SECTION C, D I, J, O AND Z

CO100. SHOULD BRIEF INTERVIEW FOR MENTAL STATUS BE CONDUCTED?

- PDPM cognitive level is utilized in the speech language pathology (SLP) payment component of PDPM.
- Only in the case of PPS assessments, staff may complete the Staff Assessment for Mental Status for an interviewable resident when the resident is unexpectedly discharged from a Part A stay prior to completion of the BIMS.
- In this case, the assessor should enter 0. No in CO100. Should Brief Interview for Mental Status Be Conducted? and proceed to the Staff Assessment for Mental Status.
D0350.–D0650.: SAFETY NOTIFICATION – PHQ9© AND PHQ9-OV ©

- Items removed: These items were completed when a responsible staff member or provider was informed there was a potential for resident self-harm.

SO WHAT SHOULD YOU DO IF THEY SAY “YES”

- The question regarding self harm is still there.
  - The question what we do about it is gone.
- What is your facility policy on what you should do
  - Check the resident’s history
  - Are they currently seeing a mental health provider?
  - Does the care plan include specific interventions regarding the possibility of self harm
  - Is all staff aware.
  - What specific interventions are included in the care plan for decreasing the potential of self harm
K0510. – K0710.: NUTRITIONAL APPROACHES AND PERCENT INTAKE BY ARTIFICIAL ROUTE

- Items removed from both K0510 and K0710.
- Removed references to potential State requirements for completion of items no longer collected by CMS.
- Removed text within Section K (and elsewhere in the manual) regarding items no longer collected by CMS.
- Missouri does not require this information. If you are not from MO please check with your State RAI Coordinator.

K0510. NUTRITIONAL APPROACHES

Removed items K0510C and D from Column 1. While NOT a Resident.

<table>
<thead>
<tr>
<th>K0510. Nutritional Approaches</th>
<th>1. While NOT a Resident</th>
<th>2. While a Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check all of the following nutritional approaches that were performed during the last 7 days.</td>
<td>Downarrow</td>
<td>Downarrow</td>
</tr>
<tr>
<td>1. While NOT a Resident</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Performed while NOT a resident of this facility and within the last 7 days. Only check column 1 if resident entered (admission or reentry) IN THE LAST 7 DAYS. If resident last entered 7 or more days ago, leave column 1 blank.</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>2. While a Resident</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Performed while a resident of this facility and within the last 7 days.</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>A. Parenteral/IV feeding</td>
<td>[ ]</td>
<td>[ ]</td>
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<tr>
<td>B. Feeding tube - nasogastric or abdominal (PEG)</td>
<td>[ ]</td>
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<tr>
<td>C. Mechanically altered diet - require change in texture of food or liquids (e.g., pureed food, thickened liquids)</td>
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<tr>
<td>D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)</td>
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<tr>
<td>Z. None of the above</td>
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</tbody>
</table>
**K0710. PERCENT INTAKE BY ARTIFICIAL ROUTE**

Removed Column 1. While NOT a Resident.

<table>
<thead>
<tr>
<th>2. While a Resident</th>
<th>2. While a Resident</th>
<th>3. During Entire 7 Days</th>
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</thead>
<tbody>
<tr>
<td>Performed <em>while a resident</em> of this facility and within the last 7 days</td>
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<tr>
<td>Performed during the entire last 7 days</td>
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</tbody>
</table>

A. Proportion of total calories the resident received through parenteral or tube feeding
- 1. 25% or less
- 2. 26-50%
- 3. 51% or more

