

RUG Categories Impacted

E0800 – Rejection of Care
E0900 – Wandering
Code 2 or 3

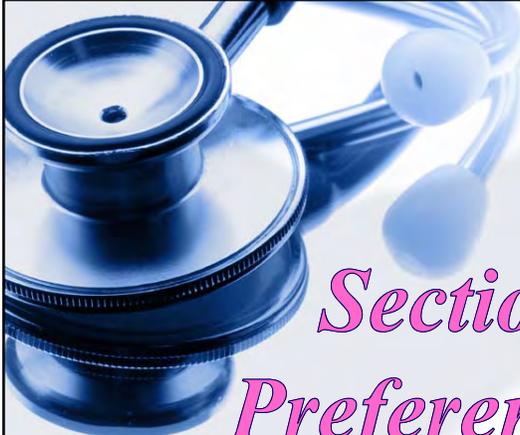
RUG-III

- Behavior Problems

RUG-IV

- Behavioral Symptoms and Cognitive Performance

201



Section F: Preferences for Customary Routine & Activities

202

Should Interview for Daily & Activity Preferences be Conducted (F0300)

- Attempt to interview residents able to communicate. If resident is unable to complete, attempt to complete interview with family member or significant other.
- Should interview for daily and activity preferences be conducted?
 - **Code 0** = No, resident is rarely/never understood and family/significant other not available
 - Skip to F0800
 - **Code 1** = Yes, continue to F0400



203

Interview for Daily Preferences (F0400) Interview for Activity Preferences (F0500)

- Explain interview response choices, showing resident a written list, such as a cue card
- Show resident the coding responses and say “While you are in this home...”
- Resident may respond verbally, by pointing to or by writing response
- No look-back period is provided to resident; he/she is being asked about current preferences but is not limited to a 7 day look-back period
- However, facility must still complete the assessment within the 7 day look-back period



204

Interview for Daily Preferences (F0400) Interview for Activity Preferences (F0500)

- A lack of attention to lifestyle preferences can contribute to depressed mood and increased behavior symptoms
- Responses may provide insights into perceived functional, emotional and sensory support needs
- Activities are a way for individuals to establish meaning in their lives
- Need for enjoyable activities does not change on admission to a nursing home

205

Interview for Daily Preferences (F0400) Interview for Activity Preferences (F0500)

Eight (8) items in F0400 and 8 items in F0500 will be evaluated using the same coding scale:

- **Code 1** = Very important
- **Code 2** = Somewhat important
- **Code 3** = Not very important
- **Code 4** = Not important at all
- **Code 5** = Important, but can't do or no choice
- **Code 9** = No response or non-responsive



206

Interview for Daily Preferences (F0400) Interview for Activity Preferences (F0500)

- Interview is considered incomplete if resident gives nonsensical responses or fails to respond to 3 or more of the 16 items
- If interview is stopped because incomplete, fill remaining items with a “9” and proceed to F0600



207

Daily and Activity Preferences Primary Respondent (F0600)

- Indicate primary respondent:
 - Code 1 = Resident
 - Code 2 = Family or significant other
 - Code 9 = Interview could not be completed



208

Should the Staff Assessment of Daily & Activity Preferences be Conducted? (F0700)

- **Code 0 = No**
 - F0400 and F0500 was completed by resident or family/significant other
 - Skip to G0110
- **Code 1 = Yes**
 - 3 or more items in F0400 or F0500 were not completed by resident or family/significant other
 - Continue to F0800

***NOTE:** If the total number of unanswered questions in F0400 - F0500 is equal to 3 or more, the interview is considered incomplete*

209

Staff Assessment of Daily & Activity Preferences (F0800)

- Conduct only if resident/family interview was not completed
- Assessment is done by observing the resident when care, routines and activities specified in these items are made available to the resident
- Observations are made by staff across all shifts and departments during the look-back period
- Check all items A-T, Z for which the resident appears content or happy during the activity:
 - Resident is involved, pays attention or smiles, etc.



210



Activities of Daily Living (ADL)

- **ADL** – Tasks related to personal care
- **ADL Self-Performance** – Measures what the resident actually did (**not** what he/she might be capable of doing) according to a performance-based scale
- **ADL Support-Provided** – Measures the most support provided by staff, even if that level of support only occurred once

212

Activities of Daily Living (ADL) Assistance (G0110)

- Code based on level of assistance when using special adaptive devices
- Do not include assistance provided by individuals hired (compensated or not) by outside facility's management/administration, hospice staff, nursing/CNA students
- Self-performance may vary day to day, shift to shift, within shifts, 24 hours a day
- It is necessary to know when activity occurs 3 or more times
- Refer to ADL self-performance algorithm on page G-6
- Code self-performance before support provided

213

ADL Self-Performance Coding (G0110 Column 1)

- Activity Occurred 3 or More Times:
 - **Code 0** = Independent, no help or staff oversight at any time
 - **Code 1** = Supervision, oversight, encouragement, or cueing
 - **Code 2** = Limited assistance:
 - Resident highly involved in activity
 - Staff provide guided maneuvering of limbs or other non-weight-bearing assistance:
 - Guided maneuvering vs. weight-bearing is determined by who is supporting the weight of the resident's extremity or body

214

ADL Self-Performance Coding (G0110 Column 1)

- **Activity Occurred 3 or More Times:**
 - **Code 3 = Extensive assistance:**
 - Resident involved in activity
 - Staff provide weight-bearing support
 - Full staff performance part but not all of the time
 - **Code 4 = Total dependence:**
 - Full staff performance every time during entire 7-day period



215

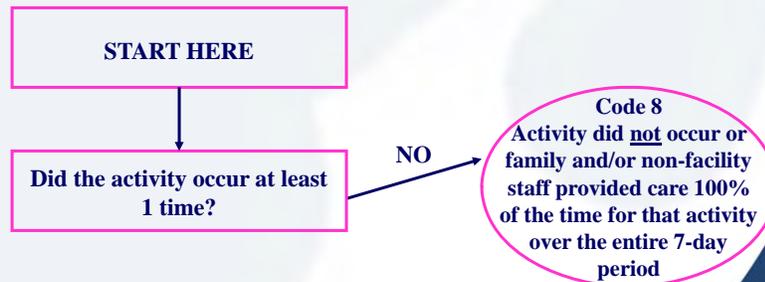
ADL Self-Performance Coding (G0110 Column 1)

- **Activity Occurred 2 or Fewer Times:**
 - **Code 7 = Activity occurred only once or twice**
 - **Code 8 = Activity did not occur:**
 - Activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

216

Instructions for the Rule of Three

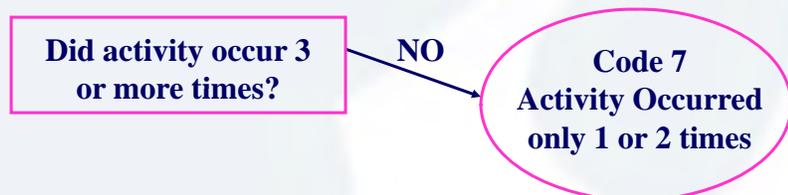
- **Code 8 - Activity Did Not Occur:**
 - Determine if the ADL occurred at least one time
 - Code 8 if the activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period



217

Instructions for the Rule of Three

- **Code 7 - Activity Occurred Only Once or Twice:**
 - Determine if ADL occurred three or more times during the look-back period
 - Code 7 if ADL occurred only once or twice



218

Instructions for the Rule of Three

- **Code 0 – Independent:**
 - Determine if the resident did not need **ANY** assistance or oversight to complete the ADL every time

Code 0
Independent

YES

Did resident fully perform the ADL activity without ANY help or oversight from staff every time?

219

Instructions for the Rule of Three

- **Code 4 - Total Dependence:**
 - Determine if the resident is unwilling or unable to perform any part of the ADL for the entire look-back period

Code 4
Total
Dependence

YES

Did resident require full staff performance every time?

220

Instructions for the Rule of Three

- **Code 3 - Extensive Assistance:**
 - Did resident require full staff performance at least 3 times but not every time or weight bearing assistance 3 or more times?

OR

- Did resident require a combination of full staff performance and weight bearing assistance 3 or more times?

Code 3
Extensive
Assistance

YES

If yes to either
question, Code 3
Extensive Assistance

221

Instructions for the Rule of Three

- **Code 2 - Limited Assistance:**
 - Did resident require non-weight bearing assistance 3 or more times?

OR

- Did resident require a combination of full staff performance/weight bearing assistance and non-weight bearing assistance 3 or more times?

Code 2
Limited
Assistance

YES

If yes to either
question, Code 2
Limited Assistance

222

Instructions for the Rule of Three

- **Code 1 – Supervision:**
 - Did resident require oversight, encouragement, or cueing 3 or more times?

OR

- If none of the Rule of 3 conditions are met, Code 1 Supervision



223

ADL Support Provided Guidelines (G0110 Column 2)

- Code the **most support** provided over all shifts, regardless of self-performance code
- Document the most support provided even if it occurred only once
- Code Column 1 and Column 2 separately

2. ADL Support Provided
Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

1. ADL Self-Performance
Code for resident's performance over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time.

2. ADL Support Provided
Code for most support provided over all shifts; code regardless of resident's self-performance classification.

