal injection.</p> <ul style="list-style-type: none"> A description that includes the name of the drug, amount given, route, and time must be documented in the clinical record for each day administered. Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment/medication administration records and the plan of care.

O01002	Special Treatments, Procedures and Programs (While a Resident)	<p>These items are coded to record any special treatments, procedures and programs that the resident received during the specified time periods.</p> <p>These documentation requirements apply to items O0100A2—O0100J2 and must be part of the clinical record:</p> <ul style="list-style-type: none"> • All treatments, procedures and programs received by the resident after admission/re-entry to the facility and within the 14-day observation period. • Do not include services that were provided solely in conjunction with a surgical procedure, such as IV medications or ventilators. Surgical procedures include pre- and post-operative procedures. • A description that includes the name of the drug, amount given, route, and time must be documented in the clinical record within the observation period. • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment/medication administration records and the plan of care.
O0100A2	Chemotherapy	<p>Any type of chemotherapy agent administered as an antineoplastic given by any route during the last 14 days.</p> <ul style="list-style-type: none"> • The chemotherapy must be given for the treatment of cancer. Does not include chemotherapy that is given for reasons other than the treatment of cancer (e.g., Megace for appetite stimulation). • A description that includes the name of the drug, amount given, route, and time must be documented in the clinical record within the observation period. • Documentation must also include the monitoring of the side effects associated with the chemotherapy.
O0100B2	Radiation Therapy	<p>Intermittent radiation therapy, as well as, radiation administered via radiation implant during the last 14 days.</p> <ul style="list-style-type: none"> • Documentation within the observation period must include the type, method of administration and time.
O0100C2	Oxygen Therapy	<p>Continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia during the last 14 days. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here.</p> <ul style="list-style-type: none"> • Do not code hyperbaric oxygen for wound therapy in this item. • Documentation within the observation period must include the method of administration, time, and amount.
O0100D2	Suctioning	<p>Only tracheal and or nasopharyngeal suctioning that occurred during the last 14 days.</p> <ul style="list-style-type: none"> • Does not include suctioning of the oral cavity. • The type, frequency, and results of the suctioning must be documented.

O0100E2	Tracheostomy Care	Code cleansing of the tracheostomy site, cannula and/or dressings to the site. <ul style="list-style-type: none"> Documentation must include the specific type and description of the tracheostomy care.
O0100F2	Ventilator or Respirator	Code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensure adequate ventilation in the resident who is unable to support his/her own respiration. A resident who is being weaned off of a respirator or ventilator during the last 14 days should also be coded here. <ul style="list-style-type: none"> Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP. Documentation must include the type of ventilatory device used and the frequency of use.
O0100H2	IV Medications	Code any drug or biological (e.g., contrast material) given by intravenous push, epidural pump, or drip through a central or peripheral port during the last 14 days. <ul style="list-style-type: none"> Epidural, intrathecal, and baclofen pumps may be coded. Do not code subcutaneous pumps in this item. Do not include IV medications of any kind that were administered during dialysis or chemotherapy. Do not code saline or heparin flushes to keep a heparin lock patent, or IV fluids without medication here. Documentation must include the time, type, frequency and method of administration.
O0100I2	Transfusions	Code transfusions of blood or any blood products (e.g., platelets, synthetic blood products), which are administered directly into the bloodstream during the last 14 days. <ul style="list-style-type: none"> Do not include transfusions that were administered during dialysis or chemotherapy. Documentation must include time, type, amount, and the monitoring of side effects.
O0100J2	Dialysis	Code renal dialysis which was administered at the nursing home or at another facility, since admission or reentry, during the last 14 days. <ul style="list-style-type: none"> Documentation must include the monitoring of side effects as well as the time and type of dialysis (e.g., hemodialysis, peritoneal dialysis).

O0400	Therapies	
		<p>These items are coded to record specialized therapies (Speech, Occupational, Physical and Respiratory) received during the last 7 days.</p> <p>The qualified therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents.</p> <p>These documentation requirements apply to items O0400A—O0400D:</p> <ul style="list-style-type: none"> • Code only medically necessary therapies that occurred after admission/readmission to the nursing home. • Must be ordered by a physician (physician’s assistant, nurse practitioner, and/or clinical nurse specialist) based on a qualified therapist’s assessment (i.e., one who meets Medicare requirements or, in some instances, under such person’s direct supervision) and treatment plan. • Must be performed by a qualified therapist, (e.g. one who meets State credentialing requirements or, in some instances under such a person’s supervision.) • Must be documented in the resident’s medical record. • Must be care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective. • Therapy treatment may occur either inside or outside of the facility. • The therapist’s time spent on documentation or on an initial evaluation is not included. • When a resident returns from a hospital stay, an initial evaluation MUST be performed upon readmission to the facility, and only those therapies that occurred since readmission to the facility may be counted. • The therapists time spent on subsequent reevaluations, conducted as part of the treatment process should be counted. • Therapy aides cannot provide skilled services. Only the time an aide spends on set-up for skilled services may be coded on the MDS (e.g., set up the treatment area for wound therapy). • Record only the actual minutes of therapy. The conversion of units to minutes or minutes to units is not appropriate. Please note that therapy logs are not an MDS requirement, but reflect a standard clinical practice expected of all therapy professionals. These therapy logs may be used to verify the provision of therapy services in accordance with the plan of care and to validate information reported on the MDS assessment.