B. Average fluid intake per day by IV or tube feeding
- 1. 500 cc/day or less
- 2. 501 cc/day or more

---

**OO100L. RESPITE CARE**

Removed O0100L. Respite Care from Column 1. While NOT a Resident

<table>
<thead>
<tr>
<th>O0100L. Special Treatments, Procedures, and Programs</th>
<th>While NOT a Resident</th>
<th>While a Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Treatments</td>
<td></td>
<td></td>
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<tr>
<td>A. Chemotherapy</td>
<td></td>
<td></td>
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<tr>
<td>B. Radiation</td>
<td></td>
<td></td>
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<tr>
<td>Respiratory Treatments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Oxygen Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Suctioning</td>
<td></td>
<td></td>
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<tr>
<td>E. Tracheostomy care</td>
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<tr>
<td>F. Invasive Mechanical Ventilator (ventilator or respiration)</td>
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<tr>
<td>G. Non-Invasive Mechanical Ventilator (SIMV/CPAP)</td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
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<tr>
<td>H. IV medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Transfusions</td>
<td></td>
<td></td>
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<tr>
<td>J. Dialysis</td>
<td></td>
<td></td>
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<tr>
<td>K. Hospice care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L. Isolation or quarantine for active infectious disease (does not include standard body/fluid isolation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M. None of the Above</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N. None of the above</td>
<td></td>
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</tbody>
</table>
SECTION I. ACTIVE DIAGNOSES: INTENT

- The items in this section are intended to code diseases that have a direct relationship to the resident’s current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death.
- One of the important functions of the MDS 3.0 assessment is to generate an updated, accurate picture of the resident’s current health status.

REVISIONS: I0020 AND I0020B
**I0020. ITEM RATIONALE**

- **Health - Related Quality of Life:** Disease processes can have a significant adverse effect on resident's functional improvement.

- **Planning for Care:** Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay.

**I0020. STEPS FOR ASSESSMENT**

- Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay.

- Carol: Why are you skillling them???
I0020. STEPS FOR ASSESSMENT (CONT. 1)

- Medical Record Resources
- Transfer Documents
- Discharge Summaries
- History and Physical
- Progress Notes
- Other resources

I0020. STEPS FOR ASSESSMENT (CONT. 2)

- There are 13 primary condition categories associated with the SNF Admission:
  - Stroke.
  - Non-Traumatic Brain Dysfunction.
  - Traumatic Brain Dysfunction.
  - Non-Traumatic Spinal Cord Dysfunction.
  - Traumatic Spinal Cord Dysfunction.
  - Progressive Neurological Conditions.
  - Other Neurological Conditions.
I0020. STEPS FOR ASSESSMENT (CONT. 3)

- Amputation.
- Hip and Knee Replacement.
- Fractures and Other Multiple Trauma.
- Other Orthopedic Conditions.
- Debility, Cardiorespiratory Conditions.
- Medically Complex Conditions.

I0020. CODING INSTRUCTIONS

- Complete only if A0310B = 01 (Start of Part A Prospective Payment System (PPS) stay) or A0310B = 08 (Interim Payment Assessment).
- Indicate the resident’s primary medical condition category that best describes the primary reason for the Medicare Part A stay, then proceed to I0020B and enter the ICD Code for that condition (with decimal).
- Include the primary medical condition coded in Item I0020 in Section I0100 through I8000: Active Diagnoses in the Last 7 Days.
I0020. CODING INSTRUCTIONS (CONT. 1)

- **Code 01, Stroke.** Examples include ischemic stroke, subarachnoid hemorrhage, cerebral vascular accident (CVA), and other cerebrovascular disease.

- **Code 02, Non-Traumatic Brain Dysfunction.** Examples include Alzheimer’s disease, dementia with or without behavioral disturbance, malignant neoplasm of brain, and anoxic brain damage.

- **Code 03, Traumatic Brain Dysfunction.** Examples include traumatic brain injury, severe concussion, and cerebral laceration and contusion.

I0020. CODING INSTRUCTIONS (CONT. 2)

- **Code 04, Non-Traumatic Spinal Cord Dysfunction.** 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.** Examples include paraplegia and quadriplegia following trauma.

- **Code 06, Progressive Neurological Conditions.** Examples include multiple sclerosis and Parkinson’s disease.
I0020. CODING INSTRUCTIONS (CONT. 3)

• Code 07, Other Neurological Conditions. Examples include cerebral palsy, polyneuropathy, and myasthenia gravis.