224

ADL Support Provided Coding (G0110 Column 2)

- Code regardless of self performance codes:
 - **Code 0** = No setup or physical help from staff
 - **Code 1** = Setup help only
 - **Code 2** = One person physical assist
 - **Code 3** = Two+ persons physical assist
 - **Code 8** = ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

225

Bathing (G0120)

- Code how resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower
- Code for the most dependent in self-performance and support provided
- **G0120A=Self Performance:**
 - **Code 0** = Independent
 - **Code 1** = Supervision
 - **Code 2** = Physical help limited to transfer only
 - **Code 3** = Physical help in parts of bathing activity
 - **Code 4** = Total dependence
 - **Code 8** = Activity did not occur
- **G0120B=Support Provided:**
 - Use the same codes as G0110 Column 2

NOTE: *excludes washing of back and hair*



226

Balance During Transitions and Walking (G0300)

- **Conducting the assessment:**
 - Can be done through observations of the resident during the entire 7-day look-back period
 - During transitions from sitting to standing, walking, turning, transfers on and off toilet, and transfer from wheelchair to bed and bed to wheelchair
 - Must have documentation that reflects the resident's stability in these activities at least once during the look-back period, otherwise the following assessment must be done

227

Balance During Transitions and Walking (G0300)

- Have assistive devices the resident normally uses available
- Start with resident sitting on the edge of the bed, in a chair or in a wheelchair
- Ask the resident to stand up and stay still for 3-5 seconds (rate G0300A now)
- Ask resident to walk approximately 15 feet using his/her usual assistive device (rate G0300B now)
- Ask resident to turn around (rate G0300C now)



228

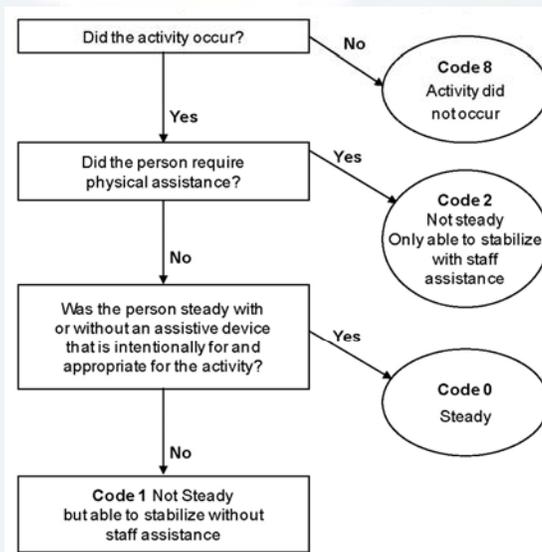
Balance During Transitions and Walking (G0300)

- f) Ask resident to:
- walk or wheel from a starting point in his/her room into the bathroom
 - prepare for toileting as normally do (including taking down pants or other clothing, but leaving undergarments on)
 - sit down on the toilet (rate G0300D now)
- g) Ask residents who use a wheelchair for mobility to transfer from a seated position in the wheelchair to a seated position on the bed (rate G0300E now)



229

Balance During Transitions and Walking Algorithm (G-21)



230

Balance During Transitions and Walking (G0300)

- Code the following walking and transition items for most dependent:
 - A = Moving from seated to standing position
 - B = Walking
 - C = Turning around
 - D = Moving on and off toilet
 - E = Surface-to-surface transfer
 - Code 0 = Steady at all times
 - Code 1 = Not steady, but able to stabilize with help
 - Code 2 = Not steady, only able to stabilize with help
 - Code 8 = Activity did not occur



231

Functional Limitation in Range of Motion (G0400)

- Test the upper and lower extremity for limitations that interfere with daily functioning or place the resident at risk of injury
- Assess ROM bilaterally at the shoulder, elbow, wrist, hand, hip, knee, ankle, foot and other joints unless contraindicated
- Ask resident to move each joint using verbal directions and demonstration. May actively assist the resident with ROM exercises.
- A = Upper extremity
- B = Lower extremity:
 - Code 0 = No impairment
 - Code 1 = Impairment on one side
 - Code 2 = Impairment on both sides



232

Mobility Devices (G0600)

- *Check all that were normally used:*
 - **A = Cane/crutch**
 - **B = Walker**
 - **C = Wheelchair**
 - **D = Limb prosthesis**
 - **Z = None of the above were used**



233

Functional Rehabilitation Potential (G0900)

- **Complete only on OBRA Admission (A0310A = 01)**
- **A = Resident believes he or she is capable of increased independence in at least some ADLs:**
 - **Code 0 = No**
 - **Code 1 = Yes**
 - **Code 9 = Unable to determine**
- **B = Direct care staff believe resident is capable of increased independence in at least some ADLs:**
 - **Code 0 = No**
 - **Code 1 = Yes**



234

RUG Categories Impacted

G0110A, Column 1 & 2 – Bed Mobility
G0110B, Column 1 & 2 – Transfer
G0100H, Column 1 & 2 – Eating
G0110I, Column 1 & 2 – Toilet Use

RUG-III

- Extensive Services
- Rehabilitation
- Special Care
- Clinically Complex
- Impaired Cognition
- Behavior Problems
- Reduced Physical Function

RUG-IV

- Rehab Plus Extensive Services
- Rehabilitation
- Extensive Services
- Special Care High
- Special Care Low
- Clinically Complex
- Behavioral Symptoms and Cognitive Performance
- Reduced Physical Function

NOTE:

- *Eating for self-performance applies in RUG-III only*
- *Eating for both self-performance and support applies in RUG-IV*

235

Section H: Bladder & Bowel

236

Appliances (H0100)

- **Check all that apply:**
 - **A = Indwelling catheter**
 - Including suprapubic catheters and nephrostomy tubes
 - **B = External catheter**
 - **C = Ostomy**
 - Any type of surgically created opening of the GI or genitourinary tract for discharge of body waste including:
 - Urostomy
 - Ileostomy
 - Colostomy
 - **D = Intermittent catheterization**
 - **Z = None of the above**

237

Urinary Toileting Program (H0200)

- An individualized, resident-centered toileting program
- A toileting program or trial toileting program refers to a specific approach that's organized, planned, documented, monitored, and evaluated
- Urinary Toileting Program has 3 components:
 - A. Trial
 - B. Program response
 - C. Current program or trial
- It does not refer to:
 - Simply tracking continence status
 - Changing pads or wet clothing
 - Random assistance with toileting or hygiene



238

Urinary Toileting Program Trial (H0200A)

- Look for evidence of a trial individualized toileting program that includes at least 3 days of toileting patterns with prompts to void recorded in a bladder record or voiding diary:
 - 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 the urinary incontinence was noted in this facility?
 - **Code 0** = No, skip to H0300
 - **Code 1** = Yes, continue to H0200B
 - **Code 9** = Unable to determine, skip to H0200C

239

Urinary Toileting Program Response (H0200B)

- B = What was the resident's response to the trial program?
 - **Code 0** = No improvement
 - **Code 1** = Decreased wetness
 - **Code 2** = Completely dry (continent)
 - **Code 3** = Unable to determine, or trial in progress

240

Current Toileting Program or Trial (H0200C)

- **C = Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?**
 - **Code 0 = No:**
 - Individualized program used less than 4 of the 7 day look-back period
 - **Code 1 = Yes:**
 - Some kind of systematic toileting program was used 4 or more days of the 7 day look-back period
- **Look for documentation in the clinical record that the following 3 requirements are met:**
 - Program was implemented
 - Program was communicated to the resident and staff
 - Resident's response to the toileting program and subsequent re-evaluations

241

Urinary Continence (H0300)

- **Continence – any void into a commode, urinal or bedpan that occurs voluntarily or as the result of prompted toileting, assisted toileting or scheduled toileting**
- **Incontinence – the involuntary loss of urine**
- **Urinary continence:**
 - **Code 0 = Always continent**
 - **Code 1 = Occasionally incontinent (less than 7 episodes)**
 - **Code 2 = Frequently incontinent (7 or more episodes with 1 or more episode or continent voiding)**
 - **Code 3 = Always incontinent (no continent voiding)**
 - **Code 9 = Not rated**

242

Bowel Continence (H0400)

- **Bowel continence:**
 - **Code 0** = Always continent
 - **Code 1** = Occasionally incontinent (1 episode of incontinence)
 - **Code 2** = Frequently incontinent (2 or more episodes of incontinence, but at least 1 continent bowel movement)
 - **Code 3** = Always incontinent (no episodes of continent bowel movements)
 - **Code 9** = Not rated

***NOTE:** Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinent*

243

Bowel Toileting Program (H0500)

- **Look for documentation in the clinical record that the following 3 requirements are met:**
 - Program was implemented
 - Program was communicated to the resident and staff
 - Resident's response to the toileting program and subsequent re-evaluations
- **Is a toileting program currently being used to manage the resident's bowel continence?**
 - **Code 0** = No
 - **Code 1** = Yes

244

Bowel Patterns (H0600)

- Constipation is defined as 2 or fewer bowel movements during the 7-day look-back period or if most stool is hard and difficult to pass (regardless of frequency)
- Fecal Impaction:
 - Fecal impaction is caused by chronic constipation
 - Fecal impaction is not synonymous with constipation
- Constipation present?
 - Code 0 = No
 - Code 1 = Yes

