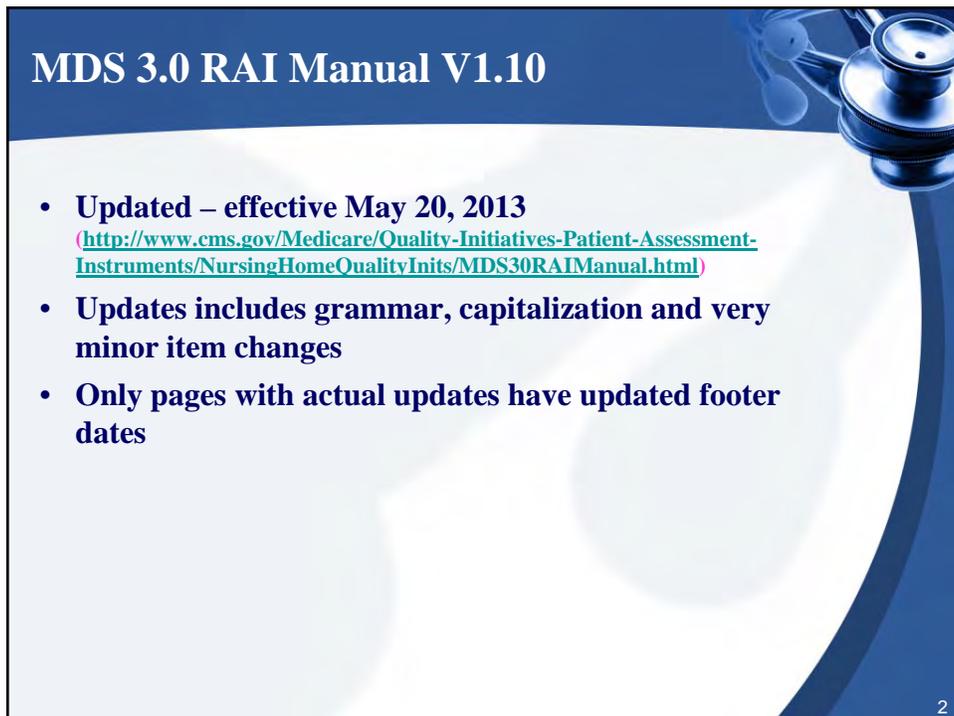


A blue-tinted image of a stethoscope in the upper left corner, with a faint, light-colored silhouette of a hand in the background. The overall design is clean and professional, with a dark blue curved border on the right side.

*Minimum Data Set 3.0 Coding and
Interpretation Training
Version 1.10
August 8th - 9th, 2013*

1

A blue-tinted image of a stethoscope in the upper right corner, with a faint, light-colored silhouette of a hand in the background. The overall design is clean and professional, with a dark blue curved border on the right side.

MDS 3.0 RAI Manual V1.10

- **Updated – effective May 20, 2013**
<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html>
- **Updates includes grammar, capitalization and very minor item changes**
- **Only pages with actual updates have updated footer dates**

2

Proposed MDS 3.0 V1.11.1 (Draft) and RAI Manual Update

- Next update to the item sets (MDS) and manual expected in September 2013
- Changes effective October 2013
- More substantial changes
- Anticipated changes include:
 - Therapy
 - ADL clarification
 - RUG Classification



3



*Proposed
MDS 3.0 Form Changes
Effective 10/1/2013*

4

Section H

- **H0200A -- Added to the following item sets:**
 - **OMRA Assessments**
 - **Discharge Assessments**
 - **PPS Assessments**

H0200. Urinary Toileting Program	
Enter Code <input type="checkbox"/>	<p>A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility?</p> <p>0. No → Skip to H0300, Urinary Continence</p> <p>1. Yes → Continue to H0200B, Response</p> <p>9. Unable to determine → Skip to H0200C, Current toileting program or trial</p>

5

Section K

- **K0700 Deleted**
- **Replaced with K0710**
 - **While a resident/While Not a Resident/Entire 7 days**

K0710. Percent Intake by Artificial Route - Complete K0710 only if Column 1 and/or Column 2 are checked for K0510A and/or K0510B			
	1. While NOT a Resident	2. While a Resident	3. During Entire 7 Days
	Enter Codes		
<p>1. While NOT a Resident Performed <i>while NOT a resident</i> of this facility and within the <i>last 7 days</i>. Only enter a code in 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.</p> <p>2. While a Resident Performed <i>while a resident</i> of this facility and within the <i>last 7 days</i>.</p> <p>3. During Entire 7 Days Performed during the entire <i>last 7 days</i>.</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>A. Proportion of total calories the resident received through parenteral or tube feeding</p> <p>1. 25% or less</p> <p>2. 26-50%</p> <p>3. 51% or more</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>B. Average fluid intake per day by IV or tube feeding</p> <p>1. 500 cc/day or less</p> <p>2. 501 cc/day or more</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6

Section M

- **M0210 – Added to the following item sets:**
 - **OMRA Assessments**
 - **Discharge Assessments**

M0210. Unhealed Pressure Ulcer(s)	
Enter Code:	Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?
<input type="checkbox"/>	0. No → Skip to M0900, Healed Pressure Ulcers
	1. Yes → Continue to M0300, Current Number of Unhealed Pressure Ulcers at Each Stage

7

Section N

- **N0300 – Added to the following item sets:**
 - **OMRA Assessments**
 - **Discharge Assessments**

N0300. Injections	
Enter Days:	Record the number of days that injections of any type were received during the last 7 days or since admission/entry or reentry if less than 7 days. If 0 → Skip to N0410, Medications Received
<input type="checkbox"/>	

8

Section O

- O0400A4, O0400B4 and O0400C4 removed from Discharge Assessments
- Therapy Start and End Dates will remain on Discharge Assessments

O0400. Therapies	
Enter Number of Days <input type="checkbox"/>	A. Speech-Language Pathology and Audiology Services 4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days. 5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started [] [] - [] [] [] [] <small>Month Day Year</small> 6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing [] [] - [] [] [] [] <small>Month Day Year</small>
Enter Number of Days <input type="checkbox"/>	B. Occupational Therapy 4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days. 5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started [] [] - [] [] [] [] <small>Month Day Year</small> 6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing [] [] - [] [] [] [] <small>Month Day Year</small>
Enter Number of Days <input type="checkbox"/>	C. Physical Therapy 4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days. 5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started [] [] - [] [] [] [] <small>Month Day Year</small> 6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing [] [] - [] [] [] [] <small>Month Day Year</small>

9

Section O

- O0400A3A, O0400B3A and O0400C3A – New Item, Co-Treatment Minutes

Enter Number of Minutes [] [] [] []	B. Occupational Therapy 1. Individual minutes - record the total number of minutes this therapy was administered to the resident individually in the last 7 days 2. Concurrent minutes - record the total number of minutes this therapy was administered to the resident concurrently with one other resident in the last 7 days 3. Group minutes - record the total number of minutes this therapy was administered to the resident as part of a group of residents in the last 7 days If the sum of individual, concurrent, and group minutes is zero, => skip to O0400B5, Therapy start date 3A. Co-treatment minutes - record the total number of minutes this therapy was administered to the resident in co-treatment sessions in the last 7 days 4. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days 5. Therapy start date - record the date the most recent therapy regimen (since the most recent entry) started [] [] - [] [] [] [] <small>Month Day Year</small> 6. Therapy end date - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing [] [] - [] [] [] [] <small>Month Day Year</small>
Enter Number of Minutes [] [] [] []	
Enter Number of Minutes [] [] [] []	
Enter Number of Minutes [] [] [] []	
Enter Number of Days <input type="checkbox"/>	

10



CMS Proposed Rule

FY 2014

Rehab RUG Classification

- **Rehab Medium**
 - 5 days across any combination of disciplines
- **Rehab Low**
 - 3 days across any combination of disciplines (plus required restorative nursing programs)

A blue stethoscope is positioned in the upper right corner of a white rectangular area. To the left, a faint, light blue silhouette of a hand is visible. The entire graphic is set against a white background with a dark blue curved border on the right side.

Rehab RUG Classification

Daily Skilled Criteria

- §409.31(b)(1) that skilled services must be needed and received on a daily basis, and the provision at §409.34(a)(2) which specifies that the “daily basis” criterion can be met by skilled rehabilitation services that are needed and provided at least 5 days per week

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Rehab RUG Classification

- PT provided M, W and Friday (90 Minutes total)
- OT provided M and Friday (60 Minutes total)

Resident qualifies for Rehab Medium based on current policy, even though only received therapy on 3 distinct calendar days.

Does not meet “daily” skilled criteria

14

Addition of New MDS Item

- **Item O0420, Distinct Calendar Days**
- **Will allow appropriate and accurate classification into the RM RUG category**
- **Will require software grouper changes**
- **Comment period through**

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A blue stethoscope is positioned in the upper left corner of the slide, with its chest piece and earbuds visible. The background is a light blue gradient with a faint, larger-scale stethoscope pattern.

Chapter 1

Resident Assessment Instrument (RAI) (V1.10)

Overview of RAI

- **Layout of the RAI and MDS:**
 - **Content**
 - **Completion**
 - **Problem identification**
- **Listing of all MDS sections (A-Z)**
- **Protecting privacy of the MDS data**



Completion of the RAI

- **Primary uses of the MDS as an assessment tool:**
 - **Using data collected for the Medicare and Medicaid Payment Systems**
 - **Monitoring the quality of care/quality measures (QM) to assist:**
 - **State Survey and Certification staff in identifying potential care problems**
 - **Nursing home providers with quality improvement activities/efforts**
 - **Nursing home consumers in understanding the quality of care provided by a nursing home**
 - **CMS with long-term quality monitoring and program planning**

Completion of the RAI

- **Primary uses of the MDS as an assessment tool (continued):**
 - **Consumer access to nursing home information including:**
 - Nursing home compare
 - Staffing
 - Quality of care measures
 - **Adapted for the hospital swing bed program**



Completion of the RAI

- **Federal regulations 42 CFR 483.20 require that:**
 - **The assessment accurately reflects the resident's status**
 - **A registered nurse conducts or coordinates each assessment with the appropriate participation of health professionals**
 - **The assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts**



Completion of the RAI

- **Nursing homes are left to determine:**
 - **Who should participate in the assessment process**
 - **How the assessment process is completed**
 - **How the assessment information is documented while remaining in compliance with the requirements of the Federal regulations and the instructions contained within the RAI manual**
- **Completion of the RAI is best accomplished by:**
 - **An interdisciplinary team (IDT) that includes nursing home staff with varied clinical backgrounds, including nursing staff and the resident's physician**



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Completion of the RAI

- **An accurate assessment requires:**
 - **Collecting information from multiple sources:**
 - **Resident (mandated by regulations)**
 - **Direct care staff on all shifts (mandated by regulations)**
 - **Resident's medical record**
 - **Physician**
 - **Family**
 - **Guardian**
 - **Significant other as appropriate or acceptable**