• Code 08, Amputation. For example, acquired absence of limb.

• Code 09, Hip and Knee Replacement. For example, total knee replacement.
  • If hip replacement is secondary to hip fracture, code as a fracture.

• Code 10, Fractures and Other Multiple Trauma. Examples include hip fracture, pelvic fracture, and fracture of tibia and fibula.

I0020. CODING INSTRUCTIONS (CONT. 4)

• Code 11, Other Orthopedic Conditions. For example, unspecified disorders of joint.

• Code 12, Debility, Cardiorespiratory Conditions. Examples include chronic obstructive pulmonary disease (COPD), asthma, and other malaise and fatigue.

• Code 13, Medically Complex Conditions. Examples include diabetes, pneumonia, chronic kidney disease, open wounds, pressure ulcer/injury, infection, and disorders of fluid, electrolyte, and acid-base balance.
I5900. BIPOLAR DISORDER

I5900, manic - depression (bipolar disease) was changed to bipolar disorder.

SECTION J. HEALTH CONDITIONS: INTENT

- The last sentence of the Intent statement was updated to reflect the new items in this section:
  - Prior Surgery.
  - Recent Surgery Requiring Active SNF Care.
  - Surgical Procedures
J1800: CODING INSTRUCTIONS

- Coding Instructions were updated to allow for a new skip pattern:
  - **Code 0. No**, if the resident has not had any fall since the last assessment: If the assessment being completed is an OBRA assessment, skip to Swallowing Disorder item (K0100).
  - If the assessment being completed is a Scheduled PPS assessment, skip to Prior Surgery item (J2000).

J1900. NUMBER OF FALLS SINCE ADMISSION/ENTRY OR PRIOR ASSESSMENT (OBRA OR SCHEDULED PPS), WHICHEVER IS MORE RECENT

<table>
<thead>
<tr>
<th>Coding:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. None</td>
</tr>
<tr>
<td>1. One</td>
</tr>
<tr>
<td>2. Two or more</td>
</tr>
</tbody>
</table>

A. **No injury** - no evidence of any injury noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall

B. **Injury (except major)** - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain

C. **Major injury** - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma
J1900. EXAMPLES CLARIFIED

• Two examples were clarified:
  • Example 1.
    – A nursing note states that Mrs. K. slipped out of her wheelchair onto the floor while at the dining room table. Before being assisted back into her chair, a range of motion assessment was completed that indicated no injury. A skin assessment conducted shortly after the fall also revealed no injury.
    – **Coding:** J1900A, No injury would be **coded 1, one**.
    – **Rationale:** Slipping to the floor is a fall. No injury was noted.

J1900. EXAMPLES CLARIFIED

• Example 5.
  – Mr. R. fell on his right hip in the facility on the Assessment Reference Date (ARD) of his Quarterly MDS and complained of mild right hip pain. The initial x-ray of the hip did not show any injury. The nurse completed Mr. R’s Quarterly Assessment and coded the assessment to reflect this information. The assessment was submitted to QIESASAP. Three days later, Mr. R. complained of increasing pain and had difficulty ambulating, so a follow-up x-ray was done. The follow-up x-ray showed a hairline fracture of the right hip. This injury is noted by the physician to be attributed to the recent fall that occurred during the look-back period of the Quarterly Assessment.
• **Original Coding:**
  - J1900B, Injury (except major) is **coded 1, one** and J1900C, Major Injury is **coded 0, none**.

• **Rationale:**
  - Mr. R. had a fall-related injury that caused him to complain of pain.

• **Modification of Quarterly Assessment:**
  - J1900B, Injury (except major), is coded 0, none; and J1900C, Major Injury, is coded 1, one.

