New York State MDS Clarification Document

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MDS 3.0 Item and **MDS 3.0 Look-back period**	**MDS 3.0 RAI Manual Definitions/Instructions**	**Minimum Documentation Requirements**
Section B **B0100** Comatose **7-Day Look-back**	Comatose: "A pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; he/she does not open eyes, does not speak and does not move extremities on command or in response to noxious stimuli (e.g. pain)." (MDS Manual, page B-1). Persistent Vegetative State: "Sometimes residents who were comatose … regain wakefulness but do not display any purposeful behavior or cognition. Their eyes are open, and they may grunt, yawn, pick with their fingers, and have random body movements. Neurological exam shows extensive damage to both cerebral hemispheres." (MDS Manual, page B-2).	Physician-documented diagnosis of coma or persistent vegetative state within the 7-day look-back. "…some residents in advanced stages of progressive neurologic disorders such as Alzheimer's disease may have severe cognitive impairment, be non-communicative and sleep a great deal of time; however, they are usually not comatose or in a persistent vegetative state, as defined here." (MDS Manual, page B-2).
B0700 Makes Self Understood **7-Day Look-back**	Makes Self Understood: "Able to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language, whether in speech, writing, sign language, gestures, or a combination of these. Deficits in the ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and/or gesturing." (MDS Manual, page B-6). The steps for assessment should include interaction with the resident using his or her preferred language and method for communication, or alternatives such as writing, pointing or using cue cards, observation of his or her interactions with others in different settings and circumstances, as well as consultation with the primary nurse assistant over all shifts, and if available, the	Documentation of the resident's ability and/or deficits in his or her ability to make self understood ["to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language, whether in speech, writing, sign language, gestures, or a combination of these"] (MDS Manual, page B-6) during the 7-day look-back period.

	resident's family and speech-language pathologist (MDS Manual, page B-7).	
C0200 - C0500 Brief Interview for Mental Status (BIMS) Summary Score **7-Day Look-back**	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." (MDS Manual, page Appendix A-3). "Steps for Assessment - 1. Determine if the resident is rarely/never understood verbally or in writing. If rarely/never understood, skip to C0700 – C1000, Staff Assessment of Mental Status. 2. Review Language item (A1100), to determine if the resident needs or wants an interpreter. • If the resident needs or wants an interpreter, complete the interview with an interpreter." (MDS Manual, page C-1). If the BIMS is stopped, complete the "Staff Assessment for Mental Status" (C0600-C1000). See "Rules for stopping the interview before it is complete" on page C-4 of the MDS Manual.	The BIMS is considered to be a source document, as it is a direct interview with the resident and does not require additional documentation in the medical record. The BIMS must be completed during the observation period. The signature date entered at Z0400 (for items C0200-C0500) must match the date of the BIMS interview and be prior to or on the Assessment Reference Date (ARD). When completing resident interviews, sign the MDS during the observation period for the interview and then sign the MDS again as needed after the ARD for the rest of the section.
C0700 Short-term Memory **7-Day Look-back**	Short-term Memory: "Steps for Assessment: Determine the resident's short-term memory status by asking him or her to describe an event 5 minutes after it occurred if you can validate the resident's response, or to follow through on a direction given 5 minutes earlier… Observation should be made by staff across all shifts and departments and others with close contact with the resident…" (MDS Manual, page C-19).	Documentation of the resident's short-term memory status during the 7-day look-back period.
C0700 - C1000 Cognitive Skills for Daily Decision Making	Daily Decision Making: "Includes: choosing clothing; knowing when to go to meals; using environmental cues to organize and plan (e.g., clocks, calendars, posted event notices); in the absence of environmental cues, seeking information appropriately (i.e. not repetitively) from others in order to plan the day; using awareness of one's own strengths and limitations to regulate the day's events (e.g., asks for help when necessary); acknowledging need	Documentation of the "resident's actual performance in making everyday decisions about tasks or activities of daily living" (MDS Manual, page C-24). "A resident's considered decision to exercise his or her right to decline treatment or recommendations by interdisciplinary team members should not be

7-Day Look-back	to use appropriate assistive equipment such as a walker." (MDS Manual, page C-23). "<u>Steps for Assessment</u>: ... Observations should be made by staff across all shifts and departments and others with close contact with the resident. 3. The intent of this item is to record what the resident is doing (performance). Focus on whether or not the resident is actively making these decisions and not whether staff believes the resident might be capable of doing so. 4. Focus on the resident's actual performance. Where a staff member takes decision-making responsibility away from the resident regarding tasks of everyday living, or the resident does not participate in decision making, whatever his or her level of capability may be, the resident should be coded as impaired performance in decision making." (MDS Manual, page C-23).	captured as impaired decision making in Item C1000, Cognitive Skills for Daily Decision Making." (MDS Manual, page C-24).
D0200 A-I Resident Mood Interview (PHQ-9©) **D0300** Total Severity Score **14-Day Look-back**	<u>Patient Health Questionnaire 9-Item (PHQ-9©)</u>: "A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a depressive disorder." (MDS Manual, page Appendix A-15). "Steps for Assessment - 1. Determine if the resident is rarely/never understood. If rarely/never understood, skip to D0500, Staff Assessment of Resident Mood (PHQ-9-OV©). 2. Review Language item (A1100) to determine if the resident needs or wants an interpreter to communicate with doctors or health care staff (A1100 = 1). • If the resident needs or wants an interpreter, complete the interview with an interpreter." (MDS Manual, page D-2). The interview should be conducted in a private setting. "PHQ-9© Resident Mood Interview is preferred as it improves the detection of a possible mood disorder. However, a small percentage of patients are unable or unwilling to complete the	The PHQ-9© is considered to be a source document, as it is a direct interview with the resident and does not require additional documentation in the medical record. "Conduct the interview preferably the day before or day of the ARD." (MDS Manual, page D-4). The signature date entered at Z0400 (for items D0200 A-I and D0300) must match the date of the PHQ-9© interview. When completing resident interviews, sign the MDS during the observation period for the interview and then sign the MDS again as needed after the ARD for the rest of the section.

	PHQ-9© Resident Mood Interview. Therefore, staff should complete the PHQ-9-OV© Staff Assessment of Mood in these instances so that any behaviors, signs, or symptoms of mood distress are identified." (MDS Manual, page D-11).	
D0500 A-J Staff Assessment of Resident Mood **D0600 Total Severity Score** **D0600** PHQ-9-OV© Total Severity Score **14-Day Look-back**	This section is completed only if a resident is unable or unwilling to complete the PHQ-9© Resident Mood Interview. "Staff should complete the PHQ-9-OV© Staff Assessment of Mood in these instances so that any behaviors, signs, or symptoms of mood distress are identified." (MDS Manual, page D-11). "PHQ-9© Resident Mood Interview is preferred as it improves the detection of possible mood disorder." (MDS Manual, page D-11). "Steps for Assessment: 1. Interview staff from all shifts who know the resident best. Conduct interview in a location that protects resident privacy. 2. The same administration techniques outlined above for the PHQ-9© Resident Mood Interview (pages D-4–D-6) and Interviewing Tips & Techniques (pages D-6–D-8) should also be followed when staff are interviewed. 3. Encourage staff to report symptom frequency, even if the staff believes the symptom to be unrelated to depression. 4. Explore unclear responses, focusing the discussion on the specific symptom listed on the assessment rather than expanding into a lengthy clinical evaluation. 5. If frequency cannot be coded because the resident has been in the facility for less than 14 days, talk to family or significant other and review transfer records to inform the selection of a frequency code." MDS Manual, page D-12).	Documentation of the presence and frequency of clinical mood indicators and how this was determined during the 14-day look-back period. The MDS is a source document for the PHQ-9© Resident Mood Interview, but is not a source document for the PHQ-9-OV© Staff Assessment of Resident Mood. Conduct the assessment/staff interviews preferably the day before or day of the ARD. "Documentation may include: Discussions with direct care givers, other disciplines, family members during 14 day look-back period. Direct observations during the 14 day look-back window." - University at Albany School of Public Health. New York's Common MDS Coding Errors: Strategies to Improve MDS Accuracy. 12/17/2014. Retrieved from https://www.albany.edu/sph/cphce/mds_coding_errors_handouts.pdf Slide # 26. (The University at Albany School of Public Health provides the only MDS trainings in New York State that are approved by the NYS Department of Health).
E0100A Hallucinations	Hallucinations: "The perception of the presence of something that is not actually there. It may be auditory, or visual or involve smell, tastes or touch." (MDS Manual, page E-1).	Documentation of actual instances of the resident's perception of the presence of something that is not actually there during the 7-day look-back period.

