MDS CHANGES FOR OCT. 1, 2018

ARE YOU READY FOR THE ROLLER COASTER RIDE???

BIG CHANGES AND NOT SO BIG CHANGES

FROM THE TOP

- The new manual goes into effect October 1, 2018
- We will then begin using RAI User's Manual Version 1.16
- If you see red print on the slide that means it is new in the manual
- If you see words that are ~~strike through~~ that means it is no longer in the manual
- Web site: https://downloads.cms.gov/files/3-MDS-30-RAI-Manual-v1-16-Replacement-Manual-Pages-and-Change-Tables-October-2018.pdf

CHAPTER 1 AND CHAPTER 2

- CMS added some names to the list of Contributors to the Manual which change the page length but nothing vital
- They are also replaced a hyperlinking Chapter 2 on page 2-4 to: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Post-Acute-Care-Quality-Initiatives/IMPACT-Act-of-2014/IMPACT-Act-of-2014-Data-Standardization-and-Cross-Setting-Measures.html

CHAPTER 2

- No other changes

CHAPTER 3
SECTION B HEARING SPEECH & VISION

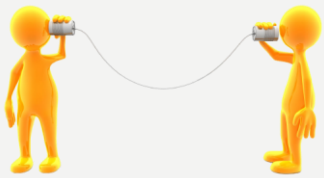
- Steps for Assessment:
  - No longer will you find the sentence: ~~This information identifies if the interview will be attempted~~
  - The focus is on the interaction in their preferred language, that he can hear you and offer alternative methods of communication
  - When doing the interview: Assess using the resident's preferred language or ***method of communication***
  - They added ***sign language*** as an alternative form of communication
  - They also have reinforced speaking to the primary nurse assists over all shifts, family and speech-language pathologist

CHAPTER 3
SECTION B HEARING SPEECH & VISION

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

CHAPTER 3
SECTION B HEARING SPEECH & VISION

- Under Steps for Assessment it reminds again that we: Assess in the resident's preferred language or preferred method of communication



CHAPTER 3 SECTION C
COGNITIVE PATTERNS

- C0100: Coding Tips
  - Again it reminds us to be sure we are using preferred language and they can hear you
  - Assess if they can communicate via writing, verbally or another method

CHAPTER 3 SECTION C COGNITIVE PATTERNS

- Coding Instructions (Abbreviated over view).
  - They have changed the wording from Coding NO "should not be conducted", then
    - Reinforces if there is another method of doing the assessment we should be doing it
    - Bottom line talk to the resident
  - Then Coding YES: it reinforces should be conducted and not "attempted" if the resident can at least sometimes be understand using the typical methods or opening the door with "or using another method"

CHAPTER 3 SECTION C COGNITIVE PATTERNS

- Coding Tips
  - Attempt to conduct the interview with ALL residents, this interview is conducted during the look back period for the ARD and is not contingent upon item B0700. Makes self understood
  - If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item C0100 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items.
  - Do not complete the Staff Assessment for Mental Status items (C0700-C1000) if the resident interview should have been conducted, but was not done.

CHAPTER 3 SECTION C COGNITIVE PATTERNS

- Coding Tips (How it affects PPS assessments)
  - There is one exception to completing the Staff Assessment for Mental Status items (C0700–C1000) in place of the resident interview. This exception is specific to a stand-alone, unscheduled PPS assessment only and is discussed on page 2-60. For this type of assessment only, the resident interview may be conducted up to two calendar days after the ARD.
  - When coding a stand-alone Change of Therapy OMRA (COT), a stand-alone End of Therapy OMRA (EOT), or a stand-alone Start of Therapy OMRA (SOT), the interview items may be coded using the responses provided by the resident on a previous assessment **only** if the DATE of the interview responses from the previous assessment (as documented in item Z0400) were obtained no more than 14 days prior to the DATE of completion for the interview items on the unscheduled assessment (as documented in item Z0400) for which those responses will be used.

CHAPTER 3 SECTION D DEPRESSION

- Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.

- Determine whether ~~if~~ the resident is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip to D0500, Staff Assessment of Resident Mood (PHQ-9-OV©).

CHAPTER 3 SECTION D DEPRESSION CODING INSTRUCTIONS

- **Code 0, no:** if the interview should not be conducted **because the resident is rarely/never understood or cannot respond verbally, in writing, or using another method, or an interpreter is needed but not available.** ~~This option should be selected for residents who are rarely/never understood, or who need an interpreter (A1100 = 1) but one was not available.~~ Skip to item D0500, Staff Assessment of Resident Mood (PHQ-9-OV©).
- **Code 1, yes:** if the resident interview should be conducted **because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available.** ~~This option should be selected for residents who are able to be understood, and for whom an interpreter is not needed or is present.~~ Continue to item D0200, Resident Mood Interview (PHQ-9©).
- ***Carol warning: I would have a not in the chart why you answered no to this question***

CHAPTER 3 SECTION D DEPRESSION CODING INSTRUCTIONS

- Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.
- Includes residents who use American Sign Language (ASL).
- If the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item D0100 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items.
- Do not complete the Staff Assessment of Resident Mood items (D0500) if the resident interview should have been conducted, but was not done.

CHAPTER 3 SECTION D DEPRESSION CODING INSTRUCTIONS

- There is one exception to completing the Staff Assessment of Resident Mood items (D0500) in place of the resident interview. This exception is specific to a stand-alone, unscheduled PPS assessment only and is discussed on page 2-60. For this type of assessment only, the resident interview may be conducted up to two calendar days after the ARD.
- When coding a stand-alone Change of Therapy OMRA (COT), a standalone End of Therapy OMRA (EOT), or a standalone Start of Therapy OMRA (SOT), the interview items may be coded using the responses provided by the resident on a previous assessment **only** if the DATE of the interview responses from the previous assessment (as documented in item Z0400) were obtained no more than 14 days prior to the DATE of completion for the interview items on the unscheduled assessment (as documented in item Z0400) for which those responses will be used

INTERVIEWS AND THE BOTTOM LINE (PER CAROL)

- CMS is really pushing that we need to be listening to the resident and talking to them for the interviews. Do not assume we know what they are doing or thinking.
- We must open the door and try and hear what they have to say or do
- Do not take the easy way out, it could come back to hurt the resident or the facility during survey

Document

CHAPTER 3 SECTION F CUSTOMARY ROUTINES AND ACTIVITIES

- Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards. (All new verbiage)
- Determine whether or not resident is rarely/never understood verbally, in writing, or using another method. ~~and if family member/significant other is available.~~ If the resident is rarely or never understood, attempt to conduct the interview with a family member or significant other.
- If resident is rarely/never understood and a family member /or significant other is not available, skip to item F0800, Staff Assessment of Daily and Activity Preferences.
- Conduct the interview during the observation period.
- ~~The resident interview should be conducted if the resident can respond:~~
  - ~~verbally,~~
  - ~~by pointing to their answers on the cue card, OR~~
  - ~~by writing out their answers~~

CHAPTER 3 SECTION F CUSTOMARY ROUTINES AND ACTIVITIES

- F0300 Coding in this section verbiage has been changed from the interview ~~attempted~~ to interview conducted

CHAPTER 3 SECTION F CUSTOMARY ROUTINES AND ACTIVITIES

- Coding Tips New additions

- Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.
- If the resident interview was not conducted within the look-back period of the ARD, item F0300 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items.
- Do not complete the Staff Assessment of Daily and Activity Preferences items (F0700–F0800) if the resident interview should have been conducted, but was not done.