245

RUG Categories Impacted

H0200C – Current toileting program or trial
H0500 – Bowel Toileting Program

RUG-III

- Rehabilitation
- Impaired Cognition
- Behavior Problems
- Reduced Physical Function

RUG-IV

- Rehab Plus Extensive Services
- Rehabilitation
- Behavioral Symptoms and Cognitive Performance
- Reduced Physical Function

246



Section I: Active Diagnosis

247

Active Diagnoses

- **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**
- **Disease processes can have a significant adverse affect on the individual's health status and quality of life**
- **This section identifies active diseases and infections that drive the current plan of care**



248

Active Diagnoses



- **2-look back periods:**
 - **Step 1 = Diagnosis identification 60-day window**
 - **Must have physician documented diagnosis (or by NP, PA, or CNS) in the last 60 days**
 - **Step 2 = Diagnosis Status: Active or Inactive 7-day window (except UTI)**
- **Coding Tips:**
 - **If disease/condition not specifically listed, check “Other” box (I8000); write in ICD code and name of diagnosis**

249

Active Diagnoses



- **Coding Tips, continued:**
 - **If diagnosis is a V-code, another diagnosis for the related primary medical condition should be checked or entered in I8000**
 - **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**

250

Active Diagnoses

- **Coding Tips, continued:**
 - **When there is no specific documentation that a disease is “active”, may confirm this using other indicators; tests, procedures, positive study, etc.**
 - **Special criteria for UTI:**
 - **Physician diagnosis of UTI in last 30 days**
 - **Signs and symptoms attributed to UTI**
 - **Positive test, study or procedure**
 - **Current medication or treatment for UTI in last 30 days**



251

Active Diagnoses (I0100-I8000)

- **I0100=Cancer**
- **I0200-I0900=Heart/Circulation**
- **I1100-I1300=Gastrointestinal**
- **I1400-I1650=Genitourinary**
- **I1700-I2500=Infections**
- **I2900-I3400=Metabolic**
- **I3700-I4000=Musculoskeletal**
- **I4200-I5500=Neurological**
- **I5600=Nutritional**
- **I5700-I6100=Psychiatric/Mood Disorder**
- **I6200-I6300=Pulmonary**
- **I6500=Vision**
- **I7900=None of Above**
- **I8000=Other**



252

RUG Categories Impacted

I2000 – Pneumonia

RUG-III

- Special Care
- Clinically Complex

RUG-IV

- Special Care High
- Clinically Complex

253

RUG Categories Impacted

I2100 – Septicemia
I2900 – Diabetes Mellitus (DM)

RUG-III

- Clinically Complex

RUG-IV

- Special Care High

254

RUG Categories Impacted

I4900 – Hemiplegia or Hemiparesis

RUG-III

- Clinically Complex

RUG-IV

- Clinically Complex

255

RUG Categories Impacted

**I4300 – Aphasia
I4400 – Cerebral Palsy
I5100 – Quadriplegia
I5200 – Multiple Sclerosis (MS)**

RUG-III

- Special Care

RUG-IV

I4300

- Not a RUG-IV item

I4400, I5200

- Special Care Low

I5100

- Special Care High

256

RUG Categories Impacted

I5300 – Parkinson’s Disease

RUG-III

- Not a RUG-III item

RUG-IV

- Special Care Low

257

RUG Categories Impacted

I6200 – Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease

RUG-III

- Not a RUG-III item

RUG-IV

- Special Care High

258

RUG Categories Impacted

I6300 – Respiratory Failure

RUG-III

- Not a RUG-III item

RUG-IV

- Special Care Low

259

Section J: Health Conditions

260

Pain Management (J0100)



- At any time in the last 5 days has the resident received:
 - A = Scheduled pain medication regimen?
 - B = PRN pain medications OR was offered and declined?
 - C = Non-medication intervention for pain?
- Coding for all of the above:
 - **Code 0** = No, for A and C, the medical record does not contain documentation that a pain medication was received, and B also includes was offered
 - **Code 1** = Yes, for A, the medical record contains documentation that a pain medication was received. For item B also include offered, but declined. For item C, the efficacy must also be documented.

261

Should Pain Assessment Interview be Conducted? (J0200)

- Attempt to conduct the interview if the resident is at least sometimes understood and an interpreter is present (or not required):
 - **Code 0** = No, resident is rarely/never understood, skip to J0800
 - **Code 1** = Yes, continue to J0300

262

Pain Assessment Interview (J0300 - J0600)

- Assessment should be conducted on the day before or the day of the ARD date
- The look back period is 5 days
- Directly ask the resident each item in J0300 thru J0600 in the order provided
- Use resident's terminology for pain – such as hurting, aching, burning



263

Pain Presence (J0300)

- Ask resident: *“Have you had pain or hurting at any time in the last 5 days?”*
- Code for the presence or absence of pain regardless of pain management efforts:
 - **Code 0** = No, resident says there was no pain even if the reason for no pain was due to receipt of pain management interventions, skip to J1100
 - **Code 1** = Yes, continue to J0400
 - **Code 9** = Unable to answer, does not respond, or gives nonsensical response, skip to J0800

264

Pain Frequency (J0400)

- Ask resident: *“How much of the time have you experienced pain or hurting over the last 5 days?”*
 - **Code 1** = Almost constantly
 - **Code 2** = Frequently
 - **Code 3** = Occasionally
 - **Code 4** = Rarely
 - **Code 9** = Unable to answer



265

Pain Effect on Function (J0500)

- **A** = Ask resident: *“Over the past 5 days, has pain made it hard for you to sleep at night?”*
- **B** = Ask resident: *“Over the past 5 days, have you limited your day-to-day activities because of pain?”*
- Coding for all of the above:
 - **Code 0** = No, pain did not interfere
 - **Code 1** = Yes, pain interfered with sleep or activities
 - **Code 9** = Unable to answer



266

Pain Intensity (J0600)



- Administer **ONLY ONE** of the Pain Intensity questions (A or B)
- A = Numeric Rating Scale (00-10)
 - Ask resident: *“Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine”*:
 - Code 00-10 = Record resident two-digit response
 - Code 99 = Unable to answer

267

Pain Intensity (J0600)



- B = Verbal Descriptor Scale
 - Ask resident: *“Please rate the intensity of your worst pain over the last 5 days”*:
 - Code 1 = Mild
 - Code 2 = Moderate
 - Code 3 = Severe
 - Code 4 = Very severe, horrible
 - Code 9 = Unable to answer
 - Use this if resident either unable, chooses not to respond, or gives a nonsensical response

268

Staff Assessment for Pain (J0700)

- Closes the pain interview and determines if the resident interview was complete or incomplete:
 - The pain interview is successfully completed if:
 - The resident reported no pain (J0300 = No)
 - If the resident reported pain (J0300 = Yes) and the follow-up question J0400 is answered
- Should the Staff Assessment for Pain be Conducted?
 - **Code 0** = No (J0400 = 1 thru 4), skip to J1100
 - **Code 1** = Yes (J0400 = 9), continue to J0800

269

Indicators of Pain (J0800)

- Complete only if Pain Assessment Interview was not completed
- *Check all indicators that apply:*
 - A = Non-verbal sounds (crying, whining, moaning)
 - B = Vocal complaints of pain (that hurts, ouch)
 - C = Facial expressions (grimaces, wincing)
 - D = Protective body movements or postures (bracing, guarding, rubbing body part/area)
 - Z = None of these signs observed or documented, skip to J1100

270

Frequency of Indicator of Pain or Possible Pain (J0850)

- Frequency with which resident complains or shows evidence of pain or possible pain:
 - **Code 1** = Indicators of pain or possible pain observed 1 to 2 days
 - **Code 2** = Indicators of pain or possible pain observed 3 to 4 days
 - **Code 3** = Indicators of pain or possible pain observed daily



271

Shortness of Breath (Dyspnea) (J1100)

- Resident may have any combination
- *Check all that apply:*
 - Resident has shortness of breath or trouble breathing:
 - A = With exertion
 - B = When sitting at rest
 - C = When lying flat
 - Z = None of the above

272

Current Tobacco Use (J1300)

- Includes tobacco used in any form:

- **Code 0** = No
- **Code 1** = Yes



273

Prognosis (J1400)

- Resident has less than 6 months to live
- Resident has a terminal illness
- Physician documentation must be in the medical record to support coding this item
- Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?
 - **Code 0** = No, medical record has no physician documentation to support this and is not receiving hospice services
 - **Code 1** = Yes, medical record documentation by the physician supports this or resident is receiving hospice services

274

Problem Conditions (J1550)

- *Check all that apply:*
 - **A = Fever**
 - Must be 2.4 degrees F above baseline
 - Temperature of 100.4 on admission
 - **B = Vomiting**
 - **C = Dehydrated**
 - Must have 2 of the 3 criteria to code
 - **D = Internal bleeding**
 - Frank
 - Occult
 - **Z = None of the above**



275

Fall History on Admission/Entry or Reentry (J1700)

- **Fall Definition:**
 - Unintentional change in position coming to rest on the ground, floor or onto the next lower surface
 - Includes any fall, no matter where it occurs
 - Falls are not the result of an overwhelming external force
 - An intercepted fall is still considered a fall
 - A resident found on the floor or ground without knowledge of how they got there, is a fall



276

Fall History on Admission/Entry or Reentry (J1700)

- Ask resident and family or significant other about falls in the past month and prior 6 months before admission (A1600 entry date)
- A = a fall any time in the last month
- B = a fall any time in last 2-6 months
- C = any fracture related to a fall in the 6 months
- Coding for all of the above:
 - Code 0 = No, no falls or fractures in time frame
 - Code 1 = Yes, a fall (A-B) or fracture (C) occurred in the time frame
 - Code 9 = Unable to determine



277

Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) (J1800)

- If this is the first assessment, review the record for the time period from admission date to ARD
- If this is not the first assessment, review the record for the time period from the day after the ARD of last MDS to the ARD of current MDS:
 - Code 0 = No, skip to K0100
 - Code 1 = Yes, continue to J1900

278

Number of Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS) (J1900)

- A = No injury
- B = Injury (except major)
- C = Major injury
- Coding for all of the above:
 - Code 0 = None
 - Code 1 = One fall with or without injury
 - Code 2 = Two or more falls with or without injury



279

Coding Tips and Example (J1900)

- If resident has multiple injuries in a single fall, code for the highest level of injury
- Code each fall only once

Example:

- The resident fell and lacerated his head. The head CT scan showed a subdural hematoma.
- J1900C would be coded as a “1”. The resident had a major injury from a fall.