7-Day Look-back	"This section focuses on the resident's actions, NOT the intent of his or her behavior." (MDS Manual, page E-1). "Code based on the behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis." (MDS Manual, page E-2).	Document clear and specific observations and examples. "Documentation should support the actual occurrence of these behaviors during the 7 day look-back period obtained either by direct observation or by interview with staff; or by notes in the resident's medical record reflecting such behaviors." - University at Albany School of Public Health. New York's Common MDS Coding Errors: Strategies to Improve MDS Accuracy. 12/17/2014. Retrieved from https://www.albany.edu/sph/cphce/mds_coding_errors_handouts.pdf Slide # 28.
E0100B Delusions **7-Day Look-back**	<u>Delusions</u>: "A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary." (MDS Manual, page E-1). "This section focuses on the resident's actions, NOT the intent of his or her behavior." (MDS Manual, page E-1). "Code based on behaviors observed and/or thoughts expressed in the last 7 days rather than the presence of a medical diagnosis." (MDS Manual, page E-2).	Documentation within the observation period with clear and specific examples of a fixed, false belief not shared by others that a resident holds even in the face of evidence to the contrary. "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." (MDS Manual, page E-3).
E0200A Physical Behavioral Symptoms Directed Toward Others **7-Day Look-back**	<u>Physical Behavioral Symptoms Directed Toward Others</u>: "Code based on whether the symptoms occurred and not based on an interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated." (MDS Manual, page E-5).	Documentation of actual instances when the resident exhibited physical behavioral symptoms directed toward others within the observation period. Documentation must include frequency. Examples: Hitting, kicking, pushing, scratching, grabbing and abusing others sexually. "Code as present, even if staff have become used to the behavior or view it as typical or tolerable." (MDS Manual, page E-5).

E0200B Verbal Behavioral Symptoms Directed Toward Others **7-Day Look-back**	Verbal Behavioral Symptoms Directed Toward Others**:** "Code based on whether the symptoms occurred and not based on an interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated." (MDS Manual, page E-5).	Documentation of actual instances when the resident exhibited verbal behavioral symptoms directed toward others within the observation period. Documentation must include frequency. Examples: Threatening others, screaming at others, cursing at others. "Code as present, even if staff have become used to the behavior or view it as typical or tolerable." (MDS Manual, page E-5).
E0200C Other Behavioral Symptoms Not Directed Toward Others **7-Day Look-back**	Other Behavioral Symptoms Not Directed Toward Others: "Code based on whether the symptoms occurred and not based on an interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated." (MDS Manual, page E-5).	Documentation of actual instances when the resident exhibited other behavioral symptoms not directed toward others within the observation period. Documentation must include frequency. Examples: Hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, verbal/vocal symptoms like screaming, disruptive sounds. "Code as present, even if staff have become used to the behavior or view it as typical or tolerable." (MDS Manual, page E-5).
E0800 Rejection of Care – Presence and Frequency **7-Day Look-back**	Rejection of Care: "Behavior that interrupts or interferes with the delivery or receipt of care. Care rejection may be manifested by verbally declining or statements of refusal or through physical behaviors that convey aversion to or result in avoidance of or interfere with the receipt of care." (MDS Manual, page E-14). "The intent of this item is to identify potential behavior problems, not situations in which care has been rejected based on a choice that is consistent with the resident's preferences or goals for health and well-being or a choice made on behalf of the resident by a family member or other proxy decision maker." (MDS Manual, page E-15).	Documentation of actual instances and frequency of the resident's rejection of care that is necessary to achieve the health and well-being of the resident during the 7-day look-back period. "Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family) and determined to be consistent with the resident's values, preferences, or goals. Residents who have made an informed choice about not wanting a particular treatment, procedure, etc., should not be identified as 'rejecting care'." (MDS Manual, page E-15).

E0900 Wandering **7-Day Look-back**	"Wandering is the act of moving (walking or locomotion in a wheel chair) 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 knows is deceased)." (MDS Manual, page E-18).	Documentation within the observation period of actual instances of moving from place to place with or without a specified course or know direction. Documentation must include the frequency of wandering. Does not include pacing within a constrained space or traveling via a planned course to another specific place (dining room or activity).
Section G Functional Status **Activities of Daily Living (ADL) Self-Performance** **G0110A** Bed Mobility **G0110B** Transfer **G0110H** Eating **G0110I** Toilet Use **Column 1 Only**	ADL Self-Performance "Measures what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last 7 days according to a performance based scale." (MDS Manual, page G-2) "Consider all episodes of the activity that occur over a 24-hour period during each day of the 7-day look-back period, as a resident's ADL self-performance and the support required may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations to occur, including but not limited to, mood, medical condition, relationship issues (e.g., willing to perform for a nursing assistant that he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident's ADL self-performance over the 7-day period, 24 hours a day (i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well)" (MDS Manual, page G-4). "For the purposes of completing Section G, 'facility staff' pertains to direct employees and facility-contracted employees (e.g. rehabilitation staff, nursing agency staff). Thus, does not	"Documentation for ADLs must reflect the number of times at each level for every ADL for each shift during the 7 day look-back period (information from all shifts) and the number of staff assisting the resident. Flow sheets. Nurse's note based on interview with direct care giver recorded at the end of each shift. Electronic data input." - University at Albany School of Public Health. New York's Common MDS Coding Errors: Strategies to Improve MDS Accuracy. 12/17/2014. Retrieved from https://www.albany.edu/sph/cphce/mds_coding_errors_handouts.pdf Slide #42. Document initials and dates to authenticate the services provided, as well as signatures and titles to authenticate initials of staff providing services. The ADL key for self-performance must include all the MDS coding options and correspond to the MDS Manual coding definitions. Utilize the ADL Self-Performance Coding Instructions, Rule of 3, and the ADL Self-Performance Algorithm, per instructions in the MDS Manual, Section G.

7-Day Look-back	include individuals hired, compensated or not, by individuals outside of the facility's management and administration. Therefore, facility staff does not include, for example, hospice staff, nursing/CNA students, etc. Not including these individuals as facility staff supports the idea that the facility retains the primary responsibility for the care of the resident outside of the arranged services another agency may provide to facility residents." (MDS Manual, page G-5).	If there are blanks on ADL Trackers, this may affect totally independent and totally dependent self-performance levels. A progress note would be required to justify the coding status. Does not include**:** • The emptying of bedpan, urinal, bedside commode, catheter bag, or ostomy bag. • The staff's assessment of the resident's potential capability to perform the ADL activity. • The type and level of assistance that the resident "should be receiving according to the written plan of care". The actual level of assistance might be very different from what is planned. • Assistance provided by individuals outside of the facility's management and administration.
ADL Support Provided **GO110A** Bed Mobility **GO110B** Transfers **GO110I** Toilet Use **Column 2 Only** **7-Day Look-back**	<u>ADL Support Provided</u> "Measures the most support provided by staff over the last 7 days, even if that level of support only occurred once." (MDS Manual, page G-3) This is a different scale and is entirely separate from ADL self-performance assessment. The responsibility of the person completing the assessment is to capture the maximum amount of support provided to the resident over the 7-day period, 24 hours a day (not how the evaluating clinician sees the resident but how much support was provided over the 7-day look-back period).	Document which ADL activities occurred, how many times each ADL activity occurred, and what level of support was provided for each ADL activity over the entire 7-day look-back period to support MDS coding. Document initials and dates to authenticate the services provided, as well as signatures and titles to authenticate initials of staff providing services. Document all interviews completed, including dates, interviewer and interviewee names/titles with responses. The ADL key for Support Provided must include all the MDS coding options and correspond to the MDS Manual coding definitions. Utilize the ADL Support Coding Instructions, per MDS Manual, Section G. Does not include:

		• The emptying of bed pan, urinal, bedside commode, catheter bag, or ostomy bag. • The staff's assessment of the resident's potential capability to perform the ADL activity. • The type and level of support provided that the resident "should be receiving according to the written plan of care". The actual level of support provided might be very different from what is planned. • Support provided by individuals outside of the facility's management and administration.
H0200C Current Urinary Toileting Program or Trial **7-Day Look-back**	"Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice." (MDS Manual, page H-6). Additional resources for toileting programs are available in the MDS Manual, Appendix C.	Documentation of a urinary toileting program trial, response to the trial toileting program, and that the following three requirements have been met: "Implementation of an individualized, resident-specific toileting program that was based on an assessment of the resident's unique voiding pattern; Evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report; and Notations of the resident's response to the toileting program and subsequent evaluations, as needed." (MDS Manual, page H-5). Does not include "simply tracking continence status, changing pads or wet garments, and random assistance with toileting or hygiene" (MDS Manual, page H-6), or if the toileting program was "used less than 4 days of the 7-day look-back period" (MDS Manual, page H-6).