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Completion of the RAI

- **Documentation should:**
 - **Contribute to identification and communication of a resident's problems, needs and strengths**
 - **Monitor the resident's condition on an on-going basis**
 - **Record treatment and response to treatment**
 - **Verify services and conditions relevant to the RUG classification system where applicable and or directed by the state**

NOTE: *Completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident*

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Completion of the RAI

- **RAI provides a structured, standardized approach for applying a problem identification process**
- **Nursing process could include:**
 - **Assessment (MDS)**
 - **Decision Making (CAA)**
 - **Identification of Outcomes**
 - **Care Planning**
 - **Implementation**
 - **Evaluation**

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Completion of the RAI

- **Protecting the privacy of the MDS data:**
 - **42 CFR Part 483.20** requires (Medicare and/or Medicaid) providers to collect resident data
 - **MDS data is protected under the conditions of participation (COP)**
 - **CFR 483.75 (1)(2)(3) and 483.75 (1)(2)(4)(i)(ii)(iii)** allows release of resident clinical record data only when required by:
 1. **Transfer to another health care institution**
 2. **Law (both State & Federal), and/or**
 3. **The resident**

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Chapter 2

Assessments for the Resident Assessment Instrument (RAI) (V1.10)

26

Introduction to the Requirements for the RAI

- **The statutory authority for the RAI is found in:**
 - Section 1819(f)(6)(A-B) for Medicare
 - 1919(f)(6)(A-B) for Medicaid
 - Social Security Act (SSA)
 - Amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987)



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Introduction to the Requirements for the RAI

- **The OBRA regulations require:**
 - Medicare certified, Medicaid certified or both to conduct initial and periodic assessments for all residents
 - RAI process is used as the basis for the accurate assessment of each nursing home resident
 - MDS 3.0 is part of that assessment process and is required by CMS
 - Required for PPS under Part A



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Introduction to the Requirements for the RAI

- **When OBRA and Medicare PPS assessment time frames coincide:**
 - One assessment may be used to satisfy both requirements
 - The most stringent requirement for MDS completion must be met
 - Nursing home staff fully understand the requirements for both types of assessments



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Nursing Home Responsibilities for Completing Assessments

- **RAI must be completed for any resident including:**
 - All residents regardless of payer
 - Hospice residents
 - Short-term or respite residents
 - Special populations
 - Swing bed residents
- **Prospective Payment System (PPS) – Medicare reimbursement for Part A:**
 - Required by Balanced Budget Act of 1997 for SNFs and hospitals with a swing bed agreement
 - Residents whose stay is covered by Part A
 - Two types of PPS assessments:
 - Scheduled
 - Unscheduled
 - Must also follow OBRA requirements



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Nursing Home Responsibilities for Completing Assessments

- The RAI process must be used with residents in facilities with different certification situations, including:
 - Newly Certified Nursing Homes
 - Adding Certified Beds
 - Change In Ownership
 - Resident Transfers:
 - Traditional
 - Natural disasters



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Nursing Home Responsibilities for Maintaining Assessments

- The Federal regulatory requirement at 42 CFR 483.20(d) requires nursing homes to maintain all resident assessments completed within the previous 15 months in the resident's active clinical record. This requirement applies to all MDS assessment types regardless of the form of storage (i.e., electronic or hard copy).



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Nursing Home Responsibilities for Maintaining Assessments

- The 15-month period for maintaining assessment data may **not** restart with each readmission to the facility:
 - When a resident is *discharged return anticipated* and returns to the facility within 30 days, facility must copy the previous RAI and transfer that copy to the chart
 - When a resident is *discharged return anticipated* and does **not** return within 30 days or *discharged return not anticipated*, facilities may develop their own policies for copying the previous record or not



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Nursing Home Responsibilities for Maintaining Assessments

- After the 15-month period, RAI information may be thinned, provided that it is easily retrievable except:
 - Demographic information (A0500-A1600) from the most recent Admission assessment **must** be maintained in the active clinical record until resident discharged return **not** anticipated
- Nursing homes may use electronic signatures:
 - Written policies must be in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs



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Nursing Home Responsibilities for Maintaining Assessments

- **Have the option for a resident's clinical record to be maintained electronically rather than in hard copy**
- **In cases where the MDS is maintained electronically without the use of electronic signatures, must maintain in the active record hard copies signed and dated of the:**
 - **CAA(s) completion (V0200B-C)**
 - **Correction completion (X1100A-E)**
 - **Assessment completion (Z0400-Z0500)**



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Nursing Home Responsibilities for Maintaining Assessments

- **Must ensure that clinical records, regardless of form, are maintained in a centralized location as deemed by facility policy and procedure**
- **Nursing homes that are not capable of maintaining MDS electronically must adhere to the current requirement that either a hand written or a computer-generated copy be maintained in the clinical record**
- **Must ensure that proper security measures are implemented via facility policy to ensure the privacy and integrity of the record**

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Assessment Types and Definitions

- **Admission** – defined as the date a person enters the facility and is admitted
- **Completion of an Admission assessment required when:**
 - Resident never admitted before
 - Was a previous resident, but Admission assessment never completed
 - Was a previous resident, but discharged return **not** anticipated
 - Was a previous resident, discharged return anticipated, but returned later than 30-days from the discharge date



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Assessment Types and Definitions

- **Assessment Combination** – defined as the use of one assessment to satisfy both OBRA and PPS required assessments when the time frames coincide:
 - Most stringent requirement applies
 - Avoids unnecessary duplication
 - One assessment may satisfy two OBRA or two PPS, such as:
 - Admission + Discharge
 - 30-day + EOT
- **Assessment Reference Date (ARD)** – defined as the last day of observation (look back period) that assessment covers
- **Assessment Scheduling** – defined as the period during which assessments take place, setting the ARD, timing, completion, submission and observation periods

38

Assessment Types and Definitions

- **Assessment Submission** – defined as the electronic data in record and file format, conforming to standard layouts and data dictionaries and passing standardized edits
- **Assessment Timing** – defined as when and how often assessments must be conducted (table pg. 15-16)
- **Assessment Transmission** – defined as the electronic submission of files to the QIES ASAP system
- **Comprehensive Assessment** – defined as assessment that includes the completion of the MDS, CAAs, and care plan
- **Death in Facility** – defined as resident death in facility or LOA; Death in Facility tracking record required

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Assessment Types and Definitions

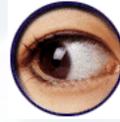
- **Discharge** – defined as the date resident leaves facility:
 - Two types of discharge:
 - Return anticipated
 - Return not anticipated
 - Discharge assessment required when:
 - Discharged to private residence
 - Admitted to hospital or other care setting
 - Hospital observation stay greater than 24 hours
- **Entry** – term used for both admission and reentry
- **Item Set** – MDS items that are active for a particular assessment type; there are 10 different item subsets for nursing homes and 8 for swing bed providers



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Assessment Types and Definitions

- **Observation (Look-Back) Period** – defined as:
 - Time over which resident’s status is captured
 - Defined by counting backwards from ARD
 - Length is specific to each MDS item, but all end at 11:59 p.m. on the ARD
 - Anything occurring before or after observation period is not captured on MDS
- **Leave of Absence (LOA)** – defined as:
 - Temporary home visit of at least one night
 - Therapeutic leave of at least one night
 - Hospital observation stay less than 24 hours
 - No assessment completion required



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OBRA Comprehensive Assessments

- Includes completion of:
 - MDS
 - CAA process
 - Care plan
- Comprehensive assessment types:
 - Admission
 - Annual
 - Significant Change in Status Assessment (SCSA)
 - Significant Correction to Prior Comprehensive Assessment (SCPA)
- Not required in swing bed facilities



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Admission Assessment (A0310A=01)

- Completed when:
 - Resident's first admission
 - Was a previous resident, but discharged prior to completing the Admission assessment
 - Was a previous resident, but discharged return not anticipated
 - Was a previous resident, discharged return anticipated, but returned later than 30-days from the discharge date
- ARD = No later than 14th day of admission
- MDS and CAAs completion = No later than 14th day of admission
- Care plan completion = CAAs completion plus 7 days
- Transmission = Care plan completion plus 14 days
- Not required if discharged before end of day 14

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Annual Assessment (A0310A=03)

- **Must be completed every 366 days unless SCSA or SCPA completed since most recent comprehensive**
- **ARD = No later than:**
 - ARD of previous comprehensive plus 366 days
 - ARD of previous quarterly plus 92 days
- **MDS & CAAs completion = ARD plus 14 days**
- **Care plan completion = CAAs completion plus 7 days**
- **Transmission = Care plan completion plus 14 days**

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Significant Change in Status Assessment (SCSA) (A0310A=04)

- **Must be completed when IDT determines resident meets significant change guidelines**
- **Guidelines include decline and improvement in status**
- **SCSA may not be completed prior to the Admission**
- **ARD = No later than 14th day after determination that significant change occurred**
- **MDS & CAAs completion = No later than 14th day after determination**
- **Care plan completion = CAAs completion plus 7 days**
- **Transmission = Care plan completion plus 14 days**

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Significant Change in Status Assessment (SCSA) (A0310A=04)

- **Hospice:**
 - **Required when enrolls in a hospice program:**
 - **ARD must be within 14 days from effective date of hospice election**
 - **Must be performed regardless of whether an assessment was recently conducted**
 - **If admitted on hospice benefit, complete Admission assessment checking Hospice Care (O0100K):**
 - **Completing an Admission assessment followed by SCSA is not required**
 - **Required when hospice revoked:**
 - **ARD must be within 14 days of:**
 - **Effective date of revocation**
 - **Expiration date of certification of terminally ill**
 - **Date physician order states, no longer terminally ill**

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Significant Change in Status Assessment (SCSA) (A0310A=04)

- **A decline or improvement in a resident's status that:**
 - **Will not normally resolve itself without intervention or by implementing standard disease-related clinical intervention**
 - **Impacts more than one area of resident's health status**
 - **Requires IDT review and/or revision of care plan**
- **Referral for PASRR Level II:**
 - **Required by law when SCSA is completed for an individual known or suspected to have a mental illness, intellectual disability, or related condition**
 - **Do not wait until the SCSA is complete**

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Significant Correction to Prior Comprehensive Assessment (SCPA) (A0310A=05)

- **Required when uncorrected significant error is identified in a prior comprehensive assessment:**
 - **Significant error in an assessment where:**
 - Resident's overall clinical status is not accurately represented
 - Error has not been corrected via submission of a more recent comprehensive assessment
- **ARD = No later than 14th day after determination**
- **MDS & CAAs completion – No later than 14th day after determination**
- **Care plan completion = CAAs completion plus 7 days**
- **Transmission = Care plan completion plus 14 days**