---

• **Rationale:**
  - The extent of the injury did not present right after the fall; however, it was directly related to the fall that occurred during the look-back period of the Quarterly Assessment.
  - Since the assessment had been submitted to QIES ASAP and the level of injury documented on the submitted Quarterly was not found to be different based on a repeat x-ray of the resident’s hip, the Quarterly Assessment needed to be modified to accurately reflect the injury sustained during that fall.
J2100. RECENT SURGERY REQUIRING ACTIVE SNF CARE

J2100 is completed only if A0310B = 01 (5 - Day PPS) or 08 (Interim Payment Assessment).
Complete J2300 through J5000 if J2100 is coded as 1, Yes.

J2100. ITEM RATIONALE

- **Health - Related Quality of Life:** A recent history of major surgery during the inpatient stay that preceded the resident's Part A admission can affect a resident’s recovery.

- **Planning for Care:** This item identifies whether the resident had major surgery during the inpatient stay that immediately preceded the resident's Part A admission. A recent history of major surgery can affect a resident’s recovery.
J2100. STEPS FOR ASSESSMENT

• Ask the resident and his or her family or significant other about any surgical procedures that occurred during the inpatient hospital stay that immediately preceded the resident’s Part A admission.

• Review the resident’s medical record to determine whether the resident had major surgery during the inpatient hospital stay that immediately preceded the resident’s Part A admission.

J2100. STEPS FOR ASSESSMENT

• Medical Record Resources
  – Transfer documents
  – Discharge Summaries
  – History and Physical
  – Progress Notes
  – Other resources
J2100. CODING INSTRUCTIONS

• **Code 0, No:** If the resident did not have major surgery during the inpatient hospital stay that immediately preceded the resident’s Part A admission.

• **Code 1, Yes:** If the resident had major surgery during the inpatient hospital stay that immediately preceded the resident’s Part A admission.

• **Code 8, Unknown:** If it is unknown or cannot be determined whether the resident had major surgery during the inpatient hospital stay that immediately preceded the resident’s Part A admission.

J2100 CODING TIPS

• Generally, major surgery for item J2100 refers to a procedure that meets the following criteria:
  - The resident was an inpatient in an acute care hospital for at least one day in the 30 days prior to admission to the SNF, and
  - The surgery carried some degree of risk to the resident’s life or the potential for severe disability.
**J2300 – J5000 SURGICAL PROCEDURES**

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

**J2300 – J5000 ITEM RATIONALE**

- **Health - Related Quality of Life:** A recent history of major surgery during the inpatient stay that preceded the resident’s Part A admission can affect a resident’s recovery.

- **Planning for Care:** This item identifies whether the resident had major surgery during the inpatient stay that immediately preceded the resident’s Part A admission. A recent history of major surgery can affect a resident’s recovery.
J2300 – J5000 STEPS FOR ASSESSMENT

• **Identify recent surgeries:** The surgeries in this section must have been documented by a physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days and must have occurred during the inpatient stay that immediately preceded the resident’s Part A admission.

J2300 – J5000 STEPS FOR ASSESSMENT

• **Determine whether the surgeries require active care during the SNF stay:** Once a recent surgery is identified, it must be determined if the surgery requires active care during the SNF stay.
  - Surgeries requiring active care during the SNF stay are surgeries that have a direct relationship to the resident’s primary SNF diagnosis, as coded in I0020B.
  - Do not include conditions that have been resolved, do not affect the resident’s current status, or do not drive the resident’s plan of care during the 7-day look-back period.
  - Check information sources in the medical record for the last 30 days to identify “active” surgeries.
J2300 – J5000 STEPS FOR ASSESSMENT

• Medical Record Resources
  – Transfer documents
  – Discharge Summaries
  – History and Physical
  – Progress Notes
  – Other resources

How do you determine whether a surgery should be coded as requiring active care during the SNF stay?

