

A0100: Facility Provider Numbers

A0100. Facility Provider Numbers	
	<p>A. National Provider Identifier (NPI):</p> <input type="text"/>
	<p>B. CMS Certification Number (CCN):</p> <input type="text"/>
	<p>C. State Provider Number:</p> <input type="text"/>

Item Rationale

- Allows the identification of the nursing home submitting assessment.

Coding Instructions

- Nursing homes must have a National Provider Number (NPI) and a CMS Certified Number (CCN).
- Enter the nursing home provider numbers:
 - National Provider Identifier (NPI)
 - CMS Certified Number (CCN)
 - State Provider Number (optional) This number is assigned by the Regional Office and provided to the intermediary/carrier and the State survey agency. When known enter the State Provider Number in A0100C. Completion of this item is not required; however, your State may require the completion of this item.

DEFINITIONS

NATIONAL PROVIDER IDENTIFIER (NPI) A unique Federal number that identifies providers of health care services. The NPI applies to the long-term care hospital and all of its patients.

CMS CERTIFICATION NUMBER (CCN) Replaces the term "Medicare/Medicaid Provider Number" in survey, certification, and assessment-related activities.

STATE PROVIDER NUMBER Medicaid Provider Number established by a state.

A0200: Type of Provider

A0200. Type of Provider	
Enter Code	<p>Type of provider</p> <ol style="list-style-type: none"> Nursing home (SNF/NF) Swing Bed

Item Rationale

- Allows designation of type of provider.

Coding Instructions

- Code 1, nursing home (SNF/NF):** if a Medicare skilled nursing facility (SNF) or Medicaid nursing facility (NF).

DEFINITION

SWING BED

A rural hospital with less than 100 beds that participates in the Medicare program that has CMS approval to provide post-hospital SNF care. The hospital may use its beds, as needed, to provide either acute or SNF care.

A1300: Optional Resident Items (cont.)

Coding Instructions for A1300D, Lifetime Occupation(s)

- Enter the job title or profession that describes the resident’s main occupation(s) before retiring or entering the nursing home. When two occupations are identified, place a slash (/) between each occupation.
- The lifetime occupation of a person whose primary work was in the home should be recorded as “homemaker.” For a resident who is a child or a mentally retarded/developmentally delayed adult resident who has never had an occupation, record as “none.”

A1500: Preadmission Screening and Resident Review (PASRR)

A1500. Preadmission Screening and Resident Review (PASRR)	
Complete only if A0310A = 01, 03, 04, or 05	
Enter Code <input type="checkbox"/>	<p>Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition?</p> <p>0. No → Skip to A1550, Conditions Related to ID/DD Status</p> <p>1. Yes → Continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions</p> <p>9. Not a Medicaid-certified unit → Skip to A1550, Conditions Related to ID/DD Status</p>

Item Rationale

Health-related Quality of Life

- All individuals who are admitted to a Medicaid certified nursing facility must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), (“mental retardation” (MR) in federal regulation)/developmental disability (DD), or related conditions regardless of the resident’s method of payment (please contact your local State Medicaid Agency for details regarding PASRR requirements and exemptions).
- Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State.
- A resident with MI or ID/DD must have a Resident Review (RR) conducted when there is a significant change in the resident’s physical or mental condition. Therefore, when a significant change in status MDS assessment is completed for a resident with MI or ID/DD, the nursing home is required to notify the State mental health authority, intellectual disability or developmental disability authority (depending on which operates in their State) in order to notify them of the resident’s change in status. Section 1919(e)(7)(B)(iii) of the Social Security Act requires the notification or referral for a significant change.¹

¹ The statute may also be referenced as 42 USC 1396r(e)(7)(B)(iii). Note that as of this revision date the statute supersedes Federal regulations at 42 CFR 483.114(c), which still reads as requiring annual resident review. The regulation has not yet been updated to reflect the statutory change to resident review upon significant change in condition.

A1500: Preadmission Screening and Resident Review (PASRR) (cont.)

- Each State Medicaid agency might have specific processes and guidelines for referral, and which types of significant changes should be referred. Therefore, facilities should become acquainted with their own State requirements.
- Please see https://www.cms.gov/PASRR/01_Overview.asp for CMS information on PASRR.

Planning for Care

- The Level II PASRR determination and the evaluation report specify services to be provided by the nursing home and/or specialized services defined by the State.
- The State is responsible for providing specialized services to individuals with MI or ID/DD. In some States specialized services are provided to residents in Medicaid-certified facilities (in other States specialized services are only provided in other facility types such as a psychiatric hospital). The nursing home is required to provide all other care and services appropriate to the resident's condition.
- The services to be provided by the nursing home and/or specialized services provided by the State that are specified in the Level II PASRR determination and the evaluation report should be addressed in the plan of care.
- Identifies individuals who are subject to Resident Review upon change in condition.

Steps for Assessment

1. Complete if A0310A = 01, 03, 04 or 05 (admission assessment, annual assessment, significant change in status assessment, significant correction to prior comprehensive assessment).
2. Review the Level I PASRR form to determine whether a Level II PASRR was required.
3. Review the PASRR report provided by the State if Level II screening was required.

Coding Instructions

- **Code 0, no:** and skip to A1550, Conditions Related to ID/DD Status, if any of the following apply:
 - PASRR Level I screening did not result in a referral for Level II screening, or
 - Level II screening determined that the resident does not have a serious mental illness and/or intellectual disability or related condition, or
 - PASRR screening is not required because the resident was admitted from a hospital after requiring acute inpatient care, is receiving services for the condition for which he or she received care in the hospital, and the attending physician has certified before admission that the resident is likely to require less than 30 days of nursing home care.