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OBRA Non-Comprehensive Assessments

- **Includes a select number of MDS items**
- **Excludes completion of:**
 - CAA process
 - Care plan
- **Non-comprehensive assessment types:**
 - Quarterly (not required for swing beds)
 - Significant Correction to Prior Quarterly Assessment (SCQA) (not required for swing beds)
 - Discharge assessment – return not anticipated (required for swing beds)
 - Discharge assessment – return anticipated (required for swing beds)
- **Entry Tracking Record**
- **Death in Facility Tracking Record**

50

Quarterly (A0310A=02)

- Must be completed every 92 days
- Used to track resident's status
- ARD = 92 days from previous OBRA assessment ARD
- MDS completion = ARD plus 14 days
- Transmission = MDS completion plus 14 days

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Significant Correction to Prior Quarterly Assessment (SCQA) (A0310A=06)

- Required when uncorrected significant error is identified in a prior quarterly assessment:
 - Error in an assessment where:
 - Resident's overall clinical status is not accurately represented
 - Error has not been corrected via submission of a more recent assessment
- ARD = No later than 14th day after determination
- Completion = No later than 14th day after determination
- Transmission = MDS completion plus 14 days

52

Entry Tracking Record (A0310F=01)

- **Two types:**
 - **Admission (A1700=01):**
 - Admitted for the first time
 - Readmitted after a discharge prior to completion of Admission assessment
 - Readmitted after a discharge return not anticipated
 - Readmitted after a discharge return anticipated when return was later than 30-days from discharge date
 - **Reentry (A1700=02):**
 - Previous resident of this facility
 - Admission assessment previously completed
 - Discharged return anticipated
 - Returned within 30 days of discharge date
- **Completion = Entry date plus 7 days**
- **Transmission = Entry date plus 14 days**

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Entry Tracking Record (A0310F=01)

- **First item set completed for all residents**
- **Completed for respite resident upon each entry**
- **Completion = within 7 days of admission/entry**
- **Transmission = no later than the 14th day after entry**
- **Required in addition to the Admission assessment or other OBRA or PPS assessments that might be required**
- **Cannot be combined with an assessment**

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Death in Facility Tracking Record (A0310F=12)

- **Must be completed when:**
 - Dies in facility
 - Dies while on leave of absence
 - Discharge assessment not required
- Consists of demographic and administrative items
- Completion = Discharge (death) date plus 7 days
- Transmission = Discharge (death) plus 14 days
- May not be combined with any type of assessment

55

Discharge Assessments

- **Two types:**
 - Discharge return not anticipated
 - Discharge return anticipated
 - OBRA required
- **Must complete Discharge assessment when:**
 - Discharged to private residence (not LOA)
 - Discharged and admitted to hospital or other care setting
 - Hospital observation stay of > 24 hours
 - Each time respite resident discharged
 - May be combined with another OBRA
 - May be combined with another PPS
- Discharge date and ARD must be the same
- Bed hold status and opening/closing of record not impacted



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Discharge Return Not Anticipated (A0310F=10)

- Discharged and not expected to return within 30 days
- Consists of demographic, administrative, and clinical items
- If resident returns, Entry tracking must be coded as Admission entry (A1700=01)
- Completion = Discharge date plus 14 days
- Transmission = Completion plus 14 days

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Discharge Return Anticipated (A0310F=11)

- Expected to return within 30 days
- For a respite resident who comes in and out frequently and return is expected
- Consists of demographic, administrative, and clinical items
- If resident returns, Entry tracking must be coded as Reentry (A1700=02)
- If return is NOT by day 30, when returns a new Entry record and new Admission assessment will be required including a new entry date
- Completion = Discharge date plus 14 days
- Transmission = MDS completion plus 14 days

58

Type of Discharge

- **Two types of discharges:**
 - **Planned**
 - **Unplanned:**
 - Acute-care transfer of the resident to a hospital or an emergency department in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation
 - Resident unexpectedly leaving the facility against medical advice
 - Resident unexpectedly deciding to go home or to another setting
- **Completion = Discharge date plus 14 days**
- **Transmission = MDS completion plus 14 days**



59

SNF PPS Assessments

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SNF PPS Assessments

- **Required for reimbursement under Medicare Part A**
- **Must also meet OBRA requirements***
- **Two types of PPS Assessments:**
 - **Scheduled (A0310B):**
 - Standard, predetermined time period for ARD
 - Grace days allowed
 - **Unscheduled (A0310C):**
 - Applicable when certain situations occur

***Swing bed providers must complete entry tracking record, discharge assessments and death in facility tracking record but not other OBRA required assessments**

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SNF PPS Assessment Windows

- **Defined days within which the ARD must be set**
- **Timeliness of the PPS assessment is defined by selecting an ARD within the prescribed ARD window**
- **First day of Medicare Part A coverage for the current stay is considered day 1 for PPS scheduling purposes**
- **Grace days allow flexibility in setting ARD:**
 - **Grace days are not applied to unscheduled PPS assessments**

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PPS Scheduled Assessments

- Medicare-required standard assessments
- Identified at A0310B as follows:
 - 01 = 5-day
 - 02 = 14-day
 - 03 = 30-day
 - 04 = 60-day
 - 05 = 90-day
 - 06 = Readmission/return assessment
- PPS scheduled assessment table (pg. 40)

63

PPS Unscheduled Assessments

- Medicare-required assessments outside the standard schedule
- Identified at A0310C as follows:
 - 1 = Start of Therapy
 - 2 = End of Therapy
 - 3 = Both Start and End of Therapy
 - 4 = Change of Therapy
- An unscheduled assessment in a scheduled assessment window cannot be followed by the scheduled assessment in that window:
 - The two assessments must be combined
- Medicare scheduled and unscheduled MDS assessment reporting schedule (pg. 42-44)

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PPS Scheduled Assessments

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Scheduled PPS Assessment Table



Medicare Scheduled Assessment Type	Reason for Assessment A0310B	ARD	ARD Grace Days	Standard Medicare Payment Days
5-day Readmission/Return	01	1-5	6-8	1 through 14
	06			
14-day	02	13-14	15-18	15 through 30
30-day	03	27-29	30-33	31 through 60
60-day	04	57-59	60-63	61 through 90
90-day	05	87-89	90-93	91 through 100

66

5-Day PPS Scheduled Assessment (A0310B=01)

- **First Medicare-required assessment completed for Part A stay**
- **Must have at least one 5-day assessment**
- **ARD = set on days 1 through 5**
- **ARD may be extended up to day 8**
- **Completion = ARD plus 14 days**
- **Transmission = Completion plus 14 days**
- **Authorizes payment from days 1 through 14**
- **If resident goes from Medicare Advantage to Medicare Part A, the Medicare PPS schedule must start over with a 5-day, etc.**

67

14-Day PPS Scheduled Assessment (A0310B=02)

- **ARD = set on days 13 through 14**
- **ARD may be extended up to day 18**
- **Completion = ARD plus 14 days**
- **Transmission = Completion plus 14 days**
- **Authorizes payment from days 15 through 30**
- **When combined with the OBRA admission, grace days may not be used**

68

30-Day PPS Scheduled Assessment (A0310B=03)

- **ARD = set on days 27 through 29**
- **ARD may be extended up to day 33**
- **Completion = ARD plus 14 days**
- **Transmission = Completion plus 14 days**
- **Authorizes payment from days 31 through 60**

69

60-Day PPS Scheduled Assessment (A0310B=04)

- **ARD = set on days 57 through 59**
- **ARD may be extended up to day 63**
- **Completion = ARD plus 14 days**
- **Transmission = Completion plus 14 days**
- **Authorizes payment from days 61 through 90**

70

90-Day PPS Scheduled Assessment (A0310B=05)

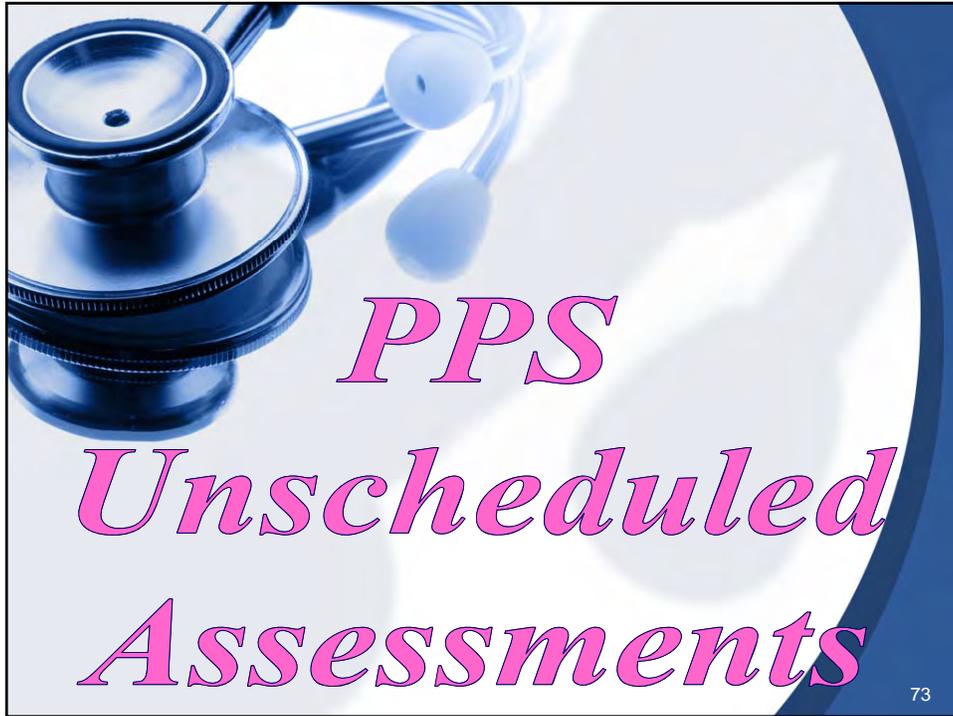
- **ARD = set on days 87 through 89**
- **ARD may be extended up to day 93**
- **Completion = ARD plus 14 days**
- **Transmission = Completion plus 14 days**
- **Authorizes payment from days 91 through 100**

71

Readmission/Return PPS Scheduled Assessment (A0310B=06)

- **Completed when resident is hospitalized, discharged return anticipated, then returns within 30 days under Part A services**
- **Entry tracking is coded as reentry (A1700=2)**
- **ARD = set on days 1 through 5**
- **ARD may be extended up to day 8**
- **Completion = ARD plus 14 days**
- **Transmission = Completion plus 14 days**
- **Authorizes payment from days 1 through 14**

72

A blue stethoscope is positioned in the upper left corner of the slide. The background features a faint, light blue silhouette of a human figure. The text is centered and written in a pink, italicized serif font.