  – Specific documentation in the medical record indicates that the SNF stay is for treatment related to the surgical intervention.
  – No specific documentation exists, but complexity of services prescribed can only be performed safely/effectively by or under general supervision of skilled nursing and/or rehabilitation, such as:
    • Surgical wound care.
    • Daily skilled rehabilitative therapies.
    • Administration of medication and skilled monitoring.
J2300 – J5000 CODING INSTRUCTIONS

• Key Points:
  – Complete J2300 through J5000 only if J2100 is coded as 1, Yes.
  – Check all surgeries that: Are documented to have occurred in the last 30 days.
    • Occurred during the inpatient stay that immediately preceded the resident’s Part A admission.
    • Have a direct relationship to the resident’s primary SNF diagnosis, as coded in I0020B.
    • Drive the resident’s plan of care during the 7-day look-back period.

SECTION 0. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS: INTENT

• The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received during the specified time periods.
00400. THERAPIES

- Group therapy was updated from four to “two to six” residents under the following headings:
  - Steps for Assessment – Group Minutes.
  - Co - Treatment – For Part A.
  - Modes of Therapy – Group Therapy Medicare Part A.

- Examples within this section were revised to update year from 2011 to 2019/2020.

00425. PART A THERAPIES

<table>
<thead>
<tr>
<th>Enter Number of Minutes</th>
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<th>Enter Number of Days</th>
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**A. Speech-Language Pathology and Audiology Services**

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident individually since the start date of the resident’s most recent Medicare Part A stay (A2400B)
2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident concurrently with one other resident since the start date of the resident’s most recent Medicare Part A stay (A2400B)
3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as part of a group of residents since the start date of the resident’s most recent Medicare Part A stay (A2400B)
4. **Co-treatment minutes** - record the total number of minutes this therapy was administered to the resident in co-treatment sessions since the start date of the resident’s most recent Medicare Part A stay (A2400B)
5. **Days** - record the number of days this therapy was administered for at least 15 minutes a day since the start date of the resident’s most recent Medicare Part A stay (A2400B)

If the sum of individual, concurrent, and group minutes is zero, skip to 00425B, Occupational Therapy.
### 00425. Part A Therapies

**B. Occupational Therapy**

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<td>Enter Number of Minutes:</td>
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<td>Enter Number of Days:</td>
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</tr>
</tbody>
</table>

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

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

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

If the sum of individual, concurrent, and group minutes is zero, skip to 00425C, Physical Therapy.

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

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

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### 00425. Part A Therapies

**C. Physical Therapy**

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<td>Enter Number of Minutes:</td>
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<tr>
<td>Enter Number of Days:</td>
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</tr>
</tbody>
</table>

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

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

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

If the sum of individual, concurrent, and group minutes is zero, skip to 00430, Distinct Calendar Days of Part A Therapy.

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

5. **Days** - record the number of days this therapy was administered for at least 15 minutes a day since the start date of the resident's most recent Medicare Part A stay (A2400B).
00425. ITEM RATIONALE

• Health - Related Quality of Life:
  – Maintaining as much independence as possible in activities of daily living, mobility, and communication is critically important to most people.
  – Functional decline can lead to depression, withdrawal, social isolation, breathing problems, and complications of immobility — such as incontinence and pressure ulcers/injuries — which contribute to diminished quality of life.

00425. ITEM RATIONALE

• The qualified therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents.
  • Rehabilitation (i.e., via Speech - Language Pathology Services and Occupational and Physical Therapies) and respiratory, psychological, and recreational therapy can help residents attain or maintain their highest level of well - being and improve their quality of life.
00425. ITEM RATIONALE

- **Planning for Care:**
  - Code only medically necessary therapies that occurred after admission/readmission to the nursing home that were: Ordered by a physician based on a qualified therapist’s assessment and treatment plan.
    - Documented in the resident’s medical record.
    - Care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective.
    - Therapy treatment may occur either inside or outside of the facility.

00425. STEPS FOR ASSESSMENT

- Complete only if A0310H (Is this a SNF Part A PPS Discharge Assessment?) = 1. Yes.
- Review the resident’s medical record (e.g., rehabilitation therapy evaluation and treatment records, recreation therapy notes, mental health professional progress notes) and consult with each of the qualified care providers to collect the information required for this item.
00425. STEPS FOR ASSESSMENT

- Look back for these items is the entire SNF Part A stay, starting at Day 1 of the Part A stay and finishing on the last day of the Part A stay.
- Once reported on the MDS, CMS grouping software will calculate by discipline the combined percentage of group and concurrent therapy that was provided to each patient as a percentage of all therapies provided to that patient.
- If the combined amount of group and concurrent therapy provided, by discipline, exceeds 25 percent, this would be deemed as non-compliance and a warning message would be received on the assessment validation report.