H0500 Bowel Toileting Program **7-Day Look-back**	Bowel (or trial bowel) toileting programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standard of practice.	Documentation that the following three requirements have been met: Implementation of an individualized, resident-specific bowel toileting program based on an assessment of the resident's unique bowel pattern; Evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, verbal and a written report; and Notations of the resident's response to the toileting program and subsequent evaluations, as needed." (MDS Manual, page H-12). Does not include simply tracking bowel continence status, changing pads or wet garments, and random assistance with toileting or hygiene.
Section I Active Diagnosis **I2000-** Pneumonia **I2100**- Septicemia **I2900** Diabetes Mellitus (DM) (e.g., Diabetic Retinopathy, Nephropathy, Neuropathy) **I4300** Aphasia	Active Diagnosis ***"There are two look-back periods for this section:*** • Diagnosis identification (Step 1) is a 60-day look-back period. • Diagnosis status: Active or Inactive (Step 2) is a 7-day look-back period (except for Item I2300 UTI, which does not use the active 7-day look-back period)." (MDS Manual, page I-3). - "Listing a disease/diagnosis (e.g., arthritis) on the resident's medical record problem list is not sufficient for determining active or inactive status. To determine if arthritis, for example, is an "active" diagnosis, the reviewer would check progress notes (including the history and physical) during the 7-day look-back period for notation of treatment of symptoms of arthritis, doctor's orders for medications for arthritis, and documentation of physical or other therapy for functional limitations caused by arthritis. - Ongoing therapy with medications or other interventions to manage a condition that requires monitoring for therapeutic efficacy or to monitor potentially severe side effects in the last 7 days. A medication indicates active disease if that medication is prescribed to manage an ongoing condition that requires	Step 1: Diagnosis identification requires a physician-documented diagnosis within the 60-day look-back period. Step 2: Diagnosis status requires documentation supporting the diagnosis was active during the 7-day look-back. In the absence of specific documentation that a disease is active, the following indicators may be used to confirm active diagnosis: • "Recent onset or acute exacerbation of the disease or condition indicated by a positive study, test or procedure, hospitalization for acute symptoms and /or recent change in therapy in the last 7 days. … Sources may include radiological reports, hospital discharge summaries, doctors' orders, etc." (MDS Manual, page I-7). • Documented "symptoms and abnormal signs indicating ongoing or decompensated disease in the last 7 days. … Sources may include radiological reports, nursing assessments and care

I4400 Cerebral Palsy **I4900** Hemiplegia/ Hemiparesis **I5100-** Quadriplegia **I5200** Multiple Sclerosis (MS) **7/60-Day Look-back**	monitoring or is prescribed to decrease active symptoms associated with a condition. This includes medications used to limit disease progression and complications. If a medication is prescribed for a condition that requires regular staff monitoring of the drug's effect on that condition (therapeutic efficacy), then the prescription of the medication would indicate active disease. - It is expected that nurses monitor all medications for adverse effects as part of usual nursing practice**.** For coding purposes, this monitoring relates to management of pharmacotherapy and not to management or monitoring of the underlying disease." (MDS Manual, page I-8).	plans, progress notes, etc." (MDS Manual, page I-8). Quadriplegia – must be a primary diagnosis resulting from injury to the spinal cord (not related to other conditions). Does not include: • Conditions that have been resolved or have no longer affected the resident's functioning or care during the 7-day look-back period. • Septicemia does not include a diagnosis of urosepsis. • Quadriplegia does not include functional quadriplegia or quadriparesis, or complete immobility related to other conditions.
Section J **J1100C** Shortness of Breath or trouble breathing when lying flat **7-Day Look-back**	<u>Shortness of Breath or trouble breathing when lying flat</u>: "If shortness of breath or trouble breathing is present when the resident attempts to lie flat. Also code this as present if the resident avoids lying flat because of shortness of breath." (MDS Manual, page J-21). "Signs of shortness of breath include: increased respiratory rate, pursed lip breathing, a prolonged expiratory phase, audible respirations and gasping for air at rest, interrupted speech pattern (only able to say a few words before taking a breath) and use of shoulder and other accessory muscles to breathe." (MDS Manual, page J-21).	Documentation of shortness of breath or trouble breathing when lying flat or avoidance of lying down flat due to shortness of breath. Does not include shortness of breath as a result of exercise or therapy or shortness of breath after exertion. "Shortness of breath can be an indication of a change in condition requiring further assessment and should be explored. The care plan should address underlying illnesses that may exacerbate symptoms of shortness of breath as well as symptomatic treatment for shortness of breath when it is not quickly reversible." (MDS Manual, page J-21).

J 1550A Fever **7-Day Look-back**	Fever is "defined as a temperature of 2.4 degrees F higher than the baseline. The resident's baseline temperature should be established prior to the Assessment Reference Date (ARD)." (MDS Manual, page J-25). The facility should have a policy/protocol in place to identify the baseline temperature.	Documentation of temperature 2.4 degrees F above the baseline OR a temperature of 100.4 degrees F (38 degrees C) on admission (i.e., prior to the establishment of the baseline temperature). The baseline temperature should be established prior to the ARD.
J1550B Vomiting **7-Day Look-back**	Vomiting is the "regurgitation of stomach contents; may be caused by many factors (e.g., drug toxicity, infection, psychogenic)" (MDS Manual, page J-25).	Documentation of description of episode(s) of vomiting (regurgitation of stomach contents). Does not include spitting up phlegm.
J1550C Dehydration **7-day Look-back**	Dehydration: "Resident's fluid loss exceeds the amount of fluids he or she takes in (e.g., loss from vomiting, fever, diarrhea, that exceeds fluid replacement)" (MDS Manual, page J-26).	Documentation requires two or more of the following dehydration indicators: • Resident takes in less than 1500 cc of fluid daily. • One or more clinical signs of dehydration, including but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, abnormal lab values, etc. • Fluid loss that exceeds daily intake. (MDS Manual, page J-26)
J1510D Internal Bleeding **7-Day Look-back**	Internal Bleeding: "Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools). Clinical indicators include black, tarry stools, vomiting "coffee grounds," hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed) that requires packing. However, nose bleeds that are easily controlled, menses, or a urinalysis that shows a small amount of red blood cells should not be coded as internal bleeding." (MDS Manual, page J-26).	Documentation of occurrence of internal bleeding during the 7-day look-back.

Section K Swallowing/ Nutritional **K0300** Weight Loss **30 and 180-Day Look-back**	"5% Weight Loss in 30 Days: Start with the resident's weight closest to 30 days ago and multiply it by .95 (or 95%). The resulting figure represents a 5% loss from the weight 30 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost more than 5% body weight. 10% Weight Loss in 180 Days: Start with the resident's weight closest to 180 days ago and multiply it by .90 (or 90%). The resulting figure represents a 10% loss from the weight 180 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost 10% or more body weight." (MDS Manual, page K-4).	Documentation of current weight coded on MDS as well as weight 30 days prior and weight 180 days prior to the current ARD.
K0510A Parenteral/IV Feeding Columns 1 & 2 **7-Day Look-back**	Parenteral/IV Feeding: "Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous)." (MDS Manual, page K-10). Column 1: Prior to admission/entry AND within the 7-day look-back. Column 2: After admission/entry AND within the 7-day look-back.	Documentation of nutritional approaches performed via Parenteral/IV feeding in the last 7 days. "Parenteral/IV feeding: The following fluids may be included when there is supporting documentation that reflects the need for additional fluid intake specifically addressing a nutrition or hydration need. This supporting documentation should be noted in the resident's medical record according to State and/or internal facility policy: IV fluids or hyperalimentation, including total parenteral nutrition (TPN), administered continuously or intermittently, IV fluids running at KVO (Keep Vein Open), IV fluids contained in IV Piggybacks, Hypodermoclysis and subcutaneous ports in hydration therapy" (MDS Manual, page K-11). "IV fluids can be coded in K0510A if needed to prevent dehydration if the additional fluid intake is specifically needed for nutrition and hydration. Prevention of dehydration should be clinically indicated and supporting documentation should be provided in the medical record." (MDS Manual, page K-12).

