Department of Health and Hospitals

Louisiana Advisor

Vol. 9, Issue 3 - September 2010

Louisiana Advisor is a quarterly notification of policy changes on the MDS related to the case mix reimbursement system

The *Louisiana Advisor* is a publication produced under contract with The Department of Health and Hospitals by Myers and Stauffer LC
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The *Louisiana Advisor* is published to keep all interested parties current on Louisiana Case Mix Reimbursement. It is our goal to provide official information on major issues such as:

** Clarifications/ changes to the Supportive Documentation Guidelines*
**Case Mix Review Process*
**Policies and Procedures*
**Upcoming Training*

MDS Clinical Questions?
Health Standards
(800) 261-8579

Documentation or Review Questions and Medicaid CMI Report Questions?
Myers and Stauffer LC
(800) 763-2278

Training Update

In July 2010, Myers and Stauffer conducted seven seminars in four cities throughout the state. These cities included Shreveport, Pineville, Lafayette and Baton Rouge with over 1,000 participants attending. This training focused on the many important updates to the RUG-III classification model as it relates to the MDS 3.0.

If you have questions or feedback pertaining to this training please email us at lahelpdesk@mslc.com. Please be sure to provide all of your contact information to ensure a speedy response.

Also if you would like to be among the first to receive emails from Myers and Stauffer regarding new training information, newsletters, resources, etc., please sign up to be a subscriber. Go to la.mslc.com, click on "Resources" and select "Subscribe".

Final Supportive Documentation Guidelines

Included with this newsletter are the final Supportive Documentation Guidelines (SDG) based on the latest CMS update noted on the last page. These guidelines are applicable to all assessments with an ARD date on or after October 1, 2010.

Important Reminder Z0400

Each person who completes a section of the MDS must sign this section, including their title, section(s) and date section(s) completed. Signing Z0400 is an acknowledgment that the MDS section(s) completed **accurately** reflects resident assessment information. It is not appropriate to code the MDS inaccurately simply because coding values conflict with medical record documentation. In fact, the last paragraph on Page 1-6 of the MDS 3.0 RAI Manual, states *"It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment."*

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ADL Tools for the Case Mix Review

ADL documentation tools used for the case mix review must contain all MDS coding options for both self performance and support provided, with the **exception of the code of "7"** in self performance. The facility does have the option of including or not including the code of "7" on the ADL documentation tool. Remember, ADL documentation tools must contain keys with the full definitions in order to be supported for the review.

ADL Clarification for Case Mix

- ***MDS Code of 4 definition-Total dependence****-full staff performance every time during the entire look back period.*
  To code a 4 on both the ADL collection form that represents a shift OR on the MDS form that represents the look back period, full staff performance must be provided **every time** the activity occurred.
- As a reminder, any time the activity occurred less than three times in the look back period it is coded a "7".
- ADL collection forms must reflect all shifts during the look back period. The look back period for ADLs may be anytime between day 1 and day 7 as determined by the facility.
- ADL documentation must be initialed/ signed by the person taking responsibility for the submitted ADL values as determined by the facility.

Dear Cindy...

The "Dear Cindy..." column is a regular feature in each issue of *Louisiana Advisor*. Cindy Smith, Myers and Stauffer's RN consultant, will discuss questions that are frequently answered by our staff. We welcome your questions for future issues. As always, please refer all coding/ regulatory issues to the state RAI Coordinator.

Dear Cindy:

Q: What RUG grouper will apply for Medicaid reimbursement after the MDS 3.0 is implemented?

A: The Louisiana Department of Health and Hospitals will apply the version 5.20 34-group RUG-III classification model beginning October 1, 2010.

Transmission Calendar

The NEW 2011 Department of Health and Hospitals - CMI Listing Report and Transmission Calendar can now be found at la.mslc.com in the "Resources" folder. For your convenience and reference, the calendar is also included on Page 5 of this newsletter.

Case Mix Documentation Requirements for Section I

RUG-III MDS 3.0 items in Section I require a two part review process to support the item.

1) First, the diagnosis must be "active" in the look back period. *An **Active Diagnosis** is defined as having a direct relationship to the resident's functional status, cognitive status, mood or behavior, medical treatment, nursing monitoring or risk of death.*
2) Second, the diagnosis must be documented by the physician within the last 60 days. *A **Documented Diagnosis** is defined as a diagnosis signed by the physician, NP, PA, CNS-if allowable under state licensure, in the last 60 days and have a relationship to the resident's functional status, cognitive status, mood or behavior, medical treatment, nursing monitoring or risk of death.*

Case Mix Documentation Requirements for BIMs and PHQ-9

Documentation Requirements for Resident Interview Sections of the MDS 3.0

Brief Interview for Mental Status (BIMS)

- If the BIMS items are completed, documentation for the case mix review includes either validation of completion of items at Z0400 **OR** evidence of resident interview in the medical records.
- If the resident is unable or unwilling to complete the resident interview items for cognition patterns, and the staff assessment items are completed, documentation requirements include an example describing the coding responses on the MDS.

BIMS items include; C0200, C0300 and C0400
Cognition items for staff assessment include; B0700, C0700 and C1000

Resident Mood Interview (Patient Health Questionnaire 9-Item or PHQ-9)

- If the PHQ-9 items are completed, documentation for the case mix review includes either validation of completion of items at Z0400 **OR** evidence of resident interview in the medical records.
- If the resident is unable or unwilling to complete the resident interview items for mood, and the staff assessment items are completed, documentation requirements include an example describing the coding responses on the MDS and the frequency of mood.

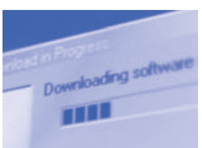
PHQ-9 items include; D0200A through I
PHQ-9OV for staff assessment include; D0500A through J

CMS Transition Recommendations

CMS has a series of PowerPoint presentations on the transition from RUG-III to RUG-IV, Start of Therapy and End of Therapy Other Medicare Required Assessments and the SNF short stay policy available for download on the following website: http://www.cms.gov/SNFPPS/02_Spotlight.asp.