SECTION G FUNCTIONAL STATUS

- Algorithm changes on page G-8

- a. Convert episodes of Total Dependence (4) to Extensive Assistance (3).– ~~if this change makes 3 episodes at Extensive Assistance (3), code as Extensive Assistance (3)~~.
- Did the resident require a combination of Total Dependence and Extensive Assistance 3 or more times but not 3 times at any one level? (Items **3a and~~&~~ 3b** Rule of 3)
- Did the resident require a combination of Total Dependence, Extensive Assistance, and/or Limited Assistance that total 3 or more times but not 3 times at any one level? (Item **3c~~b~~** Rule of 3)

SECTION GG EXPLOSION

- 56 Pages for this section alone of changes
- Be sure your therapy staff receive a copy of these changes

SECTION GG NOW INCLUDES

- Prior Functioning: Everyday Activities
  - Self Care
  - Indoor mobility (ambulation)
  - Stairs
  - Functional cognition

SECTION GG NOW INCLUDES

- Prior Device use
  - Manual wheelchair
  - Motorized wheelchair and or scooter
  - Mechanical lift
  - Walker
  - Orthotics / Prosthetics

SELF CARE

- Eating
- Oral hygiene
- Toileting hygiene
- Shower/bathe sell
- Upper body dressing
- Lower body dressing
- Putting on/taking off footwear

MOBILITY

- Roll left and right
- Sit to lying
- Lying to sitting on side of bed
- Sit to stand
- Chair/bed to chair transfer
- Car transfer
- Walk 10 feet
- Walk 50 feet with two turns
- Walk 150 feet

MOBILITY

- Walking 10 feet on uneven surfaces
- 1 step curb
- 4 steps
- 12 steps
- Picking up object
- Wheelchair (Manual or motorized)
  - Wheel 50 feet with 2 turns
  - Wheel 150 feet

FROM THE TOP
INTENT AND STEPS FOR ASSESSMENT

- **NEW DIFFERENT FOCUS ON THIS ITEM Prior Functioning: Everyday Activities**
- **Intent:** This section ~~assesses~~ includes items about functional abilities and goals. It includes items focused on **prior functioning**, admission performance, discharge goals, and discharge performance. Functional status is assessed based on the need for assistance ~~with~~ when performing self-care and mobility activities.
- **GG0100 Prior Functioning: Everyday Activities**
- **Item Rationale**
  - Knowledge of the resident's functioning prior to the current illness, exacerbation, or injury may inform treatment goals.
- **Steps for Assessment**
  - 1. Ask the resident or his or her family about, or review the resident's medical records describing, the resident's prior functioning with everyday activities
- Carol: prior level of function

CODING INSTRUCTIONS

- **Code 3, Independent:** if the resident completed the activities by himself or herself, with or without an assistive device, with no assistance from a helper.
- **Code 2, Needed Some Help:** if the resident needed partial assistance from another person to complete the activities.
- **Code 1, Dependent:** if the helper completed the activities for the resident, or the assistance of two or more helpers was required for the resident to complete the activities.
- **Code 8, Unknown:** if the resident's usual ability prior to the current illness, exacerbation, or injury is unknown.
- **Code 9, Not Applicable:** if the activities were not applicable to the resident prior to the current illness, exacerbation, or injury.

Note decrease in options for coding IN THIS SECTION

CODING TIPS

- Record the resident's usual ability to perform self-care, indoor mobility (ambulation), stairs, and functional cognition prior to the current illness, exacerbation, or injury.
- If no information about the resident's ability is available after attempts to interview the resident or his or her family and after reviewing the resident's medical record, code as 8, Unknown.

CODING EXAMPLES

- Is only looking at Self care, Indoor mobility (Ambulation), Stairs, Functional cognition
- Multiple examples for each of the ADL's listed above (Starting page 2)
- Remember this is looking at function before the hospital stay. (Prior level of function)

GG 0110 PRIOR DEVICE USE (NEW ITEM)

- **Item Rationale**
  - Knowledge of the resident's use of devices and aids immediately prior to the current illness, exacerbation, or injury may inform treatment goals.
- **Steps for Assessment**
  - 1. Ask the resident or his or her family or review the resident's medical records describing the resident's use of prior devices and aids.
- **Coding Instructions**
  - **Check all devices that apply.**
  - **Check Z, None of the above:** if the resident did not use any of the listed devices or aids immediately prior to the current illness, exacerbation, or injury.
- **Coding Tips**
  - For GG0110D, Prior Device Use - Walker: "Walker" refers to all types of walkers (for example, pickup walkers, hemi-walkers, rolling walkers, and platform walkers).

GG0130 SELF CARE (3 DAY ASSESSMENT PERIOD) ADMISSION (START OF MEDICARE PART A STAY AND DISCHARGE

- Graphic for both the admission and discharge MDS form itself has changed and been updated

SECTION GG 0130 STEPS FOR ASSESSMENT

- ~~Licensed clinicians may a~~ **Assess** the resident's self-care ~~status~~ performance based on direct observation, as well as the resident's self-report , ~~family~~ and reports, ~~and direct~~ from qualified clinicians, care staff ~~reports~~, or family documented in the resident's medical record during the three-day assessment period. **CMS anticipates that an interdisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period.** For Section GG, the admission assessment period is the first three days of the Part A stay starting with the date in A2400B, which is the Start of Most Recent Medicare Stay. On admission, these items are completed only when A0310B = 01 (5-Day PPS assessment).

STEPS FOR ASSESSMENT (CONT.)

- Minor changes/deletions of some words in looking at the helper family assistance or outside of company help
- Upgraded/changed the definition of "Usual Performance" A resident's functional status can be impacted by the environment or situations encountered at the facility. Observing the resident's interactions with others in different locations and circumstances is important for a comprehensive understanding of the resident's functional status. If the resident's admission or discharge functional status varies, record the resident's usual ability to perform each activity. Do not record the resident's best performance and do not record the resident's worst performance, but rather record the resident's usual performance.

STEPS FOR ASSESSMENT (CONT.)

- Definition of a Qualified Clinician: Healthcare professionals practicing within their scope of practice and consistent with Federal, State, and local law and regulations.
- ~~Section GG coding on admission should reflect the person's baseline admission functional status, and is based on a clinical assessment that occurs soon after the resident's admission.~~ The admission functional assessment, when possible, should be conducted prior to the person benefitting from treatment interventions in order to determine a true baseline functional status on admission. If treatment has started, for example, on the day of admission, a baseline functional status assessment can still be conducted. Treatment should not be withheld in order to conduct the functional status

NEW CODE FOR SECTION GG

- **Code 10, Not attempted due to environmental limitations:** if the resident did not attempt this activity due to environmental limitations. Examples include lack of equipment and weather constraints.

SECTION GG ASSESSMENT PERIOD

- Looking at the Admission :

- This functional assessment must be completed within the first three days (3 calendar days) of the Medicare Part A stay, starting with the date in A2400B, Start of Most Recent Medicare Stay, and the following two days, ending at 11:59 PM on day 3three. The admission function scores are to reflect the resident's admission baseline status and are to be based on an assessment. The scores should reflect the resident's status prior to any benefit from interventions. (New)
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DISCHARGE CODING TIPS

- Several items have been taken out or added (pg GG 11-13):
  - ~~When coding the resident's usual performance, use the 6-point scale or one of the 3 "activity was not attempted" codes to specify the reason why an activity was not attempted.~~
  - ~~When coding the resident's usual performance, "effort" refers to the type and amount of assistance the helper provides in order for the activity to be completed. The 6-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.~~
  - Residents with cognitive impairments/limitations may need physical and/or verbal assistance(new) ~~when coding for the resident's Discharge Goal(s), use the same 6-point scale. Instructions about coding Discharge Goals are provided below under Discharge Goal(s): Coding Tips.~~
  - ~~On discharge, use the same 6-point scale or~~ "completing an activity" ~~was not attempted codes that are used for the admission assessment to identify the resident's usual performance~~. Code based ~~on the Discharge assessment~~. (Does not make sense to me either Carol)
  - ~~Do not record the staff's assessment of the~~ resident's ~~potential capability~~ need for assistance to perform the activity safely (for example, choking risk due to rate of eating, amount of food placed into mouth, risk of falling).