PPS
Unscheduled
Assessments

73

Start of Therapy (SOT) OMRA Assessment (A0310C=1)

A blue stethoscope is positioned in the upper right corner of the slide. The background features a faint, light blue silhouette of a human figure.

74

- **Optional**
- **Completed only to classify into a Rehabilitation group**
- **Completed only if not already classified into a Rehabilitation group**
- **May be combined with scheduled PPS assessment**
- **ARD = set on days 5-7 after the start of therapy**
- **Completion = ARD plus 14 days**
- **Transmission = Completion plus 14 days**

End of Therapy (EOT) OMRA (A0310C=2)

- Completed when a beneficiary classified in a Rehabilitation group, continues to need Part A services, and did not receive any therapy services for three consecutive calendar days for any reason
- Last day therapy was provided is day 0
- Day 1 is first day after last therapy session provided whether therapy was scheduled or not scheduled
- May be combined with scheduled PPS assessment
- Establishes a new non-Rehabilitation RUG
- ARD = set for day 1, 2, or 3 after the date of the resident's last therapy session
- Completion = ARD plus 14 days
- Transmission = Completion plus 14 days

75

End of Therapy (EOT-R) OMRA (A0310C=2)

End of Therapy with Resumption (EOT-R)

- May be used when the resident will resume at the same therapy level intensity as prior to the discontinuation of therapy
- Resumption of therapy must occur no more than five days after the last day of therapy provided
- Providers are not required to consider possible ADL changes when determining if a resumption of therapy will occur
- EOT and Day of Discharge:
 - If a resident is discharged from the Medicare Part A portion of the stay prior to missing three full days of therapy, then an EOT would not be required



76

End of Therapy (EOT-R) OMRA (A0310C=2)

End of Therapy with Resumption Billing

- The facility should bill the non-therapy RUG given on the EOT beginning the day after the patient's last therapy session. The facility would then begin billing the therapy RUG that was in effect prior to the EOT beginning on the day that therapy resumed (O0450B).
- The HIPPS code used to bill the days affected by this assessment should include the AI code used on the EOT-R (Second character = A, B, or C)

77

Start & End of Therapy (A0310C=3)

- SOT/EOT – Both Start and End of Therapy:
 - ARD must be 5-7 days after the start of therapy
 - ARD must be 1-3 days after the last day of therapy
 - Completed to classify into a Rehabilitation Plus Extensive Services or Rehabilitation AND into a non-therapy group when Part A continues after the discontinuation of all therapy
- If assessment does not classify into a therapy RUG CMS will not accept the assessment

78

Change of Therapy OMRA (A0310C=4)

- **COT Observation Period:** A successive 7-day window beginning the day following the ARD of the resident's last PPS assessment used for payment
- A COT is required if the therapy received during the COT observation period does not reflect the RUG-IV classification level on the patient's most recent PPS assessment used for payment
- May be used to classify a patient into a higher or lower RUG category

79

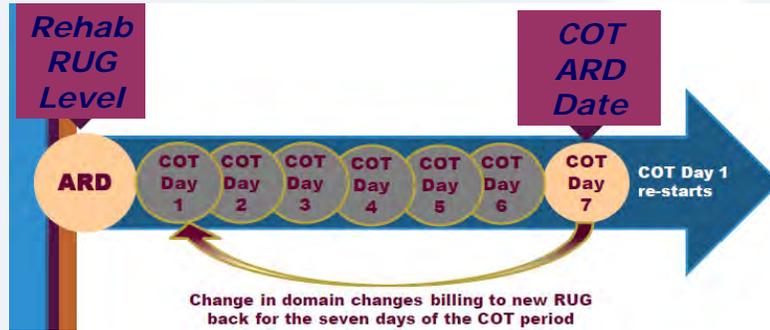
Rolling 7 Day Informal Observation Period

Example:

- ARD of 14-day PPS assessment = Day 13
- Window for COT observation = Days 14-20
- Next COT observation window = Days 21-27
- Next COT observation window = Days 28-34, etc.

80

Determine if there is a change in the RTM/RUG Level



81

Change of Therapy OMRA (A0310C=4)

- In order to determine if a COT is required, providers should perform an informal change of therapy evaluation that considers the intensity of the therapy the resident received during the COT observation period

But what must a facility actually consider?



82

Change of Therapy OMRA (A0310C=4)

- A COT is required in cases where the therapy received during the COT observation period would cause the resident to be classified into a different RUG category
- ADL changes are excluded from this determination

RUG Category Shortcut = Second character in RUG code

RUC: Ultra-High Rehab

RHL: High Rehab

RVX: Very-High Rehab

RMA: Medium Rehab

As long as the second character does not change, no COT OMRA is required!

83

Is a COT OMRA required?

Patient Current Classification: RUB (827 RTM)

		Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
PT	Individual	60		60			60	45
	Concurrent (/2)		30				30	
	Group (/4)					60		
OT	Individual							
	Concurrent (/2)							
	Group (/4)							
SLP	Individual	45	45	60		45		
	Concurrent (/2)				60			
	Group (/4)		60			60		
Subtotals		105	75	120	30	75	75	45
Number of RNP								
						Total RTM		525

84

Is a COT OMRA required?

Patient Current Classification: RHC (365 RTM)

		Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
PT	Individual	60		60			60	45
	Concurrent (/2)		30				30	
	Group (/4)					60		
OT	Individual							
	Concurrent (/2)							
	Group (/4)							
SLP	Individual	45	45	60		45		
	Concurrent (/2)				60			
	Group (/4)		60			60		
Subtotals		105	75	120	30	75	75	45
Number of RNP								
							Total RTM	525

85

Change of Therapy OMRA and SNF Billing

- The COT retroactively establishes a new RUG beginning Day 1 of the COT observation period and continues until the next scheduled or unscheduled PPS assessment
- **Example:** A resident's 30-day assessment ARD set for Day 30. Based on the 30-day assessment ARD, the therapy services provided to this resident are evaluated on Day 37. If a COT is required, then payment would be set back to Day 31.

86

Change of Therapy OMRA and Index Maximization

- **Index maximization:** In some situations a resident may simultaneously meet the qualifying criteria for both a therapy and a non-therapy RUG. For some of these cases the RUG-IV per diem payment rate for the non-therapy RUG will be higher; therefore, although the resident is receiving therapy services, the index maximized RUG is a non-therapy RUG.
- *A facility is required to complete a change of therapy evaluation for all residents receiving any amount of skilled therapy services, including those who have index maximized into a non-therapy RUG group*

87

Change of Therapy OMRA and Index Maximization Example

- A COT is only required for residents in such cases that the therapy services received during the COT observation period are no longer reflective of the RUG-IV category after considering index maximization. Consider the following two examples:

Resident qualifies for RMB (\$344.47) but index maximizes into HC2 (\$401.48). During the COT observation period, resident receives only enough therapy to qualify for RLB (\$356.78) and HC2 (\$401.48).

Resident qualifies for RMB (\$344.47) but index maximizes into HC2 (\$401.48). During the COT observation period, resident receives enough therapy to qualify for RUB (\$558.79) and HC2 (\$401.48).

88

Non-Therapy RUG

- COT observation windows must be observed even when in non-therapy RUG
- **Example:** Resident with fever and weight loss receives therapy at Rehabilitation High and Special Care High levels
 - HE2 = \$454.49 RHC = \$417.71
- Review therapy provided each week to determine if therapy changed enough to cause a change in RUG. If yes, complete COT.

89

Change of Therapy OMRA (A0310C=4)

- COT and Day of Discharge:
 - If Day 7 of the COT observation period is also on or before the day of discharge, then a COT OMRA would not be required
- COT and Scheduled PPS Assessments:
 - If the ARD of a scheduled PPS assessment is set for on or prior to Day 7 of the COT observation period, then no COT OMRA would be required. This resets the COT observation period.

90

Completing Resident Interviews on Unscheduled Assessments

- Providers are encouraged to complete resident interviews in as timely a manner as possible, which in the case of a COT might occur 1-2 days after the ARD of the COT



Every effort should be made to provide the residents an opportunity to make their voices heard!

91

Unscheduled “Stand Alone” PPS Assessment Interview Items

- Includes SOT, EOT, COT
- 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 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 Z0400) for which those responses will be used

92

Setting the ARD for Unscheduled “Stand Alone” PPS Assessments

- Set the ARD for a day within the allowable ARD window, but may only do so no more than 2 days after the window has passed
- **Example:** If a resident misses therapy on July 2-4, then the facility must complete an EOT OMRA for this resident and the ARD must be set for either July 2nd, 3rd, or 4th. However, the decision for which of those days should be used for the ARD on the EOT OMRA may be made after July 4th, the last day of the ARD window but NO later than July 6.

93



Combining PPS Scheduled and Unscheduled Assessments

94

PPS SNF Assessment Combinations

- Can **NEVER** combine 2 PPS scheduled assessments
- May combine scheduled PPS assessment with unscheduled PPS assessment
- May combine any PPS assessment with any OBRA assessment
- When combining assessments use the more stringent requirements

95

Combining Scheduled and Unscheduled PPS Assessments

- If an unscheduled PPS assessment is required in the assessment window of the scheduled assessment; the scheduled assessment **MUST** be combined with the unscheduled assessment setting the ARD for the unscheduled assessment
- A scheduled PPS assessment cannot occur after an unscheduled assessment in the assessment window--the scheduled assessment must be combined with the unscheduled assessment using the ARD for the unscheduled assessment
- When the facility fails to combine a scheduled and unscheduled PPS assessment required by policy, the payment is controlled by the unscheduled assessment

96

Combining Scheduled and Unscheduled PPS Assessments

- **Example:** If the ARD for an EOT is Day 14 and an ARD of the 14-day scheduled PPS assessment is set for Day 15, this would violate the combined assessment policy if not combined. Consequently, the EOT would control the payment.
- The EOT would begin payment on Day 12, and continue paying until the next scheduled or unscheduled assessment



97

Combining Scheduled and Unscheduled PPS Assessments

- The ARD for the unscheduled assessment should be used when combining assessments
- If the ARD of the scheduled assessment is mistakenly set for a day that is after the ARD set for the unscheduled assessment, the scheduled assessment is deemed invalid and payment is set as if the assessments had been combined properly
- An assessment is considered to be “used for payment” in that it controls the payment for a given period or with scheduled assessment may set the basis for payment for a given period
- Assessment combination details pg. 53-70

98

Factors Impacting the SNF Medicare Assessment Schedule

- **Leave of Absence:**
 - **Scheduled PPS assessment:** the Medicare schedule is adjusted to exclude the LOA when determining the ARD
 - **Unscheduled PPS assessment:** the ARD is not affected by the LOA
 - **COT Example:** If the ARD for a resident's 30-day assessment were set for November 7 and the resident went to the emergency room at 11:00pm on November 9, returning at 2:00pm on November 10, Day 7 of the COT observation period would remain November 14
- NOTE:** The COT evaluation process and payment implications remain unchanged*