Also included are the options for transitioning from RUG-III to RUG-IV for Medicare/PPS assessments completed between the September and October 2010 transition period.

jRAVEN is the new data entry software, which Nursing Home providers may use to collect and maintain the MDS 3.0 assessment, resident and facility data and create the MDS 3.0 submission files.



The RAVEN 8.3 software should continue to be used for the MDS 2.0 system. Do NOT uninstall or remove this software.

For the latest jRAVEN / RAVEN Download information, go to https://www.qtso.com/ravendownload.html

Information obtained from QTSO website.

Transition Process MDS 2.0 to MDS 3.0

CMS has provided a Transition document which is a user friendly (i.e., non-programmer's) description of the transition from completing the MDS 2.0 assessment to the MDS 3.0 assessment. The information contained in the document provides a reference for the clinician in terms of transitioning and completing the MDS 3.0 assessment for the first time. The transition document especially facilitates completing the MDS 3.0 assessment in instances (item or section related) where there has been a change on the MDS 3.0 assessment (compared to the MDS 2.0 assessment) and in understanding look back periods/dates. The transition document is presented by section and by item with a brief process description specific to that section and item.

To obtain the Transition Process MDS 2.0 to MDS 3.0 document in its entirety (9 pages), visit http://www.cms.gov/NursingHomeQualityInits/downloads/MDS30TransitionFromMDS20.pdf

Information obtained from CMS website.

MDS 3.0 Web Page Update

To find the latest available information on changes to the MDS 3.0 RAI Manual, visit http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp. The following updates were posted on September 13, 2010:

Specific Changes:

- The following revisions to the MDS 3.0 Manual are reflected in this posting (**Please Note: All revised sections are indicated with "V1.04 and September 2010" in the file name and within the respective documents**):
  - Chapter2
  - Chapter 3 Sections A, E, F, G, I, J, K, M, O, Q, V, and X
  - Chapter 5
  - Chapter 6
  - Appendices B and C

General Changes:

- Revisions to the respective chapters or sections are reflected in a **separate change** document (Example File Name for the Change Document – "MDS 3.0 Appendix B V1.04 September 2010 (change-table).pdf").
- The change documents only reflect changes made from the last published version.

Update posted on September 23, 1010: "Important Notice - MDS 3.0 RAI Manual Chapter 3, Section O, Page O-17 Errata Document: A formatting issue was identified on page O-17 of Section O of the latest published version of the MDS 3.0 RAI Manual (MDS_3.0_Chapter_3_-_Section_O_V1.04_Sept_2010.pdf) which may have resulted in mis-coding of item O0400 on the MDS 3.0. Please download the PDF file labeled "MDS 3.0 Chapter 3 Section O Page O-17 Errata Document September 2010" and insert the new page O-17 in your MDS 3.0 RAI Manual."

Information obtained from CMS website.

New System Security Requirement

Effective November 15, 2010, the Transport Layer Security (TLS) 1.0 must be active in your web browser in order to access QIES National Systems, including the new MDS 3.0 Submission System. Follow the steps below to activate TLS 1.0.

Note: You must have administrative rights to your workstation in order to update this value. If you do not have administrative rights, contact your IT support.

1. Open the Internet Explorer browser.
2. Select "Tools" from the Menu bar.
3. Click on "Internet Options".
4. Select the "Advanced" tab.
5. Underneath "Security", ensure that the box next to "Use TLS 1.0" is checked (this should be located near the bottom of the list).
6. Click "Apply".
7. Click "Ok".

If you have any questions concerning this information, please contact the QTSO Help Desk at help@qtso.com or 1 800-339-9313.

Information obtained from QTSO website.

2011 Louisiana Department of Health and Hospitals – CMI Listing Report and Transmission Schedule

January 2011

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

February 2011

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28					

March 2011

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

Tan Day of the Month

Cut-off date for MDS transmission of the Preliminary CMI Listing Report.

April 2011

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

May 2011

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

June 2011

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

Blue Day of the Month

Posting of the Preliminiary CMI Listing Reports to Provider's CMS MDS validation report directory (around the 16th of the month).

July 2011

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

August 2011

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

September 2011

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

Yellow Day of the Month

Cut-off date for MDS transmission of the Final CMI Listing Report.

October 2011

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

November 2011

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

December 2011

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Orange Day of the Month

Posting of the Final CMI Listing Reports to Provider's CMS MDS validation report directory (around the 16th of the month).

MDS 3.0 Location, Field Description, Observation Period	***MDS 2.0***	***RUG-III Categories Impacted***	***Minimum Documentation and Review Standards Required during the Specified Observation Period Denoted in Column One***
Section B: Hearing, Speech, and Vision			
B0100 Comatose (CPS) ***(7-day look back)*** (pages: B1-2)	**B1**	*~Clinically Complex* *~Impaired Cognition* *~(Contributes to ES count)*	**Comatose** is defined as a pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The resident is unresponsive and cannot be aroused; he/she does not open eyes, does not speak and does not move extremities on command or in response to noxious stimuli (e.g. pain). **Persistent Vegetative State** is defined as a resident who does not display 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. ***Does require:*** • Diagnosis of coma or persistent vegetative state
B0700 Makes Self Understood (CPS) ***(7-day look back)*** (pages: B6-7)	**C4**	*~Impaired Cognition* *~(Contributes to ES count)*	***Does require:*** • Example of the resident's ability and degree of impairment to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language whether in speech, writing, sign language, or a combination of these
Section C: Cognitive Patterns			
C0200 Repetition of three words (BIMS) ***(7-day look back)*** (pages: C2-8)	**None**	*~Impaired Cognition* *~(Contributes to ES count)*	***Does require:*** • Validation of completion of item at Z0400 **OR** • Evidence of resident interview of BIMS items in medical record
C0300 A,B,C Temporal Orientation (BIMS) ***(7-day look back)*** (pages: C8-11)	**None**	*~Impaired Cognition* *~(Contributes to ES count)*	***Does require:*** • Validation of completion of item at Z0400 **OR** • Evidence of resident interview of BIMS items in medical record
C0400 A,B,C Recall (BIMS) ***(7-day look back)*** (pages: C12-14)	**None**	*~Impaired Cognition* *~(Contributes to ES count)*	***Does require:*** • Validation of completion of item at Z0400 **OR** • Evidence of resident interview of BIMS items in medical record
C0500 BIMS summary score (pages: C15-16)	**None**	*Informational Only*	***Brief Interview for Mental Status (BIMS) defined:*** Score range is 0-15 • Score <=9, cognitively impaired • Score >=10, cognitively intact
C0700 Short-Term Memory (CPS) ***(7-day look back)*** (pages: C18-20)	**B2a**	*~Impaired Cognition* *~(Contributes to ES count)*	***Does require:*** • Example describing an event 5 minutes after it occurred **OR** • Example describing a follow through on a direction given 5 minutes earlier