DISCHARGE CODING TIPS (CONT)

- If the resident does not attempt the activity and a helper does not complete the activity for the resident during the entire assessment period, code the reason the activity was not attempted. For example, code as 07 if the resident refused to attempt the activity;, code as 09 if the activity is not applicable for the resident (the activity did not ~~perform~~ this activity occur at the time of the assessment and prior to the current illness, injury, or exacerbation, ~~or injury);~~ code as 10 if the resident was not able to attempt the activity due to environmental limitations;, or code as 88 if the resident was not able to attempt the activity due to medical condition or safety concerns.

DISCHARGE CODING TIPS

- An activity can be completed independently with or without devices. If the resident uses adaptive equipment and uses the device independently when performing an activity, enter code 06, Independent.
- If two or more helpers are required to assist the resident into completing the activity, code as 01, Dependent.
- To clarify your own understanding of the resident's performance of an activity, ask probing questions to the care staff about the resident, beginning with the general and proceeding to the more specific. See examples of probing questions at the end of this section
- ~~Clinicians may code the eating item using the appropriate response codes if the resident eats using his/her hands rather than using utensils (e.g., can feed himself/herself using finger foods). If the resident eats finger foods with his/her hands independently, for example, the resident would be coded as 06, Independent.~~ *Do not panic we will see this again in just a little bit*
- ~~Coding~~ A dash ("-") ~~in these items~~ indicates "No information." CMS expects dash use ~~for SNF QRP items~~ to be a rare occurrence. ~~Use of dashes for these items may result in a reduction in the annual payment update.~~ Do not use a dash if the reason the item was not assessed was ~~that~~ because the resident refused (code 07), the item is not applicable because the resident did not perform this activity prior to the current illness, exacerbation, or injury (code 09), the activity was not attempted due to environmental limitations (code 10), or the activity was not attempted due to medical condition or safety concerns (code 88) ~~use these codes instead of a dash ("-").~~ ~~Please note that **a dash may be used for GG0130 Discharge Goal items provided that at least one Self-Care or one Mobility item has a Discharge Goal coded using the 6-point scale**. Using the dash in this allowed instance does not affect APU determination. Further information about the use of a dash ("-") for Discharge Goals is provided below under Discharge Goal(s): Coding Tips.~~

DISCHARGE CODING TIPS

- For the cross-setting quality measure, the *Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function*, a minimum of one Self-Care or Mobility Discharge Goal must be coded per resident stay on the 5-Day PPS assessment. Even though only one Discharge Goal is required, the facility may choose to code more than one Discharge Goal for a resident

- Completion of the Self-Care items is not required if the resident has an unplanned discharge to an acute-care hospital, or if the SNF PPS Part A Stay is less than 3 days.

CODING TIPS FOR CODING THE RESIDENT'S USUAL PERFORMANCE

- When coding the resident's usual performance and discharge goal(s), use the six-point scale, or use one of the 4 "activity was not attempted" codes to specify the reason why an activity was not attempted.
- When coding the resident's usual performance, "effort" refers to the type and amount of assistance a helper provides in order for the activity to be completed. The six-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.
- Do not record the resident's best performance, and do not record the resident's worst performance, but rather record the resident's usual performance during the assessment period.

CODING TIPS FOR CODING THE RESIDENT'S USUAL PERFORMANCE

- Code based on the resident's performance. Do not record the staff's assessment of the resident's potential capability to perform the activity.
- If the resident performs the activity more than once during the assessment period and the resident's performance varies, coding in Section GG should be based on the resident's "usual performance," which is identified as the resident's usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the resident's Self-Care performance varies during the assessment period, report the resident's usual performance, **not** the resident's most independent performance and **not** the resident's most dependent performance. A provider may need to use the entire three-day assessment period to obtain the resident's usual performance.

CODING TIPS FOR GG130A EATING

- Resident receives tube feedings or total parenteral nutrition (TPN):
  - If the resident does not eat or drink by mouth and relies **solely** on nutrition and liquids through tube feedings or TPN because of a **new (recent-onset) medical condition,** code GG0130A as 88, Not attempted due to medical condition or safety concerns. Assistance with tube feedings or TPN is not considered when coding the Eating item.
  - If the resident does not eat or drink by mouth at the time of the assessment, and the resident did not eat or drink by mouth **prior to the current** illness, injury, or exacerbation, code GG0130A as 09, Not applicable. Assistance with tube feedings or TPN is not considered when coding the Eating item.
  - If the resident eats and drinks by mouth, and relies **partially** on obtaining nutrition and liquids via tube feedings or TPN, code the Eating item based on the amount of assistance the resident requires to eat and drink by mouth. Assistance with tube feedings or TPN is not considered when coding the Eating item.

CODING TIPS FOR GG130A EATING

- If the resident eats finger foods using his or her hands, then code the Eating item based upon the amount of assistance provided. If the resident eats finger foods with his or her hands independently, for example, the resident would be coded as 06, Independent.

CODING TIP FOR GG0130B, ORAL HYGIENE

- If a resident does not perform oral hygiene during therapy, determine the resident's abilities based on performance on the nursing care unit.
- **Oral hygiene:** Mr. G has Parkinson's disease, resulting in tremors and incoordination. The certified nursing assistant retrieves all oral hygiene items for Mr. G and applies toothpaste to his toothbrush. Mr. G requires assistance to guide the toothbrush into his mouth and to steady his elbow while he brushes his teeth. Mr. G usually starts by brushing his upper and lower front teeth ~~tooth brushing~~ and the certified nursing assistant usually completes the activity by ~~performing more than half of this activity~~ brushing the rest of his teeth.

CODING TIPS FOR GG0130C, TOILETING HYGIENE

- Toileting hygiene includes the tasks of managing undergarments, clothing, and incontinence products and performing perineal cleansing before and after voiding or having a bowel movement. If the resident does not usually use undergarments, then assess the resident's need for assistance to manage lower-body clothing and perineal hygiene.
- Toileting hygiene (managing clothing and perineal cleansing) can take place before and after use of the toilet, commode, bedpan, or urinal. If the resident completes a bowel toileting program in bed, code Toileting hygiene based on the resident's need for assistance in managing clothing and perineal cleansing.

If the resident has an indwelling urinary catheter and has bowel movements, code the Toilet hygiene item based on the amount of assistance needed by the resident when moving his or her bowels.

TOILETING HYGIENE EXAMPLE

- 6. **Toileting hygiene:** Ms. Q has a progressive neurological disease that affects her fine and gross motor coordination, balance, and activity tolerance. She wears a hospital gown and underwear during the day. Ms. Q uses a bedside commode as she steadies herself in standing with one hand and initiates pulling down her underwear with the other hand but needs assistance to complete this activity owing to her coordination impairment. After voiding, Ms. Q wipes her perineal area without assistance while sitting on the commode. When Ms. Q has a bowel movement, a certified nursing assistant performs perianal hygiene as Ms. Q needs to steady herself with both hands to stand for this activity. Ms. Q is usually too fatigued at this point and requires full assistance to pull up her underwear.
  - **Coding:** GG0130C, Toileting hygiene, would be coded 02, Substantial/maximal assistance.
  - **Rationale:** The helper provided more than half the effort needed for the resident to complete the activity of toileting hygiene.

CODING TIPS FOR GG0130E, SHOWER/BATHE SELF

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

EXAMPLES FOR GG0130E, SHOWER/BATHE SELF

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

Coding: GG0130E, Shower/bathe self, would be coded 04, Supervision or touching assistance.

Rationale: The helper provides supervision as Mr. J washes, rinses, and dries himself. The transfer onto or off of the tub bench is not considered when coding the Shower/bathe self activity.

EXAMPLES FOR GG0130E, SHOWER/BATHE SELF

- Three new examples of how to code Shower/Bathe self

CODING TIPS FOR GG0130F, UPPER BODY DRESSING, GG0130G, LOWER BODY DRESSING, AND GG0130H, PUTTING ON/TAKING OFF FOOTWEAR

- For upper body dressing, lower body dressing, and putting on/taking off footwear, if the resident dresses himself or herself and a helper retrieves or puts away the resident's clothing, then code 05, Setup or clean-up assistance.
- If donning and doffing an elastic bandage, elastic stockings, or an orthosis or prosthesis occurs while the resident is dressing/undressing, then count the elastic bandage/elastic stocking/orthotic/prosthetic as a piece of clothing when determining the amount of assistance the resident needs when coding the dressing item.