99

Factors Impacting the SNF Medicare Assessment Schedule

- **Early PPS Assessment:**
 - If an assessment is performed earlier than the schedule indicates (ARD is not in the defined window), the facility will be paid at the default rate for the total number of days the assessment is out of compliance
 - **Example:**
 - Medicare 14-day with ARD on day 12 (1 day early) would be paid at the default rate for the first day of the payment period that begins on day 15

100

Factors Impacting the SNF Medicare Assessment Schedule

- **Early PPS Assessment:**

- **Example:**

- 30-day assessment ARD is Day 30:
 - Day 7 of the COT observation period is Day 37
 - COT ARD set for Day 35 (2 days out of compliance)
 - Facility would be paid the default rate for Days 29 and 30
 - Facility would then be paid the RUG from the early COT beginning on Day 31 until the next scheduled or unscheduled assessment used for payment
 - The early COT resets the COT calendar, so the next COT check in this scenario would be Day 42 (day 35+7)

101

Factors Impacting the SNF Medicare Assessment Schedule

- **Late PPS Assessment:**

- If the SNF fails to set the ARD within the defined ARD window for a Medicare-required assessment, including grace days, and the resident is still on Part A, the facility must complete a later assessment
 - The ARD can be no earlier than the day the error was identified
 - The total number of days the assessment is out of compliance, including the late ARD, must be billed at default beginning on the day that the assessment would have controlled payment

102

Factors Impacting the SNF Medicare Assessment Schedule

- **Late PPS Assessment:**

- **Example:**

- Resident last received therapy on Day 33
 - EOT ARD set for Day 39 (3 days out of compliance)
 - Facility would bill the default rate for Days 34 through 36 (3 days out of compliance). Facility would then bill RUG from late EOT from Day 37 until next scheduled or unscheduled assessment used for payment.

103

Factors Impacting the SNF Medicare Assessment Schedule

- **Late PPS Assessment:**

- **Example:**

- 30-day assessment ARD is Day 30:
 - Day 7 of the COT observation period is Day 37
 - COT ARD set for Day 40 (3 days out of compliance)
 - Facility would bill the default rate for Days 31 through 33. Facility would then bill RUG from late COT from Day 34 until next scheduled or unscheduled assessment used for payment.
 - Late COT resets COT ARD calendar. Next COT ARD would be Day 47 (day 41-47)

104

Factors Impacting the SNF Medicare Assessment Schedule

- **Missed PPS Assessment:**
 - If the SNF fails to set the ARD for a scheduled PPS assessment within the defined ARD window for that assessment, and the resident has been discharged from Part A, the assessment cannot be completed
 - All days which would have been paid by the missed assessment, had it been completed timely, are considered provider-liable and may not be billed

105

Factors Impacting the SNF Medicare Assessment Schedule

- **Missed PPS Assessment:**
 - If the SNF fails to set the ARD for an unscheduled PPS assessment within the defined ARD window for that assessment, and the resident has been discharged from Part A, the assessment cannot be completed
 - All days which would have been paid by the missed assessment, had it been completed timely, are considered provider-liable and may not be billed

106

Factors Impacting the SNF Medicare Assessment Schedule

- **Missed PPS Assessment:**
 - **Example:**
 - **30-day assessment ARD is Day 30:**
 - Day 7 of the COT observation period is Day 37
 - **COT is missed**
 - **Resident is discharged from Part A on Day 40**
 - **Facility may not bill any of the days between Days 31 and 40**

107

Factors Impacting the SNF Medicare Assessment Schedule

- **Missed PPS Assessment:**
 - **Example:**
 - **30-day assessment ARD is Day 30:**
 - Day 7 of the COT observation period is Day 37
 - **COT is not completed**
 - **EOT completed timely with ARD set for Day 42:**
 - Resident last received therapy on Day 39
 - **Resident discharged from Part A on Day 45**
 - **Facility may not bill any days from Days 31 through 39**
 - **Facility would then bill RUG from EOT beginning on Day 40 and continue until discharge**

108

Expected Order of MDS Records

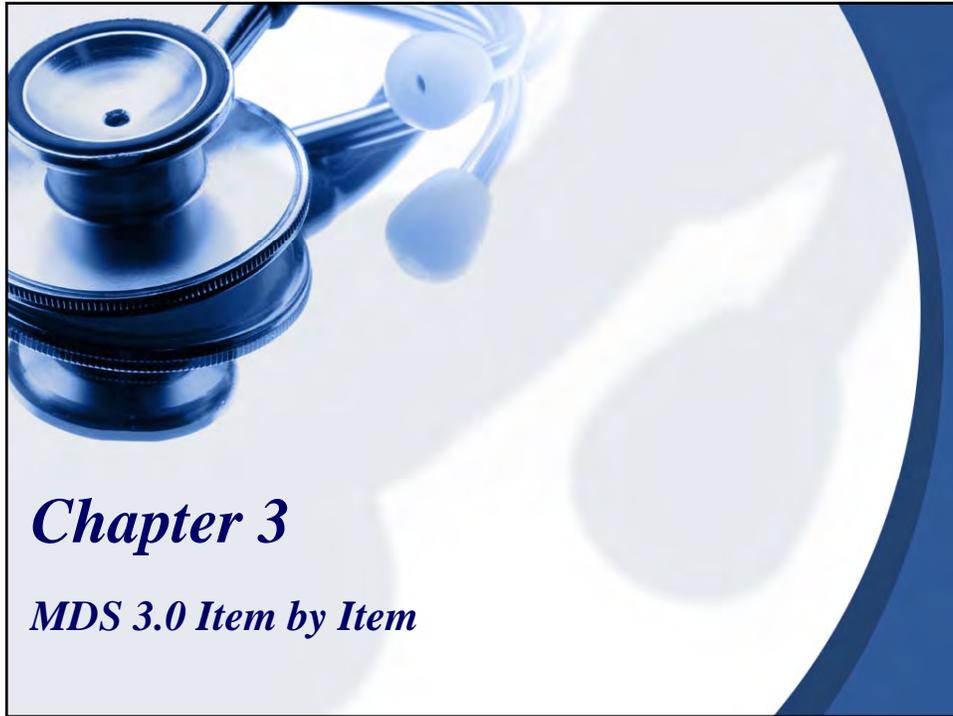
- MDS records are expected to occur in a specific order:
 - **Example:**
 1. Entry Tracking record
 2. Admission assessment
 3. 5-day Medicare, etc.
- The target date is used to determine the order of records:
 - A2300 for assessments
 - A1600 for entry records
 - A2000 for discharges or death in facility
- Out of order records will generate a warning on the CMS validation report
- Expected order of records table on pg 2-76

109

Item Set for an MDS Record

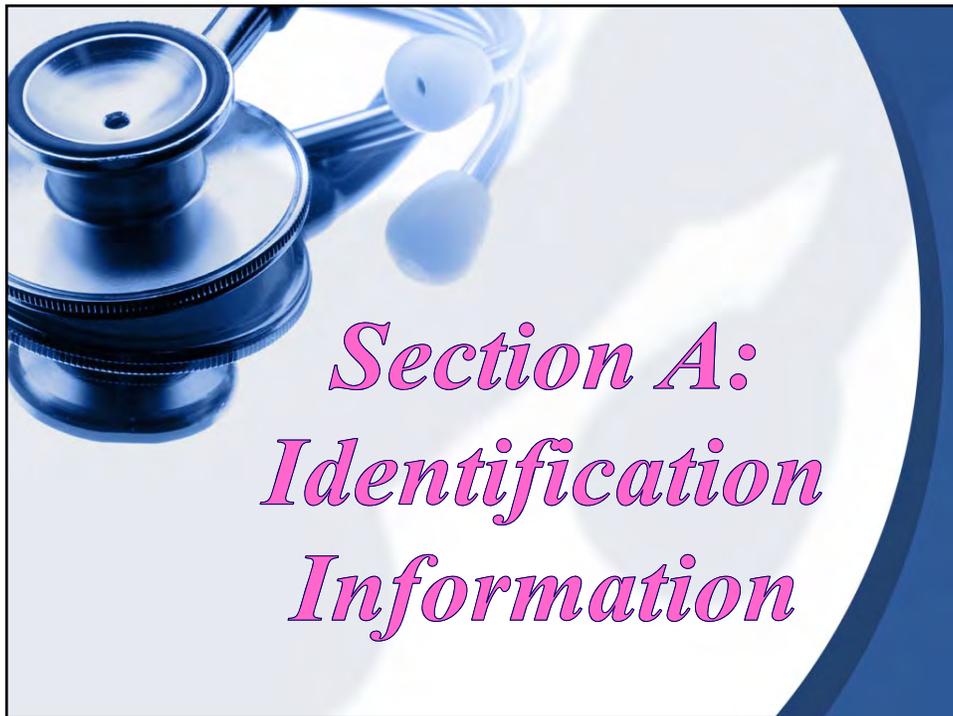
- Item set is determined by the reason for assessment:
 - A0310A
 - A0310B
 - A0310C
 - A0310F
- Nursing home item set code (ISC) reference table on page 2-77
- **Example:**
 - A0310A-01, A0310B=99, A0310C=0, A0310F=99
 - Standalone Admission assessment (**NC**)
 - A0310A-99, A0310B=99, A0310C=0, A0310F=12
 - Death in facility (**NT**)
 - A0310A-99, A0310B=99, A0310C=0, A0310F=99
 - No such record combination exists
 - Fatal error (rejected record)

110



Chapter 3

MDS 3.0 Item by Item



Section A: Identification Information

Type of Record (A0050)

- **Coding instructions:**
 - **Code 1 = Add new record:**
 - A new record not previously submitted
 - Continue to A0100
 - **Code 2 = Modify existing record:**
 - Already submitted and accepted
 - Continue to A0100
 - Refer to Chapter 5
 - **Code 3 = Inactive existing record:**
 - Already submitted and accepted
 - Skip to X0150
 - Refer to Chapter 5

113

Facility Provider Numbers (A0100) Type of Provider (A0200)

- **A0100 = Facility Provider Numbers:**
 - **A = National Provider Identifier (NPI)**
 - **B = CMS Certification Number (CCN)**
 - **C = State Provider Number**
(optional – but Medicaid number necessary)
- **A0200 = Type of Provider:**
 - **Code 1 = Nursing home (SNF/NF)**
 - **Code 2 = Swing bed**

114

Type of Assessment (A0310)

- **A0310A = Federal OBRA Reason for Assessment:**
 - **Code 01** = Admission assessment (required by day 14)
 - **Code 02** = Quarterly review assessment
 - **Code 03** = Annual assessment
 - **Code 04** = Significant change in status assessment
 - **Code 05** = Significant correction to prior comprehensive assessment
 - **Code 06** = Significant correction to prior quarterly assessment
 - **Code 99** = None of the above