A1500: Preadmission Screening and Resident Review (PASRR) (cont.)

- **Code 1, yes:** if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.
- **Code 9, not a Medicaid-certified unit:** if bed is not in a Medicaid-certified nursing home. Skip to A1550, Conditions Related to ID/DD Status. The PASRR process does not apply to nursing home units that are not certified by Medicaid (unless a State requires otherwise) and therefore the question is not applicable.
 - Note that the requirement is based on the certification of the part of the nursing home the resident will occupy. In a nursing home in which some parts are Medicaid certified and some are not, this question applies when a resident is admitted, or transferred to, a Medicaid certified part of the building.

A1510: Level II Preadmission Screening and Resident Review (PASRR) Conditions

A1510. Level II Preadmission Screening and Resident Review (PASRR) Conditions	
Complete only if A0310A = 01, 03, 04, or 05	
↓ Check all that apply	
<input type="checkbox"/>	A. Serious mental illness
<input type="checkbox"/>	B. Intellectual Disability ("mental retardation" in federal regulation)
<input type="checkbox"/>	C. Other related conditions

Steps for Assessment

1. Complete if A0310A = 01, 03, 04 or 05 (admission assessment, annual assessment, significant change in status assessment, significant correction to prior comprehensive assessment).
2. Check all that apply.

Coding Instructions

- **Code A, Serious mental illness:** if resident has been diagnosed with a serious mental illness.
- **Code B, Intellectual Disability (“mental retardation” in federal regulation)/Developmental Disability:** if resident has been diagnosed with intellectual disability/developmental disability.
- **Code C, Other related conditions:** if resident has been diagnosed with other related conditions.

A1550: Conditions Related to Intellectual Disability/Developmental Disability (ID/DD) Status

A1550. Conditions Related to ID/DD Status	
If the resident is 22 years of age or older, complete only if A0310A = 01	
If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05	
↓ Check all conditions that are related to ID/DD status that were manifested before age 22, and are likely to continue indefinitely	
	ID/DD With Organic Condition
<input type="checkbox"/>	A. Down syndrome
<input type="checkbox"/>	B. Autism
<input type="checkbox"/>	C. Epilepsy
<input type="checkbox"/>	D. Other organic condition related to ID/DD
	ID/DD Without Organic Condition
<input type="checkbox"/>	E. ID/DD with no organic condition
	No ID/DD
<input type="checkbox"/>	Z. None of the above

Item Rationale

- To document conditions associated with intellectual or developmental disabilities.

Steps for Assessment

- If resident is 22 years of age or older on the assessment reference date, complete only if A0310A = 01 (admission assessment).
- If resident is 21 years of age or younger on the assessment reference date, complete if A0310A = 01, 03, 04, or 05 (admission assessment, annual assessment, significant change in status assessment, significant correction to prior comprehensive assessment).

Coding Instructions

- Check all conditions related to ID /DD status that were present before age 22.
- When age of onset is not specified, assume that the condition meets this criterion AND is likely to continue indefinitely.
- Code A:** if Down syndrome is present.
- Code B:** if autism is present.
- Code C:** if epilepsy is present.
- Code D:** if other organic condition related to ID/DD is present.

DEFINITIONS

DOWN SYNDROME

A common genetic disorder in which a child is born with 47 rather than 46 chromosomes, resulting in developmental delays, intellectual disability, low muscle tone, and other possible effects.

AUTISM

A developmental disorder that is characterized by impaired social interaction, problems with verbal and nonverbal communication, and unusual, repetitive, or severely limited activities and interests.

EPILEPSY

A common chronic neurological disorder that is characterized by recurrent unprovoked seizures.

A1550: Conditions Related to Intellectual Disability/Developmental Disability (ID/DD) Status (cont.)

- **Code E:** if an ID/DD condition is present but the resident does not have any of the specific conditions listed.
- **Code Z:** if ID/DD condition is not present.

DEFINITION

OTHER ORGANIC CONDITION RELATED TO ID/DD

Examples of diagnostic conditions include congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macroencephaly, meningomyelocele, congenital hydrocephalus, etc.

A1600: Entry Date (date of this admission/entry or reentry into the facility)

A1600. Entry Date (date of this admission/entry or reentry into the facility)

Month		Day		Year					

Item Rationale

- To document the date of admission/entry or reentry into the nursing home.

Coding Instructions

- Enter the most recent date of admission/entry or reentry to this nursing home. Use the format: Month-Day-Year: XX-XX-XXXX. For example, October 12, 2010, would be entered as 10-12-2010.

DEFINITION

ENTRY DATE

The initial date of admission to the nursing facility, or the date the resident most recently returned to your nursing facility after being discharged.

A1700: Type of Entry

A1700. Type of Entry

Enter Code <input type="checkbox"/>	1. Admission 2. Reentry
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Item Rationale

- Captures whether date in A1600 is an admission/entry or reentry date.

Coding Instructions

- **Code 1, admission/entry:** when one of the following occurs:

A1800: Entered From (cont.)

Coding Instructions

Enter the 2-digit code that corresponds to the location or program the resident was admitted from for this admission.