00425. STEPS FOR ASSESSMENT

- Providers should follow the steps outlined below for calculating compliance with the concurrent/group therapy limit:
  - Step 1: Total Therapy Minutes, by discipline (O0425X1 + O0425X2 + O0425X3).
  - Step 2: Total Concurrent and Group Therapy Minutes, by discipline (O0425X2+O0425X3).
  - Step 3: Concurrent/Group Ratio (Step 2 result/Step 1 result).
  - Step 4: If Step 3 result is greater than 0.25, then the provider is non-compliant.
00425. MODES OF THERAPY

- A resident may receive therapy via different modes during the same day or even treatment session. These modes are:
  - Individual,
  - Concurrent, and
  - Group therapy.

- When developing the plan of care, the therapist and assistant must determine which mode(s) of therapy and the amount of time the resident receives for each mode and code the MDS appropriately.

00425. MODES OF THERAPY

- The therapist and assistant should document the reason a specific mode of therapy was chosen as well as anticipated goals for that mode of therapy.
- For any therapy that does not meet one of the therapy mode definitions, those minutes may not be counted on the MDS.
00425. CODING TIPS AND SPECIAL POPULATIONS

• For detailed descriptions of how to code minutes of therapy and an explanation of skilled versus nonskilled therapy services, co-treatment, therapy aides, and students, please refer to these topic headings in the discussion of item O0400 in Section O of the RAI Manual.

00425. CODING INSTRUCTIONS: PART A THERAPY MINUTES

• Individual Therapy:
  – Treatment provided by one therapist or assistant to one resident at a time.

• Individual Minutes
  – Enter the total number of minutes of therapy that were provided on an individual basis during the entire Part A stay (i.e., from the date in A2400B through the date in A2400C).
  – Enter 0 if none were provided.
00425. CODING INSTRUCTIONS: PART A THERAPY MINUTES

- Concurrent Therapy: Treatment of two residents at the same time when the residents are **not** performing the same or similar activities, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant.

- Concurrent Minutes: Enter the total number of minutes of therapy that were provided on a concurrent basis during the entire Part A stay (i.e., from the date in A2400B through the date in A2400C). Enter 0 if none were provided.

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00425. CODING INSTRUCTIONS: PART A THERAPY MINUTES

- **Group Therapy**: Treatment of two to six residents, regardless of payer source, who are performing the same or similar activities and are supervised by a therapist or an assistant who is not supervising any other individuals.

- **Group Therapy Minutes**: Enter the total number of minutes of therapy that were provided in a group during the entire Part A stay (i.e., from the date in A2400B through the date in A2400C).

- Enter 0 if none were provided.
00425. CODING INSTRUCTIONS: PART A THERAPY MINUTES

- Co-Treatment: When two clinicians (therapists or therapy assistants), each from a different discipline, treat one resident at the same time with different treatments.
- Co-Treatment Minutes: Enter the total number of minutes each discipline of therapy was administered to the resident in co-treatment sessions during the entire Part A stay (i.e., from the date in A2400B through the date in A2400C).
- Skip the item if none were provided

00425. CODING INSTRUCTIONS: THERAPY DAYS

- Remember: A day of therapy is defined as skilled treatment for 15 minutes or more during the day. Use total minutes of therapy provided (individual, plus concurrent, plus group), without any adjustment to determine if the day is counted.
- If the resident receives more than one therapy discipline on a given calendar day, this may only count for 1 calendar day for the purposes of coding this item.
00425. CODING INSTRUCTIONS: THERAPY DAYS

• Speech-Language Pathology Days
  – Enter the number of days speech-language pathology therapy services were provided over the entire Part A stay (i.e., from the date in A2400B through the date in A2400C).
  – Enter 0 if therapy was provided but for less than 15 minutes every day during the stay.
  – If the total number of minutes (individual, plus concurrent, plus group) during the stay is 0, skip this item and leave blank.