280

RUG Categories Impacted

J1100C – Shortness of Breath (dyspnea)

RUG-III

- Not a RUG-III item

RUG-IV

- **Special Care High**

281

RUG Categories Impacted

**J1550A – Fever
J1550B – Vomiting**

RUG-III

- **Special Care**

RUG-IV

- **Special Care High**

282

RUG Categories Impacted

J1550C – Dehydrated

RUG-III

- Special Care
- Clinically Complex

RUG-IV

- Not a RUG-IV item

283

RUG Categories Impacted

J1550D – Internal Bleeding

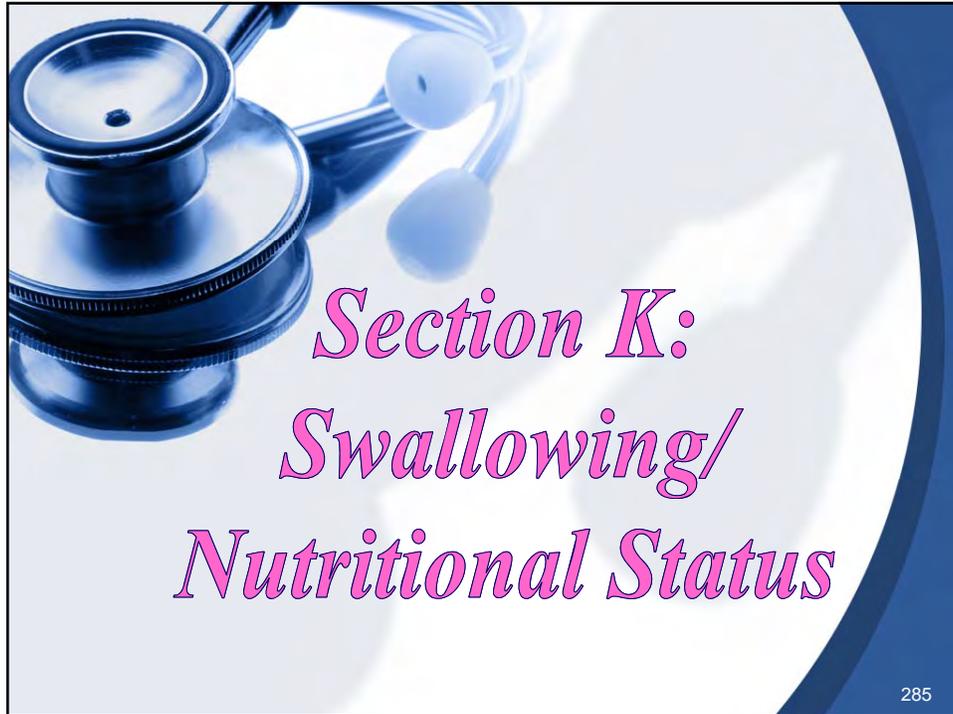
RUG-III

- Clinically Complex

RUG-IV

- Not a RUG-IV item

284



Section K: Swallowing/ Nutritional Status

285

Swallowing Disorder (K0100)

- Signs and symptoms of possible swallowing disorder even if occurred only once
- *Check all that apply:*
 - A = Loss of liquids/solids from mouth when eating or drinking
 - B = Holding food in mouth/cheeks or residual food in mouth after meals
 - C = Coughing or choking during meals or when swallowing medications
 - D = Complaints of difficulty or pain with swallowing
 - Z = None of the above



NOTE: Do not code a problem when interventions have been successful in treating the problem and no S&S are present

286

Height and Weight (K0200)

- Record a current height and weight in order to monitor nutrition and hydration over time
- A = Height (in inches):
 - On admission, measure and record height in inches – to the nearest whole inch
 - Use mathematical rounding (.1 to .4 inches round down, .5 or greater round up)
 - Re-measure if last height was over a year ago
 - Measure consistently



287

Height and Weight (K0200)

- B = Weight (in pounds):
 - Base weight on most recent measure in last 30 days
 - On subsequent assessments, enter weight taken within 30 days of ARD
 - If multiple weights in preceding month, record most recent one
 - Use mathematical rounding (if weight is .5# or more round up; if weight is .1 to .4#, round down)
 - Weigh consistently
 - If unable to weigh, code with a dash (-), no information available code, and document reason in medical record



288

Weight Loss (K0300)

- Compares resident's current weight to the weight from two distinct points in time only
- Mathematically round weights
- Look first at whether the resident lost 5% or more weight in the last 30 days or 10% or more in last 180 days:
 - **Code 0** = No or unknown
 - **Code 1** = Yes, on physician-prescribed weight-loss regimen
 - **Code 2** = Yes, not on physician-prescribed weight-loss regimen
 - Physician-prescribed weight-loss regimen is a weight reduction plan ordered by the physician. Includes planned diuresis; it is important that weight loss is intentional

NOTE: A weight variance between snapshots are not captured on MDS

289

Weight Gain (K0310)

- Compares resident's current weight to the weight from two distinct points in time only
- Determine if there was a gain of 5% or more in the last 30 days or gain of 10% or more in last 180 days:
 - **Code 0** = No or unknown
 - **Code 1** = Yes, on physician-prescribed weight-gain regimen
 - **Code 2** = Yes, not on physician-prescribed weight-gain regimen



NOTE: A weight variance between snapshots are not captured on MDS

290

Nutritional Approaches (K0510)

- Identify nutritional approaches that vary from the normal or that rely on alternative methods while not a resident or while a resident
- *Check all that apply:*
 - A = Parenteral/IV feeding for nutrition or hydration
 - B = Feeding tube
 - C = Mechanically altered diet
 - D = Therapeutic diet
 - Not defined by the content of what is provided or when it is served, but why the diet is required
 - Z = None of the above

291

Percent Intake by Artificial Route (K0700)

- Complete only if K0510A or K0510B are checked
- A = Proportion of total calories the resident received through parenteral or tube feeding:
 - Review intake record for actual intake received:
 - Code 1 = 25% or less
 - Code 2 = 26-50%
 - Code 3 = 51% or more
- B = Average fluid intake per day by IV or tube feeding:
 - Code 1 = 500 cc/day or less
 - Code 2 = 501 cc/day or more

292

K0700A Calculate Proportion

- Dietician report of total calories:

	Oral	Tube
Sun.	500	2,000
Mon.	250	2,250
Tues.	250	2,250
Wed.	350	2,250
Thurs.	500	2,000
Fri.	250	2,250
Sat.	50	2,000
Total	2,450	15,000

K0700A Calculate Proportion

- Total oral intake = 2,450 calories
- Total tube intake = 15,000 calories
- Total calories = 2,450 + 15,000 = 17,450
- Percentage of calories by tube feeding
 - $15,000 \div 17,450 = 0.859$
 - $0.859 \times 100 = 85.9\%$

RUG Categories Impacted

K0300, Code 1 or 2 – Weight Loss

RUG-III

- **Special Care**

RUG-IV

- **Special Care High**

295

RUG Categories Impacted

K0510A – Parenteral/IV feeding

RUG-III

- **Extensive Services**
- **ADL Score**

RUG-IV

- **Special Care High**

296

RUG Categories Impacted

K0510B – Feeding tube

RUG-III

- Special Care
- Clinically Complex
- ADL Score

RUG-IV

- Special Care High
- Special Care Low

297

RUG Categories Impacted

K0700A – Total calories parenteral/tube feeding K0700B – Average fluid intake by IV or tube feeding

RUG-III

- Special Care
- Clinically Complex
- ADL Score

RUG-IV

- Special Care High
- Special Care Low

298



Section L: Oral/Dental Status

299

Dental (L0200)

- To identify any dental problems
- Conduct oral exam of lips and oral cavity
- Mouth or facial pain coded here should also be coded in Section J, where appropriate
- *Check all that apply:*
 - A = Broken or loosely fitting full or partial dentures
 - B = No natural teeth or tooth fragment(s)
 - C = Abnormal mouth tissue
 - D = Obvious or likely cavity or broken natural teeth
 - E = Inflamed or bleeding gums or loose natural teeth
 - F = Mouth or facial pain, discomfort or difficulty with chewing
 - G = Unable to examine
 - Z = None of the above were present



300

A blue stethoscope is positioned in the upper right corner of the slide. The background features a faint, light-colored silhouette of a human heart. The slide has a dark blue curved border on the right side.