- **Code 01, community (private home/apt, board/care, assisted living, group home):** if the resident was admitted from a private home, apartment, board and care, assisted living facility or group home.
- **Code 02, another nursing home or swing bed:** if the resident was admitted from an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds.
- **Code 03, acute hospital:** if the resident was admitted from an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons.
- **Code 04, psychiatric hospital:** if the resident was admitted from an institution that is engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill residents.
- **Code 05, inpatient rehabilitation facility (IRF):** if the resident was admitted from an institution that is engaged in providing, under the supervision of physicians, services for the rehabilitation of injured, disabled or sick persons. Includes IRFs that are units within acute care hospitals.
- **Code 06, ID/DD facility:** if the resident was admitted from an institution that is engaged in providing, under the supervision of a physician, any health and rehabilitative services for individuals who have intellectual or developmental disabilities.
- **Code 07, hospice:** if the resident was admitted from a program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the State as a hospice provider and/or certified under the Medicare program as a hospice provider. Includes community-based or inpatient hospice programs.
- **Code 09, long term care hospital (LTCH):** if the resident was admitted from an institution that is certified under Medicare as a short-term, acute-care hospital which has been excluded from the Inpatient Acute Care Hospital Prospective Payment System (IPPS) under §1886(d)(1)(B)(iv) of the Social Security Act. For the purpose of Medicare payment, LTCHs are defined as having an average inpatient length of stay (as determined by the Secretary) of greater than 25 days.

DEFINITION

DEFINITIONS PRIVATE HOME OR APARTMENT

Any house, condominium, or apartment in the community whether owned by the resident or another person. Also included in this category are retirement communities and independent housing for the elderly.

BOARD AND CARE/ ASSISTED LIVING/ GROUP HOME

A non-institutional community residential setting that includes services of the following types: home health services, homemaker/personal care services, or meal services.

K0200: Height and Weight (cont.)

- If a resident cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code (-) and document rationale on the resident's medical record.

K0300: Weight Loss

K0300. Weight Loss	
Enter Code <input type="checkbox"/>	Loss of 5% or more in the last month or loss of 10% or more in last 6 months 0. No or unknown 1. Yes, on physician-prescribed weight-loss regimen 2. Yes, not on physician-prescribed weight-loss regimen

Item Rationale

Health-related Quality of Life

- Weight loss can result in debility and adversely affect health, safety, and quality of life.
- For persons with morbid obesity, controlled and careful weight loss can improve mobility and health status.
- For persons with a large volume (fluid) overload, controlled and careful diuresis can improve health status.

Planning for Care

- Weight loss may be an important indicator of a change in the resident's health status or environment.
- If significant weight loss is noted, the interdisciplinary team should review for possible causes of changed intake, changed caloric need, change in medication (e.g., diuretics), or changed fluid volume status.
- Weight loss should be monitored on a continuing basis; weight loss should be assessed and care planned at the time of detection and not delayed until the next MDS assessment.

Steps for Assessment

This item compares the resident's weight in the current observation period with his or her weight at two snapshots in time:

- At a point closest to 180-days preceding the current weight.
- At a point closest to 30-days preceding the current weight.

DEFINITIONS

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.

M0900: Healed Pressure Ulcers (cont.)

- Current clinical standards do not support reverse staging or backstaging. For example, over time, a Stage 4 pressure ulcer has been healing such that it is less deep, wide, and long. Previous standards using reverse or backstaging would have permitted identification of the pressure ulcer as a Stage 2 pressure ulcer when it reached a depth consistent with Stage 2 pressure ulcers. Current standards require that it continue to be documented as a Stage 4 pressure ulcer until it has completely healed. For care planning purposes, a healed Stage 4 pressure ulcer will remain at increased risk for future breakdown or injury and will require continued monitoring.

Steps for Assessment

Complete on all residents, including those without a current pressure ulcer.

*Look-back period for this item is the ARD of the prior assessment. **If no prior assessment (i.e., if this is the first OBRA or scheduled PPS assessment), do not complete this item. Skip to M1030.***

1. Review medical records to identify whether any pressure ulcers that were noted on the prior MDS assessment have completely closed by the ARD (A2300) of the current assessment.
2. Identify the deepest anatomical stage (see definition on page M-5) of each resurfaced (or healed) pressure ulcer.
3. Count the number of healed pressure ulcers for each stage.

Coding Instructions for M0900A

Complete on all residents (even if M0210 = 0)

- **Enter 0:** if there were no pressure ulcers on the prior assessment and skip to **Number of Venous and Arterial Ulcers** item (M1030).
- **Enter 1:** if there were pressure ulcers noted on the prior assessment.

Coding Instructions for M0900B, C, and D.

- **Enter the number** of pressure ulcers that have healed since the last assessment for each Stage 2 through 4.
- **Enter 0:** if there were no pressure ulcers at the given stage or no pressure ulcers that have healed.

Coding Tips

- Coding this item will be easier for nursing homes that systematically document and follow pressure ulcer status.
- If the prior assessment documents that a pressure ulcer healed between MDS assessments, but another pressure ulcer occurred at the same location, do not consider the first pressure ulcer to have healed, and do NOT record the pressure ulcer as healed.

M1040: Other Ulcers, Wounds and Skin Problems (cont.)

Item Rationale

Health-related Quality of Life

- 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.

Planning for Care

- This list represents only a subset of skin conditions or changes that nursing homes will assess and evaluate in residents.
- The presence of wounds and skin changes should be accounted for in the interdisciplinary care plan.
- This information identifies residents at risk for further complications or skin injury.