• Occupational Therapy Days
  – Enter the number of days occupational therapy services were provided over the entire Part A stay (i.e., from the date in A2400B through the date in A2400C).
  – Enter 0 if therapy was provided but for less than 15 minutes every day during the stay.
  – If the total number of minutes (individual, plus concurrent, plus group) during the stay is 0, skip this item and leave blank.
00425. CODING INSTRUCTIONS: THERAPY DAYS

- Physical Therapy Days
  - Enter the number of days physical therapy services were provided over the entire Part A stay (i.e., from the date in A2400B through the date in A2400C).
  - Enter 0 if therapy was provided but for less than 15 minutes every day during the stay.
  - If the total number of minutes (individual, plus concurrent, plus group) during the stay is 0, skip this item and leave blank.

00430  DISTINCT CALENDAR DAYS OF PART A THERAPY

This item is completed only on a Part A PPS Discharge Assessment (A0310H = 1).
00430 ITEM RATIONALE

• To record the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, OT, or PT for at least 15 minutes during the Part A SNF stay.

00430 CODING INSTRUCTIONS

• Enter the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, OT, or PT for at least 15 minutes during the SNF Part A stay (i.e., from the date in A2400B through the date in A2400C).

• If a resident receives more than one therapy discipline on a given calendar day, this may only count for 1 calendar day for the purposes of coding item 00430.
**00450 RESUMPTION OF THERAPY**

- This item is no longer required by CMS; however, some States continue to require its completion. It is important to know your State's requirements for completing this item.
- This item is not needed in the state of Missouri.

**00500 RESTORATIVE NURSING**

- Steps for Assessment:
- In the third Step for Assessment, fourth and fifth bullets, a statement was added related to **not coding** services that actually require the involvement of a qualified therapist in this item, and ensure that those services are coded in O0400 and O0425 for restorative nursing.
## V0100. ITEMS FROM THE MOST RECENT PRIOR OBRA OR SCHEDULED PPS ASSESSMENT

Removed Retired PPS Assessment Response Codes from V0100B and Added Response Code 08 for IPA.

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<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>01</td>
<td>Admission assessment (required by day 14)</td>
</tr>
<tr>
<td>02</td>
<td>Quarterly review assessment</td>
</tr>
<tr>
<td>03</td>
<td>Annual assessment</td>
</tr>
<tr>
<td>04</td>
<td>Significant change in status assessment</td>
</tr>
<tr>
<td>05</td>
<td>Significant correction to prior comprehensive assessment</td>
</tr>
<tr>
<td>06</td>
<td>Significant correction to prior quarterly assessment</td>
</tr>
<tr>
<td>99</td>
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**B. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment)**

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<tbody>
<tr>
<td>01</td>
<td>Today's scheduled assessment</td>
</tr>
<tr>
<td>99</td>
<td>None of the above</td>
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**C. Prior Assessment Reference Date (A2500 value from prior assessment)**

<table>
<thead>
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<th>Day</th>
<th>Year</th>
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</thead>
</table>

**D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 value from prior assessment)**

**E. Prior Assessment Resident Mood Interview (PHQ-9/9-V) Total Severity Score (D0300 value from prior assessment)**

**F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score (D0600 value from prior assessment)**

## X0570. OPTIONAL STATE ASSESSMENT NOT IN MO

<table>
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<th>Code</th>
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<tbody>
<tr>
<td>A. Is this assessment for state payment purposes only?</td>
<td></td>
</tr>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
</tbody>
</table>

**B. Assessment type**

1. Start of therapy assessment
2. End of therapy assessment
3. Both Start and End of therapy assessment
4. Change of therapy assessment
5. Other payment assessment