K0510B- Feeding Tube Columns 1 & 2 **7-Day Look-back**	Feeding tube is the "presence of any type of tube that can deliver food/nutritional substance/fluids/medications directly into the gastrointestinal system. Examples include but are not limited to: nasogastric tubes; gastrostomy tubes; jejunostomy tubes; percutaneous endoscopic gastrostomy (PEG) tubes." (MDS Manual, page K-10). Column 1: Prior to admission/entry AND within the 7-day look-back. Column 2: After admission/entry AND within the 7-day look-back.	Documentation of the presence of any feeding tube prior to admission/entry AND during the 7-day look-back period. Documentation of the presence of any feeding tube after admission/entry AND during the 7-day look-back period.
K0710A3 Proportion of Total Calories the Resident Received through Parenteral or Tube Feeding During Entire 7 Days **7-Day Look-back**	The proportion of total calories the resident received for nutrition or hydration through parenteral or tube feeding during the entire 7 days. Column 3: During Entire 7 Days. "The assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately." (MDS Manual, page K-1).	Documentation must support the proportion of calories actually received through Parenteral or Tube Feeding during the entire 7 Days. The facility must provide documentation to support actual caloric intake from each route (oral, parenteral, and tube feeding) during the entire 7 days (while not a resident AND while a resident) as well as documentation demonstrating calculation of the percent of calories received through parenteral or tube feeding during the entire 7 days. Pleasure feedings are not included unless there are specific calories listed (MDS Manual, Section K).
K0710B3 Average Fluid Intake Per Day by IV or Tube Feeding During the Entire 7 Days **7-Day Look-back**	The average fluid intake received per day by IV or tube feeding during the entire 7-day look-back. Column 3: During Entire 7 Days. "The assessor should collaborate with the dietitian and dietary staff to ensure that items in this section have been assessed and calculated accurately." (MDS Manual, page K-1). "Steps for Assessment 1. Review intake records from the last 7 days.	Documentation must support actual fluid intake per day by IV and/or tube feeding during the 7-day look-back period. The facility must provide documentation to support actual fluid intake per day by IV and/or tube feeding during the entire 7-day look-back (while not a resident AND while a resident) as well as documentation demonstrating calculation of the average fluid intake received per day by IV or tube feeding during the entire 7 days (MDS Manual, Section K).

	2. Add up the total amount of fluid received each day by IV and/or tube feedings only. 3. Divide the week's total fluid intake by 7 to calculate the average of fluid intake per day. 4. Divide by 7 even if the resident did not receive IV fluids and/or tube feeding on each of the 7 days." (MDS Manual, page K-15).	
M0300A No. of Stage 1 **M0300B1** No. of Stage 2 **M0300C1** No. of Stage 3 **M0300D1** No. of Stage 4 **M0300F1** No. of Unstageable **7-day Look-back**	Pressure Ulcer: "A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction." (MDS Manual, page M-4). See the MDS Manual for Staging Pressure Ulcers. "For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement, or suspected deep tissue injury (sDTI) that declares itself, should be coded in terms of what is assessed (seen or palpated, i.e. visible tissue, palpable bone) during the look-back period. Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. However, since CMS has adapted the NPUAP guidelines for MDS purposes, the definitions do not perfectly correlate with each stage as described by NPUAP. Therefore, you cannot use the NPUAP definitions to code the MDS. You must code the MDS according to the instructions in this manual." (MDS Manual, page M-4). "For the purposes of coding, determine that the lesion being assessed is primarily related to pressure and that other conditions have been ruled out. If pressure is not the primary cause, do not code here." (MDS Manual, page M-14). "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." (MDS Manual, page M-5).	Detailed current description of pressure ulcer by RN or physician within the 7-day observation period, including, but not limited to: location, dimensions, size (length, width, and depth), tissue color, drainage, etc. Pressure ulcer staging must be clearly defined by description and/or measurement in order to support MDS coding during the observation period. Documentation of history of pressure ulcer if ulcer was ever classified at a deeper stage than the current description. Documentation must indicate the number of pressure ulcers on any part of the body observed during the observation period. Does not include: • Reverse staging. • Pressure ulcers that are healed before the look-back period (code at M0900). • Facility reports that are not part of the clinical record, such as one tracking sheet for a unit. • A pressure ulcer surgically repaired with a flap or graft. • If pressure is not the primary cause. • Oral mucosal ulcers caused by pressure (reported at L0200C). (MDS Manual, Section M)

M1030 No. of Venous/ Arterial Ulcers **7-Day Look-back**	Venous Ulcers: "Ulcers caused by peripheral disease, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg." (MDS Manual, page M-31). Arterial Ulcers: "Ulcers caused by peripheral artery disease, which commonly occur on the tips and tops of the toes, tops of the foot, or distal to the medial malleolus." (MDS Manual, page M-31).	Detailed current description of the venous/arterial ulcer by RN or physician within the 7-day observation period including, but not limited to: location, dimensions, size (length, width, and depth), drainage, tissue color, impaired circulation, etc. Diagnosis of PVD, PAD, and specific type of vascular ulcer is determined by the physician. Does not include facility reports that are not part of the clinical record, such as one tracking sheet for a unit. (MDS Manual, Section M).
M1040A Infection of the Foot (e.g., cellulitis, purulent drainage) **7-Day Look-back**	Infection of the Foot (e.g., cellulitis, purulent drainage): "Skin wounds and lesions affect quality of life for residents because they may limit activity, may be painful, and may require time-consuming treatments and dressing changes. Many of these ulcers, wounds and skin problems can worsen or increase risk for local and systemic infections. … The presence of wounds and skin changes should be accounted for in the interdisciplinary care plan." This item includes infection of the foot (e.g., cellulitis, purulent drainage).	Detailed current description and location of the infection (i.e. cellulitis, purulent drainage) of the foot by RN or physician within the 7-day observation period. Does not include pressure ulcers coded in M0300-M0900 or open lesions of the ankle.
M1040B Diabetic Foot Ulcer(s) **7-Day Look-back**	Diabetic Foot Ulcer(s): "Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful." (MDS Manual, page M-33).	Detailed current description of diabetic foot ulcer(s), including location and appearance by RN or physician within the 7-day observation period. Diagnosis of Diabetes Mellitus and Diabetic Foot Ulcer are determined by the physician. Does not include pressure ulcers that occur on residents with Diabetes Mellitus or ulcers located on the ankle. The ankle is not considered part of the foot.
M1040C Other open lesion(s) on the foot (e.g. cuts, ulcers, fissures)	Other open lesion(s) on the foot (e.g. cuts, ulcers, fissures): This area includes but is not limited to other open lesion(s), such as cuts, ulcers and/or fissures on the foot. (MDS Manual, Section M).	Detailed current description of other open lesion(s), such as cuts, ulcers and/or fissures on the foot, including location and appearance by RN or physician within the 7-day observation period.