Steps for Assessment

1. Review the medical record, including skin care flow sheets or other skin tracking forms.
2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review.
3. Examine the resident and determine whether any ulcers, wounds, or skin problems are present.
 - Key areas for diabetic foot ulcers include the plantar (bottom) surface of the foot, especially the metatarsal heads (the ball of the foot).

Coding Instructions

Check all that apply in the last 7 days. If there is no evidence of such problems in the last 7 days, check none of the above. Pressure ulcers coded in M0200 through M0900 should NOT be coded here.

- **M1040A**, infection of the foot (e.g., cellulitis, purulent drainage)
- **M1040B**, diabetic foot ulcer(s)
- **M1040C**, other open lesion(s) on the foot (e.g., cuts, fissures)

DEFINITIONS

DIABETIC FOOT ULCERS

Ulcers caused by the neuropathic and small blood vessel complications of diabetes. Diabetic foot ulcers typically occur over the plantar (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudate, and callused wound edges. The wounds are very regular in shape and the wound edges are even with a punched-out appearance. These wounds are typically not painful.

SURGICAL WOUNDS

Any healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites.

OPEN LESION OTHER THAN ULCERS, RASHES, CUTS

Most typically skin ulcers that develop as a result of diseases and conditions such as syphilis and cancer.

BURNS (SECOND OR THIRD DEGREE)

Skin and tissue injury caused by heat or chemicals and may be in any stage of healing.

Scenarios for Pressure Ulcer Coding (cont.)

Quarterly Assessment #2:

Coding:

- **M0300A** (Number of Stage 1 pressure ulcers), Code 0.
- **M0300B1** (Number of Stage 2 pressure ulcers), Code 0 and skip to **M0300C**, Stage 3 pressure ulcers.
- **M0300C1** (Number of Stage 3 pressure ulcers). Code 1.
- **M0300C2** (Number of these Stage 3 pressure ulcers that were present upon admission//entry or reentry). Code 0.
- **M0300D1, M0300E1, M0300F1, and M0300G1** Code 0's and proceed to code **M0610** (Dimensions of unhealed Stage 3 or 4 pressure ulcers or unstageable pressure ulcer related to slough or eschar) with the dimensions of the Stage 3 ulcer.
- **M0610A** (Pressure ulcer length), Code 03.0, **M0610B** (Pressure ulcer width), Code 02.4, **M0610C** (Pressure ulcer depth) Code 00.2.
- **M0700** (Most severe tissue type for any pressure ulcer), Code 2, Granulation tissue.
- **M0800** (Worsening in pressure ulcer status since prior assessment – (OBRA or scheduled PPS or Last Admission/Entry or Reentry) – **M0800A** (Stage 2) Code 0, **M0800B** (Stage 3) Code 1, **M0800C** (Stage 4) Code 0.

Rationale:

- **M0300B1** is coded 0 due to the fact that the resident now has a Stage 3 pressure ulcer and no longer has a Stage 2 pressure ulcer. Therefore, you are required to skip to **M0300C** (Stage 3 pressure ulcer).
- **M0300C1** is coded as 1 due to the fact the resident has one Stage 3 pressure ulcer.
- **M0300C2** is coded as 0 due to the fact that the Stage 3 pressure ulcer was not present on admission, but worsened from a Stage 2 to a Stage 3 in the facility.
- **M0300D1, M0300E1, M0300F1, and M0300G1** are coded as zeros (due to the fact the resident does not have any Stage 4 or unstageable ulcers). Proceed to code **M0610** with the dimensions of the Stage 3 ulcer.
- **M0610A** is coded, 03.0 for length, **M0610B** is coded 02.4 for width, and **M0610C** is coded 00.2 for depth. Since this resident only had one Stage 3 pressure ulcer at the time of second quarterly assessment, these are the dimensions that would be coded here as the largest ulcer.
- **M0700** is coded as 2 (Granulation tissue) because this is the most severe type of tissue present.
- **M0800A** is coded as 0, **M0800B** is coded as 1, and **M0800C** is coded as 0 because the Stage 2 pressure ulcer that was present on admission has now worsened to a Stage 3 pressure ulcer since the last assessment.

Scenarios for Pressure Ulcer Coding (cont.)

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage	
Enter Number <input type="text" value="0"/>	A. Number of Stage 1 pressure ulcers Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues
Enter Number <input type="text" value="0"/>	B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister
Enter Number <input type="text"/>	1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3 2. Number of these Stage 2 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry 3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown: <div style="display: flex; align-items: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="font-size: 10px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="font-size: 10px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; font-size: 8px; margin-top: 2px;"> Month Day Year </div>
Enter Number <input type="text" value="1"/>	C. Stage 3: 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 the depth of tissue loss. May include undermining and tunneling
Enter Number <input type="text" value="0"/>	1. Number of Stage 3 pressure ulcers - If 0 → Skip to M0300D, Stage 4 2. Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
Enter Number <input type="text" value="0"/>	D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling
Enter Number <input type="text"/>	1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable: Non-removable dressing 2. Number of these Stage 4 pressure ulcers that were present upon admission/entry or reentry - enter how many were noted at the time of admission/entry or reentry
M0300 continued on next page	

N0300: Injections (cont.)