CODING TIPS FOR GG0130F, UPPER BODY DRESSING, GG0130G, LOWER BODY DRESSING, AND GG0130H, PUTTING ON/TAKING OFF FOOTWEAR

- The following items are considered a piece of clothing when coding the dressing items:
  - Upper body dressing examples: thoracic-lumbar-sacrum orthotic (TLSO), abdominal binder, back brace, elastic stockings, stump sock/shrinker, upper body support device, neck support, hand or arm prosthetic.
  - Lower body dressing examples: knee brace, elastic bandage, elastic stockings, stump sock/shrinker, lower-limb prosthetic.
  - Footwear examples: ankle-foot orthosis (AFO), elastic bandages, foot orthotics, orthopedic walking boots, compression stockings (considered footwear because of dressing don/doff over foot).
-

CODING TIPS FOR GG0130F, UPPER BODY DRESSING, GG0130G, LOWER BODY DRESSING, AND GG0130H, PUTTING ON/TAKING OFF FOOTWEAR

- Upper body dressing items used for coding include bra, undershirt, T-shirt, button-down shirt, pullover shirt, sweatshirt, sweater, nightgown (not hospital gown), and pajama top. Upper body dressing cannot be assessed based solely on donning/doffing a hospital gown.
- Lower body dressing items used for coding include underwear, incontinence brief, slacks, shorts, capri pants, pajama bottoms, and skirts.
- Footwear dressing items used for coding include socks, shoes, boots, and running shoes.

CODING TIPS FOR GG0130F, UPPER BODY DRESSING, GG0130G, LOWER BODY DRESSING, AND GG0130H, PUTTING ON/TAKING OFF FOOTWEAR

- For residents with bilateral lower extremity amputations with or without use of prosthetics, the activity of putting on/taking off footwear may not occur. For example, the socks and shoes may be attached to the prosthetic associated with the upper or lower leg.
  - If the resident performed the activity of putting on/taking off footwear immediately prior to the current illness, exacerbation, or injury, code as 88, Not attempted due to medical condition or safety concerns.
  - If the resident did not perform the activity of putting on/taking off footwear immediately prior to the current illness, exacerbation, or injury because the resident had bilateral lower-extremity amputations and the activity of putting on/taking off footwear was not performed during the assessment period, code as 09, Not applicable.

CODING TIPS FOR GG0130F, UPPER BODY DRESSING, GG0130G, LOWER BODY DRESSING, AND GG0130H, PUTTING ON/TAKING OFF FOOTWEAR

- For residents with a single lower extremity amputation with or without use of a prosthetic, the activity of putting on/taking off footwear could apply to the intact limb or both the limb with the prosthetic and the intact limb.
  - If the resident performed the activity of putting on/taking off footwear for the intact limb only, then code based upon the amount of assistance needed to complete the activity.
  - If the resident performed the activity of putting on/taking off footwear for both the intact limb and the prosthetic limb, then code based upon the amount of assistance needed to complete the activity.

CODING EXAMPLES

- Multiple examples. How to code and the rationale for
  - Upper body dressing
  - Lower body dressing
  - Putting on/taking off footwear

DISCHARGE GOAL~~(S)~~: CODING TIPS

- ~~Use the 6-point scale~~ **Discharge goal(s) are coded with each Admission (Start of SNF PPS Stay) assessment.**
- For the SNF Quality Reporting Program (QRP), a minimum of one self-care or mobility discharge goal must be coded. However, facilities may choose to complete more than one self-care or mobility discharge goal. Code the resident's discharge goal(s~~). Do not use~~ using the six-point scale. Use of the "activity was not attempted" codes (07, 09, 10, and or 88) is permissible to code discharge goal(s). Use of a dash (-) to indicate is permissible for any remaining self-care or mobility goals that ~~a specific activity is not a Discharge Goal. Of note, at least one Discharge Goal must be indicated for either Self Care or Mobility.~~ were not coded. Using the dash in this allowed instance after the coding of at least one goal does not affect APU determination.
- Licensed, qualified clinicians can establish a resident's discharge goal(s) at the time of admission based on the ~~5 Day PPS~~ resident's prior medical condition, admission assessment self-care and mobility status, discussions with the resident and family, professional judgment, ~~and~~ the professional's standard of practice, expected treatments, the resident's motivation to improve, anticipated length of stay, and the resident's discharge plan. Goals should be established as part of the resident's care plan.
- ~~For the cross-setting quality measure, the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, a minimum of one Self-Care or Mobility Discharge Goal must be coded per resident stay on the 5-Day PPS assessment. Even though only one Discharge Goal is required, the facility may choose to code more than one Discharge Goal for a resident.~~

DISCHARGE GOAL(S): CODING TIPS

- For the cross-setting quality measure, the Application of Percent of Long-Term Care Hospital Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function, a minimum of one Self-Care or Mobility Discharge Goal must be coded per resident stay on the 5-Day PPS assessment. Even though only one Discharge Goal is required, the facility may choose to code more than one Discharge Goal for a resident
- Goals may be determined based on the resident's admission functional status, prior functioning, medical conditions/comorbidities, discussions with the resident and family concerning discharge goals, anticipated length of stay, and the clinician's consideration of expected treatments, and resident motivation to improve.

DISCHARGE GOAL: CODING EXAMPLES

- Throughout this section CMS has added the word "qualified" clinician to determine the goals

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

- The MDS form picture has been updated to include the new "10" code (environment)

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

- **Item Rationale**
- ~~Residents in~~ During a Medicare Part A SNF ~~stays~~stay, residents may have mobility limitations on admission. In addition, residents may be at risk of further functional decline during their stay in the SNF.

- **Steps for Assessment**
- 1. Assess the resident's mobility ~~status~~ performance based on direct observation, as well as the resident's self-report and the reports of, ~~family reports, and direct~~ qualified clinicians, direct care staff ~~reports documented in the resident's medical record~~, or family during the three-day assessment period. CMS anticipates that a multidisciplinary team of qualified clinicians is involved in assessing the resident during the three-day assessment period. For Section GG on admission, the assessment period is the first three days of the Part A stay, starting with the date in A2400B, which is the Start of Most Recent Medicare Stay. On admission, these items are completed only when A0310B = 01 (5-Day PPS assessment).

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

- Removed:
- ~~5. Section GG coding on admission should reflect the person's baseline admission functional status, and is based on a clinical assessment that occurs soon after the resident's admission.~~
- ~~If the resident performs the activity more than once during the assessment period and the resident's performance varies, coding in Section GG should be based on the resident's "usual performance," which is identified as the resident's usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. Therefore, if the resident's Mobility performance varies during the assessment period, report the resident's usual performance, **not** the resident's most independent performance and **not** the resident's most dependent performance. A provider may need to use the entire 3-day assessment period to obtain the resident's usual performance.~~

—

ADMISSION OR DISCHARGE PERFORMANCE CODING TIPS

- The admission function scores are to reflect the resident's admission baseline status and are to be based on an assessment. The scores should reflect the resident's status prior to any benefit from interventions.

ADMISSION AND DISCHARGE PERFORMANCE CODING TIPS

- Removed several bullets which are repeated elsewhere such as:
  - Discussion for "usual" performance
  - Reminder to use the same 6 point scale for discharge
- Added discussion on the new 10 code (Environment)
- Added discussion on Independent with a device is still independent
- Removed the bullet on turn explanation
- Re-emphasized not to use the "-"

TIPS FOR CODING THE RESIDENT'S USUAL PERFORMANCE

- New additional bullets
  - When coding the resident's usual performance and the resident's discharge goal(s), use the six-point scale, or one of the four "activity was not attempted" codes (07, 09, 10, and 88), to specify the reason why an activity was not attempted.
  - When coding the resident's usual performance, "effort" refers to the type and amount of assistance a helper provides in order for the activity to be completed. The six-point rating scale definitions include the following types of assistance: setup/cleanup, touching assistance, verbal cueing, and lifting assistance.
  - Do not record the resident's best performance, and do not record the resident's worst performance, but rather record the resident's usual performance during the assessment period.