7-Day Look-back		Documentation that the lesion is open during the observation period. Does not include pressure ulcers or open lesions to the ankle. The ankle is not considered part of the foot.
M1040D Open Lesions other than Ulcers, Rashes, Cuts (e.g., cancer lesions) **7-Day Look-back**	Open Lesions other than Ulcers, Rashes, Cuts: "Most typically skin ulcers that develop as a result of diseases and conditions such as syphilis and cancer." (MDS Manual, page M-33).	Detailed current description of open lesions other than Ulcers, Rashes, Cuts, (e.g., cancer lesions), including location and appearance by RN or physician within the 7-day observation period. Includes lesions that develop as a result of a disease and conditions such as cancer and syphilis, or Herpes Zoster lesions that are weeping, etc. "Do not code rashes, skin tears, cuts/lacerations here…" (MDS Manual, page M-34).
M1040E Surgical Wound(s) **7-Day Look-back**	Surgical wounds are "any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites." (MDS Manual, page M-33). "Code pressure ulcers that require surgical intervention for closure with graft and/or flap procedures in this item (e.g., excision of pressure ulcer with myocutaneous flap). Once a pressure ulcer is excised and a graft and/or flap is applied, it is no longer considered a pressure ulcer, but a surgical wound." (MDS Manual, page M-35).	Detailed current description of a surgical wound by RN or physician within the 7-day observation period. "This category does not include healed surgical sites and healed stomas or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds. Surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing. A pressure ulcer that has been surgically debrided should continue to be coded as a pressure ulcer." (MDS Manual, page M-34).
M1040F Burn(s) **7-Day Look-back**	"Burns (second and third degree): "Skin and tissue injury cause by heat or chemicals and may be in any stage of healing." (MDS Manual, page M-33).	Detailed current description of the second or third degree burn in any stage of healing, including degree, location, appearance, drainage, type of burn (chemical or heat), cause, tissue involvement, etc. by RN or physician within the 7-day observation period. "Do not include first degree burns (changes in skin color only)." (MDS Manual, page M-35).

M1200A Pressure Reducing Device for Chair **M1200B** Pressure Reducing Device for Bed **7-Day Look-back**	Pressure Reducing Device: "Equipment that aims to relieve pressure away from areas of high risk. May include foam, air, water gel, or other cushioning placed on a chair, wheelchair, or bed. Include pressure relieving, pressure reducing, and pressure redistributing devices. Devices are available for use with beds and seating." (MDS Manual, page M-37). "Pressure reducing devices redistribute pressure so that there is some relief on or near the area of the ulcer. The appropriate reducing (redistribution) device should be selected based on the individualized needs of the resident" (MDS Manual, page M-38).	**Does Require:** Documentation of each pressure reducing device with evidence of use within the 7-day look-back period. "Do not include egg crate cushions of any type in this category. Do not include doughnut or ring devices in chairs." (MDS Manual, page M-38).
M1200C Turning/ Repositioning Program **7-Day Look-back**	Turning/Repositioning Program: "includes a consistent program for changing the resident's position and realigning the body. 'Program' is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs." (MDS Manual, page M-38).	Documentation in the 7-day look-back that "the turning/repositioning program is specific as to the approaches for changing the resident's position and realigning the body. The program should specify the intervention (e.g., reposition on side, pillows between knees) and frequency (e.g., every 2 hours)." (MDS Manual, page M-38). "Progress notes, assessments, and other documentation (as dictated by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention." (MDS Manual, page M-38).

M1200D Nutrition or Hydration Intervention to Manage and/or Prevent Skin Problems **7-Day Look-back**	Nutrition or Hydration Intervention to Manage Skin Problems: "Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions, e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplementation to prevent skin breakdown, high-protein supplementation for wound healing." (MDS Manual, page M-38). "The determination as to whether or not one should receive nutritional or hydration interventions for skin problems should be based on an individualized nutritional assessment. The interdisciplinary team should review the resident's diet and determine if the resident is taking in sufficient amounts of nutrients and fluids or are already taking supplements that are fortified with the US Recommended Daily Intake (US RDI) of nutrients…. If it is determined that nutritional supplementation, i.e. adding additional protein, calories, or nutrients is warranted, the facility should document the nutrition or hydration factors that are influencing skin problems and/or wound healing and 'tailor nutritional supplementation to the individual's intake, degree of under-nutrition, and relative impact of nutrition as a factor overall; and obtain dietary consultation as needed,' (AMDA PU Therapy Companion, page 4). It is important to remember that additional supplementation is not automatically required for pressure ulcer management. Any interventions should be specifically tailored to the resident's needs, condition, and prognosis (AMDA PU Therapy Companion, page 11)." (MDS Manual, page M-38-39).	Documentation of individualized nutritional assessment by the interdisciplinary team, with identification of the nutrition or hydration factors that are influencing specific skin problems and/or wound healing. Documentation of dietary consultation and evidence of the nutrition or hydration interventions received by the resident to manage and/or prevent specific skin problems within the 7-day look-back period.
M1200E Pressure Ulcer Care **7-Day Look-back**	"Pressure ulcer care includes any intervention for treating pressure ulcers coded in Current Number of Unhealed Pressure Ulcers at Each Stage (M0300A-G)." (MDS Manual, page M-39).	Documentation of intervention for treating unhealed pressure ulcers coded at M0300A-G during the 7-day look-back with administration record. "Examples may include the use of topical dressings, enzymatic, mechanical or surgical debridement, wound irrigations, negative pressure wound therapy (NPWT), and/or hydrotherapy." (MDS Manual, page M-39).

M1200 F Surgical Wound Care **7-Day Look-back**	"Surgical wound care may include any intervention for treating or protecting any type of surgical wound." (MDS Manual, page M-39).	Documentation of intervention for protecting or treating any type of surgical wound during the 7-day look-back with administration record. "Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application." (MDS Manual, page M-39). Does not include post-operative care following oral or eye surgery, OR surgical debridement of a pressure ulcer (MDS Manual, page M-39).
M1200G Application of Non-Surgical Dressings (with or without topical medications) other than to feet **7-Day Look-back**	Application of Non-Surgical Dressings (with or without topical medications) other than to feet: "Dressings do not have to be applied daily in order to be coded on the MDS assessment. If any dressing meeting the MDS definition was applied even once during the 7-day look-back period, the assessor should check that MDS item." (MDS Manual, page M-40).	Documentation of application of a non-surgical dressing (with or without topical medications) other than to feet during the 7-day look-back with administration record. "This category may include but is not limited to: dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles used to treat a skin condition, compression bandages, etc. Non-surgical dressings do not include adhesive bandages (e.g., BAND- AID® bandages)." (MDS Manual, page M-40). Does not include dressing for pressure ulcer on the foot or topical medications for pressure ulcers. Use pressure ulcer care M1200E.

M1200I Application of Dressings to Feet (with or without Topical Medications) **7-Day Look-back**	<u>Application of Dressings to Feet (with or without Topical Medications)</u>: This area "includes interventions to treat any foot wound or ulcer other than a pressure ulcer." (MDS Manual, page M-40).	Documentation of application of dressings to the feet (with or without topical medication) including interventions to treat any foot wound or ulcer other than a pressure ulcer. Documentation of administration of intervention. Does not include application of dressings to pressure ulcers on the foot, use Pressure Ulcer Care - M1200E. Does not include application of dressings to the ankle. The ankle is not considered part of the foot. (MDS Manual, page M-40).
Section N0300 Injections **7-Day Look-back**	<u>Injections</u>: "Record the number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that the resident received any type of medication, antigen, vaccine, etc., by subcutaneous, intramuscular, or intradermal injection. Insulin injections are counted in this item as well as in Item N0350." (MDS Manual, page N-1).	Documentation of the number of days for any type of injection (subcutaneous, intramuscular, or intradermal) received while a resident of the nursing home within the 7-day look-back. For subcutaneous pumps, code only the number of days that the resident actually required a subcutaneous injection to restart the pump. (MDS Manual, page N-1 and N-2).
Section N N0350A Days of Insulin Injections **7-Day Look-back**	<u>Days of Insulin Injections</u>: "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" (MDS Manual, page N-2).	Documentation of the number of days insulin injections received while a resident of the nursing home within the 7-day look-back. For subcutaneous insulin pumps, code only the number of days that the resident actually required a subcutaneous injection to restart the pump. (MDS Manual, page N-3).
Section N N0350B Orders for Insulin **7-day Look-back**	<u>Orders for Insulin</u>: "The number of days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that the physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) changed the resident's insulin orders." (MDS Manual, page N-3).	Documentation of "days during the 7-day look-back period (or since admission/entry or reentry if less than 7 days) that the physician (nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) changed the resident's insulin orders." (MDS Manual, page N-3). For sliding scale orders: "A sliding scale dosage schedule that is written to cover different dosages