Pressure Ulcer Risk Factors

- **Immobility and decreased functional ability**
- **Co-morbid conditions (ESRD, thyroid, diabetes)**
- **Drugs such as steroids**
- **Impaired diffuse or localized blood flow**
- **Resident refusal of care and treatment**
- **Cognitive impairment**
- **Exposure of skin to urinary and fecal incontinence**
- **Under-nutrition, malnutrition, and hydration deficits**
- **Healed pressure ulcer**
- **Common risk tools include the Braden Scale for Predicting Pressure Sore Risk, etc.**

302

Determination of Pressure Ulcer Risk (M0100)

- *Check all that apply:*
 - **A = Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device:**
 - Pressure ulcer description/staging
 - Non-removable dressing, cast, brace
 - **B = Formal assessment instrument/tool has been used:**
 - Braden Scale
 - Norton Scale
 - **C = Clinical assessment:**
 - Head-to-toe assessment
 - Medical record review
 - Identify risk factors
 - **Z = None of the above**

303

Risk of Pressure Ulcers (M0150)

- Based on items reviewed for M0100
- Is this resident at risk of developing pressure ulcers?
 - **Code 0** = No, resident is not at risk for developing pressure ulcers
 - **Code 1** = Yes, resident is at risk for developing pressure ulcers

304

Unhealed Pressure Ulcer(s) (M0210)

- If an ulcer arises from a combination of factors which are primarily caused by pressure, then the ulcer should be included in this section as a pressure ulcer
- Oral mucosal ulcers caused by pressure should not be coded here (code at L0200C)
- If a pressure ulcer is surgically closed with a flap or graft, it should be coded as a surgical wound and not as a pressure ulcer (If the flap or graft fails, continue to code it as a surgical wound until healed)
- If a pressure ulcer on the last assessment is now healed, complete Healed Pressure Ulcers item (M0900)
- If a pressure ulcer healed during the look-back period, and was not present on prior assessment, code 0

305

Unhealed Pressure Ulcer(s) (M0210)

- Residents with diabetes mellitus (DM) can have a pressure, venous, arterial, or diabetic neuropathic ulcer. The primary etiology should be considered when coding whether the diabetic has an ulcer that is caused by pressure or other factors:
 - If a resident with DM has a heel ulcer from pressure, code 1 and proceed to code items M0300–M0900 as appropriate for the pressure ulcer
 - If a resident with DM has an ulcer on the plantar (bottom) surface of the foot closer to the metatarsal, code 0 and proceed to M1040 to code the ulcer as a diabetic foot ulcer
- Scab and eschar are different both physically and chemically

306

Unhealed Pressure Ulcer(s) (M0210)

- Pressure ulcer definitions in RAI are adapted from the National Pressure Ulcer Advisory Panel (NPUAP)
- Numeric staging or DTI should be coded as assessed
- Facilities may adopt the NPUAP guidelines
- The RAI staging definitions do not perfectly correlate with the NPUAP staging definitions
- MDS must be coded according to the instructions in the RAI manual!!
- Pressure ulcer staging is an assessment system that provides a description and classification based on anatomic depth of soft tissue damage:
 - Tissue damage can be visible or palpable in the ulcer bed
 - Pressure ulcer staging also informs expectations for healing time

307

Unhealed Pressure Ulcer(s) (M0210)

- Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?
- Code based on presence of any pressure ulcer, regardless of stage, in past 7 days:
 - **Code 0** = No, skip to M0900
 - **Code 1** = Yes, continue to M0300

308

Current Number of Unhealed Pressure Ulcers at Each Stage (M0300)

- Staging is based on the deepest anatomical soft tissue damage that is visible or palpable
- Identify unstageable pressure ulcers
- Determine “present on admission”



309

Deepest Anatomical Stage

- Ulcer staging should be based on the deepest anatomic soft tissue damage that is visible or palpable
- If ulcer tissue is obscured, consider it to be unstageable
- Review ulcer history and maintain in medical record
- Once the initial staging is identified, the pressure ulcer remains that stage until the ulcer heals, worsens or becomes unstageable
- As pressure ulcers heal they are NEVER reverse staged

310

Identifying Unstageable Pressure Ulcer

- **Must visualize wound bed**
- **Pressure ulcers that have eschar or slough – anatomic depth cannot be visualized or palpated – should be classified as unstageable**
- **If wound bed is partially covered by eschar or slough – anatomical depth can be visualized or palpated – stage the ulcer**
- **A pressure ulcer with intact skin that is a suspected tissue injury (sDTI) should be coded as unstageable**
- **Pressure ulcers covered by a non-removeable dressing/device should be coded unstageable**

311

Determine “Present on Admission”

- **If the PU was present on admission/entry or reentry and subsequently increased in numerical stage during the stay, the PU is coded at that higher stage, and that higher stage should not be considered as “PoA”**
- **If the PU was unstageable on admission/entry or reentry, but becomes numerically stageable later, the PU is coded at the numerical stage and should be considered as “PoA”. If it subsequently increases in numerical stage, that higher stage is not considered “PoA”**
- **If a resident who has a PU is hospitalized and returns with that PU at the same numerical stage, the PU should not be considered “PoA”**
- **If a current PU increases in numerical stage during a hospitalization, it is coded at the higher stage and should be considered as “PoA”**

312

Definition of Stage 1 Pressure Ulcer

- Observable, pressure-related alteration of intact skin, as compared to adjacent or opposite area on the body
- May include changes in one or more parameters:
 - Redness of tissue that does not turn white or pale when pressure is applied (non-blanchable)
 - Skin may include changes in temperature, tissue consistency, sensation or coloration
 - Darkly pigmented skin may not have visible blanching
 - Color may differ from the surrounding area
 - Does not include deep tissue injury

313

313

Number of Stage 1 Pressure Ulcers (M0300A)

- A = Number of Stage 1 pressure ulcers:
 - Code = 0-9



314

Definition of Stage 2 Pressure

- Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough
- Presents as a shiny or dry shallow ulcer (without slough or bruising)
- May also appear as an intact or open/ruptured blister
- Do not include skin tears, tape burns, moisture associated skin damage, or excoriation here
- When a PU presents as an intact blister, examine the adjacent and surrounding area for signs of deep tissue injury. When a deep tissue injury is determined, do not code as a Stage 2
- Most stage 2 pressure ulcers should heal in a reasonable time frame (60 days)

315

Stage 2 Pressure Ulcer(s) (M0300B)

- **B = Stage 2:**
 - 1 = Number of Stage 2 pressure ulcers
 - 2 = Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry
 - 3 = Date of oldest Stage 2 pressure ulcer



316

Definition of Stage 3 Pressure Ulcer

- Full thickness tissue loss
- Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed
- Slough may be present but does not obscure depth
- May include undermining or tunneling
- May be shallow in areas that do not have subcutaneous tissue (bridge of nose, ear, occiput, malleolus)

317

Stage 3 Pressure Ulcer(s) (M0300C)

- C = Stage 3:
 - 1 = Number of Stage 3 pressure ulcers
 - 2 = Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry



318

Definition of Stage 4 Pressure Ulcer

- Full thickness tissue loss with exposed bone, tendon or muscle is visible or directly palpable
- At risk for osteomyelitis
- Cartilage serves the same anatomical function as bone
- Slough or eschar may be present on some parts of the wound bed
- Often includes undermining and tunneling:
 - **Tunneling** - a passage way of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound
 - **Undermining** - the destruction of tissue or ulceration extending under the skin edges so that the pressure ulcer is larger at its base than at the skin surface

319

Stage 4 Pressure Ulcer(s) (M0300D)

- **D = Stage 4:**
 - 1 = Number of Stage 4 pressure ulcers
 - 2 = Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry



320

Unstageable Pressure Ulcer Related to Non-Removable Dressing/Device (M0300E)

- Examples include, a primary surgical dressing that cannot be removed, an orthopedic device, or cast
- Unstageable – non-removable dressing/device:
 - 1 = Number of unstageable pressure ulcers due to non-removable dressing/device



- 2 = Number of these unstageable pressure ulcers that were present upon admission/entry or reentry

321

Unstageable Pressure Ulcers Related to Slough/Eschar (M0300F)

- Slough tissue – non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture
- Eschar tissue – dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color; may appear scab-like
- True depth cannot be determined
- Unstageable-slough/eschar:
 - 1 = Number of unstageable pressure ulcers due to coverage of wound bed by slough/eschar
 - 2 = Number of these unstageable pressure ulcers that were present upon admission/entry or reentry

322

Unstageable Pressure Ulcers Related to Slough/ Eschar (M0300F)



323

Unstageable Pressure Ulcer Related to Suspected Deep Tissue Injury (M0300G)