MDS 3.0 Location, Field Description, Observation Period	**MDS 2.0**	*RUG-III Categories Impacted*	***Minimum Documentation and Review Standards Required during the Specified Observation Period Denoted in Column One***
C1000 Cognitive Skills for Daily Decision Making (CPS) ***(7-day look back)*** (pages: C23-25)	**B4**	*~Impaired Cognition* *~(Contributes to ES count)*	***Does require:*** • Example demonstrating degree of compromised daily decision-making that reflects resident's actual performance ***Does NOT include:*** • Resident's decision to exercise his/her right to decline treatment or recommendations by staff
Section D: Mood			
D0200A-I, Column 2 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 TV 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 ***(14-day look back)*** (pages: D3-8)	**None**	*~Clinically Complex*	***Does require:*** • Validation of completion of item at Z0400 **OR** • Evidence of resident mood interview (PHQ-9) in medical record

MDS 3.0 Location, Field Description, Observation Period	*MDS 2.0*	*RUG-III Categories Impacted*	*Minimum Documentation and Review Standards Required during the Specified Observation Period Denoted in Column One*
D0300 Total Severity Score (PHQ-9) (pages: D8-9)	**None**	*Informational Only*	***Total Severity Score defined:*** • Sum of all frequency items (D0200 Column 2) • Total Severity Score range is 00-27 • Score >=10 resident is depressed • Score <10 resident is not depressed
D0500A, Column 2 Little interest or pleasure in doing things ***(14-day look back)*** (pages: D11-14)	**None**	*~Clinically Complex*	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). ***Does require:*** • Example that demonstrates resident's lack of interest or pleasure in doing things • Evidence of frequency of mood
D0500B, Column 2 Feeling or appearing down, depressed, or hopeless ***(14-day look back)*** (pages: D11-14)	**None**	*~Clinically Complex*	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). ***Does require:*** • Example that demonstrates resident's feeling or appearing down, depressed, or hopeless • Evidence of frequency of mood
D0500C, Column 2 Trouble falling or staying asleep, or sleeping too much ***(14-day look back)*** (pages: D11-14)	**None**	*~Clinically Complex*	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). ***Does require:*** • Example that demonstrates resident's trouble falling or staying asleep, or sleeping too much • Evidence of frequency of mood
D0500D, Column 2 Feeling tired or having little energy ***(14-day look back)*** (pages: D11-14)	**None**	*~Clinically Complex*	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). ***Does require:*** • Example that demonstrates resident's feeling tired or having little energy • Evidence of frequency of mood
D0500E, Column 2 Poor appetite or overeating ***(14-day look back)*** (pages: D11-14)	**None**	*~Clinically Complex*	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). ***Does require:*** • Example that demonstrates resident's poor appetite or overeating • Evidence of frequency of mood
D0500F, Column 2 Indicating that s/he feels bad about self, or is a failure, or has let self or family down ***(14-day look back)*** (pages: D11-14)	**None**	*~Clinically Complex*	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). ***Does require:*** • Example that demonstrates resident's indication that s/he feels bad about self, or is a failure, or has let self or family down • Evidence of frequency of mood

MDS 3.0 Location, Field Description, Observation Period	*MDS 2.0*	*RUG-III Categories Impacted*	*Minimum Documentation and Review Standards Required during the Specified Observation Period Denoted in Column One*
D0500G, Column 2 Trouble concentrating on things, such as reading the newspaper or watching TV ***(14-day look back)*** (pages: D11-14)	**None**	*~Clinically Complex*	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). ***Does require:*** • Example that demonstrates resident's trouble concentrating on things, such as reading the newspaper or watching TV • Evidence of frequency of mood
D0500H, Column 2 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 ***(14-day look back)*** (pages: D11-14)	**None**	*~Clinically Complex*	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). ***Does require:*** • Example that demonstrates resident's 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 • Evidence of frequency of mood
D0500I, Column 2 States that life isn't worth living, wishes for death, or attempts to harm self ***(14-day look back)*** (pages: D11-14)	**None**	*~Clinically Complex*	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). ***Does require:*** • Example that demonstrates resident's statements that life isn't worth living, wishes for death, or attempts to harm self • Evidence of frequency of mood
D0500J, Column 2 Being short tempered, easily annoyed ***(14-day look back)*** (pages: D11-14)	**None**	*~Clinically Complex*	If resident is unable or unwilling to be interviewed; refer to Staff Assessment of Mood (D0500A-J). ***Does require:*** • Example that demonstrates resident's being short tempered, easily annoyed • Evidence of frequency of mood
D0600 Total Severity Score (PHQ-9-OV) (pages: D14-15)	**None**	*Informational Only*	***Total Severity Score defined:*** • Sum of all frequency items (D0500 Column 2) • Total Severity Score range is 00-30 • Score >=10 resident is depressed • Score <10 resident is not depressed

Resource Utilization Group, Version III, Revised
Final Supportive Documentation Guidelines
For MDS 3.0 Assessments with an ARD on or after 10/01/2010