PPS Assessment (A0310B)

- **PPS Scheduled Assessments for a Medicare Part A Stay:**
 - **Code 01** = 5-day scheduled assessment
 - **Code 02** = 14-day scheduled assessment
 - **Code 03** = 30-day scheduled assessment
 - **Code 04** = 60-day scheduled assessment
 - **Code 05** = 90-day scheduled assessment
 - **Code 06** = Readmission/return assessment
- **PPS Unscheduled Assessments for a Medicare Part A Stay:**
 - **Code 07** = Unscheduled assessments used for PPS
 - Includes SCSA and SCPA
- **Not PPS Assessment:**
 - **Code 99** = None of above

PPS Other Medicare Required Assessment — OMRA (A0310C)

- Indicates whether the assessment is related to therapy services
- Complete this item for all assessments
- PPS Other Medicare Required Assessment – OMRA:
 - Code 0 = No
 - Code 1 = Start of therapy assessment
 - Code 2 = End of therapy assessment
 - Code 3 = Both Start and End of therapy assessment
 - Code 4 = Change of therapy assessment

117

Is this a Swing Bed clinical change assessment? (A0310D) Is this Assessment the First Assessment Since the Most Recent Admission/Entry or Reentry? (A0310E)

- A0310D = Indicate whether this is a swing bed clinical change assessment:
 - Complete only if A0200=2:
 - Code 0 = No
 - Code 1 = Yes
- A0310E = Indicates whether this is the first OBRA, Scheduled PPS, or Discharge assessment since the most recent admission/entry or reentry:
 - Code 0 = No
 - Code 1 = Yes

118

Entry/Discharge Reporting (A0310F)

- Indicates reason for Federal OBRA & PPS entry/discharge reporting:
 - **Code 01** = Entry tracking record
 - **Code 10** = Discharge assessment-return not anticipated
 - **Code 11** = Discharge assessment-return anticipated
 - **Code 12** = Death in facility tracking record
 - **Code 99** = None of the above



119

Type of Discharge (A0310 G)

- Two types of discharges:
 - **Code 1** = Planned
 - **Code 2** = Unplanned:
 - Acute-care transfer of the resident to a hospital or an emergency department in order to either stabilize a condition or determine if an acute-care admission is required based on emergency department evaluation
 - Resident unexpectedly leaving the facility against medical advice
 - Resident unexpectedly deciding to go home or to another setting
- **Completion** = Discharge date plus 14 days
- **Transmission** = Completion plus 14 days



120

Submission Requirement (A0410)

- Designates the submission authority for the resident assessment
- Must be a federal authority to submit the MDS assessment to the QIES ASAP system
- HMO, Medicare Advantage, etc. may not be submitted to State or QIES ASAP system

A0410. Submission Requirement	
Enter Code <input type="text"/>	<ol style="list-style-type: none">1. Neither federal nor state required submission2. State but not federal required submission (FOR NURSING HOMES ONLY)3. Federal required submission

121

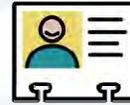
Submission Requirement (A0410)

- **Code 1** = Neither federal nor state required submission:
 - May be used for HMO, Medicare Advantage, private insurance if assessment required by plan
 - These assessments are not to be submitted under code 2 or 3
- **Code 2** = State but not federal required submission:
 - May be used if state has authority
 - Resident in a unit not certified under Medicare/Medicaid
- **Code 3** = Federal required submission:
 - Federal authority to receive all Medicare/Medicaid certified units
 - Includes all OBRA and PPS assessments

122

Legal Name of Resident (A0500)*

- Enter the resident's name as it appears on the resident's Medicare card
- If not in program, check Medicaid card or other government issued document
- Used to identify resident and match records



A0500. Legal Name of Resident

A. First name:	B. Middle initial:
<input type="text"/>	<input type="text"/>
C. Last name:	D. Suffix:
<input type="text"/>	<input type="text"/>

**CMS Identifier*

123

Section A (A0600A-A1300)

- A0600A = Social Security Number*
- A0600B = Medicare Number
- A0700 = Medicaid Number:
 - “+” if pending
 - “N” if not a Medicaid recipient
- A0800 = Gender*
- A0900 = Birth Date*
- A1000 = Race/Ethnicity – *check all that apply*
- A1100 = Language
- A1200 = Marital Status
- A1300 = Optional Resident Items:
 - Optional but very useful in NH



**CMS Identifier*

124

*CMS Identifiers

- State ID
- Facility Internal ID

MDS Items

- Legal Name (A0500)
- SSN (A0600A)
- Gender (A0800)
- Birth Date (A0900)



125

Preadmission Screening and Resident Review (PASRR) Overview

- All admissions to a Medicaid certified facility must have a Level I PASRR completed
- Individuals who have or are suspected of MI or ID/DD or related conditions may not be admitted unless Level II approval
- Resident Review (RR) required of residents with MI or ID/DD when a physical or mental significant change occurs:
 - Consult your State Medicaid Agency for PASRR procedures
- Ensures that individuals with serious mental illness or intellectual disability or related condition are not placed in a NF inappropriately

126

Preadmission Screening and Resident Review (A1500)

- Complete only if comprehensive assessment
- Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?
 - **Code 0** = No, skip to A1550
 - **Code 1** = Yes, continue to A1550
 - **Code 9** = Not a Medicaid-certified unit, skip to A1550

127

Level II PASRR Conditions (A1510)

- Complete only if comprehensive assessment
- *Check all that apply:*
 - **A** = Serious mental illness
 - **B** = Intellectual Disability
 - **C** = Other related conditions

128

Conditions Related to ID/DD Status (A1550)

- Documents conditions associated with intellectual disability or developmental disabilities
- If resident is 22 years or older as of ARD date:
 - Complete only if Admission assessment (A0310A = 01)
- If resident is 21 years or younger as of ARD date:
 - Complete only if a comprehensive assessment
- Check all conditions related to ID/DD status present before age 22
- When age of onset is not specified, assume that the condition meets this criterion AND is likely to continue indefinitely

129

Conditions Related to ID/DD Status (A1550)

- ID/DD With Organic Condition:
 - A = Down syndrome
 - B = Autism
 - C = Epilepsy
 - D = Other organic condition related to ID/DD
- ID/DD Without Organic Condition:
 - E = ID/DD condition with no specific conditions listed
- No ID/DD:
 - Z = None of the above

130

PASRR Resources

- Your SMA is overall responsible for PASRR & should direct you to agencies or vendors:
 - National Association of PASRR Professionals
www.PASRR.org
 - The PASRR Technical Assistance Center (PTAC) is for state agencies, but website is informative:
www.PASRRassist.org
 - Kentucky PASRR documents may be downloaded at: www.chfs.ky.gov/dms/mnfs.htm

131

Entry Data (A1600) Type of Entry (A1700)

- A1600 = Entry Date:
 - Initial date of admission to the facility
 - Date resident most recently returned to facility after being discharged
- A1700 = Type of Entry:
 - **Code 1** = Admission
 - **Code 2** = Reentry
- Day of discharge from the facility is not counted in the 30 days
- Swing bed facilities always code resident's entry as an admission (A1700=1)



132

Entered From (A1800)

- Enter the two-digit code that corresponds to the location or program the resident was admitted from for this admission:
 - Code 01 = Community
 - Code 02 = Another nursing home or swing bed
 - Code 03 = Acute hospital
 - Code 04 = Psychiatric hospital
 - Code 05 = Inpatient rehabilitation facility
 - Code 06 = ID/DD facility
 - Code 07 = Hospice
 - Code 09 = Long Term Care Hospital (LTCH)
 - Code 99 = Other



NOTE: If resident enrolled in a home-based hospice program, enter 07, not 01

133

Discharge Date (A2000)

- Complete only if A0310F = 10, 11 or 12
- Enter the date the resident leaves the facility
- Discharge date and ARD (A2300) must be the same for discharge assessments
- If resident is receiving services under Part A PPS, the discharge date may be later than the end of Medicare stay date (A2400C)
- Do not include leaves of absence or hospital stays less than 24 hours unless admitted



134

Discharge Status (A2100)

- Complete only if A0310F = 10, 11 or 12:
 - Code 01 = Community
 - Code 02 = Another nursing home or swing bed
 - Code 03 = Acute hospital
 - Code 04 = Psychiatric hospital
 - Code 05 = Inpatient rehabilitation facility
 - Code 06 = ID/DD facility
 - Code 07 = Hospice
 - Code 08 = Deceased
 - Code 09 = Long Term Care Hospital (LTCH)
 - Code 99 = Other

135

Previous ARD for Significant Correction (A2200)

- Required only for a significant correction to a prior comprehensive or quarterly assessment (A0310A = 05 or 06)
- Enter the ARD of the prior assessment for which a significant error has been identified and a correction is required

A2200. Previous Assessment Reference Date for Significant Correction

Complete only if A0310A = 05 or 06

	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Month		Day			Year			

136

Assessment Reference Date (ARD) (A2300)

- Look-back period includes observations and behaviors through the end of the day (midnight) of the ARD
- Team members should consider the following when selecting the ARD:
 - Reason for the assessment
 - Compliance with timing and scheduling requirements outlined in Chapter 2
- **MUST** adjust ARD to equal the discharge date if resident dies or is discharged prior to end of the look-back period
- All sections have to use the same ARD; it cannot be changed after the assessment is completed



137

Medicare Stay (A2400)

- Identifies when a resident is receiving services under the scheduled PPS
- Identifies when a resident's Medicare Part A stay begins and ends
- The end date is used to determine if the resident's stay qualifies for the short stay assessment
- A = Has the resident had a Medicare-covered stay since the most recent entry?
 - **Code 0** = No, skip to B0100
 - **Code 1** = Yes, continue to A2400B

138

Medicare Stay Start Date (A2400B) Medicare Stay End Date (A2400C)

- If A2400A is coded 1 (Yes):
 - Enter start date of most recent Medicare stay (B)
 - Enter end date of most recent Medicare stay (C)
 - Enter dashes if stay is on-going

B. Start date of most recent Medicare stay:
<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Month Day Year
C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:
<input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Month Day Year

139

Medicare Stay End Date (A2400C)

- The end of Medicare date is coded as follows, whichever occurs first:
 - Date SNF benefit exhausts
 - Date of last day covered as recorded on the effective date from the Generic Notice
 - The last paid day of Medicare A when payer source changes (regardless if the resident was moved to another bed or not)
 - Date resident was discharged from facility
- When resident returns from LOA or hospital <24 hours, not a new Part A stay (continued stay)
- End of Part A stay may be earlier than discharge date
- Enter dashes to indicate the stay is ongoing
- Medicare Stay End Date Algorithm (pg. 28)

140



*Section B:
Hearing, Speech
and Vision*

141

Comatose (B0100)