		depending on lab values does not count as an order change simply because a different dose is administered based on the sliding scale guidelines. If the sliding scale order is new, discontinued, or is the first sliding scale order for the resident, these days can be counted and coded" (MDS Manual, page N-3).
Section O0100 Special Treatments, Procedures and Programs Columns 1 & 2 **14-Day Look-back**	"Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures." (MDS Manual, page O-1). "Coding Instructions for Column 1: Check all treatments, procedures, and programs received or performed by the resident prior to admission/entry or reentry to the facility and within the 14-day look-back period. Leave Column 1 blank if the resident was admitted/entered or reentered the facility more than 14 days ago. If no items apply in the last 14 days, check Z, none of the above. Coding Instructions for Column 2: Check all treatments, procedures, and programs received or performed by the resident after admission/entry or reentry to the facility and within the 14-day look-back period." (MDS Manual, page O-2).	Documentation of the following: "Reevaluation of special treatments and procedures the resident received or performed, or programs that the resident was involved in during the 14-day look-back period is important to ensure the continued appropriateness of the treatments, procedures, or programs. Residents who perform any of the treatments, programs, and/or procedures below should be educated by the facility on the proper performance of these tasks, safety and use of any equipment needed, and be monitored for appropriate use and continued ability to perform these tasks." (MDS Manual, page O-2).
Section O O0100A Chemotherapy **14-Day Look-back**	Chemotherapy: "Code any type of chemotherapy agent administered as an antineoplastic given by any route in this item. Each drug should be evaluated to determine its reason for use before coding it here. The drugs coded here are those actually used for cancer treatment. For example, megestrol acetate is classified as an antineoplastic drug. One of its side effects is appetite stimulation and weight gain. If megestrol acetate is being given only for appetite stimulation, do not code it as	Documentation of administration of any type of chemotherapy agent administered as an antineoplastic given by any route for cancer treatment during the 14-day look-back while not a resident or while a resident. Documentation of a diagnosis of cancer. The resident may go out of the facility for chemotherapy treatment. Must provide documentation of administration.

	chemotherapy in this item, as the resident is not receiving the medication for chemotherapy purposes in this situation. IVs, IV medication, and blood transfusions administered during chemotherapy are not recorded under items K0510A (Parenteral/IV), O0100H (IV Medications), or O01001 (Transfusions)." (MDS Manual, page O-2).	
O0100B Radiation **14-Day Look-back**	Radiation: Administration of "intermittent radiation therapy, as well as radiation administered via radiation implant" in the last 14 days while not a resident or while a resident. (MDS Manual, page O-2).	Documentation of administration of radiation during the 14-day look-back while not a resident or while a resident. The resident may go out of the facility for radiation. Must provide documentation of administration. Payment items in the MDS must be supported with documented evidence within the observation period.
O0100C Oxygen Therapy **14-Day Look-back**	Oxygen Therapy: "Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item. This item may be coded if the resident places or removes his/her own oxygen mask, cannula." (MDS Manual, page O-3).	Documentation of continuous or intermittent oxygen administered via mask, cannula, etc., including oxygen used in BiPAP/CPAP, delivered to a resident to relieve hypoxia within the 14-day look-back while not a resident or while a resident. Document if the resident places or removes his/her own oxygen mask, cannula.
O0100D Suctioning **14-Day Look-back**	Suctioning: Includes "tracheal and/or nasopharyngeal suctioning in this item. Do not code oral suctioning here. This item may be coded if the resident performs his/her own tracheal and/or nasopharyngeal suctioning. (MDS Manual, page O-3).	Documentation of tracheal and/or nasopharyngeal suctioning within the 14-day look-back while not a resident or while a resident. The resident may perform his/her own tracheal and/or nasopharyngeal suctioning. Does not include oral suctioning.

O0100E Tracheostomy Care **14-Day Look-back**	<u>Tracheostomy care</u>: Includes "cleansing of the tracheostomy and/or cannula in this item. This item may be coded if the resident performs his/her own tracheostomy care." (MDS Manual, page O-3).	Documentation of cleansing of the tracheostomy and/or cannula within the 14-day look-back while not a resident or while a resident. The resident may perform his/her own tracheostomy care.
O0100F Ventilator or Respirator **14-Day Look-back**	<u>Ventilator or respirator</u>: Includes "any type of electrically or pneumatically powered closed-system mechanical ventilator support devices that ensure adequate ventilation in the resident who is, or who may become, unable to support his or her own respiration in this item. Residents receiving closed-system ventilation includes those residents receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) as well as those residents with a tracheostomy. A resident who is being weaned off of a respirator or ventilator in the last 14 days should also be coded here. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP." (MDS Manual, page O-3).	Documentation of the type of electrically or pneumatically powered closed-system mechanical ventilator support devices that ensure adequate ventilation in the resident who is, or who may become, unable to support his or her own respiration, including frequency used during the 14-day look-back while not a resident or while a resident.
O0100H IV Medications **14-Day Look-back**	<u>IV Medication</u>: Includes "any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port in this item. Do not code flushes to keep an IV access port patent, or IV fluids without medication here. Epidural, intrathecal, and baclofen pumps may be coded here, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Subcutaneous pumps are not coded in this item. Do not include IV medications of any kind that were administered during dialysis or chemotherapy. Dextrose 50% and/or Lactated Ringers given IV are not considered medications, and should not be coded here." (MDS Manual, page O-3).	Documentation of IV medication administration record during the 14-day look-back while not a resident or while a resident.

O0100I Transfusions **14-Day Look-back**	<u>Transfusions</u>: Includes "transfusions of blood or any blood products (e.g., platelets, synthetic blood products), that are administered directly into the bloodstream in this item. Do not include transfusions that were administered during dialysis or chemotherapy." (MDS Manual, page O-4)	Documentation of transfusion administration record during the 14-day look-back while not a resident or while a resident.
O0100J Dialysis **14-Day Look-back**	<u>Dialysis</u>: Includes "peritoneal or renal dialysis which occurs at the nursing home or at another facility, record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are not to be coded under items K0510A (Parenteral/IV), O0100H (IV medications), or O0100I (transfusions). This item may be coded if the resident performs his/her own dialysis." (MDS Manual, page O-4).	Documentation of dialysis treatment in the nursing facility or at another facility during the 14-day look-back while not a resident or while a resident. The resident may perform his/her own dialysis.

<u>General Therapy Requirements</u>

<u>O0400 Therapies</u>
<u>(A) Speech-Language Pathology Services (SLP)</u>
<u>(B) Occupational Therapy (OT)</u>
<u>(C) Physical Therapy (PT)</u>

<u>7-Day Look-back</u>

- "Code only medically necessary therapies that occurred after admission/readmission to the nursing home that were (1) ordered by a physician (physician's assistant, nurse practitioner, and/or clinical nurse specialist) based on a qualified therapist's assessment (i.e., one who meets Medicare requirements or, in some instances, under such a person's direct supervision) and treatment plan, (2) documented in the resident's medical record, and (3) care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective. Therapy treatment may occur either inside or outside of the facility." (MDS Manual, page O-17).
- "The qualified therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents." (MDS Manual, page O-16). The documentation must include interdisciplinary notes addressing the need for skilled services.

- "Only skilled therapy time (i.e., requires the skills, knowledge and judgment of a qualified therapist and all the requirements for skilled therapy are met) shall be recorded on the MDS. In some instances, the time during which a resident received a treatment modality includes partly skilled and partly unskilled time; only time that is skilled may be recorded on the MDS. Therapist time during a portion of a treatment that is non-skilled; during a non-therapeutic rest period; or during a treatment that does not meet the therapy mode definitions may not be included." (MDS Manual, page O-19).
- "The services must be directly and specifically related to an active written treatment plan that is approved by the physician after any needed consultation with the qualified therapist and is based on an initial evaluation performed by a qualified therapist prior to the start of therapy services in the facility" (MDS Manual, page O-20).
- "The services must be of a level of complexity and sophistication, or the condition of the resident must be of a nature that requires the judgment, knowledge, and skills of a therapist" (MDS Manual, page O-20).
- "The services must be provided with the expectation, based on the assessment of the resident's restoration potential made by the physician, that the condition of the patient will improve materially in a reasonable and generally predictable period of time; or, the services must be necessary for the establishment of a safe and effective maintenance program; or, the services must require the skills of a qualified therapist for the performance of a safe and effective maintenance program." (MDS Manual, page O-20).
- "The services must be considered under accepted standards of medical practice to be specific and effective treatment for the resident's condition" (MDS Manual, page O-20).
- "The services must be reasonable and necessary for the treatment of the resident's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable and they must be furnished by qualified personnel." (MDS Manual, page O-20).
- "Medical care and services will be considered excessive or not medically necessary unless the medical basis and specific need for them are fully and properly documented in the client's medical record" 18 NYCRR 518.3(b).
- Of primary importance for the purposes of this audit is that the nursing home remain obligated to comply with the documentation requirements for Medicaid generally, including 10 NYCRR 86-2.17 and 18 NYCRR 504.3 (a), 518.3 (b) and 517.3.
- As "specific documentation procedures" have not been imposed for MDS reporting, the standard remains, as with all Medicaid reimbursement, whether the resident record as a whole reasonably documents a medical basis and specific need in compliance with Medicaid regulations.