MDS 3.0 Location, Field Description, Observation Period	*MDS 2.0*	*RUG-III Categories Impacted*	*Minimum Documentation and Review Standards Required during the Specified Observation Period Denoted in Column One*
Section E: Behavior			
E0100A Hallucinations ***(7-day look back)*** (pages: E1-3)	**J1i**	*~Behavior Problems*	***Does require:*** • Example of a resident's perception of the presence of something that is not actually there • Auditory, visual, tactile, olfactory or gustatory false sensory perceptions that occur in the absence of any real stimuli
E0100B Delusions ***(7-day look back)*** (pages: E1-3)	**J1e**	*~Behavior Problems*	***Does require:*** • Example of a fixed, false belief not shared by others that a resident holds even in the face of evidence to the contrary ***Does NOT include:*** • A resident's expression of a false belief when easily accepts a reasonable alternative explanation
E0200A (code 2 or 3) Physical behavioral symptoms *directed toward others* Presence & Frequency ***(7-day look back)*** (pages: E4-6)	**E4cA**	*~Behavior Problems*	***Does require:*** • Example and frequency of physical behavior symptoms directed toward others • Hitting, kicking, pushing, scratching, grabbing, abusing others sexually
E0200B (code 2 or 3) Verbal behavioral symptoms *directed toward others* Presence & Frequency ***(7-day look back)*** (pages: E4-6)	**E4bA**	*~Behavior Problems*	***Does require:*** • Example and frequency of verbal behavior symptoms directed toward others • Threatening others, screaming at others, cursing at others
E0200C (code 2 or 3) Other behavioral symptoms *<u>not</u> directed toward others* Presence & Frequency ***(7-day look back)*** (pages: E4-6)	**E4dA**	*~Behavior Problems*	***Does require:*** • Example and frequency of other behavioral symptoms NOT directed toward others • Hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily waste, or verbal/vocal symptoms like screaming, disruptive sounds
E0800 (code 2 or 3) Rejection of Care Presence & Frequency ***(7-day look back)*** (pages: E13-17)	**E4eA**	*~Behavior Problems*	***Does require:*** • Example of the resident's rejection of care (e.g., blood work, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being ***Does NOT include:*** • Behaviors that have already been addressed and/or determined to be consistent with resident values, preferences or goals

MDS 3.0 Location, Field Description, Observation Period	***MDS 2.0***	***RUG-III Categories Impacted***	***Minimum Documentation and Review Standards Required during the Specified Observation Period Denoted in Column One***
E0900 (code 2 or 3) Wandering – Presence and Frequency ***(7-day look back)*** (pages: E17-18)	**E4aA**	*~Behavior Problems*	***Does require:*** • Example and frequency of wandering from place to place without a specified course or known direction ***Does NOT include:*** • Pacing • Traveling via a planned course to another specific place (dining room or activity)
Section G: Functional Status			
G0110A, Bed Mobility **G0110B,** Transfers **G0110I,** Toilet Use Column 1 & 2 **G0110H,** Eating Column 1 ONLY **(7-day look back)** (pages: G1-17)	**G1a, G1b, G1i, Col. A & B** **G1hA, Col. A ONLY**	*~Extensive Services* *~Rehabilitation* *~Special Care* *~Clinically Complex* *~Impaired Cognition* *~Behavior Problems* *~Reduced Physical Functions*	***Does require:*** • Documentation 24 hours/observation period <u>while in the facility</u> • Initials and dates to authenticate the services provided • Signatures to authenticate initials • Staff who actually provided the service and/or take responsibility for the service must initial documentation • The ADL key for self-performance and support provided must be equivalent to the intent and definition of the MDS key • If using narrative notes to support ADLs, one note is considered one occurrence and must include the specific ADL(s) and degree of self-performance and support provided. Wording must be equivalent to MDS key definitions such as "extensive (weight-bearing) assist of one for transfers" • ADL documentation must be maintained as part of the legal medical record ***Does NOT include:*** • One signature/initial to authenticate an ADL grid • Eating/drinking during medication administration • General supervision in dining room • Services provided pre-admission • Services provided other than by staff in the facility • The lack of codes for all possible MDS coding options (except "7") for both self performance and support provided • ADL keys with words for self-performance such as limited, extensive assist, etc., without the full definitions • Two different ADL tools per assessment. Facility will be asked to designate the one to be used for the review

Resource Utilization Group, Version III, Revised
Final Supportive Documentation Guidelines
For MDS 3.0 Assessments with an ARD on or after 10/01/2010

MDS 3.0 Location, Field Description, Observation Period	*MDS 2.0*	*RUG-III Categories Impacted*	*Minimum Documentation and Review Standards Required during the Specified Observation Period Denoted in Column One*
Section H: Bladder and Bowel			
H0200C Current urinary toileting program or trial Restorative Nursing ***(7-day look back)*** (pages: H3-7)	**H3a**	*~Rehabilitation* *~Impaired Cognition* *~Behavior Problems* *~Reduced Physical Functions*	Documentation must show that the following requirements have been met: ***Does require:*** • Implementation of an individualized toileting program that was based on an assessment of the resident's unique voiding pattern • Evidence that the program was communicated verbally and through a care plan, flow records, and a written report • Resident's response to the program and evaluation by a licensed nurse **provided during the observation period** • Toileting plan that is being managed during 4 or more days of the 7-day look back period with some type of systematic toileting program • A specific approach that is organized, planned, documented, monitored, and evaluated ***Does NOT include:*** • Less than 4 days of a systematic toileting program • Simply tracking continence status • Changing pads or wet garments • Random assistance with toileting or hygiene
H0500 Bowel toileting program Restorative Nursing ***(7-day look back)*** (pages: H11-12)	**H3a**	*~Rehabilitation* *~Impaired Cognition* *~Behavior Problems* *~Reduced Physical Functions*	Documentation must show that the following requirements have been met: ***Does require:*** • Implementation of an individualized, resident-specific bowel toileting program that was based on an assessment of the resident's unique bowel pattern • Evidence that the program was communicated verbally and through a care plan, flow records, and a written report • Resident's response to the program and evaluation by a licensed nurse **provided during the observation period** ***Does NOT include:*** • Simply tracking of bowel continence status • Changing pads or soiled garments • Random assistance with toileting or hygiene