- Purple or maroon area of discolored intact skin due to damage of underlying soft tissue
- Area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue
- If suspected deep tissue injury opens to an ulcer, reclassify the ulcer into appropriate stage
- In dark skin tones, area is probably not purple/maroon, rather darker than surrounding tissue
- Unstageable – Deep tissue:
 - 1 = Number of unstageable pressure ulcers with suspected deep tissue injury evolution
 - 2 = Number of these unstageable pressure ulcers that were present upon admission/entry or reentry

324

324

Unstageable Pressure Ulcer Related to Suspected Deep Tissue Injury (M0300G)



325

325

Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Unstageable Ulcers (M0610)

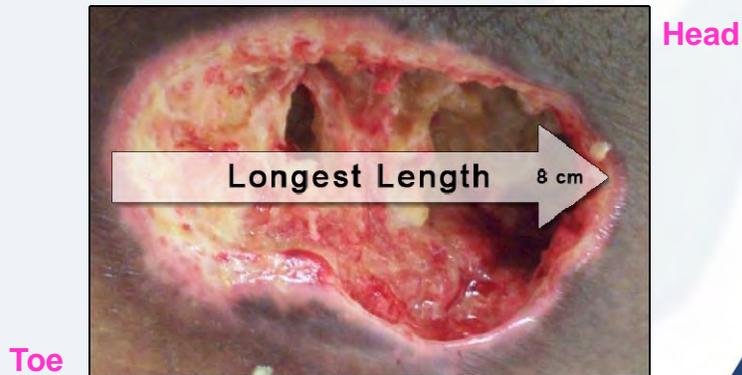
- **Identify pressure ulcer with the largest surface (length x width) area from the following:**
 - Unhealed Stage 3 or 4
 - Unstageable pressure ulcer due to slough or eschar
- **Measure after dressing and exudate has been removed**
- **Record in centimeters:**
 - A = Pressure ulcer length
 - B = Pressure ulcer width
 - C = Pressure ulcer depth

326

326

Pressure Ulcer Length (M0610A)

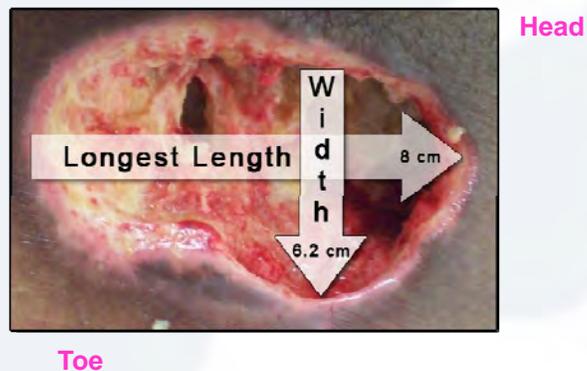
- Measure the longest length from head to toe using a disposable device



327
327

Pressure Ulcer Width (M0610B)

- Measure widest width of the same pressure ulcer side to side perpendicular (90° angle) to length



328

Pressure Ulcer Depth (M0610C)

- **Moisten a cotton-tipped applicator with 0.9% sodium chloride (NaCl) solution or sterile water**
- **Place applicator tip in deepest aspect of the wound and measure distance to the skin level**



329

Most Severe Tissue Type for Any Pressure Ulcer (M0700)

- **Examine the wound bed of the most severe type of tissue present in any pressure ulcer bed**
- **Code for the most severe type of tissue:**
 - **Code 1** = Epithelial tissue
 - **Code 2** = Granulation tissue
 - **Code 3** = Slough (any amount, but no eschar)
 - **Code 4** = Necrotic tissue (Eschar)
 - **Code 9** = None of the above
- **If wound bed is covered with a mix of different types of tissue, code for the most severe type**
- **Stage 2 pressure ulcer should be coded as a 1**

330

Worsening in Pressure Ulcer Status Since Prior Assessment (M0800)

- PU acquired during hospital admission; code “present on admission/entry or reentry”, do not include in count of worsening pressure ulcers
- If PU worsens to more severe stage during hospitalization; code as “present on admission/entry or reentry”, do not include in worsening pressure ulcers
- If a previously staged pressure ulcer becomes unstageable due to slough or eschar, do not include in worsening pressure ulcers
- If a previously staged pressure ulcer becomes unstageable, is then debrided and staged, if the stage has worsened, code as a worsening pressure ulcer
- If two pressure ulcers merge, do not code as worsened unless there is an increase in the numerical stage

331

Worsening in Pressure Ulcer Status Since Prior Assessment (M0800)

- Complete only if A0310E = 0
- Indicate the number of current ulcers that were not present or were at a lesser stage on a prior assessment (OBRA or scheduled PPS) or last entry
- Enter 0 if no current pressure ulcers at a given stage:
 - A = Stage 2
 - B = Stage 3
 - C = Stage 4

332

Healed Pressure Ulcers (M0900)

- **Healed pressure ulcer** – completely closed, fully epithelialized, covered completely with epithelial tissue, or resurfaced with new skin, even if the area continues to have some surface discoloration:
 - **A = Were pressure ulcers present on the prior assessment (OBRA or scheduled PPS)?**
 - **Code 0** = No, skip to M1030
 - **Code 1** = Yes, continue to M0900B
 - **B = Enter the number of healed Stage 2 ulcers**
 - **C = Enter the number of healed Stage 3 ulcers**
 - **D = Enter the number of healed Stage 4 ulcers:**
 - If no healed pressure ulcer at a given stage since the prior OBRA or scheduled PPS, enter 0

333

Definition Of Venous Ulcers

- Caused by peripheral venous disease
- Commonly occur proximal to medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of leg
- Wound may start due to minor trauma
- Characterized by:
 - Irregular wound edges
 - Hemosiderin staining
 - Leg edema
 - Possible pain
 - Red granular wound bed
 - Yellow fibrinous material
 - Exudate



334

Definition Of Arterial Ulcers

- **Caused by peripheral arterial disease**
- **Wound may start due to minor trauma**

- **Common location:**
 - **Top of toes**
 - **Top of foot**
 - **Distal to medial malleolus**



335

Definition Of Arterial Ulcers

- **Ischemia is major etiology**
- **Characterized by:**
 - **Necrotic tissue or pale pink wound bed**
 - **Lower extremity and foot pulses may be diminished or absent**
 - **Often painful**
 - **Minimal exudate**
 - **Minimal bleeding**
 - **Trophic skin changes:**
 - **Dry skin**
 - **Loss of hair growth**
 - **Muscle atrophy**
 - **Brittle nails**



336

Number of Venous and Arterial Ulcers (M1030)

- Do **not** code pressure ulcers in this item
- These wounds are typically **not** found over bony prominences and pressure forces play virtually no role in the development of the ulcers
- Enter the total number of venous and arterial ulcers present

337

Other Ulcers, Wounds, and Skin Problems (M1040)

- *Check all that apply:*
 - **Foot Problems**
 - A = Infection of the foot
 - B = Diabetic foot ulcer(s)
 - C = Other open lesion(s) on the foot
 - **Other Problems**
 - D = Open lesion(s) other than ulcers, rashes, cuts
 - E = Surgical wound(s)
 - F = Burn(s)
 - G = Skin tear(s)
 - H = Moisture Associated Skin Damage (MASD)
 - **None of the Above**
 - Z = None of the above were present

338

Skin and Ulcer Treatments (M1200)

- Document any specific or general skin treatment that the resident received in the past 7 days
- *Check all that apply:*
 - A = Pressure reducing device for chair
 - B = Pressure reducing device for bed
 - C = Turning/repositioning program
 - D = Nutrition or hydration intervention
 - E = Pressure ulcer care
 - F = Surgical wound care

339

Skin and Ulcer Treatments (M1200)

- G = Application of non-surgical dressings (with or without topical medications) other than to feet
- H = Application of ointments/medications other than to feet
- I = Application of dressings to feet (with or without topical medications)
 - Includes interventions to treat any foot wound or ulcer other than a pressure ulcer
- Z = None of the above were provided



340

RUG Categories Impacted

M0300A – Number of Stage 1 pressure ulcers
M0300B1 – Number of Stage 2 pressure ulcers
M0300C1 – Number of Stage 3 pressure ulcers
M0300D1 – Number of Stage 4 pressure ulcers
M0300F1 – Number of Unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar

RUG-III

- Special Care

RUG-IV

M0300A

- Not a RUG-IV item

M0300B1, M0300C1, M0300D1, M0300F1

- Special Care Low

341

RUG Categories Impacted

M1030 – Number of Venous and Arterial Ulcers

RUG-III

- Special Care

RUG-IV

- Special Care Low

342

RUG Categories Impacted

M1040A – Infection of the foot
M1040B – Diabetic foot ulcer(s)
M1040C – Other open lesion(s) on the foot

RUG-III

- Clinically Complex

RUG-IV

- Special Care Low

343

RUG Categories Impacted

M1040D – Open lesion(s) other than ulcers, rashes, cuts
M1040E – Surgical wound(s)

RUG-III

- Special Care

RUG-IV

- Clinically Complex

344

RUG Categories Impacted

M1040F – Burn(s)

RUG-III

- Clinically Complex

RUG-IV

- Clinically Complex

345

RUG Categories Impacted

M1200A-E – Skin and Ulcer Treatments

RUG-III

- Special Care

RUG-IV

- Special Care Low

M1200F – Skin and Ulcer Treatments

RUG-III

- Special Care

RUG-IV

- Clinically Complex

M1200G-H – Skin and Ulcer Treatments

RUG-III

- Special Care

RUG-IV

- Special Care Low
- Clinically Complex

346

RUG Categories Impacted

M1200I – Application of dressings to feet

RUG-III

- Clinically Complex

RUG-IV

- Special Care Low

347



Section N: Medications

348

Injections (N0300)