TIPS FOR CODING THE RESIDENT'S USUAL PERFORMANCE

- Code based on the resident's performance. Do not record the staff's assessment of the resident's potential capability to perform the activity.
- If the resident performs the activity more than once during the assessment period and the resident's performance varies, coding in Section GG is based on the resident's "usual performance," which is identified as the resident's usual activity/performance for any of the Self-Care or Mobility activities, not the most independent or dependent performance over the assessment period. A provider may need to use the entire three-day assessment period to obtain the resident's usual performance.

NEW EXAMPLES

- Roll left and right
- Sit to lying

CODING TIPS FOR GG0170C, LYING TO SITTING ON SIDE OF BED

- The activity includes resident transitions from lying on his or her back to sitting on the side of the bed with his or her feet flat on the floor and sitting upright on the bed without back support. The resident's ability to perform each of the tasks within this activity and how much support the resident requires to complete the tasks within this activity is assessed.
- For item GG0170C, Lying to sitting on side of bed, clinical judgment should be used to determine what is considered a "lying" position for a particular resident.

CODING TIPS FOR GG0170C, LYING TO SITTING ON SIDE OF BED

- If the resident's feet do not reach the floor upon lying to sitting, the qualified clinician will determine if a bed height adjustment or a footstool is required to accommodate foot placement on the floor/footstool.
- Back support refers to an object or person providing support for the resident's back.
- If the qualified clinician determines that bed mobility cannot be assessed because of the degree to which the head of the bed must be elevated because of a medical condition, then code the activities GG0170A, Roll left and right, GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, as 88, Not attempted due to medical condition or safety concern.
- Removed several paragraphs and replaced with above verbiage

CODING TIPS FOR GG0170E, CHAIR/BED-TO-CHAIR TRANSFER

- Took out
- ~~Item GG0170E, Chair/bed-to-chair transfer, begins with the resident sitting in a chair or wheelchair or sitting upright at the edge of the bed and returning to sitting in a chair or wheelchair or sitting upright at the edge of the bed. The activities of GG0170B, Sit to lying, and GG0170C, Lying to sitting on side of bed, are two separate activities that are not assessed as part of GG0170E.~~
- ~~If a mechanical lift is used to assist in transferring a resident for a chair/bed-to-chair transfer and two helpers are needed to assist with the mechanical lift transfer, then code as 01, Dependent, even if the resident assists with any part of the chair/bed-to-chair transfer.~~

NEW EXAMPLES

- GG 0170G Discussion on Car Transfers
- GG01701 Walk 10 feet
- GG0170L Walking 10 feet on uneven surfaces
- GG0170M 1 step (curb)
- GG1070N 4 steps
- GG1070O 12 steps
- GG0170P Picking up object
- GG0170Q1 Does the resident use a wheelchair/scooter
- GG0170R and GG0170S Wheelchair items

CODING TIPS FOR WALKING ITEMS

- Walking activities do not need to occur during one session. Allowing a resident to rest between activities or completing activities at different times during the day or on different days may facilitate completion of the activities.
- When coding GG0170 walking items, **do not** consider the resident's mobility performance when using parallel bars. Parallel bars are not a portable assistive device. If safe, assess and code walking using a portable walking device.

SECTION I NEW QUESTION

I0020. Indicate the resident's primary medical condition category

Enter Code ☐☐

Indicate the resident's primary medical condition category that best describes the primary reason for admission
Complete only if A0310B = 01

01. **Stroke**
02. **Non-Traumatic Brain Dysfunction**
03. **Traumatic Brain Dysfunction**
04. **Non-Traumatic Spinal Cord Dysfunction**
05. **Traumatic Spinal Cord Dysfunction**
06. **Progressive Neurological Conditions**
07. **Other Neurological Conditions**
08. **Amputation**
09. **Hip and Knee Replacement**
10. **Fractures and Other Multiple Trauma**
11. **Other Orthopedic Conditions**
12. **Debility, Cardiorespiratory Conditions**
13. **Medically Complex Conditions**
14. **Other Medical Condition** If "Other Medical Condition," enter the ICD code in the boxes

I0020A.

☐☐☐☐☐☐☐☐

- **Item Rationale**
  - **Health-related Quality of Life**
    - Disease processes can have a significant adverse effect on residents' functional improvement.
- **Planning for Care**
  - This item identifies the primary medical condition category that resulted in the resident's admission to the facility and that influences the resident's functional outcomes.

- **Steps for Assessment**
- 1. Review the documentation in the medical record to identify the resident's primary medical condition associated with admission to the facility. Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.

CODING INSTRUCTIONS

- *Complete only if A0310B = 01 5 day MDS*

- Enter the code that represents the primary medical condition that resulted in the resident's admission. If codes 1–13 do not apply, use code 14, "Other Medical Condition," and proceed to I0020A.
- Include the primary medical condition coded in this item in Section I: Active Diagnoses in the last 7 days.

Code 01, Stroke, if the resident's primary medical condition category is due to stroke. Examples include ischemic stroke, subarachnoid hemorrhage, cerebral vascular accident (CVA), and other cerebrovascular disease.

Code 02, Non-Traumatic Brain Dysfunction, if the resident's primary medical condition category is non-traumatic brain dysfunction. Examples include Alzheimer's disease, dementia with or without behavioral disturbance, malignant neoplasm of brain, anoxic brain damage.

Code 03, Traumatic Brain Dysfunction, if the resident's primary medical condition category is traumatic brain dysfunction. Examples include traumatic brain injury, severe concussion, and cerebral laceration and contusion.

CODING INSTRUCTIONS

- **Code 04, Non-Traumatic Spinal Cord Dysfunction,** if the resident's primary medical condition category is non-traumatic spinal cord injury. Examples include spondylosis with myelopathy, transverse myelitis, spinal cord lesion due to spinal stenosis, and spinal cord lesion due to dissection of aorta.
- **Code 05, Traumatic Spinal Cord Dysfunction,** if the resident's primary medical condition category is due to traumatic spinal cord dysfunction. Examples include paraplegia and quadriplegia following trauma.
- **Code 06, Progressive Neurological Conditions,** if the resident's primary medical condition category is a progressive neurological condition. Examples include multiple sclerosis and Parkinson's disease.

CODING INSTRUCTIONS

- **Code 07, Other Neurological Conditions,** if the resident's primary medical condition category is other neurological condition. Examples include cerebral palsy, polyneuropathy, and myasthenia gravis.
- **Code 08, Amputation,** if the resident's primary medical condition category is an amputation. An example is acquired absence of limb.
- **Code 09, Hip and Knee Replacement,** if the resident's primary medical condition category is due to a hip or knee replacement. An example is total knee replacement. If hip replacement is secondary to hip fracture, code as fracture.
- **Code 10, Fractures and Other Multiple Trauma,** if the resident's primary medical condition category is fractures and other multiple trauma. Examples include hip fracture, pelvic fracture, and fracture of tibia and fibula.
- **Code 11, Other Orthopedic Conditions,** if the resident's primary medical condition category is other orthopedic condition. An example is unspecified disorders of joint.

CODING INSTRUCTIONS

- **Code 12, Debility, Cardiorespiratory Conditions,** if the resident's primary medical condition category is debility or a cardiorespiratory condition. Examples include chronic obstructive pulmonary disease (COPD), asthma, and other malaise and fatigue.
- **Code 13, Medically Complex Conditions,** if the resident's primary medical condition category is a medically complex condition. Examples include diabetes, pneumonia, chronic kidney disease, open wounds, pressure ulcer/injury, infection, and disorders of fluid, electrolyte, and acid-base balance.
- **Code 14, Other Medical Condition,** if the resident's primary medical condition category is not one of the listed categories. Enter the International Classification of Diseases (ICD) code, including the decimal, in I0200A. If item I0020 is coded 1–13, do not complete I0020A.