MDS 3.0 Location, Field Description, Observation Period	*MDS 2.0*	*RUG-III Categories Impacted*	*Minimum Documentation and Review Standards Required during the Specified Observation Period Denoted in Column One*
Section I: Active Diagnosis			
***Active Diagnosis** look back period* Diagnosis that has a direct relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look back period.			***Documented Diagnosis** look back period* A physician documented diagnosis (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 60 days that has a relationship to the resident's functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look back period.
Step 1 Determine diagnosis status: active or inactive in the 7-day look back period. **Step 2** Identify documented diagnosis in the 60-day look back period.			
I2000 Pneumonia ***(7-day look back)*** (page: I1-10)	**I2e**	*~Special Care* *~Clinically Complex* *~(Contributes to ES count)*	***Does require:*** • Code only active diagnosis • Physician documented diagnosis ***Does NOT include:*** • A hospital discharge note referencing pneumonia during hospitalization
I2100 Septicemia **I2900** Diabetes Mellitus **I4900** Hemiplegia/ Hemiparesis ***(7-day look back)*** (pages: I1-10)	**I2g** **I1a** **I1v**	*~Clinically Complex* *~(Contributes to ES count)*	***Does require:*** • Code only active diagnosis • Physician documented diagnosis ***Does NOT include:*** • A hospital discharge note referencing septicemia during hospitalization
I4300 Aphasia **I4400** Cerebral Palsy **I5100** Quadriplegia **I5200** Multiple Sclerosis (MS) ***(7-day look back)*** (page: I1-10)	**I1r** **I1s** **I1z** **I1w**	*~Special Care* *~(Contributes to ES count)*	***Does require:*** • Code only active diagnosis • Physician documented diagnosis

MDS 3.0 Location, Field Description, Observation Period	*MDS 2.0*	*RUG-III Categories Impacted*	*Minimum Documentation and Review Standards Required during the Specified Observation Period Denoted in Column One*
Section J: Health Conditions			
J1550A Fever ***(7-day look back)*** (page: J24-26)	**J1h**	*~Special Care* *~(Contributes to ES count)*	The route (rectal, oral, etc.) of temperature measurement to be consistent between the baseline and the elevated temperature. ***Does require:*** • Fever of 2.4 degrees above the baseline • A baseline temperature established prior to the ARD • A temperature of 100.4 on admission is a fever
J1550B Vomiting ***(7-day look back)*** (page: J24-26)	**J1o**	*~Special Care* *~(Contributes to ES count)*	Documentation of regurgitation of stomach contents.
J1550C Dehydrated; output exceeds intake ***(7-day look back)*** (page: J24-26)	**J1c**	*~Special Care* *~Clinically Complex* *~(Contributes to ES count)*	Documentation does require 2 or more of the 3 potential dehydration indicators. ***Does require:*** • Usually takes in less than 1500 cc of fluid daily • 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 or increased confusion, fever, abnormal lab values, etc. • Fluid loss that exceeds intake daily ***Does NOT include:*** • A hospital discharge note referencing dehydration during hospitalization unless 2 of the 3 dehydration indicators are present and documented • A diagnosis of dehydration
J1550D Internal Bleeding ***(7-day look back)*** (pages: J24-26)	**J1j**	*~Clinically Complex* *~(Contributes to ES count)*	Documentation of frank or occult blood. ***Does require:*** • Black, tarry stools • Vomiting "coffee grounds" • Hematuria • Hemoptysis • Severe epistaxis (nosebleed) that requires packing ***Does NOT include:*** • Nosebleeds that are easily controlled • Menses • Urinalysis that shows a small amount of red blood cells

MDS 3.0 Location, Field Description, Observation Period	*MDS 2.0*	*RUG-III Categories Impacted*	*Minimum Documentation and Review Standards Required during the Specified Observation Period Denoted in Column One*
Section K: Swallowing/Nutritional			
K0300 Weight Loss ***(1 month and 6 month look back)*** (pages: K4-8)	**K3a**	*~Special Care* *~(Contributes to ES count)*	Documentation in the medical record of the resident's weight loss of 5% or more in last month OR 10% or more in last 6 months. ***Does require:*** • Percentage based on the actual weight • Mathematical rounding
K0500A Parenteral / IV Feeding ***(7-day look back)*** (pages: K8-10)	**K5a**	*~Extensive Services* *~ADL Score*	Includes any and all nutrition and hydration received by the nursing home resident in the last 7 days either at the nursing home, at the hospital as an outpatient or an inpatient, provided they were administered for nutrition or hydration. ***Does include:*** • Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous) • TPN • IV at KVO • Hypodermoclysis and sub-Q ports in hydration therapy • IV fluids administered for the purpose of "prevention" of dehydration ***Does NOT include:*** • IV medications • IV fluids used to reconstitute and/or dilute meds • IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay • IV fluids administered solely as flushes • IV fluids administered in conjunction with chemotherapy or dialysis
K0500B Feeding Tube ***(7-day look back)*** (pages: K8-10)	**K5b**	*~Special Care* *~Clinically Complex* *~(Contributes to ES count)* *~ADL Score*	Includes any and all nutrition and hydration received by the nursing home resident in the last 7 days either at the nursing home, at the hospital as an outpatient or an inpatient, provided they were administered for nutrition or hydration. ***Does require:*** • Documentation of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the GI system ***Does include:*** • NG tubes, gastrostomy tubes, J-tubes, PEG tubes