Coding Tips and Special Populations

- For subcutaneous pumps, code only the number of days that the resident actually required a subcutaneous injection to restart the pump.
- If an antigen or vaccination is provided on one day, and another vaccine is provided on the next day, the number of days the resident received injections would be **coded as 2 days**.
- If two injections were administered on the same day, the number of days the resident received injections would be **coded as 1 day**.

Examples

1. During the 7-day look-back period, Mr. T. received an influenza shot on Monday, a PPD test (for tuberculosis) on Tuesday, and a Vitamin B₁₂ injection on Wednesday.

Coding: N0300 would be coded 3.

Rationale: The resident received injections on 3 separate days during the 7-day look-back period.

2. During the 7-day look-back period, Miss C. received both an influenza shot and her vitamin B₁₂ injection on Thursday.

Coding: N0300 would be coded 1.

Rationale: The resident received injections on one day during the 7-day look-back period.

N0350: Insulin

N0350. Insulin	
Enter Days <input type="checkbox"/>	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
Enter Days <input type="checkbox"/>	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

Item Rationale

Health-related Quality of Life

- Insulin is a medication used to treat diabetes mellitus (DM).
- Individualized meal plans should be created with the resident's input to ensure appropriate meal intake. Residents are more likely to be compliant with their DM diet if they have input related to food choices.

N0410: Medications Received (cont.)

Planning for Care

- The indications for initiating, withdrawing, or withholding medication(s), as well as the use of non-pharmacological interventions, are determined by assessing the resident's underlying condition, current signs and symptoms, and preferences and goals for treatment. This includes, where possible, the identification of the underlying cause(s), since a diagnosis alone may not warrant treatment with medication.
- Target symptoms and goals for use of these medications should be established for each resident. Progress toward meeting the goals should be evaluated routinely.
- Possible adverse effects of these medications should be well understood by nursing staff. Educate nursing home staff to be observant for these adverse effects.
- Implement systematic monitoring of each resident taking any of these medications to identify adverse consequences early.

Steps for Assessment

1. Review the resident's medical record for documentation that any of these medications were received by the resident during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
2. Review documentation from other health care settings where the resident may have received any of these medications while a resident of the nursing home (e.g., valium given in the emergency room).

Coding Instructions

- N0410A, Antipsychotic: Record the number of days an antipsychotic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days)
- N0410B, Antianxiety: Record the number of days an anxiolytic medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).
- N0410C, Antidepressant: Record the number of days an antidepressant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days).

DEFINITIONS

DOSE

The total amount/strength/concentration of a medication given at one time or over a period of time. The individual dose is the amount/strength/concentration received at each administration. The amount received over a 24-hour period may be referred to as the "daily dose."

MONITORING

The ongoing collection and analysis of information (such as observations and diagnostic test results) and comparison to baseline and current data in order to ascertain the individual's response to treatment and care, including progress or lack of progress toward a goal. Monitoring can detect any improvements, complications or adverse consequences of the condition or of the treatments; and support decisions about adding, modifying, continuing, or discontinuing, any interventions.

N0410: Medications Received (cont.)

- Many psychoactive medications increase confusion, sedation, and falls. For those residents who are already at risk for these conditions, nursing home staff should develop plans of care that address these risks.
- Adverse drug reaction (ADR) is a form of adverse consequence. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication or any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnosis, or treatment. The term “side effect” is often used interchangeably with ADR; however, side effects are but one of five ADR categories, the others being hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions. A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence.
- Doses of psychoactive medications differ in acute and long-term treatment. Doses should always be the lowest possible to achieve the desired therapeutic effects and be deemed necessary to maintain or improve the resident’s function, well-being, safety, and quality of life. Duration of treatment should also be in accordance with pertinent literature, including clinical practice guidelines.
- Since medication issues continue to evolve and new medications are being approved regularly, it is important to refer to a current authoritative source for detailed medication information, such as indications and precautions, dosage, monitoring, or adverse consequences.
- During the first year in which a resident on a psychoactive medication is admitted, or after the nursing home has initiated such medication, nursing home staff should attempt to taper the medication or perform gradual dose reduction (GDR) as long as it is not medically contraindicated. Information on GDR and tapering of medications can be found in the **State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities** (the **State Operations Manual** can be found at <http://www.cms.gov/Manuals/IOM/list.asp>).
- Prior to discontinuing a psychoactive medication, residents may need a GDR or tapering to avoid withdrawal syndrome (e.g., for medications such as selective serotonin reuptake inhibitors [SSRIs], tricyclic antidepressants [TCAs], etc.).

DEFINITIONS

GRADUAL DOSE REDUCTION (GDR)

Step-wise tapering of a dose to determine whether or not symptoms, conditions, or risks can be managed by a lower dose or whether or not the dose or medication can be discontinued.

MEDICATION INTERACTION

The impact of medication or other substance (such as nutritional supplements including herbal products, food, or substances used in diagnostic studies) upon another medication. The interactions may alter absorption, distribution, metabolism, or elimination. These interactions may decrease the effectiveness of the medication or increase the potential for adverse consequences.

N0410: Medications Received (cont.)

Additional information on psychoactive medications can be found in the **Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)** (or subsequent editions) (<http://www.psychiatryonline.com/resourceTOC.aspx?resourceID=1>), and the **State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities** [the **State Operations Manual** can be found at (<http://www.cms.gov/Manuals/IOM/list.asp>)].

Additional information on medications can be found in:

The Orange Book, <http://www.fda.gov/cder/ob/default.htm>

The National Drug Code Directory, <http://www.fda.gov/cder/ndc/database/Default.htm>

O0400: Therapies (cont.)