CODING EXAMPLES

- CMS has included multiple coding examples for this question

QUADS

- Further clarification on what CMS includes as a quad:

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

J: PAIN

- Same new information on Steps for Assessment in regards to speaking to the resident in regards to interviews . Attempt to conduct the interview with ALL residents. Reminder if we do not do the resident assessment we should not go back and do the staff assessment.
- There is the also the exception in regards to the PPS assessment only and this question. This is noted in the other interview discussions,

J 200 PRIOR SURGERY

- This is asking if they had a history of major surgery during the 100 days prior to admission
- Generally, major surgery for item J2000 refers to a procedure that meets *all* the following criteria:

1. the resident was an inpatient in an acute care hospital for at least one day in the 100 days prior to admission to the skilled nursing facility (SNF),
2. the resident had general anesthesia during the procedure, *and*
3. the surgery carried some degree of risk to the resident's life or the potential for severe disability

SECTION K 510 NUTRITIONAL APPROACHES

- **CMS does not require completion of Column 1 for items K0510C and K0510D; however, some States continue to require its completion. It is important to know your State's requirements for completing these items. Missouri does not require completion of these columns, but you must fill it out the column for while a resident**
- If the State does not require the completion of Column 1 for items K0510C and K0510D, use the standard "no information" code (a dash, "-").

SECTION M

- 50 pages of changes in this section

SECTION M

- Item Rationale
  - CMS has now added "injury" to pressure ulcers so now you will see pressure ulcers/injuries
  - External factors in regards to pressure ulcers now includes the word "microclimate"

SECTION M

HEALED PRESSURE ULCER

- Completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, *even if* the area continues to have some surface discoloration.

SECTION M

- The pressure ulcer/injury definitions used in the RAI Manual have been adapted from those recommended by the National Pressure Ulcer Advisory Panel (NPUAP) **2016** Pressure Injury Staging System.

IMPORTANT REMINDER

- This is not new but an important reminder with one new exclusion:
  - For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or DTI that declares itself, should be coded in terms of what is assessed (seen or palpated, i.e. visible tissue, palpable bone) during the look-back period. Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. However, since CMS has adapted the NPUAP guidelines for MDS purposes, the definitions do not perfectly correlate with each stage as described by NPUAP. Therefore, ~~you cannot use the NPUAP definitions to code the MDS.~~ You must code the MDS according to the instructions in this manual.
  - Pressure ulcer/injury staging is an assessment system that provides a description and classification based on visual appearance and/or anatomic depth of soft tissue damage. This tissue damage can be visible or palpable in the ulcer bed. Pressure ulcer/injury staging also informs expectations for healing times.

The comprehensive care plan should be reevaluated to ensure that appropriate preventative measures and pressure ulcer/injury management principles are being adhered to when new pressure ulcers/injuries develop or when existing pressure ulcers/injuries worsen.

CODING TIPS

- If an ulcer/injury arises from a combination of factors that ~~which~~ are primarily caused by pressure, then the area ~~ulcer~~ should be included in this section as a pressure ulcer/injury.
- ~~If a resident had a pressure ulcer on the last assessment and it is now healed, complete **Healed Pressure Ulcers** item (M0900).~~
- If two pressure ulcers/injuries occur on the same bony prominence and are separated, at least superficially, by skin, then count them as two separate pressure ulcers/injuries. Stage and measure each pressure ulcer/injury separately.

CODING TIPS

- **DEFINITIONS**
  - **EPITHELIAL TISSUE**
    - New skin that is light pink and shiny (even in persons with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and at the edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound.
  - **GRANULATION TISSUE**
    - Red tissue with "cobblestone" or bumpy appearance; bleeds easily when injured.

CODING TIPS

- Pressure ulcers do not heal in a reverse sequence, that is, the body does not replace the types and layers of tissue (e.g., muscle, fat, and dermis) that were lost during pressure ulcer development before they re-epithelialize. Stage 3 and 4 pressure ulcers fill with granulation tissue. This replacement tissue is never as strong as the tissue that was lost and hence is more prone to future breakdown.

- Clinical standards do not support reverse staging or backstaging as a way to document healing, as it does not accurately characterize what is occurring physiologically as the ulcer heals. For example, over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue. Previous standards using reverse staging or backstaging would have permitted identification of such a pressure ulcer as a Stage 3, then a Stage 2, and so on, when it reached a depth consistent with these stages. Clinical standards now would require that this ulcer continue to be documented as a Stage 4 pressure ulcer until it has completely healed. Nursing homes can document the healing of pressure ulcers using descriptive characteristics of the wound (i.e., depth, width, presence or absence of granulation tissue, etc.) or by using a validated pressure ulcer healing tool. Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage—in this example, a healed Stage 4 pressure ulcer. For care planning purposes, this healed Stage 4 pressure ulcer would remain at increased risk for future breakdown or injury and would require continued monitoring and preventative care.

IDENTIFYING UNSTAGEABLE PRESSURE ULCERS

- If, after careful cleansing of the pressure ulcer/injury, a pressure ulcer's/injury's anatomical tissues remain obscured such that the extent of soft tissue damage cannot be observed or palpated, the pressure ulcer/injury is considered unstageable.
- Known pressure ulcers/injuries covered by a non-removable dressing/device (e.g., primary surgical dressing, cast) should be coded as unstageable. "Known" refers to when documentation is available that says a pressure ulcer/injury exists under the non-removable dressing/device.

"PRESENT ON ADMISSION"

- If the pressure ulcer/injury was present on admission/entry or reentry and becomes unstageable due to slough or eschar, during the resident's stay, the pressure ulcer/injury is coded at M0300F and **should not be coded as "present on admission."**
- If a resident who has a pressure ulcer/injury is hospitalized and the ulcer/injury increases in numerical stage or becomes unstageable ~~as a result~~ of due to slough or eschar during the hospitalization, it **should be coded as "present on admission"** at that higher stage upon reentry.
- If a pressure ulcer was numerically staged, then became unstageable, and is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the numerical stage has increased, code this pressure ulcer as **not present on admission.**

- If a pressure ulcer was numerically staged, then became unstageable, and is subsequently debrided sufficiently to be numerically staged, compare its numerical stage before and after it was unstageable. If the numerical stage has increased, code this pressure ulcer as **not present on admission** **Bottom line it got worse on your watch**
- If two pressure ulcers merge, that were both "present on admission," continue to code the merged pressure ulcer as "present on admission." Although two merged pressure ulcers might increase the overall surface area of the ulcer, there needs to be an increase in numerical stage or a change to unstageable due to slough or eschar in order for it to be considered not "present on admission."

DEFINITION OF STAGE 2 PU

- **STAGE 2 PRESSURE ULCER**
- Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough or bruising
- Stage 2 pressure ulcers by definition have partial thickness loss of the dermis. Granulation tissue, slough, and eschar are not present in Stage 2 pressure ulcers
- **Not new but more FYI:** For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is **not** the primary cause, do **not** code here.
- CMS has removed the date for the oldest stage 2 pressure ulcer

PLANNING FOR CARE

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

PRESSURE ULCER EXAMPLES

- CMS has added additional examples for how to code pressure ulcers

STAGE 4 PRESSURE ULCERS

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

ELIMINATION

- M0610 Dimensions of Unhealed Stage 3 or 4 Pressure ulcers or Unstageable pressure ulcer due to slough and or eschar
- M0700 Most Severe Tissue type for any pressure ulcer
- M0800 Worsening in Pressure Ulcer status since prior assessment
- M0900 Healed Pressure Ulcers

DEFINITIONS

- **DIABETIC FOOT ULCERS**
  - Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (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 exudate, and callused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful.
- **SURGICAL WOUNDS**
  - Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites.
- **OPEN LESION OTHER THAN ULCERS, RASHES, CUTS**
  - Most typically skin lesions ulcers that develop as a result of diseases and conditions such as syphilis and cancer.
- **BURNS (SECOND OR THIRD DEGREE)**
  - Skin and tissue injury caused by heat or chemicals and may be in any stage of healing.