MDS 3.0 Location, Field Description, Observation Period	*MDS 2.0*	*RUG-III Categories Impacted*	*Minimum Documentation and Review Standards Required during the Specified Observation Period Denoted in Column One*
K0700A Calorie Intake ***(7-day look back)*** (pages: K10-12)	**K6a**	*~Special Care* *~Clinically Complex* *~(Contributes to ES count)* *~ADL Score*	Documentation must support the proportion of all calories <u>actually received</u> for nutrition or hydration through parenteral or tube feeding. ***For residents receiving P.O. nutrition and tube feeding, documentation must demonstrate how the facility calculated the % of calorie intake the tube feeding provided and include:*** 1) Calories tube feeding provided during observation period 2) Calories oral feeding provided during observation period 3) Percent of total calories provided by tube feeding 4) Calories by tube/total calories consumed
K0700B Average Fluid Intake ***(7-day look back)*** (pages: K12-13)	**K6b**	*~Special Care* *~Clinically Complex* *~(Contributes to ES count)* *~ADL Score*	Documentation must support average fluid intake per day by IV and/or tube feeding. ***This is calculated by:*** • Review the intake records • Add the total amount of fluid received each day by IV and/or tube feedings <u>only</u> • Divide the week's total fluid intake by 7 to calculate the average of fluid intake per day • Divide by 7 even if the resident did not receive IV fluids and/or tube feeding on each of the 7 days
		Section M: Skin Conditions	
M0300A <u>AND</u> **M1030** **M0300B1** **M0300C1** **M0300D1** **M0300F1** Ulcers/Staging ***(7-day look back)*** (pages: M5-17 and M28-29)	**M1a** **M1b** **M1c** **M1d**	*~Special Care* *~(Contributes to ES count)*	***Does require:*** • Documentation of history of pressure ulcer if ever classified at a deeper stage than is currently observed • Staging if the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured • Description of the ulcer including the stage for pressure ulcer ***Does NOT include:*** • Reverse staging • Pressure ulcers that are healed before the look-back period (these are coded at M0900) • Coding unstageable when the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured • Documentation on a weekly skin report or log that includes multiple residents listed

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M0300C1 **M0300D1** **M0300F1** Pressure Ulcer • Stage III, IV or unstageable ***(7-day look back)*** (pages: M5-17 and M28-29)	**M2a**	*~Special Care* *~(Contributes to ES count)*	***Does require:*** • Documentation of history of pressure ulcer if ever classified at a deeper stage than is currently observed • Description of the largest surface area of the unhealed ulcer including the length, width, depth and stage • Staging if the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured ***Does NOT include:*** • Reverse staging • Pressure ulcers that are healed before the look-back period. (These are coded at M0900) • Coding unstageable when the wound bed is partially covered by eschar or slough, but the depth of tissue loss can be measured • Documentation on a weekly skin report or log that includes multiple residents listed
M1040A Infection of the foot ***(7-day look back)*** (pages: M30-32)	**M6b**	*~Clinically Complex* *~(Contributes to ES count)*	Documentation of signs and symptoms of infection of the foot. ***Does include:*** • Cellulitis • Purulent drainage ***Does NOT include:*** • Ankle problems • Pressure ulcers coded in M0300-M0900
M1040B Diabetic foot ulcer **M1040C** Other open lesion on the foot ***(7-day look back)*** (pages: M30-32)	**M6c**	*~Clinically Complex* *~(Contributes to ES count)*	Documentation of signs and symptoms of foot ulcer or lesions. ***Does require:*** • Description of foot ulcer and or open lesion such as location and appearance ***Does NOT include:*** • Pressure ulcers coded in M0300-M0900 • Pressure ulcers that occur on residents with diabetes mellitus

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MDS 3.0 Location, Field Description, Observation Period	*MDS 2.0*	*RUG-III Categories Impacted*	*Minimum Documentation and Review Standards Required during the Specified Observation Period Denoted in Column One*
M1040D Open lesions other than ulcers, rashes, cuts ***(7-day look back)*** (page: M30-32)	**M4c**	*~Special Care* *~(Contributes to ES count)*	***Does include:*** • Skin lesions that develop as a result of diseases and conditions such as syphilis and cancer ***Does require:*** • Description of the open lesion such as location and appearance • Documentation in the care plan ***Does NOT include:*** • Pressure ulcers coded in M0300-M0900 • Skin tears, cuts, abrasions
M1040E Surgical Wounds ***(7-day look back)*** (page: M30-32)	**M4g**	*~Special Care* *~(Contributes to ES count)*	***Does include:*** • Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body • Pressure ulcers that are surgically repaired with grafts and flap procedures ***Does require:*** • Description of the surgical wound such as location and appearance ***Does NOT include:*** • Healed surgical sites and stomas or lacerations that require suturing or butterfly closure • PICC sites, central line sites, peripheral IV sites • Pressure ulcers that have been surgically debrided
M1040F Burns ***(7-day look back)*** (pages: M30-32)	**M4b**	*~Clinically Complex* *~(Contributes to ES count)*	Documentation to include a description of the appearance of the second or third degree burns. ***Does include:*** • Second or third degree burns only; may be in any stage of healing • Skin and tissue injury caused by heat or chemicals ***Does NOT include:*** • First-degree burns (changes in skin color only)

MDS 3.0 Location, Field Description, Observation Period	***MDS 2.0***	***RUG-III Categories Impacted***	***Minimum Documentation and Review Standards Required during the Specified Observation Period Denoted in Column One***
M1200A Pressure Reducing Device/***chair*** **M1200B** Pressure Reducing Device/***bed*** ***(7-day look back)*** (pages: M32-36)	**M5a** **M5b**	*~Special Care* *~(Contributes to ES count)*	Equipment aimed at reducing pressure away from areas of high risk. ***Does include:*** • Foam, air, water, gel, or other cushioning • Pressure relieving, reducing, redistributing devices ***Does NOT include:*** • Egg crate cushions of any type • Doughnut or ring devices
M1200C Turning/ repositioning program ***(7-day look back)*** (pages: M32-36)	**M5c**	*~Special Care* *~(Contributes to ES count)*	Documentation of a consistent <u>program</u> for changing the resident's position and realigning the body. "Program" is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs. ***Does require:*** • Documentation of the intervention and frequency of program • Documentation of monitoring and reassessing the program to determine the effectiveness of the intervention • Documentation by licensed nurse describing an evaluation of the resident's response to the program within the observation period
M1200D Nutrition or hydration intervention to manage skin problems ***(7-day look back)*** (pages: M32-36)	**M5d**	*~Special Care* *~(Contributes to ES count)*	Documentation of dietary intervention(s) to prevent or treat specific skin conditions. ***Does require:*** • Description of specific skin condition ***Does include:*** • Vitamins and or supplements
M1200E Ulcer Care ***(7-day look back)*** (pages: M32-36)	**M5e**	*~Special Care* *~(Contributes to ES count)*	Documentation to include any intervention for treating pressure ulcers coded at M0300. ***Does include:*** • Use of topical dressings • Chemical or surgical debridement • Wound irrigations • Negative pressure wound therapy (NPWT) • Hydrotherapy • Dressing for pressure ulcer on the foot