Dates of Therapy

A resident may have more than one regimen of therapy treatment during an episode of a stay. When this situation occurs the Therapy Start Date for the most recent episode of treatment for the particular therapy (SLP, PT, or OT) should be coded. When a resident's episode of treatment for a given type of therapy extends beyond the ARD (i.e., therapy is ongoing), enter dashes in the appropriate Therapy End Date. When a resident's Medicare Part A stay is eight days or less, therapy is considered to be ongoing if:

- The resident was discharged and therapy was planned to continue had the resident remained in the facility, or
- The resident's SNF benefit exhausted and therapy continued to be provided, or
- The resident's payer source changed and therapy continued to be provided.

For example, Mr. N. was admitted to the nursing home following a fall that resulted in a hip fracture in November 2011. Occupational and Physical therapy started December 3, 2011. His physical therapy ended January 27, 2012 and occupational therapy ended January 29, 2012. Later on during his stay at the nursing home, due to the progressive nature of his Parkinson's disease, he was referred to SLP and OT February 10, 2012 (he remained in the facility the entire time). The speech-language pathologist evaluated him on that day and the occupational therapist evaluated him the next day. The ARD for Mr. N.'s MDS assessment is February 28, 2012.

Coding values for his MDS are:

- Item O0400A5 (SLP start date) is 02102012,
- O0400A6 (SLP end date) is dash filled,
- O0400B5 (OT start date) is 02112012,
- O0400B6 (OT end date) is dash filled,
- O0400C5 (PT start date) is 12032011, and
- O0400C6 (PT end date) is 01272012.

NOTE: When an EOT-R is completed, the Therapy Start Date (O0400A5, O0400B5, and O0400C5) on the next PPS assessment is the same as the Therapy Start Date on the EOT-R. If therapy is ongoing, the Therapy End Date (O0400A6, O0400B6, and O0400C6) would be filled out with dashes.

General Coding Example:

Following a stroke, Mrs. F. was admitted to the skilled nursing facility in stable condition for rehabilitation therapy on 10/06/11 under Part A skilled nursing facility coverage. She had slurred speech, difficulty swallowing, severe weakness in both her right upper and lower extremities, and a Stage III pressure ulcer on her left lateral malleolus. She was referred to SLP, OT, and PT with the long-term goal of returning home with her daughter and son-in-law. Her initial SLP evaluation was performed on 10/06/11, the PT initial evaluation on 10/07/11, and the OT initial evaluation on 10/09/11. She was also referred to recreational therapy and respiratory therapy. The interdisciplinary team determined that 10/19/11 was an appropriate ARD for her Medicare-required 14-day MDS. During the look-back period she received the following:

If criteria for Significant Change in Status Assessment were not met, then a Significant Correction to Prior Assessment is required.

When errors in an OBRA comprehensive or quarterly assessment in the QIES ASAP system have been corrected in a more current OBRA comprehensive or quarterly assessment (Item A0310A = 01 through 06), the nursing home is not required to perform a new additional assessment (Significant Change in Status or Significant Correction to Prior assessment). In this situation, the nursing home has already updated the resident's status and care plan. However, the nursing home must use the Modification process to assure that the erroneous assessment residing in the QIES ASAP system is corrected.

Inactivation Requests

An Inactivation should be used when a record has been accepted into the QIES ASAP system but the corresponding event did not occur. For example, a Discharge assessment was submitted for a resident but there was no actual discharge. An Inactivation (Item A0050 = 3) **must** be completed when any of the following items are inaccurate: Type of Provider (Item A0200), Type of Assessment (A0310), Entry Date (Item A1600) on an Entry tracking record, Discharge Date (Item A2000) on a Discharge/Death in Facility record, or Assessment Reference Date (A2300) on an OBRA or PPS assessment.

When inactivating a record, the provider is required to submit an electronic Inactivation Request record. This record is an MDS record but only the Section X items and A0050 are completed. This is sufficient information to locate the record in the QIES ASAP system, inactivate the record and document the reason for inactivation.

For instances when the provider determines that an event date (ARD, entry date, and discharge date) or type of assessment item (A0310) is incorrect, the provider must inactivate the record in the QIES ASAP system, then complete and submit a new MDS 3.0 record with the correct event date or type of assessment, ensuring that the clinical information is accurate.

If the ARD or Type of Assessment is entered incorrectly, and the provider does not correct it within the encoding period, the provider must complete and submit a new MDS 3.0 record.

Inactivations should be rare and are appropriate only under the narrow set of circumstances that indicate a record is invalid.

In such instances a new ARD date must be established based on MDS requirements, which is the date the error is determined or later, but not earlier. The new MDS 3.0 record being submitted to replace the inactivated record must include new signatures and dates for all items based on the look-back period established by the new ARD and according to established MDS assessment completion requirements.

5.8 Special Manual Record Correction Request

A few types of errors in a record in the QIES ASAP system cannot be corrected with an automated Modification or Inactivation request. These errors are:

1. The record is a test record inadvertently submitted as production.
2. The record has the wrong submission requirement in item A0410.
3. The record has the wrong facility ID in the control item FAC_ID.

In all of these cases, the facility must contact the State Agency to have the problems fixed. The State Agency will send the facility the MDS 3.0 Manual Assessment Correction/Deletion Request form. The facility is responsible for completing the form. The facility **must** submit the completed form to the State Agency via certified mail through the United States Postal Service (USPS). The State Agency **must** approve the provider's request and submit a signed form to the QIES Help Desk via certified mail through the USPS.