- 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
- Insulin injections are counted in N0300 as well as in N0350
- For subcutaneous pumps, code only number of days pump restarted
- If 0, skip to N0410



349

Insulin (N0350)

- A = Insulin injections - Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days
- B = Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders during the last 7 days or since admission/entry or reentry if less than 7 days



350

Medications Received (N0410)

- Medication categories should only be checked according to the medications therapeutic category or pharmacological classification.
 - **Example:** Oxazepam may be used as a hypnotic, but it is classified as an anti-anxiety medication. It would be coded as an anti-anxiety medication.
- Include meds by any route
- Code if med given only once
- Code long-acting med only when given
- Combination meds should be coded in all categories
- OTC sleeping meds not coded



351

Medications Received (N0410)

- Enter the number of days medication was received in the last 7 days by any route:
 - A = Antipsychotic
 - B = Antianxiety
 - C = Antidepressant
 - D = Hypnotic
 - E = Anticoagulant
 - F = Antibiotic
 - G = Diuretic
- Check the manual for information on Adverse Drug Reactions, Gradual Dose Reduction and other Care Planning considerations



352

RUG Categories Impacted

N0300 – Injections

RUG-III

- Clinically Complex

RUG-IV

- Not a RUG-IV item

353

RUG Categories Impacted

N0350A – Insulin Injections N0350B – Orders for insulin

RUG-III

- Not a RUG-III item

RUG-IV

- Special Care High

354



*Section O:
Special Treatments,
Procedures and
Programs*

355

Special Treatments, Procedures and Programs (O0100)



- **Look-back period is the last 14 days**
- **Code even if resident performs procedure or after set up**
- **Do not code if service was provided solely in conjunction with a surgical procedure (including routine pre-and post-operative procedures) or diagnostic procedure**
- **Two columns to record information:**
 - **Column 1 – while not a resident within the last 14 days**
 - **Column 2 – while a resident within the last 14 days**

356

Special Treatments, Procedures and Programs (O0100)

- **Cancer Treatments:**
 - **A = Chemotherapy:**
 - Antineoplastic given by any route
 - Only drugs actually used for cancer treatment-evaluate reason for medication use
 - IV, IV med, blood transfusions during chemo are not coded
 - **B = Radiation:**
 - Intermittent therapy
 - Radiation implant
- **Respiratory Treatments:**
 - **C = Oxygen therapy:**
 - Continuous or intermittent to relieve hypoxia
 - Code when used in BiPAP/CPAP
 - Hyperbaric oxygen for wound therapy not coded

357

Special Treatments, Procedures and Programs (O0100)

- **Respiratory Treatments:**
 - **D = Suctioning:**
 - Tracheal or nasopharyngeal only
 - Oral suctioning not included
 - **E = Tracheostomy care:**
 - Cleansing of trach or cannula
 - **F = Ventilator or respirator:**
 - Any electric or pneumatic closed-system that ensures ventilation
 - **G = BiPAP/CPAP:**
 - Any type that prevents airways from closing
 - If ventilator or respirator is used as a substitute for BiPAP or CPAP may code here not O0100F

358

Special Treatments, Programs and Procedures (O0100)

- Other:
 - H = IV Medications:
 - Do not code flushes to keep IV patent
 - Do not code subcutaneous pumps
 - Do not code Dextrose 50% or LR
 - Do not code IV meds administered during dialysis or chemo
 - Does include epidural, intrathecal, and baclofen pumps
 - I = Transfusions:
 - Any blood or blood products (platelets, synthetic blood products), given directly into the bloodstream
 - Do not code when administered during dialysis or chemo
 - J = Dialysis:
 - Peritoneal or renal dialysis
 - IV, IV med, blood transfusions during dialysis are not coded



359

Special Treatments, Programs and Procedures (O0100)

- Other:
 - K = Hospice Care:
 - Hospice must be licensed by the state or certified under Medicare program
 - L = Respite Care:
 - Short-term stay
 - M = Isolation or quarantine for active infectious disease:
 - **Does not include standard precautions**
 - Code only when transmission-based precautions required
 - Code only when a single room isolation is required because of active infection with highly transmissible or epidemiologically significant pathogens acquired by physical contact or airborne or droplet transmission
 - Do not code for history of infectious disease (MSRA)
 - Z = None of the above

360

Definition for “Single Room Isolation”

1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission
2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect.
3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation.
4. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g. rehabilitation, activities, dining, etc.).

361

Influenza Vaccine (O0250)

- A = Did the resident receive Influenza vaccine in this facility for this year’s Influenza season?
 - Code 0 = No, skip to O0250C
 - Code 1 = Yes, continue to O0250B
- B = Date vaccine received:
 - MM-DD-YYYY
 - Do not leave blank
- If vaccinated status cannot be determined, administer vaccine according to standards of clinical practice



362

Influenza Vaccine (O0250)

- **C = If Influenza vaccine not received, state reason:**
 - **Code 1** = Resident not in facility
 - **Code 2** = Received outside of this facility
 - **Code 3** = Not eligible (medical contraindication)
 - **Code 4** = Offered and declined
 - **Code 5** = Not offered
 - **Code 6** = Inability to obtain vaccine
 - **Code 9** = None of the above
- Influenza season ends when influenza is no longer active in area
- O0250C value carries forward until new season begins

363

Pneumococcal Vaccine (O0300)

- **A = Is the resident's Pneumococcal vaccination up to date?**
 - **Code 0** = No, continue to O0300B
 - **Code 1** = Yes, skip to O0400
- **B = If Pneumococcal vaccination not received, state reason:**
 - **Code 1** = Not eligible (medical contradiction)
 - **Code 2** = Offered and declined
 - **Code 3** = Not offered

**See RAI manual, pages O 9-13 for
complete vaccine details**

364

Therapies (O0400)

- Captures medically necessary therapies that occurred after admission/readmission
- Therapy can occur inside or outside facility
- All Therapies must be:
 - Ordered by a physician (or approved extender)
 - Performed by a qualified therapist
 - Based on a 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



365

Minutes for ST, OT and PT (O0400)

- 1 = Individual Minutes:
 - Total number of minutes of therapy provided by one therapist or assistant to one resident at a time
- 2 = Concurrent Minutes:
 - Medicare Part A - total number of minutes of therapy provided, with line-of-sight of treating therapist or assistant, to 2 residents at the same time, performing the same or similar activities
 - Medicare Part B - residents cannot be treated concurrently
 - All other payers follow Medicare Part A instructions



366

Minutes for ST, OT and PT (O0400)

- **3 = Group Minutes:**
 - Total number of minutes of therapy provided in a group setting
 - Medicare Part A – treatment of 4 residents performing same or similar activities and supervised by a therapist or assistant who is not supervising anyone else
 - Medicare Part B - treatment of 2 or more residents at the same time
 - All other payers follow Medicare Part A instructions



367

Days and Dates for ST, OT, and PT (O0400)

- **4 = Days:**
 - Number of days therapy services were provided in the last 7 days (a day = skilled treatment for 15 minutes or more)
 - Use total minutes of therapy (individual+concurrent+group) to determine if the day is counted
- **5 = Therapy Start Date:**
 - Record the date the most recent therapy regimen (since the most recent entry) started
 - If more than one therapy; enter the most recent date
 - The date the initial therapy evaluation is conducted regardless if treatment was rendered or not
 - Date of resumption if EOT OMRA

368

Therapy- for ST, OT, and PT (O0400)

- **6 = Therapy End Date:**
 - Record the date the most recent therapy regimen (since the most recent entry) ended
 - Last date resident received skilled therapy
 - If therapy is ongoing, enter dashes

See RAI manual, pages O 15-30 for complete details

369

Respiratory Therapy (O0400D)

- Services provided by a qualified professional (respiratory therapist, respiratory nurse)
- Services include coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds and mechanical ventilation, etc.
- A respiratory nurse must be proficient in the modalities either through formal nursing or specific training and may provide these modalities as allowed under the state Nurse Practice Act and applicable laws



370

Psychological Therapy (O0400E) Recreational Therapy (O0400F)

- **Psychological Therapy:**
 - Provided by a psychiatrist, psychologist, clinical social worker, clinical nurse specialist in mental health (allowable under state laws)
- **Recreational Therapy:**
 - Services provided or directly supervised by a qualified recreational therapist
 - Includes treatment and activities using a variety of techniques; including arts and crafts, animals, games, etc.