Does not include:

- "Services provided at the request of the resident or family that are not medically necessary (sometimes referred to as family-funded services) shall not be counted in item O0400 Therapies, even when performed by a therapist or an assistant." (MDS Manual, page O-21).

Minutes of Therapy Requirements

- Only skilled therapy minutes should be reported on the MDS
- Only skilled services should be reported on the MDS after the initial evaluation
- Reimbursable (actual) therapy minutes (RTM) only

- Documentation of RTM for each specific mode of therapy
- Documentation should be differentiated between RTM and billable minutes/units
- Therapist time spent on subsequent reevaluations conducted as part of the treatment process should be counted
- The time required to adjust equipment or otherwise prepare the treatment area for skilled rehabilitation service is the set-up time and is to be included in the count of minutes of therapy delivered to the resident. Set-up may be performed by the therapist, therapy assistant, or therapy aide.
- "Therapy Aides cannot provide skilled services. Only the time a therapy aide spends on set-up preceding skilled therapy may be coded on the MDS (e.g., set up the treatment area for wound therapy) and should be coded under the appropriate mode for the skilled therapy (individual, concurrent, or group) in O0400. The therapy aide must be under direct supervision of the therapist or assistant (i.e., the therapist/assistant must be in the facility and immediately available)." (MDS Manual, page O-22).
- Family education when the resident is present is counted and must be documented in the resident's record.

Does not include:

- Therapist time spent on documentation or on initial evaluation is not counted
- Conversion of units to minutes or minutes to units
- Rounding to the nearest 5th minute
- Non-therapeutic rest periods
- Treatment or portion of the treatment that is not skilled
- Initial evaluation minutes
- Unattended e-stim minutes

O0400 Therapy Minutes SLP OT PT **7-Day Look-back**	**Individual Minutes**: total number of minutes of therapy that were provided on an individual basis in the last 7 days. Individual services are provided by one therapist or an assistant to one resident at a time. **Concurrent Minutes:** total number of minutes of therapy that were provided on a concurrent basis in the last 7 days. Concurrent therapy is defined as the treatment of 2 residents at the same time when the residents are not performing the same or similar activities, both of whom must be in the line-of-sight of the treating therapist or assistant. **Group minutes**: the treatment of 4 residents, who are performing the same or similar activities, and are supervised by a therapist or an assistant who is not supervising any other individuals. (MDS Manual, page O-17).	Documentation of actual therapy days and minutes that skilled treatment was provided with associated initials/signatures during the 7-day look-back The medically necessary therapies shall meet all of the criteria listed in the MDS Manual, Section O. Does not include: • Treatment for less than 15 minutes per day. • The exclusions listed in the MDS Manual, Section O.

O0400D Respiratory Therapy Days **7-Day Look-back**	Respiratory Therapy Days: "Services that are provided by a qualified professional (respiratory therapist, respiratory nurse). Respiratory therapy services are for the assessment, treatment and monitoring of patients with deficiencies or abnormalities of pulmonary function. Respiratory therapy services include coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds and mechanical ventilation, etc. which must be provided by a respiratory therapist or a respiratory nurse. A respiratory nurse must be proficient in the modalities listed above either through formal nursing or specific training and may deliver these modalities as allowed under NYS Nurse Practice Act and under applicable state laws." (MDS Manual, page Appendix A-19).	Documentation of Respiratory Therapy services provided by a qualified professional (respiratory therapist, respiratory nurse). Record the number of days this therapy was administered, for at least 15 minutes a day, in the last 7 days. The following criteria must be met to record services for Respiratory Therapy: "The physician orders the therapy; The physician's order includes a statement of frequency, duration, and scope of treatment; The services must be directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by qualified personnel … The services are required and provided by qualified personnel … The services must be reasonable and necessary for treatment of the resident's condition." (MDS Manual, page O-21). Count only the time that a qualified professional spends time with the resident, which includes the performance of respiratory assessments before, during, and after the treatment. Does not include treatment for less than 15 minutes per day.
O0500A-J Restorative Nursing Program Days **O0500A** Range of Motion-Passive **O0500 B** Range of Motion Active	"Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental and psychosocial functioning." (MDS Manual, page O-36). "A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a restorative nursing program. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents. Restorative nursing does not require a physician's order. Nursing homes may elect to have licensed rehabilitation professionals perform repetitive exercises and other maintenance treatments or	Documentation must include the number of days on which the Restorative Nursing technique, training or skill practice was performed for a total of at least 15 minutes during the 24-hour period with associated initials/signatures to verify services. The following criteria for restorative nursing programs must be met in order to code O0500: "Measureable objective and interventions must be documented in the care plan and in the medical record. If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process. Good clinical

O0500C Splint/Brace Assistance **O0500D** Bed Mobility **O0500E** Transfer **O0500F** Walking **O0500G** Dressing and/or Grooming **O0500H** Eating and/or Swallowing **O0500I** Amputation/ Prosthesis Care **O0500J** Communication **7-Day Look-back**	to supervise aides performing these maintenance services. In situations where such services do not actually require the involvement of a qualified therapist, the services may not be coded as therapy in item O0400, Therapies, because the specific interventions are considered restorative nursing services (see item O0400, Therapies). The therapist's time actually providing the maintenance service can be included when counting restorative nursing minutes. Although therapists may participate, members of the nursing staff are still responsible for overall coordination and supervision of restorative nursing programs." (MDS Manual, page O-37). "The use of continuous passive motion (CPM) devices in a restorative nursing program is coded when the following criteria are met: (1) ordered by a physician, (2) nursing staff have been trained in technique (e.g., properly aligning resident's limb in device, adjusting available range of motion), and (3) monitoring of the device. Nursing staff should document the application of the device and the effects on the resident. Do not include the time the resident is receiving treatment in the device. Include only the actual time staff were engaged in applying and monitoring the device." (MDS Manual, page 40).	practice would indicate that the results of this reassessment should be documented in the resident's medical record. Evidence of periodic evaluation by the licensed nurse must be present in the resident's medical record. When not contraindicated by state practice act provisions, a progress note written by the restorative aide and countersigned by a licensed nurse is sufficient to document the restorative nursing program once the purpose and objectives of treatment have been established. Nursing assistants/aides must be trained in the techniques that promote resident involvement in the activity… This category does not include groups with more than four residents per supervising helper or caregiver." (MDS Manual, page O-37). "For both active and passive range of motion: movement by a resident that is incidental to dressing, bathing, etc., does not count as part of a formal restorative nursing program. For inclusion in this section, active or passive range of motion must be a component of an individualized program that is planned, monitored evaluated, and documented in the resident's medical record. Range of motion should be delivered by staff who are trained in the procedures." (MDS Manual, page O-39). Does not require a physician order. Does not include treatment for less than 15 minutes per day.