When a test record is in the QIES ASAP system, the problem must be manually evaluated in the QIES ASAP system and the QIES ASAP system appropriately corrected. A normal Inactivation request will not totally fix the problem, since it will leave the test record in a history file and may also leave information about a fictitious resident. Manual correction is necessary to completely remove the test record and associated information.

A QIES ASAP system record with an incorrect submission requirement in item A0410 is a very serious problem. Submission of MDS assessment records to the QIES ASAP system constitutes a release of private information and must conform to privacy laws. Item A0410 is intended to allow appropriate privacy safeguards, controlling who can access the record and whether the record can even be accepted into the QIES ASAP system. A normal Modification or Inactivation request cannot be used to correct the A0410 value, since a copy of the record in error will remain in the QIES ASAP system history file with the wrong access control. Consider a record in the QIES ASAP system with an A0410 value of 3 (federal submission requirement) but there was actually no state or federal requirement for the record (A0410 should have been 1). The record should not be in the QIES ASAP system at all and manual correction is necessary to completely remove the record from the QIES ASAP system. Consider a record with an A0410 value of 3 (federal submission requirement) but the record is only required by the state (A0410 should have been 2). In this case there is both federal and state access to the record, but access should be limited to the state. Manual correction is necessary to correct A0410 and reset access control, without leaving a copy of the record with the wrong access in the QIES ASAP system history file.

If a QIES ASAP system record has the wrong main facility ID (control item FAC_ID), then the record must be removed without leaving any trace in the QIES ASAP system. The record also should be resubmitted with the correct FAC_ID value when indicated.

CATEGORY IV: SPECIAL CARE HIGH

RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

STEP # 1

Determine whether the resident is coded for **one** of the following conditions or services:

B0100, ADLs	Comatose and completely ADL dependent or ADL did not occur (G0110A1, G0110B1, G0110H1, and G0110I1 all equal 4 or 8)
I2100	Septicemia
I2900, N0350A,B	Diabetes with both of the following: Insulin injections (N0350A) for all 7 days Insulin order changes on 2 or more days (N0350B)
I5100, ADL Score	Quadriplegia with ADL score ≥ 5
I6200, J1100C	Chronic obstructive pulmonary disease and shortness of breath when lying flat
J1550A, others	Fever and one of the following; I2000 Pneumonia J1550B Vomiting K0300 Weight loss (1 or 2) K0510B1 or K0510B2 Feeding tube*
K0510A1 or K0510A2	Parenteral/IV feedings
O0400D2	Respiratory therapy for all 7 days

*Tube feeding classification requirements:

- (1) K0700A is 51% or more of total calories OR
- (2) K0700A is 26% to 50% of total calories and K0700B is 501 cc or more per day fluid enteral intake in the last 7 days.

If the resident does not have one of these conditions, skip to Category V now.

STEP # 2

If at least **one** of the special care conditions above is coded and the resident has a total RUG-IV ADL score of 2 or more, he or she classifies as Special Care High. **Move to Step #3. If the resident's ADL score is 0 or 1, he or she classifies as Clinically Complex. Skip to Category VI, Step #2.**

CATEGORY V: SPECIAL CARE LOW RUG-IV, 66-GROUP HIERARCHICAL CLASSIFICATION

The classification groups in this category are based on certain resident conditions or services. Use the following instructions:

STEP # 1

Determine whether the resident is coded for **one** of the following conditions or services:

I4400, ADL Score	Cerebral palsy, with ADL score ≥ 5
I5200, ADL Score	Multiple sclerosis, with ADL score ≥ 5
I5300, ADL Score	Parkinson's disease, with ADL score ≥ 5
I6300, O0100C2	Respiratory failure and oxygen therapy while a resident
K0510B1 or K0510B2	Feeding tube*
M0300B1	Two or more stage 2 pressure ulcers with two or more selected skin treatments**
M0300C1,D1,F1	Any stage 3 or 4 pressure ulcer with two or more selected skin treatments**
M1030	Two or more venous/arterial ulcers with two or more selected skin treatments**
M0300B1, M1030	1 stage 2 pressure ulcer and 1 venous/arterial ulcer with 2 or more selected skin treatments**
M1040A,B,C; M1200I	Foot infection, diabetic foot ulcer or other open lesion of foot with application of dressings to the feet
O0100B2	Radiation treatment while a resident
O0100J2	Dialysis treatment while a resident

*Tube feeding classification requirements:

- (1) K0700A is 51% or more of total calories OR
- (2) K0700A is 26% to 50% of total calories and K0700B is 501 cc or more per day fluid enteral intake in the last 7 days.

**Selected skin treatments:

- M1200A,B# Pressure relieving chair and/or bed
- M1200C Turning/repositioning
- M1200D Nutrition or hydration intervention
- M1200E Ulcer care
- M1200G Application of dressings (not to feet)
- M1200H Application of ointments (not to feet)

#Count as one treatment even if both provided

If the resident does not have one of these conditions, skip to Category VI now.