371

Therapy Coding Tips (O0400)

- **Include only therapies provided after resident admitted to the nursing home**
- **If a resident returns from a hospital stay, an initial evaluation must be done again after reentry and only those therapies that occurred since reentry can be coded on the MDS**
- **Therapist time:**
 - Do not count initial evaluation or documentation time
 - Can count subsequent re-evaluation time if part of the treatment process

372

Therapy Coding Tips (O0400)

- Resident's treatment time starts when they begin the first treatment activity or task, and ends when resident finishes the last task or last apparatus
- Only skilled therapy time shall be coded in the MDS
- Time required to adjust equipment or prepare for individualized therapy is set-up time and can be included in the count of minutes
- COTA and PTA services for OT and PT only count as long as they function under the direction of the therapist
- Do not round up minutes; record actual minutes, not units

373

Co-treatment (O0400)

- Medicare Part A:
 - Two clinicians (therapists or therapy assistant), each from a different discipline, treat one resident at the same time with different treatments
 - Both disciplines may code the treatment in full
- Medicare Part B:
 - Therapists or therapy assistants, working together as a “team” to treat one or more residents cannot each bill separately for the same or different service provided at the same time

374

Therapy Aides and Students

- **Therapy Aides:**
 - May not provide skilled services
 - Only time spent on set-up preceding skilled therapy may be coded
 - Must be under direct supervision of the therapist or assistant
- **Therapy Students:**
 - Medicare Part A:
 - Therapy students are not required to be in line-of-sight
 - Medicare Part B:
 - Qualified professional must be present the entire session
 - Practitioner not engaged in another resident or tasks
 - Qualified professional is responsible for services and doco
 - PT and OT assistants may serve as instructors for students within scope of work and under the direction/ supervision of a licensed therapist

375

Resumption of Therapy (O0450)

- Complete only if A0310C = 2 or 3 and A0310F = 99
- Therapy resumes after the EOT OMRA is performed
- Resumption of therapy is no more than 5 consecutive calendar days after the last day of therapy provided
- Therapy services have resumed at the same RUG-IV classification level that had been in effect prior to EOT
- The EOT-R reduces the number of assessments to be completed:
 - A = Has a previous rehab therapy regimen ended and now resumed at exactly the same level for each discipline?
 - Code 0 = No, skip to O0500
 - Code 1 = Yes
 - B = Date on which therapy resumed:
 - MM-DD-YYYY

376

Resumption of Therapy (O0450)

- **NOTE:**
 - If the EOT has **not** been accepted in the QIES ASAP when therapy resumes, code O0450A+B and submit
 - If the EOT has been accepted in the QIES ASAP, then submit a modification for the EOT and check X0900E
 - When the EOT-R is completed, the therapy start date on the next PPS assessment is the resumption date on the EOT-R

377

Restorative Nursing Programs (O0500)

- Nursing interventions that promote resident's ability to adapt and adjust to living as independently and safely as possible
- Focus is to achieve and maintain optimal physical, mental and psychosocial functioning



378

Restorative Nursing Programs (O0500)

- **Must meet specific criteria prior to coding:**
 - **Measurable objectives and interventions documented in care plan and medical record**
 - **Evaluation by licensed nurse in medical record dated within the observation period**
 - **Nursing assistants/aides must be trained in the techniques that promote resident involvement**
 - **An RN or LPN must supervise the activities in a nursing restorative program**
 - **Groups no larger than 4 residents per supervising helper or caregiver**



379

Restorative Nursing Programs (O0500)

- **Techniques provided by restorative nursing staff:**
 - **A = Range of Motion (Passive)**
 - **B = Range of Motion (Active)**
 - **C = Splint or Brace Assistance**
- **Training and Skill Practice in:**
 - **D = Bed Mobility**
 - **E = Transfer**
 - **F = Walking**
 - **G = Dressing and/or Grooming**
 - **H = Eating and/or Swallowing**
 - **I = Amputation/Prosthesis Care**
 - **J = Communication**



380

Restorative Nursing Programs (O0500)

- Record the number of days that each of the restorative nursing programs were performed for at least 15 minutes/day in the last 7 days
- Enter 0 if none or programs were less than 15 minutes daily
- The time provided for the programs must be coded separately
- Cannot claim techniques that therapists claim under O0400A, B or C
- Does not require a physician order

381

Physician Examinations (O0600)

- Enter number of days in the last 14 days that the physician examined the resident
- Includes MDs, DOs, Podiatrists, Dentists and authorized Physician Assistants, Nurse Practitioners or Clinical Nurse Specialists working in collaboration with the physician as allowable by state law
- Examination (full or partial) can occur in facility or in physician's office
- Telehealth included per requirements
- Does not include exams prior to admission or readmission, in ER, while in hospital observation stay or by a Medicine Man
- Does include off-site exam (dialysis or radiation therapy) with documentation



Podiatry

382

Physician Orders (O0700)

- Enter number of days in last 14 days that the physician changed the orders
- Includes written, telephone, fax or consultation orders for new or altered treatment
- Excludes standard admit orders, return admit orders, renewal orders, clarification orders without changes
- Orders on day of admission as a result of an unexpected change/deterioration or injury are considered new or altered orders and do count
- Orders written to increase RUG classification and facility payment are not acceptable



383

Physician Orders (O0700)

- Sliding scale dosage schedule to cover dosages depending on lab values does not count as an order change when a dose is given
- PRN orders already on file and notification of the physician to activate order does not count as ne order
- Medicare cert/recert does not count
- Orders for a consult may count but must be reasonable (for a new or altered tx)
- Order on the last day of OP for a consult planned 3-6 months in the future should be reviewed carefully
- Order to transfer care to another physician is not counted
- Orders written by a pharmacist does not count

384

RUG Categories Impacted

O0100A1 – Chemotherapy – While not a Resident
O0100A2 – Chemotherapy – While a Resident

RUG-III

- Clinically Complex

RUG-IV

O0100A1

- Not a RUG-IV item

O0100A2

- Clinically Complex

385

RUG Categories Impacted

O0100B1 – Radiation – While not a Resident
O0100B2 – Radiation – While a Resident

RUG-III

- Special Care

RUG-IV

O0100B1

- Not a RUG-IV item

O0100B2

- Special Care Low

386

RUG Categories Impacted

O0100C1 – Oxygen therapy – While not a Resident
O0100C2 – Oxygen therapy – While a Resident

RUG-III

- Clinically Complex

RUG-IV

O0100C1

- Not a RUG-IV item

O0100C2

- Clinically Complex
- Special Care Low

387

RUG Categories Impacted

O0100D1 – Suctioning – While not a Resident
O0100D2 – Suctioning – While a Resident
O0100E1 – Tracheostomy Care – While not a Resident
O0100E2 – Tracheostomy Care – While a Resident
O0100F1 – Ventilator or respirator – While not a Resident
O0100F2 – Ventilator or respirator – While a Resident
O0100H1 – IV medications – While not a Resident
O0100H2 – IV medications – While a Resident

RUG-III

- Extensive Services

388

RUG Categories Impacted

O0100D1 – Suctioning – While not a Resident
O0100E1 – Tracheostomy Care – While not a Resident
O0100F1 – Ventilator or respirator – While not a Resident
O0100H1 – IV medications – While not a Resident

RUG-IV

- Not a RUG-IV item

389

RUG Categories Impacted

O0100D2 – Suctioning – While a Resident
O0100E2 – Tracheostomy Care – While a Resident
O0100F2 – Ventilator or respirator – While a Resident
O0100H2 – IV medications – While a Resident

RUG-IV

O0100D2

- Not a RUG-IV item

O0100E2, O0100F2

- Extensive Services

O0100H2

- Clinically Complex

390

RUG Categories Impacted

O0100I1 – Transfusions – While not a Resident
O0100I2 – Transfusions – While a Resident
O0100J1 – Dialysis – While not a Resident
O0100J2 – Dialysis – While a Resident

RUG-III

- Clinically Complex

391

RUG Categories Impacted

O0100I1 – Transfusions – While not a Resident
O0100J1 – Dialysis – While not a Resident

RUG-IV

- Not a RUG-IV item

392

RUG Categories Impacted

O0100I2 – Transfusions – While a Resident
O0100J2 – Dialysis – While a Resident

RUG-IV

O0100I2

- **Clinically Complex**

O0100J2

- **Special Care Low**

393

RUG Categories Impacted

**O0100M – Isolation or quarantine for
active infectious disease**

RUG-III

- **Not a RUG-III item**

RUG-IV

- **Extensive Services**

394

RUG Categories Impacted

O0400A – Speech-Language Pathology & Audiology Services
O0400B – Occupational Therapy
O0400C – Physical Therapy
1, 2 or 3 (Minutes)

RUG-III

- Rehabilitation

RUG-IV

- Rehabilitation Plus Extensive Services
- Rehabilitation

395

RUG Categories Impacted

O0400A4 – Speech-Language Pathology & Audiology Services
O0400B4 – Occupational Therapy
O0400C4 – Physical Therapy
(Days)

RUG-III

- Rehabilitation

RUG-IV

- Rehabilitation Plus Extensive Services
- Rehabilitation

396

RUG Categories Impacted

O0400D2 – Respiratory Care (Days)

RUG-III

- Special Care

RUG-IV

- Special Care High

397

RUG Categories Impacted

O0500A-J – Restorative Nursing Programs

RUG-III

- Rehabilitation
- Impaired Cognition
- Behavior Problems
- Reduced Physical Function

RUG-IV

- Rehabilitation Plus Extensive Services
- Rehabilitation
- Behavioral Symptoms and Cognitive Performance
- Reduced Physical Function

398

RUG Categories Impacted

O0600 – Physician Examinations
O0700 – Physician Orders

RUG-III

- Clinically Complex

RUG-IV

- Not RUG-IV items

399

Section P: Restraints

400