MDS 3.0 Location, Field Description, Observation Period	*MDS 2.0*	*RUG-III Categories Impacted*	*Minimum Documentation and Review Standards Required during the Specified Observation Period Denoted in Column One*
M1200F Surgical Wound Care ***(7-day look back)*** (pages: M32-36)	**M5f**	*~Special Care* *~(Contributes to ES count)*	Documentation to include any intervention for treating or protecting any type of surgical wound. ***Does include:*** • Topical cleansing • Wound irrigation • Application of antimicrobial ointments • Application of dressings of any type • Suture/staple removal • Warm soaks or heat application ***Does NOT include:*** • Post-operative care following eye or oral surgery • Surgical debridement of pressure ulcer • The observation of the surgical wound
M1200G Application of non-surgical dressings; other than to feet ***(7-day look back)*** (pages: M32-36)	**M5g**	*~Special Care* *~(Contributes to ES count)*	Documentation of application of non-surgical dressing (with or without topical medications) to the body other than to the feet. ***Does include:*** • Dressing application even once • Dry gauze dressings • Dressings moistened with saline or other solutions • Transparent dressings • Hydrogel dressings • Dressings with hydrocolloid or hydroactive particles • Dressing application to the ankle ***Does NOT include:*** • Dressing for pressure ulcer on the foot
M1200H Application of ointments/ medications other than to feet ***(7-day look back)*** (pages: M32-36)	**M5h**	*~Special Care* *~(Contributes to ES count)*	Documentation of application of ointments/medications (used to treat a skin condition) other than to feet. ***Does include:*** • Topical creams • Powders • Liquid sealants ***Does NOT include:*** • Ointments/medications (e.g. chemical or enzymatic debridement) for pressure ulcers
M1200I Applications of Dressings (feet) ***(7-day look back)*** (pages: M32-36)	**M6f**	*~Clinically Complex* *~(Contributes to ES count)*	Documentation of dressing changes to the feet (with or without topical medication) ***Does require:*** • Interventions to treat any foot wound or ulcer ***other than a pressure ulcer*** ***Does NOT include:*** • Dressing application to the ankle

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Section N: Medications			
N0300 Injections ***(7-day look back)*** (pages: N1-2)	**O3**	*~Clinically Complex* *~(Contributes to ES count)*	Documentation includes the number of days that the resident received any medication, antigen, vaccine, etc., by subcutaneous, intramuscular or intradermal injection while resident is in facility. ***Does include:*** • Subcutaneous pumps, only the number of days that the resident actually required a subcutaneous injection to restart the pump • Insulin injections
Section O: Special Treatments, Procedures, and Programs			
O0100A, either 1 or 2 Chemotherapy ***(14-day look back)*** (pages: O1-2)	**P1aa**	*~Clinically Complex* *~(Contributes to ES count)*	Documentation to include the administration of any type of chemotherapy (anticancer drug) given by any route for the sole purpose of cancer treatment. ***Does include:*** A nurse's note that resident went out for chemotherapy treatment will be sufficient if there is a corresponding physician order.
O0100B, either 1 or 2 Radiation ***(14-day look back)*** (pages: O1-2)	**P1ah**	*~Special Care* *~(Contributes to ES count)*	Documentation of procedure must include administration inside or outside of facility. ***Does include:*** • Intermittent radiation therapy • Radiation administered via radiation implant • A nurse's note that resident went out for radiation treatment will be sufficient if there is a corresponding physician order
O0100C, either 1 or 2 Oxygen Therapy ***(14-day look back)*** (pages: O1-2)	**P1ag**	*~Clinically Complex* *~(Contributes to ES count)*	Documentation must include the administration of oxygen. ***Does require:*** • The administration of oxygen continuously or intermittently via mask, cannula, etc. • Code when used in BiPAP/CPAP ***Does NOT include:*** • Hyperbaric oxygen for wound therapy
O0100D, either 1 or 2 Suctioning ***(14-day look back)*** (pages: O1-2)	**P1ai**	*~Extensive Services*	Documentation of **ONLY** nasopharyngeal or tracheal suctioning. ***Does require:*** • Nasopharyngeal suctioning • Tracheal suctioning ***Does NOT include:*** • Oral suctioning

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O0100E, either 1 or 2 Tracheostomy Care ***(14-day look back)*** (pages: O1-2)	**P1aj**	*~Extensive Services*	Documentation of tracheostomy and/or cannula cleansing. ***Does include:*** • Changing a disposable cannula • Cleansing of the trach and/or cannula
O0100F, either 1 or 2 Ventilator or Respirator ***(14-day look back)*** (pages: O1-3)	**P1al**	*~Extensive Services*	Documentation of any type of electrically or pneumatically powered closed system mechanical ventilator support devices. ***Does include:*** • Any resident who was in the process of being weaned off the ventilator or respirator in the last 14 days ***Does NOT include:*** • CPAP or BiPAP in this field
O0100H, either 1 or 2 IV Medication **(14-day look back)** (pages: O1-3)	**P1ac**	*~Extensive Services*	Documentation of IV medication by push, epidural pump, or drip administration through a central or peripheral port. ***Does include:*** • Any drug or biological (contrast material) • Epidural, intrathecal, and baclofen pumps • Additives such as electrolytes and insulin, which are added to the resident's TPN or IV fluids ***Does NOT include:*** • Saline or heparin flush to keep a heparin lock patent • IV fluids without medication • Subcutaneous pumps • IV medications administered only during dialysis or chemotherapy • Dextrose 50% and Lactated Ringers
O0100I, either 1 or 2 Transfusions ***(14-day look back)*** (pages: O1-3)	**P1ak**	*~Clinically Complex* *~(Contributes to ES count)*	Documentation must include transfusions of blood or any blood products administered directly into the bloodstream. ***Does NOT include:*** • Transfusions administered during dialysis or chemotherapy