- Must be documented by physician
- Persistent vegetative state/no discernible consciousness:
 - **Code 0** = No, continue to B0200, Hearing
 - **Code 1** = Yes, skip to G0110, ADL

B0100. Comatose	
Enter Code	Persistent vegetative state/no discernible consciousness
<input type="checkbox"/>	0. No → Continue to B0200, Hearing
	1. Yes → Skip to G0110, Activities of Daily Living (ADL) Assistance

0	No
1	Yes

142

Hearing (B0200)

- Code the response option that best reflects the resident's hearing ability:
 - **Code 0** = Adequate, no difficulty in normal conversation, listening to TV
 - **Code 1** = Minimal difficulty, difficulty in some environments (person speaks softly, setting noisy)
 - **Code 2** = Moderate difficulty, speaker has to increase volume and speak distinctly
 - **Code 3** = Highly impaired, absence of useful hearing



143

Hearing Aid (B0300) Speech Clarity (B0600)

- B0300 – Aid or device used in completing B0200:
 - **Code 0** = No
 - **Code 1** = Yes
- Determine the quality of resident's speech, not the content or appropriateness – just words spoken
- B0600 – Select best description of speech pattern:
 - **Code 0** = Clear speech – distinct intelligible words
 - **Code 1** = Unclear speech – slurred or mumbled words
 - **Code 2** = No speech – absence of spoken words



144

Makes Self Understood (B0700)

- Ability to express ideas and wants, consider both verbal and non-verbal expression:
 - **Code 0** = Understood
 - **Code 1** = Usually understood
 - **Code 2** = Sometimes understood
 - **Code 3** = Rarely/never understood
- Interact with the resident
- Offer alternative means of communication
- Consult with primary nurse assistant over all shifts, resident's family and speech-language pathologist



145

Ability to Understand Others (B0800)

- Enter the code that best reflects the resident's ability to understand verbal content however able (with hearing aid or device if used):
 - **Code 0** = Understands
 - **Code 1** = Usually understands
 - **Code 2** = Sometimes understands
 - **Code 3** = Rarely/never understands



146

Vision (B1000)

- If the resident is unable to read English, ask the resident to read numbers or name items in a small picture
- If the resident is unable to communicate or follow directions, observe eye movements
- Enter the code that best reflects the resident's ability to see in adequate light (with glasses or other visual appliances):
 - **Code 0** = Adequate
 - **Code 1** = Impaired
 - **Code 2** = Moderately impaired
 - **Code 3** = Highly impaired
 - **Code 4** = Severely impaired

147

Corrective Lenses (B1200)

- Code if resident uses corrective lenses (contacts, glasses or magnifying glass) used in B1000:
 - **Code 0** = No
 - **Code 1** = Yes



148

RUG Categories Impacted

B0100 – Comatose

RUG-III

- Clinically Complex
- Impaired Cognition

RUG-IV

- Special Care High
- Behavioral Symptoms and Cognitive Performance

149

RUG Categories Impacted

Staff Assessment for Mental Status **B0700 – Makes Self Understood**

RUG-III

- Impaired Cognition

RUG-IV

- Behavioral Symptoms and Cognitive Performance

150



Cognitive Patterns

- **Determine resident's:**
 - Attention
 - Orientation
 - Ability to register and recall new information
- **Crucial factors for care planning decisions**

A cartoon illustration of a man in a suit sitting at a desk, looking confused. He has his hand to his forehead, and there are question marks floating around his head. He is holding a pen and looking at a piece of paper on the desk.

152

Brief Interview for Mental Status (BIMS)

- The BIMS is a brief screener that aids in detecting cognitive impairment
- It does not assess all possible aspects of cognitive impairment
- A diagnosis of dementia should only be made after a careful assessment for other reasons for impaired cognitive performance
- The final determination of the level of impairment should be made by the resident's physician or mental health care specialist

153

Should Resident Interview be Conducted (C0100)

- Should Brief Interview for Mental Status be Conducted?
 - **Code 0** = No, skip to C0700
 - **Code 1** = Yes, continue to C0200

NOTE: Includes residents who use American Sign Language (ASL)

154

Conducting the BIMS Interview (C0200 - C0400)

- C0200 = Repetition of Three Words
- C0300A-C = Temporal Orientation:
- C0400A-C = Recall
- Interview is considered complete if resident attempted and provided relevant answer to at least four (4) of the questions in C0200-C0400
- Nonsensical responses should be coded as zero
- Refer to Appendix D for effective interviewing techniques
- When primary method of communication is writing; BIMS can be administered in writing



155

Stopping the Interview

- Stop the interview after C0300C “Day of the Week” if:
 - All responses have been nonsensical
 - There has been no verbal or written response to any items up to that point
 - There has been no verbal or written response to some items and nonsensical responses to the other questions
- If interview stopped:
 - Code -, dash in C0400A-C
 - Code 99 in C0500
 - Code 1, yes in C0600
 - Complete staff assessment



156

BIMS Summary Score (C0500)

- The total score is calculated by adding values for all questions from C0200-C0400:
 - Ranges from 00 – 15 and 99
 - Allows comparison with future and past performance
 - Decreases chance of incorrect labeling of dementia
 - Improves detection of delirium
 - Provides more reliable estimate of resident function
 - Score ≤ 9 – cognitively impaired for RUG purposes
 - Code 99 if:
 - Resident chooses not to participate
 - 4 or more items were coded 0
 - Any BIMS items is coded with a -, dash



157

Should the Staff Assessment be Conducted (C0600)

- Staff assessment completed when resident unable or refuse to participate in the resident interview
- Should the staff assessment for mental status (C0700-1000) be conducted?
 - **Code 0** = No, skip to C1300
 - **Code 1** = Yes, continue to C0700



158

Staff Assessment of Mental Status (C0700 - C0800)

- **C0700 = Short-term Memory OK:**
 - **Code 0** = Memory OK
 - **Code 1** = Memory problem
 - If the test cannot be conducted (resident uncooperative or non-responsive, etc.) and staff were unable to make a determination based on observation, code -, dash to indicate that the information is not available because it could not be assessed
- **C0800 = Long-term Memory OK:**
 - **Code 0** = Memory OK
 - **Code 1** = Memory problem
 - If the test cannot be conducted (resident uncooperative or non-responsive, etc.) and staff were unable to make a determination based on observation, code -, dash to indicate that the information is not available because it could not be assessed

159

Staff Assessment of Mental Status (C0900 - C1000)

- **C0900 = Memory/Recall Ability: (check all that apply)**
 - A. Current season
 - B. Location of own room
 - C. Staff names and faces
 - D. That he or she is in a nursing home
 - Z. None of above were recalled
- **C1000 = Cognitive Skills for Daily Decision Making:**
 - **Code 0** = Independent
 - **Code 1** = Modified independence
 - **Code 2** = Moderately impaired
 - **Code 3** = Severely impaired
 - If resident “rarely or never” made a decision, despite opportunities and cues, Code C1000=3
 - If resident makes decision, although poorly, C1000=2
 - A residents cognitive decision to exercise his/her right to decline treatment should not be captured as impaired decision making in C1000

160

Delirium

- **Mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness or hallucinations**
- **Associated with:**
 - **Increased mortality**
 - **Functional decline**
 - **Development or worsening of incontinence**
 - **Behavior problems**
 - **Withdrawal from activities**
 - **Re-hospitalizations and increased length of stay**



161

Delirium

- **Delirium can be misdiagnosed as dementia**
- **A recent deterioration in cognitive function**
- **May be reversible if detected and treated timely**
- **Planning for care:**
 - **May be symptom of acute, treatable illness**
 - **Reaction to medications**
 - **Prompt detection essential**

162

Assessment of Delirium (C1300)

- **While completing the BIMS:**
 - **Observe resident behavior for signs and symptoms of delirium**
- **If conducting a staff assessment:**
 - **Ask staff members who conducted the assessment about observations of signs and symptoms of delirium**
- **Review medical record**
- **Interview staff, family, etc.**
- **Additional guidelines in Appendix C**



163

Signs and Symptoms of Delirium (C1300)

- **Standardized instrument developed to facilitate detection of delirium**
- **Consists of 4 components:**
 - **A = Inattention**
 - **B = Disorganized thinking**
 - **C = Altered level of consciousness**
 - **D = Psychomotor retardation**

164

Signs and Symptoms of Delirium (C1300) Acute Onset Mental Status Change (C1600)

- Enter code in boxes for C1300A-D:
 - **Code 0** = Behavior not present
 - **Code 1** = Behavior continuously present, does not fluctuate
 - **Code 2** = Behavior presents, fluctuates (comes and goes, changes in severity)
- Is there evidence of an acute change in mental status from the resident's baseline? (C1600)
 - **Code 0** = No
 - **Code 1** = Yes

165

RUG Categories Impacted

Brief Interview for Mental Status
C0200 – Repetition of Three Words
C0300 – Temporal Orientation
C0400 – Recall

RUG-III

- Impaired Cognition

RUG-IV

- Behavioral Symptoms and Cognitive Performance

166

RUG Categories Impacted

Staff Assessment for Mental Status
C0700 – Short-term Memory
C1000 – Cognitive Skills for Daily Decision Making

RUG-III

- Impaired Cognition

RUG-IV

- Behavioral Symptoms and Cognitive Performance

167



Section D: Mood

168

Resident Mood

- Identify the presence or absence of clinical mood indicators, not to diagnose depression or a mood disorder
- Determination is made by either a resident interview (PHQ-9©) or by staff assessment (PHQ-9-OV©)
- Attempt to conduct interview with all residents
- D0100 – Should resident mood interview be conducted?
 - Code 0 = No, skip to D0500
 - Code 1 = Yes, continue to D0200

169

Resident Mood Interview PHQ-9© (D0200)

- Patient Health Questionnaire (PHQ-9©)
- PHQ-9© is a 9-item validated interview that screens for symptoms of depression
- A standardized severity score and rating for evidence of depressive disorder
- Look-back period is 14 days
- There are two parts for each item:
 - Symptom presence (column 1)
 - Symptom frequency (column 2)
- Conduct interview preferably day before or day of ARD



170

Resident Mood Interview PHQ-9© (D0200A-I)

- **Symptom Presence (column 1):**
 - **Code 0** = No
 - **Code 1** = Yes
 - **Code 9** = No response, leave column 2 blank
- **Symptom Frequency (column 2):**
 - **Code 0** = Never or 1 day
 - **Code 1** = 2-6 days
 - **Code 2** = 7-11 days
 - **Code 3** = 12-14 days
 - If resident has difficulty selecting between two frequency responses, code for the higher frequency code

171

Total Severity Score (D0300)