M1040D OPEN LESIONS OTHER THAN ULCERS, RASHES, CUTS

- Open lesions that develop as part of a disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and vesicles, should be coded in this item.

SKIN TEAR(S)

- Do not code cuts/lacerations or abrasions here. Although not recorded on the MDS, these skin conditions should be considered in the plan of care
-

M1040H MOISTURE ASSOCIATED SKIN DAMAGE (MASD)

- **DEFINITION**
- **Moisture Associated Skin Damage:** Is superficial skin damage caused by sustained exposure to moisture such as incontinence, wound exudate, or perspiration.
- Moisture exposure and MASD are risk factors for pressure ulcer/injury development. Provision of optimal skin care and early identification and treatment of minor cases of MASD can help avoid progression and skin breakdown.
- MASD without skin erosion is characterized by red/bright red color (hyperpigmentation), and the surrounding skin may be white (hypopigmentation). The skin damage is usually blanchable and diffuse and has irregular edges. Inflammation of the skin may also be present.
- MASD with skin erosion has superficial/partial thickness skin loss and may have hyper- or hypopigmentation; the tissue is blanchable and diffuse and has irregular edges. Inflammation of the skin may also be present. Necrosis is not found in MASD.

M1040H MOISTURE ASSOCIATED SKIN DAMAGE (MASD)

- If pressure and moisture are both present, code the skin damage as a pressure ulcer/injury in M0300.

If there is tissue damage extending into the subcutaneous tissue or deeper and/or necrosis is present, code the skin damage as a pressure ulcer in M0300.

DRESSING CLARIFICATION

- Non-surgical dressings do not include adhesive bandages (e.g., BAND-AID® bandages, wound closure strips).

SECTION M
CODING SAMPLES

- Some were deleted due to changes in Section M and some were updated

N2001 DRUG REGIMEN REVIEW

- **Intent:** The intent of the drug regimen review items is to document whether a drug regimen review was conducted upon the resident's admission (start of Skilled Nursing Facility [SNF] Prospective Payment System [PPS] stay) and throughout the resident's stay (through Part A PPS discharge) and whether any clinically significant medication issues identified were addressed in a timely manner.
- **DEFINITIONS: DRUG REGIMEN REVIEW**
- A drug regimen review includes medication reconciliation, a review of all medications a resident is currently using, and a review of the drug regimen to identify, and if possible, prevent potential clinically significant medication adverse consequences.
- The drug regimen review includes all medications, prescribed and over the counter (OTC), nutritional supplements, vitamins, and homeopathic and herbal products, administered by any route. It also includes total parenteral nutrition (TPN) and oxygen.

N2001 DRUG REGIMEN REVIEW ITEM RATIONALE

- Potential and actual resident medication adverse consequences and errors are prevalent in health care settings and often occur during transitions in care.
- Adverse consequences related to medications may result in serious harm or death, emergency department visits, and rehospitalizations and affect the resident's health, safety, and quality of life.
- Drug regimen review is intended to improve resident safety by identifying and addressing potential and actual clinically significant medication issues at the time of a resident's admission (start of SNF PPS stay) and throughout the resident's stay (through Part A PPS discharge).

PLANNING FOR CARE

- Drug regimen review is an important component of the overall management and monitoring of a resident's medication regimen.
- Prevention and timely identification of potential and actual medication-related adverse consequences reduces the resident's risk for harm and improves quality of life.
- Educate staff in proper medication administration techniques and adverse effects of medications, as well as to be observant for these adverse effects.
- Implement a system to ensure that each resident's medication usage is evaluated upon admission and on an ongoing basis and that risks and problems are identified and acted upon.

STEPS FOR ASSESSMENT

- Complete if A0310B = 01. 5 day PPS
- 1. Complete a drug regimen review upon admission (start of SNF PPS stay) or as close to the actual time of admission as possible to identify any potential or actual clinically significant medication issues.
- 2. Review medical record documentation to determine whether a drug regimen review was conducted upon admission (start of SNF PPS stay), or as close to the actual time of admission as possible, to identify any potential or actual clinically significant medication issues.
  - Medical record sources include medical records received from facilities where the resident received health care, the resident's most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available.
  - Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, the resident, and the resident's family/significant other) may supplement and/or clarify the information gleaned from the resident's medical records.

STEPS FOR ASSESSMENT

- 3. Clinically significant medication issues may include, but are not limited to:
  - Medication prescribed despite documented medication allergy or prior adverse reaction.
  - Excessive or inadequate dose.
  - Adverse reactions to medication.
  - Ineffective drug therapy.
  - Drug interactions (serious drug-drug, drug-food, and drug-disease interactions).
  - Duplicate therapy (for example, generic-name and brand-name equivalent drugs are coprescribed).
  - Wrong resident, drug, dose, route, and time errors.

STEPS FOR ASSESSMENT (CONT.)

- Medication dose, frequency, route, or duration not consistent with resident's condition, manufacturer's instructions, or applicable standards of practice.
- Use of a medication without evidence of adequate indication for use.
- Presence of a medical condition that may warrant medication therapy (e.g., a resident with primary hypertension does not have an antihypertensive medication prescribed).
- Omissions (medications missing from a prescribed regimen).
- Nonadherence (purposeful or accidental).

DEFINITIONS POTENTIAL OR ACTUAL CLINICALLY SIGNIFICANT MEDICATION ISSUES

- A clinically significant medication issue is a potential or actual issue that, in the clinician's professional judgment, warrants physician (or physician-designee) communication and completion of prescribed/recommended actions by midnight of the next calendar day at the latest.
- "Clinically significant" means effects, results, or consequences that materially affect or are likely to affect an individual's mental, physical, or psychosocial well-being, either positively, by preventing a condition or reducing a risk, or negatively, by exacerbating, causing, or contributing to a symptom, illness, or decline in status.
- Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the purpose of the drug regimen review items.

CODING INSTRUCTIONS

- **Code 0, No:** if no clinically significant medication issues were identified during the drug regimen review.
- **Code 1, Yes:** if one or more clinically significant medication issues were identified during the drug regimen review.
- **Code 9, NA:** if the resident was not taking any medications at the time of the drug regimen review.

CODING TIPS

- A dash (–) value is a valid response for this item; however, CMS expects dash use to be a rare occurrence.
- The drug regimen review includes all medications, prescribed and over the counter (OTC), including nutritional supplements, vitamins, and homeopathic and herbal products, administered by any route. The drug regimen review also includes total parenteral nutrition (TPN) and oxygen.

N2003 MEDICATION FOLLOW UP DEFINITION

- The process of contacting a physician to communicate an identified medication issue and completing all physician-prescribed/recommended actions by midnight of the next calendar day at the latest
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ITEM RATIONALE

- Integral to the process of safe medication administration practice is timely communication with a physician when a potential or actual clinically significant medication issue has been identified.
- Physician-prescribed/recommended actions in response to identified potential or actual clinically significant medication issues must be completed by the clinician in a time frame that maximizes the reduction in risk for medication errors and resident harm.

PLANNING FOR CARE

- When a potential or actual clinically significant medication issue is identified, prompt communication with the physician and implementation of prescribed actions is necessary to protect the health and safety of the resident

STEPS FOR ASSESSMENT

- This item is completed if one or more potential or actual clinically significant medication issues were identified during the admission drug regimen review (N2001 = 1).
- 1. Review the resident's medical record to determine whether the following criteria were met for any potential or actual clinically significant medication issues that were identified upon admission:
  - Two-way communication between the clinician(s) and the physician was completed by midnight of the next calendar day, AND
  - All physician-prescribed/-recommended actions were completed by midnight of the next calendar day.
- Medical record sources include medical records received from facilities where the resident received health care, the resident's most recent history and physical, transfer documents, discharge summaries, medication lists/records, clinical progress notes, and other resources as available.
- Discussions (including with the acute care hospital, other staff and clinicians responsible for completing the drug regimen review, the resident, and the resident's family/significant other) may supplement and/or clarify the information gleaned from the resident's medical records.