O0400A	Speech-Language Pathology/Audiology	<p>This item is coded to record services that are provided by a licensed speech-language pathologist and/or audiologist.</p> <ul style="list-style-type: none"> • Rehabilitative treatment addresses physical and/or cognitive deficits/disorders resulting in difficulty with communication and/or swallowing (dysphagia). • Communication includes speech, language (both receptive and expressive) and non-verbal communication such as facial expression and gesture. • Swallowing problems managed under speech therapy are problems in the oral, laryngeal, and/or pharyngeal stages of swallowing. • Common treatments may range from physical strengthening exercises, instructive or repetitive practice and drilling, to the use of audio-visual aids and introduction of strategies to facilitate functional communication. Speech therapy may also include sign language and the use of picture symbols. • Speech-language pathology assistants are not recognized therefore should not provide services and should not be code on the MDS.
O0400B	Occupational Therapy	<p>This item is coded to record services that are provided or directly supervised by a licensed occupational therapist.</p> <ul style="list-style-type: none"> • A qualified occupational therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include services provided by a qualified occupational therapy assistant who is employed by (or under contract to) the nursing home only if he or she is under the direction of a licensed occupational therapist. • Occupational therapy interventions address deficits in physical, cognitive, psychosocial, sensory, and other aspects of performance in order to support engagement in everyday life activities that affect health, well-being, and quality of life.
O0400C	Physical Therapy	<p>This item is code to record services that are provided or directly supervised by a licensed physical therapist.</p> <ul style="list-style-type: none"> • A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. • Include services provided by a qualified physical therapy assistant who is employed by (or under contract to) the nursing home only if he or she is under the direction of a licensed physical therapist. • Interventions may include therapeutic exercise, functional training, manual therapy techniques, assistive and adaptive devices and equipment, physical agents, and electrotherapeutic modalities.

O0400D	Respiratory Therapy	<p>This item is coded to record 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.</p> <ul style="list-style-type: none"> • Respiratory therapy services include coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds and mechanical ventilation, etc. • A trained respiratory nurse is one who has received specific training on the administration of respiratory treatments and procedures when permitted by the state Nurse Practice Act. This training may have been provided at a hospital or nursing facility as part of work experience or as part of an academic program. Nurses do not necessarily learn these procedures as part of their formal nurse training programs. • Does not include hand-held medication dispensers. • Count only the time that a qualified professional spends with the resident. • Respiratory therapy must meet all of the requirements of other specialized therapies. • Documentation must include a respiratory assessment pre and post treatment that includes but is not limited to the following: heart rate, respiratory rates, breath sounds, direct care minutes and toleration.
O0400A1 O0400B1 O0400C1 O0400D1	Individual Therapy Minutes	<p>These items are coded to record the total number of minutes of therapy provided on an individual basis during the 7 day observation period.</p> <p>Individual therapy is the treatment of one resident at a time. The resident is receiving the therapist's or the assistant's full attention.</p>
O0400A2 O0400B2 O0400C2	Concurrent Therapy Minutes	<p>These items are coded to record the total number of minutes of therapy provided on a concurrent basis during the 7 day observation period.</p> <p>Concurrent therapy is the treatment of 2 residents at the same time, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant.</p>
O0400A3 O0400B3 O0400C3	Group Therapy Minutes	<p>These items are coded to record the total number of minutes of therapy that was provided in a group during the 7 day observation period.</p> <p>Group therapy is the treatment of 2 to 4 residents, regardless of payer source, who are performing similar activities, and are supervised, by a therapist or assistant who is not supervising any other individuals.</p>
O0400A4 O0400B4 O0400C4 O0400D2	Days	<p>These items are coded to record the total number of days that therapy services were provided during the 7 day observation period.</p> <p>A day of therapy is defined as treatment for 15 minutes or more during a day.</p>