O0600 Physician Examinations **14-Day Look-back**	Physician Examinations: "Health status that requires frequent physician examinations can adversely affect an individual's sense of well-being and functional status and can limit social activities. Frequency of physician examinations can be an indication of medical complexity and stability of the resident's health status." (MDS Manual, page O-42). "Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law. Examination (partial or full) can occur in the facility or in the physician's office. Included in this item are telehealth visits as long as the requirements are met for physician/practitioner type as defined above and whether it qualifies as a telehealth billable visit…" (MDS Manual, page O-43). "If a resident has multiple physicians (e.g., surgeon, cardiologist, internal medicine), and they all visit and write orders on the same day, the MDS must be coded as 1 day during which a physician visited, and 1 day in which orders were changed. (MDS Manual, page O-45).	Documentation of physician progress notes reflecting that a physician examined the resident during the 14-day look-back (or since admission if less than 14 days ago). "If a resident is evaluated by a physician off-site (e.g., while undergoing dialysis or radiation therapy), it can be coded as a physician examination as long as documentation of the physician's evaluation is included in the medical record. The physician's evaluation can include partial or complete examination of the resident, monitoring the resident for response to the treatment, or adjusting the treatment as a result of the examination." (MDS Manual, page O-43). "Do not include physician examinations that occurred prior to admission or readmission to the facility (e.g., during the resident's acute care stay). Do not include physician examinations that occurred during an emergency room visit or hospital observation stay… The licensed psychological therapy by a Psychologist (PhD) should be recorded in O0400E, Psychological Therapy. Does not include visits made by Medicine Men." (MDS Manual, page O-43).
O0700 Physician Orders **14-Day Look-back**	Physician Orders: Health status that requires frequent physician order changes can adversely affect an individual's sense of well-being and functional status and can limit social activities. Frequency of physician order changes can be an indication of medical complexity and stability of the resident's health status." (MDS Manual, page O-44). "Includes orders written by medical doctors, doctors of osteopathy, podiatrists, dentists, and physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law.	Documentation of physician order changes during the 14-day look-back (or since admission if less than 14 days ago). Does not include orders prior to the date of admission or re-entry. "A sliding scale dosage schedule that is written to cover different dosages depending on lab values, does not count as an order change simply because a different dose is administered based on the sliding scale guidelines." (MDS Manual, page O-44).

	Includes written, telephone, fax, or consultation orders for new or altered treatment. Does not include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. Orders written on the day of admission as a result for an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes. The prohibition against counting standard admission or readmission orders applies regardless of whether or not the orders are given at one time or are received at different times on the date of admission or readmission." (MDS Manual, page O-44). "If a resident has multiple physicians (e.g., surgeon, cardiologist, internal medicine), and they all visit and write orders on the same day, the MDS must be coded as 1 day during which a physician visited, and 1 day in which orders were changed. (MDS Manual, page O-45).	"When a PRN (as needed) order was already on file, the potential need for the service had already been identified. Notification of the physician that the PRN order was activated does not constitute a new or changed order and may not be counted when coding this item. A Medicare Certification/Recertification is a renewal of an existing order and should not be included when coding this item. Orders requesting a consultation by another physician may be counted. However, the order must be reasonable (e.g., for a new or altered treatment). An order written on the last day of the MDS observation period for a consultation planned 3-6 months in the future should be carefully reviewed. Orders written to increase the resident's RUG classification and facility payment are not acceptable. Orders for transfer of care to another physician may not be counted. Do not count orders written by a pharmacist." (MDS Manual, page O-45).

<u>MDS Documentation Clarification</u>

- This *New York State MDS Clarification Document* should be used in conjunction with the MDS 3.0 RAI Manual.
- Information coded on the MDS should be based on clinical assessment, direct observation, resident-self-report and report from care staff and family/caregivers **as documented in the resident's medical record**. Resident interviews (e.g., BIMS, PHQ-9©) are considered to be sole source documents, as they are direct interviews with the resident (and/or family, as in the case of Section F) and do not require additional documentation in the medical record.
- Changes in the resident's status, either minor or major, must be documented in the resident's record (nursing notes, progress notes, interdisciplinary notes, etc.) in accordance with standards of clinical practice and documentation. Such monitoring and documentation is part of the provider's responsibility to provide necessary care and services.
- "Regulations require facilities to complete, at a minimum and at regular intervals, a comprehensive, standardized assessment of each resident's functional capacity and needs, in relation to a number of specified areas (e.g., customary routine, vision, and continence). The results of the assessment, which must accurately reflect the resident's status and needs, are to be used to develop, review, and revise each resident's comprehensive plan of care." (MDS Manual, page 4-1).

- "Increased Clarity of Documentation. When the approaches to achieving a specific goal are understood and distinct, the need for voluminous documentation diminishes. Likewise, when staff members are communicating effectively among themselves with respect to resident care, repetitive documentation is not necessary and contradictory notes do not occur. In addition, new staff, consultants, or others who review records have found that the increased clarity of information documented about a resident makes tracking care and outcomes easier to accomplish" (MDS Manual, pages 1-10 and 1/11).
- "Documentation. What happens when the medical record is in conflict with itself? Two disciplines assess resident differently. Data conflict. Write a progress note that clarifies the discrepancy and resolve the issue" - University at Albany School of Public Health. New York's Common MDS Coding Errors: Strategies to Improve MDS Accuracy. 12/17/2014. Retrieved from https://www.albany.edu/sph/cphce/mds_coding_errors_handouts.pdf Slide # 71
- Any corrections made including, but not limited to the Activities of Daily Living (ADL) must have an associated note of explanation per correction within the observation period. There should be one line crossing out the error, with a date and initial of the person making the correction.
- Improper or illegible documentation will not be accepted for the MDS documentation review.
- All documentation, including corrections, must be part of the original legal record.

Rules of General Applicability

To be considered as allowable in determining reimbursement rates, costs shall be properly chargeable to necessary patient care.
10 NYCRR 86-2.17(a)

…residential health care facilities shall submit to the department the data contained in the comprehensive assessment and review of assessments…required to be completed by facilities in accordance with section 415.11 of this Title and section 483.20 of 42 CFR (Minimum Data Set Plus for Nursing Home Resident Assessment and Care Screening [MDS+]) …
10 NYCRR 86-2.37(a)

The direct component of the price shall be subject to a case mix adjustment in accordance with the following: The application of the relative Resource Utilization Groups System (RUGS-III) as published by the Centers for Medicare and Medicaid Services…
10 NYCRR 86-2.40(m)(1)

The adjustments and related patient classifications for each facility shall be subject to audit review by the Office of the Medicaid Inspector General.
10 NYCRR 86-2.40(m)(5)

The operator…shall submit to the Department a written certification…attesting that all of the "minimum data set" (MDS) data reported by the facility for each census roster submitted to the department is complete and accurate.
10 NYCRR 86-2.40(m)(9)

The facility shall conduct a comprehensive assessment of each resident's needs, which describes the resident's ability to perform daily life functions and identifies significant impairments in functional capacity. All comprehensive assessments completed on or after April 1, 1991 shall be recorded on a uniform data instrument designated by the Department of Health.
10 NYCRR 415.11(a)(1)

By enrolling the provider agrees:(a) to prepare and maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished…
18 NYCRR 504.3(a)

By enrolling the provider agrees:(e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons.
18 NYCRR 504.3(e)

All fiscal and statistical records and reports of providers which are used for the purpose of establishing rates of payment made in accordance with the medical assistance program and all underlying books, records, documentation and reports which formed the basis for such fiscal and statistical records and reports are subject to audit. All underlying books, records and documentation which formed the basis for the fiscal and statistical reports filed by a provider with any State agency responsible for the establishment of rates of payment or fees must be kept and maintained by the provider for a period of not less than six years from the date of filing of such reports, or the date upon which the fiscal and statistical records were required to be filed, or two years from the end of the last calendar year during any part of which a provider's rate or fee was based on the fiscal or statistical reports, whichever is later. In this respect, any rate of payment certified or established by the commissioner of the Department of Health or other official or agency responsible for establishing such rates will be construed to represent a provisional rate until an audit is performed and completed, or the period within which to conduct an audit has expired without such audit having been begun or notice of such audit having been issued, at which time such rate or adjusted rate will be construed to represent the final rate as to those items audited.
18 NYCRR 517.3(a)(1)

The department may require repayment from the person submitting an incorrect or improper claim, or the person causing such claim to be submitted, or the person receiving payment for the claim.
18 NYCRR 518.3(a)

The department may require repayment for inappropriate, improper, unnecessary or excessive care, services or supplies from the person furnishing them, or the person under whose supervision they were furnished, or the person causing them to be furnished. In this respect, the department may recover the amount paid for such care, services or supplies from the person ordering or prescribing them even though

payment was made to another person. Medical care, services or supplies ordered or prescribed will be considered excessive or not medically necessary unless the medical basis and specific need for them are fully and properly documented in the client's medical record.
18 NYCRR 518.3(b)

(b)Comprehensive assessments -
(1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information.
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychosocial well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnoses and health conditions.
(xi) Dental and nutritional status.
(xii) Skin condition.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.
42 CFR 483.20 (b)(1)