DEFINITION CONTACT WITH PHYSICIAN

- Communication with the physician to convey an identified potential or actual clinically significant medication issue, *and* a response from the physician to convey prescribed/recommended actions in response to the medication issue. Communication can be in person, by telephone, voice mail, electronic means, facsimile, or any other means that appropriately conveys the resident's status.

CODING INSTRUCTIONS

- **Code 0, No:** if the facility did not contact the physician and complete prescribed/recommended actions in response to *each* identified potential or actual clinically significant medication issue *by midnight of the next calendar day.*
- **Code 1, Yes:** if the facility contacted the physician AND completed the prescribed/recommended actions *by midnight of the next calendar day* after each potential or actual clinically significant medication issue was identified

CODING TIPS

- If the physician prescribes/recommends an action that will take longer than midnight of the next calendar day to complete, then **code 1, Yes,** should still be entered, if by midnight of the next calendar day the facility has taken the appropriate steps to comply with the prescribed/recommended action.
- CMS then examples of within the next calendar day and not
- A dash (–) value is a valid response for this item; however, CMS expects dash use to be a rare occurrence

N2005: MEDICATION INTERVENTION ITEM RATIONALE & PLANNING FOR CARE

- Integral to the process of safe medication administration practice is timely communication with a physician when a potential or actual clinically significant medication issue has been identified.
- Physician-prescribed/-recommended actions in response to identified potential or actual clinically significant medication issues must be completed by the clinician in a time frame that maximizes the reduction in risk for medication errors and resident harm.
- Potential or actual clinically significant medication issues can occur throughout the resident's stay
- Every time a potential or actual clinically significant medication issue is identified throughout the resident's stay, it must be communicated to a physician, and the physician-prescribed/-recommended actions must be completed by the clinician in a time frame that maximizes the reduction in risk for medication errors and resident harm

STEPS FOR ASSESSMENT

- The observation period for this item is from the date of admission (start of SNF PPS stay) through discharge (Part A PPS discharge).
  - 1. Review the resident's medical record to determine whether the following criteria were met for any potential and actual clinically significant medication issues that were identified upon admission or at any time during the resident's stay
    - Two-way communication between the clinician(s) and the physician was completed by midnight of the next calendar day, AND
    - All physician-prescribed/-recommended actions were completed by midnight of the next calendar day.
- Medical record sources and discussions with other staff and clinicians

CODING INSTRUCTIONS

- **Code 0, No:** if the facility did not contact the physician *and* complete prescribed/ recommended actions by midnight of the next calendar day each time a potential or actual clinically significant medication issue was identified since admission (start of SNF PPS stay).
- **Code 1, Yes:** if the facility contacted the physician *and* completed prescribed/ recommended actions by midnight of the next calendar day each time a potential or actual clinically significant medication issue was identified since admission (start of SNF PPS stay).
- **Code 9, NA:** if there were no potential or actual clinically significant medication issues identified at admission or throughout the resident's stay or the resident was not taking any medications at admission or at any time throughout the stay.

CODING EXAMPLES

- Multiple coding examples are given

SECTION O

- Clarification and example for chemotherapy:
  - Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer should **not** be coded in this item, as they are not considered chemotherapy for the purpose of coding the MDS.

VENTILATORS

- **O0100F, Invasive Mechanical Ventilator (Ventilator or respirator) :** During invasive mechanical ventilation the resident's breathing is controlled by the ventilator Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.
- **O0100G, Non-invasive Mechanical Ventilator (BiPAP/CPAP)** The BiPAP/CPAP mask/device enables the individual to **support his or her own spontaneous respiration** by providing enough pressure when the individual inhales to keep his or her airways open, unlike ventilators that "breathe" for the individual

FLU VACCINE

- **Code 3, Not eligible—medical contraindication:** if influenza vaccine not received due to medical contraindications. Influenza vaccine is contraindicated for a resident with severe reaction (e.g., respiratory distress) to a previous dose of influenza vaccine or to a vaccine component. Precautions for influenza vaccine include moderate to severe acute illness with or without fever (influenza vaccine can be administered after the acute illness) and history of Guillain-Barré Syndrome within six weeks after previous influenza vaccination. ~~Contraindications include, but are not limited to; allergic reaction to eggs or other vaccine component(s) (e.g., thimerosal preservative), previous adverse reaction to influenza vaccine, a physician order not to immunize, moderate to severe illness with or without fever, and/or history of Guillain-Barré Syndrome within 6 weeks of previous influenza vaccination.~~

PNEUMONIA VACCINE

- ~~Pneumococcal disease accounts for more deaths than any other vaccine-preventable bacterial disease.~~
- ~~Case fatality rates for pneumococcal bacteremia are approximately 20%; however, they can be as high as 60% in the elderly (CDC, 2009).~~
- Pneumococcus is one of the leading causes of community-acquired infections in the United States, with the highest disease burden among the elderly.
- Adults 65 years of age and older and those with chronic medical conditions are at increased risk for invasive pneumococcal disease and have higher case fatality rates.
- Pneumococcal vaccines can help reduce the risk of invasive pneumococcal disease and pneumonia.

PLANNING FOR CARE

- Individuals living in nursing homes and other long-term care facilities with an identified increased risk of invasive pneumococcal disease or its complications, i.e., those 65 years of age and older or with certain medical conditions, should receive pneumococcal vaccination.
- Conditions that increase the risk of invasive pneumococcal disease include: decreased immune function;, damaged or no spleen;, sickle cell and other hemoglobinopathies;, cerebrospinal fluid (CSF) leak;, cochlear implants;, and chronic diseases of the heart, lungs, liver, and kidneys, including dialysis, diabetes, alcoholism, and smoking. ~~Other risk factors include smoking and cerebrospinal fluid (CSF) leak (CDC, 2009).~~

STEPS FOR ASSESSMENT

- Note CMS removed the old instructions including the figure to determine if the pneumo vac should
  - 1. Review the resident's medical record to determine whether any pneumococcal vaccines have been received. If vaccination status is unknown, proceed to the next step.
  - 2. Ask the resident if he or /she received any pneumococcal vaccines outside of the facility. If vaccination status is still unknown, proceed to the next step.
  - 3. If the resident is unable to answer, ask the same question of a the responsible party/legal guardian and/or primary care be given.. New steps are:

STEPS FOR ASSESSMENT

- If pneumococcal vaccination status cannot be determined, administer the recommended appropriate vaccine(s) to the resident, according to the standards of clinical practice.
  - If the resident has had a severe allergic reaction to a pneumococcal vaccine or its components, the vaccine should not be administered.
  - If the resident has a moderate to severe acute illness, the vaccine should be administered after the illness.
  - If the resident has a minor illness (e.g., a cold), check with the resident's physician before administering the vaccine.

UPDATED WEB SITES

- Specific guidance about pneumococcal vaccine recommendations and timing for adults can be found at https://www.cdc.gov/vaccines/vpd/pneumo/downloads/pneumo-vaccine-timing.pdf
- "Up to date" in item O0300A means in accordance with current Advisory Committee on Immunization Practices (ACIP) recommendations.

- For up-to-date information on timing and intervals between vaccines, please refer to ACIP vaccine recommendations available at
  - https://www.cdc.gov/vaccines/schedules/hcp/index.html
  - http://www.cdc.gov/

FYI ON PNEUMO VAC

- If a resident has received one or more pneumococcal vaccinations and is indicated to get an additional pneumococcal vaccination but is not yet eligible for the next vaccination because the recommended time interval between vaccines has not lapsed, ~~and it has been less than one year since the resident received the vaccination, he/she is not yet eligible for the second pneumococcal vaccination; therefore,~~ O0300A is coded 1, yes, indicating the resident's pneumococcal vaccination is up to date.