O0500	Restorative Nursing Programs	<p>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. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.</p> <p>These documentation requirements apply to items O0500A—O0500J and must meet the following criteria for restorative care:</p> <ul style="list-style-type: none"> • Measureable objectives and interventions must be documented in the care plan and in the medical record. • If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this reassessment should be documented in the record. • "Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated on an assessment of the resident's needs. • Evidence of periodic evaluation by the licensed nurse must be present in the medical record. • Nursing assistants/aides must be skilled in the techniques that promote resident involvement in the activity. • A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a nursing restorative program. • This category does not include groups with more than four residents per supervising helper or caregiver. • Training and skill practice are activities including repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse. • These exercises must be planned, scheduled, and documented in the clinical record. • Each restorative technique must be provided for at least 15 minutes during a day to be counted as a "day"; however, the 15 minutes of time in a day may be totaled across 24 hours
O0500A	Range of Motion (Passive) Number of Days	<p>The provision of passive movements in order to maintain flexibility and useful motion in the joints of the body.</p> <ul style="list-style-type: none"> • The resident provides no assistance • Does not include passive movement by the resident that is incidental to dressing, bathing, etc. <p>This item is coded to record the total number of days (during the 7 day observation period) on which passive range of motion was received.</p>
O0500B	Range of Motion (Active) Number of Days	<p>Exercises performed by the resident, with cueing, supervision, or physical assist by staff.</p> <ul style="list-style-type: none"> • Includes active ROM and active-assisted ROM. • Does not include active movement by the resident that is incidental to dressing, bathing, etc. <p>This item is coded to record the total number of days (during the 7 day observation period) on which active range of motion was received.</p>

O0500C	Splint or Brace Assistance	<p>The provision of:</p> <ol style="list-style-type: none"> (1) verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint; or (2) a scheduled program of applying and removing a splint or brace. <ul style="list-style-type: none"> • For splint and/or brace assistance: assess the resident's skin and circulation under the device, and reposition the limb in correct alignment periodically and document in the clinical record. <p>This item is coded to record the total number of days (during the 7 day observation period) on which splint or brace assistance was received.</p>
O0500D	Bed Mobility	<p>Activities provided to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side and positioning himself or herself in bed.</p> <p>This item is coded to record the total number of days (during the 7 day observation period) on which bed mobility training and skill practice was received.</p>
O0500E	Transfer	<p>Activities provided to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.</p> <p>This item is coded to record the total number of days (during the 7 day observation period) on which transfer training and skill practice was received.</p>
O0500F	Walking	<p>Activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices.</p> <p>This item is coded to record the total number of days (during the 7 day observation period) on which training and skill practice for walking was received.</p>
O0500G	Dressing and/or Grooming	<p>Activities provided to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.</p> <p>This item is coded to record the total number of days (during the 7 day observation period) on which training and skill practice in dressing and grooming activities was received.</p>
O0500H	Eating and/or Swallowing	<p>Activities provided to improve or maintain the resident's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.</p> <p>This item is coded to record the total number of days (during the 7 day observation period) on which eating and swallowing training and skill practice was received.</p>

O0500I	Amputation/ Prosthesis Care	<p>Activities provided to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket).</p> <p>This item is coded to record the total number of days (during the 7 day observation period) on which amputation/prosthesis care training and skill practice was received.</p>
O0500J	Communication	<p>Activities provided to improve or maintain the resident's self-performance in functional communication skills or assisting the resident in using residual communication skills and adaptive devices.</p> <p>This item is coded to record the total number of days (during the 7 day observation period) on which communication training and skill practice was received.</p>
O0600	Physician Examinations	<p>This item is coded to record the number of days over the last 14 days, when the physician (or nurse practitioner) examined the resident.</p> <ul style="list-style-type: none"> • Include medical doctors, doctors of osteopathy, podiatrists, dentists and authorized physician assistants, nurse practitioners or clinical nurse specialists working in collaboration with the physician. • Examination (partial or full) can occur in the facility or in the physician's office. • Documentation of the physician's visit and examination/evaluation must be included in the clinical record. • Do not include exams conducted in the Emergency Room as part of an unscheduled emergency room visit or hospital observation stay. • Do not count examinations done prior to the date of admission or re-entry. • Off-site evaluations by a physician (e.g. while undergoing dialysis or radiation therapy), can be coded as a physician examination as long as documentation of the physician's evaluation is included in the medical record. • Examination by a Psychologist (PhD) should be recorded in O0400E, Psychological Therapy. • Does not include visits made by Medicine Men.



O0700	Physician Orders	<p>This item is coded to record the number of days over the last 14 days, when the physician (or nurse practitioner) changed the resident's orders.</p> <ul style="list-style-type: none">• Do not include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes.• Do not count orders prior to the date of admission or re-entry.• Orders written on the day of admission as a result for an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes.• Includes written, telephone, fax or consultation orders for new or altered treatment.• Notification of the physician that the PRN order was activated does not constitute a new or changed order and may not be counted when coding this item.• Orders written to increase the resident's RUG classification and facility payment are not acceptable.• Orders for transfer of care to another physician may not be counted.• Do not count orders written by a pharmacist.
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