- A summary of the frequency scores that indicates the extent of potential depression symptoms
- The score does not diagnose a mood disorder
- The interview is considered successfully completed if resident answered frequency response on 7 or more items
- If symptom frequency is blank for 3 or more items, interview is not complete, the Total Severity Score is coded 99 and the Staff Assessment of Mood should be done
- Add the numeric scores across all frequency responses from Column 2
- Total Severity Score range (00-27 and 99):
 - Score ≥ 10 – depressed for RUG purposes

172

Safety Notification (D0350)

- Complete only if D0200I, (Thoughts you would be better off dead or of hurting yourself in some way), is coded as a 1 (symptom present)
- May indicate the possibility of resident self-harm
- Was responsible staff or provider informed that there is a potential for resident self harm?
 - Code 0 = No
 - Code 1 = Yes

173

Staff Assessment of Resident Mood (PHQ-9-OV©) (D0500)

- Alternate means of assessing mood for residents who cannot communicate, or refuse or are unable to participate in PHQ-9© interview
- Look-back period is 14 days
- Use same interview techniques with staff as in PHQ-9© interviews
- The staff assessment has one additional item (J)

174

Staff Assessment of Resident Mood (PHQ-9-OV©) (D0500A-J)

- **Symptom Presence (column 1):**
 - **Code 0** = No
 - **Code 1** = Yes
- **Symptom Frequency (column 2):**
 - **Code 0** = Never or 1 day
 - **Code 1** = 2-6 days
 - **Code 2** = 7-11 days
 - **Code 3** = 12-14 days
 - **If a longer item is separated into its components, select the highest frequency reported**
 - **If it is difficult to select between two frequencies, select the higher frequency**

175

Total Severity Score (D0600)

- **The interview is successfully completed if staff members were able to answer the frequency responses of at least 8 or more items**
- **Add the numeric scores across all frequency responses from Column 2**
- **Total Severity Score range (00-30):**
 - **Score ≥ 10 – depressed for RUG purposes.**

176

Safety Notification (D0650)

- Complete only if D0500I, (States that Life isn't Worth Living, Wishes for Death, or Attempts to Harm Self), is coded as a 1 (symptom present)
- May indicate the possibility of resident self-harm
- Was responsible staff or provider informed that there is a potential for resident self harm?
 - Code 0 = No
 - Code 1 = Yes



177

RUG Categories Impacted

Resident Mood Interview (PHQ-9 ©)
D0200A-I, Column 2 – Resident Mood Interview
(Symptom Frequency)

RUG-III

- Clinically Complex

RUG-IV

- Special Care High
- Special Care Low
- Clinically Complex

178

RUG Categories Impacted

Staff Assessment of Resident Mood
D0500A-J, Column 2
(Symptom Frequency)

RUG-III

- Clinically Complex

RUG-IV

- Special Care High
- Special Care Low
- Clinically Complex

179



Section E: Behavior

180

Behaviors

- **Identify behavioral symptoms in the last 7 days that:**
 - May cause distress to the resident
 - Are distressing or disruptive to facility residents, staff members or the care environment
- **Behaviors may:**
 - Place resident at risk for injury, isolation, inactivity
 - May indicate unrecognized needs, preferences, illness
- **Emphasis is on identifying behaviors**
- **Do not take resident's intent into account when coding**
- **Staff may have become used to resident's behavior:**
 - May underreport or minimize



181

Potential Indicators of Psychosis (E0100)

- **When resident expresses a belief that is plausible but alleged by others to be false, try to verify the facts:**
 - Determine whether there is reason to believe that it happened, or
 - Whether it is likely that the belief is false
- **When resident expresses a clearly false:**
 - Determine if it can be readily corrected by a simple explanation of the facts, or
 - Demonstration of evidence to the contrary
 - Do not challenge the resident
- **The resident's responses to the offering of a potential alternative explanation is often helpful in determining whether the false belief is held strongly enough to be considered fixed**

182

Potential Indicators of Psychosis (E0100)

- **E0100A = Hallucinations:**
 - Perception of something being present that is **not** actually there
 - May be auditory or visual or involve smells, tastes or touch
- **E0100B = Delusions:**
 - Fixed false belief **not** shared by others that the resident holds even in the face of evidence to the contrary
- **E0100Z = None of the above**

183

Potential Indicators of Psychosis (E0100)

- **Coding Tips for Delusion:**
 - If a belief cannot be objectively shown to be false, or it is **not** possible to determine whether it is false, do **not** code it as a delusion
 - If a resident expresses a false belief but easily accepts a reasonable alternative explanation, do **not** code it as a delusion
 - If the resident continues to insist that the belief is correct despite an explanation or direct evidence to the contrary, code as a delusion

184

Behavioral Symptom (E0200)

- **New onset of behavioral symptoms warrants:**
 - **Prompt evaluation**
 - **Assurance of resident safety**
 - **Relief of distressing symptoms**
 - **Caring response to the resident**
- **Prompt identification and treatment of reversible and treatable causes**
- **Development of management strategies to minimize the amount of disability and distress**



185

Behavioral Symptom (E0200)

- **Code based on whether the symptoms occurred and not based on an interpretation of the behavior's meaning**
- **Code as present even if staff have become used to the behavior or view it as typical or tolerable**
- **Behaviors in these categories should be coded as present or not present, whether or not they might represent a rejection of care**
- **E0200C does not include wandering**

186

Behavioral Symptom Presence & Frequency (E0200)

- To identify the presence and frequency of 3 types of behaviors:
 - A = Physical behavioral symptoms directed towards others
 - B = Verbal behavioral symptoms directed toward others
 - C = Other behavioral symptoms not directed toward others
- Goal - to develop interventions to improve symptoms or reduce their impact
- Observe resident, interview staff and review resident record

187

Behavioral Symptom Presence & Frequency (E0200)

- For each behavior symptom note presence of symptoms and their frequency:
 - **Code 0** = Behavior not exhibited
 - **Code 1** = Behavior of this type occurred 1 to 3 days
 - **Code 2** = Behavior of this type occurred 4 to 6 days
 - **Code 3** = Behavior of this type occurred daily

188

Overall Presence of Behavioral Symptoms (E0300)

- Were any behavioral symptoms in questions E0200 coded 1, 2 or 3?
 - **Code 0** = No, skip to E0800
 - **Code 1** = Yes, proceed to E0500



189

Impact on Resident (E0500)

- Identify behaviors that may require treatment planning and intervention
- Consider all behavioral symptoms coded in E0200
- Evaluate impact of behaviors in 3 areas
- Did any of the identified symptom(s):
 - A = Put the resident at significant risk for physical illness or injury?
 - **Code 0** = No
 - **Code 1** = Yes
 - Code based on whether risk for physical injury/illness is known to commonly occur under similar circumstances

190

Impact on Resident (E0500)

- **Did any of the identified symptom(s) (continued):**
 - **B = Significantly interfere with the resident's care?**
 - **Code 0** = No
 - **Code 1** = Yes
 - Code if care delivery is impeded to such an extent that necessary or essential care cannot be received safely, completely or timely
 - **C = Significantly interfere with the resident's participation in activities or social interactions?**
 - **Code 0** = No
 - **Code 1** = Yes
 - Code if behaviors keep resident from participating in solitary or group activities, or having positive social encounters with visitors, other residents or staff



191

Impact on Others (E0600)

- **Identify behaviors in E0200 that may require treatment planning and intervention**
- **Evaluate impact of behaviors in 3 areas**
- **Did any of the identified symptom(s):**
 - **A = Put others at significant risk for physical injury?**
 - **B = Significantly intrude on the privacy or activity of others?**
 - **C = Significantly disrupt care or living environment?**
 - **Code for all 3 impacts:**
 - **Code 0** = No
 - **Code 1** = Yes



192

Rejection of Care Presence & Frequency (E0800)

- Residents' preferences do not have to appear logical or rational to the clinician
- It is really a matter of resident choice; education is provided and resident's choices become part of the care plan
- On future assessments, this behavior would not be coded in this item
- Care might conflict with resident's preferences and goals; in such cases, rejection of care is not considered a problem
- Rejection of care might be caused by underlying neuropsychiatric, medical, or dental problems

193

Rejection of Care Presence & Frequency (E0800)

- Identify potential behavioral problems, not situations where care is rejected based on a choice that is consistent with the resident's preferences or goals for health and well-being or a choice made by the resident's family or proxy decision maker
- Rejection of care may appear as:
 - Verbally declining or making statements of refusal
 - Physical behaviors that avoid or interfere with care
- Did the resident reject evaluation or care that is necessary to achieve the resident's goals for health and well-being?
 - **Code 0** = Behavior not exhibited
 - **Code 1** = Behavior of this type occurred 1 to 3 days
 - **Code 2** = Behavior of this type occurred 4 to 6 days
 - **Code 3** = Behavior of this type occurred daily



194

Wandering Presence & Frequency (E0900)

- Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction
- Wandering may or may not be aimless
- The wandering resident may be oblivious to his or her physical or safety needs
- The resident may have a purpose such as searching to find something, but he or she persists without knowing the exact direction or location of the object, person or place
- The behavior may or may not be driven by confused thoughts or delusional ideas (e.g., when a resident believes she must find her mother, who staff know is deceased)

195

Wandering Presence & Frequency (E0900)

- Has the resident wandered?
 - **Code 0** = Behavior not exhibited, skip to E1100
 - **Code 1** = Behavior of this type occurred 1 to 3 days
 - **Code 2** = Behavior of this type occurred 4 to 6 days
 - **Code 3** = Behavior of this type occurred daily
- Pacing within a constrained space is not included in wandering
- Traveling via a planned course is not considered wandering



196

Wandering - Impact (E1000)

- Answer this item only if E0900, Wandering, was coded 1, 2 or 3
- A – Does the wandering place the resident at significant risk of getting to a potentially dangerous place?
 - Code 0 = No
 - Code 1 = Yes
- B - Does the wandering significantly intrude on the privacy or activities of others?
 - Code 0 = No
 - Code 1 = Yes



197

Change in Behavior or Other Symptoms (E1100)

- Consider all responses in E0100 thru E1000
- Compare with responses on prior MDS assessments
- This item should be rated to reflect the overall direction of behavior change
- How does resident's current behavior status, care rejection, or wandering compare to prior assessment (OBRA or Scheduled PPS)?
 - Code 0 = Same
 - Code 1 = Improved
 - Code 2 = Worse
 - Code 3 = N/A because no prior MDS assessment



198

RUG Categories Impacted

E0100A – Hallucinations
E0100B – Delusions

RUG-III

- Behavior Problems

RUG-IV

- Behavioral Symptoms and Cognitive Performance

199

RUG Categories Impacted

E0200A – Physical behavior symptoms directed toward others
E0200B – Verbal behavior symptoms directed toward others
E0200C – Other behavior symptoms not directed toward others
Code 2 or 3

RUG-III

- Behavior Problems

RUG-IV

- Behavioral Symptoms and Cognitive Performance

200