<input checked="" type="checkbox"/>	Diseases and conditions that may impede ability to interact with others	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input type="checkbox"/>	<ul style="list-style-type: none"> Delirium (C1300, C1600 = 1, Delirium CAA) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Intellectual disability /developmental disability (A1550) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Alzheimer's disease (I4200) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Aphasia (I4300) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Other dementia (I4800) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Depression (I5800) 	

<input checked="" type="checkbox"/>	Health status factors that may inhibit social involvement	
<input type="checkbox"/>	<ul style="list-style-type: none"> Decline in activities of daily living (G0110) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Health problem, such as falls (J1700, J1800), pain (J0300, J0800), fatigue, etc. 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Mood (D0200A1, D0300, D0500A1, D0600) or behavior (E0200) problem that impacts interpersonal relationships or that arises because of social isolation (See Mood State and Behavioral Symptoms CAAs) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Change in communication (B0700, B0800), vision (B1000), hearing (B0200), cognition (C0100, C0600) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Medications with side effects that interfere with social interactions, such as incontinence, diarrhea, delirium, or sleepiness 	

<input checked="" type="checkbox"/>	Environmental factors that may inhibit social involvement	
<input type="checkbox"/>	<ul style="list-style-type: none"> Use of physical restraints (P0100) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Change in residence leading to loss of autonomy and reduced self-esteem (A1700) 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Change in room assignment or dining location or table mates 	
<input type="checkbox"/>	<ul style="list-style-type: none"> Living situation limits informal social interaction, such as isolation precautions (O0100M) 	

✓	Functional problems that affect ability to eat	Supporting Documentation (Basis/reason for checking the item, including the location, date, and source (if applicable) of that information)
<input type="checkbox"/>	• Swallowing problem (K0100)	
<input type="checkbox"/>	• Arthritis (I3700)	
<input type="checkbox"/>	• Contractures (G0400)	
<input type="checkbox"/>	• Functional limitation in range of motion (G0400)	
<input type="checkbox"/>	• Partial or total loss of arm movement (G0400A)	
<input type="checkbox"/>	• Hemiplegia/hemiparesis (I4900)(G0400 A and B = 1)	
<input type="checkbox"/>	• Quadriplegia/paraplegia (I5100/I5000) (G0400 A and/or B =2)	
<input type="checkbox"/>	• Inability to perform ADLs without significant physical assistance (G0110)	
<input type="checkbox"/>	• Inability to sit up (G0300)	
<input type="checkbox"/>	• Missing limb(s) (G0600D)	
<input type="checkbox"/>	• Vision problems (B1000)	
<input type="checkbox"/>	• Decreased ability to smell or taste food	
<input type="checkbox"/>	• Need for special diet or altered consistency which might not appeal to resident	
<input type="checkbox"/>	• Recent decline in Activities of Daily Living (ADLs) (G0110-G0600)	

✓	Cognitive, mental status, and behavior problems that can interfere with eating	
<input type="checkbox"/>	• Review Cognitive Loss CAA	
<input type="checkbox"/>	• Alzheimer's Disease (I4200)	
<input type="checkbox"/>	• Other dementia (I4800)	
<input type="checkbox"/>	• Intellectual disability /developmental disability (A1550)	
<input type="checkbox"/>	• Paranoid fear that food is poisoned	
<input type="checkbox"/>	• Requires frequent/constant cueing	
<input type="checkbox"/>	• Disruptive behaviors (E0200)	
<input type="checkbox"/>	• Indicators of psychosis (E0100)	
<input type="checkbox"/>	• Wandering (E0900)	
<input type="checkbox"/>	• Pacing (E0200)	
<input type="checkbox"/>	• Throwing food (E0200C)	
<input type="checkbox"/>	• Resisting care (E0800)	
<input type="checkbox"/>	• Very slow eating	
<input type="checkbox"/>	• Short attention span	
<input type="checkbox"/>	• Poor memory (C0500, C0700-C0900)	
<input type="checkbox"/>	• Anxiety problems (I5700)	

Scoring Rules: Staff Assessment of Resident Mood Total Severity Score: D0600 (cont.)

In this example, one of the items in Column 2 (D0500E2) has a missing value (it is equal to dash) and the other 9 items have non-missing values. D0600 is computed as follows: =

1. Compute the sum of the 9 items with non-missing values. This sum is 12. =
2. Multiply this sum by 1.111 (See bullet 5 on page E-5 for calculation of = multiplier). In the example, the sum of non-missing values is 12. Therefore, the = calculation is: $12 \times 1.111 = 13.332$. =
3. Round the result to the nearest integer. In the example, 13.332 rounds to 13. =
4. Place the rounded result in D0600. =

Example 3: Two Missing Values in Column 2

The following example shows how to score the resident interview when two of the items = in Column 2 have missing values: =

Item	Value
D0500A2 =	0 =
D0500B2 =	1 =
D0500C2 =	2 =
D0500D2 =	2 =
D0500E2 =	- =
D0500F2 =	0 =
D0500G2 =	1 =
D0500H2 =	- =
D0500I2 =	2 =
D0500J2 =	1 =
D0600	11

In this example, two of the items in Column 2 have missing values: D0500E2 and = D0500H2 are equal to dash. The other 8 items have non-missing values. D0600 is = computed as follows: =

1. Compute the sum of the 8 items with non-missing values. This sum is 9. =
2. Multiply this sum by 1.250 (See bullet 6 on page E-5 for calculation of = multiplier). In the example, the sum of non-missing values is 9. Therefore, the = calculation is: $9 \times 1.250 = 11.250$. =
3. Round the result to the nearest integer. In the example, 11.250 rounds to 11. =
4. Place the rounded result in D0600. =

=