MDS 3.0 Location, Field Description, Observation Period	*MDS 2.0*	*RUG-III Categories Impacted*	*Minimum Documentation and Review Standards Required during the Specified Observation Period Denoted in Column One*
O0100J, either 1 or 2 Dialysis ***(14-day look back)*** (pages: O1-3)	**P1ab**	*~Clinically Complex* *~(Contributes to ES count)*	Documentation must include evidence that peritoneal or renal dialysis occurred at the facility or another facility. ***Does include:*** • Hemofiltration • Slow Continuous Ultrafiltration (SCUF) • Continuous Arteriovenous Hemofiltration (CAVH) • Continuous Ambulatory Peritoneal Dialysis (CAPD) • A nurse's note that resident went out for dialysis treatment will be sufficient if there is a corresponding physician order. ***Does NOT include:*** • IV, IV medication and blood transfusion during dialysis
O0400A, 1, 2 & 3 **O0400B, 1, 2 & 3** **O0400C, 1, 2 & 3** Therapy minutes ***(7-day look back)*** (pages: O13-26)	**P1baB** **P1bbB** **P1bcB**	*~Rehabilitation* ***Individual therapy*** ~Treatment of one resident at a time ***Concurrent therapy*** ~Treatment of 2 residents at the same time in line-of-sight for Part A only ~Residents may not be treated concurrently for Part B—instead report under Group therapy ***Group therapy*** ~Treatment of 2 to 4 residents at the same time-Part A only ~Treatment of 2 or more residents at the same time-Part B only	Documentation of direct therapy minutes with associated initials/ signature(s) to be cited in the medical record on a daily basis to support the total number of minutes of direct therapy provided. ***Does require:*** • Only therapy provided while a resident in the facility • Skilled therapy ONLY • Physician order, treatment plan and assessment • Actual therapy minutes ONLY • Time provided for each therapy must be documented separately ***Does include:*** • Subsequent reevaluations • Set-up time • Co-treatment when minutes are split between disciplines and do not exceed the total time • Therapy treatment inside or outside the facility • Time required to adjust equipment or otherwise prepare for individualized therapy ***Does NOT include:*** • Therapy provided prior to admission • Time spent on documentation • Time spent on initial evaluation • Conversion of units to minutes • Rounding to the nearest 5th minute • Therapy services that are not medically reasonable and necessary • Therapy provided as restorative nursing • Services provided by aides • Services provided by a speech-language pathology assistant

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O0400A4 **O0400B4** **O0400C4** Therapy days ***(7-day look back)*** (pages: O13-26)	**P1baA** **P1bbA** **P1bcA**	*~Rehabilitation*	Documentation of direct therapy days with associated initials/ signature(s) to be cited in the medical record on a daily basis to support the total number of days of direct therapy provided. ***Does require:*** • Treatment for 15 minutes or more during the day ***Does NOT include:*** • Treatment for less than 15 minutes during the day
O0400D, 2 Respiratory Therapy Therapy days ***(7-day look back)*** (pages: O13-26)	**P1bdA**	*~Special Care* *~(Contributes to ES count)*	Documentation of direct therapy minutes with associated initials/signature(s) to be cited in the medical record on a daily basis to support the total number of minutes of direct therapy provided. ***Does require:*** • Only therapy provided while a resident in the facility • Physician order for therapy • Services must be directly and specifically related to active written treatment plan • Based on an initial evaluation performed by qualified personnel (respiratory therapist, respiratory nurse) • Services are required and provided by qualified personnel • Actual therapy minutes ONLY • Evidence of licensed nurse training ***Does include:*** • Subsequent reevaluation time • Set-up time ***Does NOT include:*** • Therapy provided prior to admission • Time spent on documentation or initial evaluation • Conversion of units to minutes • Rounding to the nearest 5th minute • Therapy services that are not medically necessary

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O500A-J Restorative Nursing Programs ***(7-day look back)*** (pages: O27-34)	**P3a-j**	*~Rehabilitation* *~Impaired Cognition* *~Behavior Problems* *~Reduced Physical Functions*	Documentation must include the five criteria to meet the definition of a restorative nursing program: 1) Care plan with measurable objectives and interventions 2) Periodic evaluation by a licensed nurse *****Periodic evaluation is defined as an evaluation by a licensed nurse within the observation period.*** 3) Staff trained in the proper techniques 4) Supervision by nursing 5) No more than 4 residents per supervising staff personnel *****When residents are part of a group, provide documentation to identify the group, program, minutes and initials of person providing program.*** Program validation must include initials/ signature(s) on a daily basis to support the total days and minutes of nursing restorative programs provided. ***Does require:*** • Days for which 15 or more minutes of restorative nursing was provided within a 24 hour period • For splint or brace assistance, assessment of the residents skin and circulation under the device, and reposition the limb in correct alignment • Time provided for each program must be documented separately ***Does NOT include:*** • Requirement for Physician orders • Procedures or techniques carried out by or under the direction of qualified therapists • Movement by a resident that is incidental to care

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O0600 Physician examination ***(14-day look back)*** (pages: O34-35)	**P7**	*~Clinically Complex* *~(Contributes to ES count)*	Documentation must include establishing an exam by the physician to be counted as a physician examination. ***Does include:*** • Partial or full exam in facility or in physician's office ***Does NOT include:*** • Exams conducted prior to admission or readmission • Exams conducted during an ER visit or hospital observation stay • Exam by a Medicine Man
O0700 Physician orders **(14-day look back)** (pages: O35-36)	**P8**	*~Clinically Complex* *~(Contributes to ES count)*	***Does include:*** • Written, telephone, fax, or consultation orders for new or altered treatment • Orders written on the day of admission as a result of 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 ***Does NOT include:*** • Standard admission orders; return admission orders, renewal orders, or clarifying orders without changes • Activation of a PRN order already on file • Monthly Medicare certification • Orders to increase the RUG classification • Orders written by a pharmacist • Orders for transfer of care to another physician

NOTE: All page numbers and data provided in this document are current as of 9/17/2010.