Office of Medicaid Policy and Planning

SUPPORTIVE DOCUMENTATION REQUIREMENTS USER GUIDE

RUG-IV MDS Items 48-Grouper

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- **Revised for MDS Assessments with an ARD on or After April 1, 2019**
- **EOT Episode(s) Beginning January 1, 2019**

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Introduction

Accuracy of the MDS item responses is very important for many reasons: responses guide the care provided to the resident; Quality Measures assist state survey in identifying potential care problems in a nursing facility; and the Medicare Prospective Payment System rates are set based on MDS responses. Beginning with rates effective July 1, 2016, the Office of Medicaid Policy and Planning reimbursement rate calculations for nursing facilities classified MDS assessments into one of 48 Resource Utilization Groups version IV (RUG-IV) and adjusted facility rates based on an average Case Mix Index (CMI) for each facility. See the Indiana Roster Report User Guide for a more complete description of the Medicaid reimbursement system and CMI and the RUG-IV Calculation Guide for RUG classification details.

These Supportive Documentation Requirements apply to all Indiana Medicaid-certified nursing facilities that are scheduled for case mix reviews on or after July 1, 2019.

SOURCE OF DOCUMENTATION REQUIREMENTS

Good documentation is expected of all trained and licensed health care professionals. The submitted MDS data for each resident should accurately reflect the resident's condition as documented in the resident's clinical records maintained by the nursing facility. The information in these Requirements has been compiled in conjunction with the Long-Term Care Facility Resident Assessment Instrument User's Manual (RAI Manual), instructions that are printed on the MDS 3.0 form itself, and the Data Submission Specifications for MDS 3.0. Nursing facility personnel should review these resources thoroughly to accurately understand MDS coding and meet all federal requirements. If later guidance is released by the Center for Medicare and Medicaid Services (CMS) that contradicts or augments guidance provided in this document, the more current information from the CMS becomes the minimum acceptable standard.

MDS ITEMS FOR REVIEW

While good documentation and accurate coding of the MDS is essential for all MDS item responses, the RUG-IV classification system uses only a subset of the MDS assessment items; those that may have an impact on your facility's rate. As such, these requirements identify only those MDS items used in the RUG-IV system.

OVERALL DOCUMENTATION INSTRUCTIONS

According to the RAI manual in Chapter 1, *"While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident."* In addition, OMPP requires documentation to substantiate MDS items associated with the RUG classifications applicable to reimbursement as defined in this user guide.

All conditions or treatments must have been present or occurred within the designated observation or look-back period, which includes the full 24 hours of the Assessment Reference Date (ARD) located at MDS Section A2300. The ARD is defined in Section A of the RAI Manual as the specific end point for look-back periods in the MDS assessment process. Almost all MDS items refer to the resident's status over a designated time period referring back in time from the ARD. Unless otherwise noted on the MDS form, this look-back period, also called the observation period or assessment period, is a 7-day look-back period ending on the ARD. Thus, look-back periods covering 7 days end on this date, 14 days end on this date, etc. Some assessments may have an observation period less than 7 days (such as a Medicare 5-day assessment) however; the ARD is always the end point for the observation period.

Documentation in the clinical record should consistently support the MDS item response and reflect care related to the symptom/problem. Documentation must apply to the appropriate look-back period and reflect the resident's status on all shifts. Conflicting documentation identified within the observation period shall be deemed as unsupported documentation.

Documentation from all disciplines and all portions of the resident's clinical record within the look-back period may be used to verify an MDS item response. Supportive documentation entries must be dated and their authors identified by signature or initials. Signatures are required to authenticate all clinical records. At a minimum, the signature must include the first initial, last name, and title/credential. Any time a facility chooses to use initials in any part of the record for authentication of an entry, there must also be corresponding full identification of the initials on the same form or on a signature legend. Initials may never be used where a signature is required by law (i.e., on the MDS). When electronic signatures are used, there must be a written policy in place to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs and must include safeguards to prevent unauthorized use of electronic signatures.

In cases of corrections, obliterations, errors or mistaken entries, staff must, at a minimum draw a line through the incorrect information and include the staff's initials, the date the correction was made and the correct information. See the *Medical Record Correction for the MDS Case Mix Review* policy effective July 1, 2015.

Care Plans and the Case Mix Review Requirements

The care plan is an interdisciplinary communication tool that must include measureable objectives and time frames and must describe the services that are to be provided to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be person-centered and reflect the resident's needs, strengths, goals, life history and preferences consistent with the resident's rights, and must be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessment, and the services provided or arranged must be consistent with the resident's written plan of care.

Effective November 28, 2017 and after, the facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care that meet professional standards of care. The baseline care plan must: 1) be developed within 48 hours of admission; 2) include the minimum healthcare information necessary to properly care for a resident including, but not limited to: a) initial goals based on admission; b) physician orders; c) dietary orders; d) therapy services; e) social services; and f) PASRR recommendations, if applicable.

A person-centered comprehensive care plan must be developed and implemented for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychological needs identified in the assessment.

The expectation of the OMPP is that nursing facilities maintain and have readily available supporting original legal medical documentation. All MDS RUG items require supporting documentation as outlined in the Supportive Documentation Requirements User Guide.

Additionally, Z0400 requires the **signature, title, sections and dated sections** completed by all persons completing any part of the MDS. Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response.

Z0400 certification reads as follows:
"I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment for such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf."

Z0500 certifies that the RN Assessment Coordinator signature and date verifies the assessment is complete. Use the actual date that the MDS was completed, reviewed, and signed as complete. This date will generally be later than the date at Z0400, which documents when portions of the assessment information were completed by assessment team members.

MDS assessment date requirements may be found in the RAI Manual, Chapter 2.

Supportive Documentation Requirements

REQUIREMENTS TABLE EXPLANATION

The Supportive Documentation Requirements table contains a header per section as well as three columns described below. Each section header also identifies that section's look-back period (7-day look-back, 14-day look-back, etc.).

MDS 3.0 Item Location and Item Description

This column identifies the MDS 3.0 item location by section letter, item number and the description of the MDS item. A notation of CPS (Cognitive Performance Scale) in this column indicates the MDS item affects the results of the cognitive determination used in some of the RUG classifications. A notation of BIMS indicates the MDS item is associated with the Brief Interview for Mental Status severity score. A notation of Restorative Nursing in this column indicates the MDS item is used in the count of Restorative Nursing programs in the RUG-IV system.

RUG-IV Categories Impacted

This column identifies any RUG-IV group(s) impacted by the MDS item. Additionally, there may be informational data in a particular area denoted by *Informational Only.*

Minimum Documentation and Review Standards Required Within the Specified Observation Period

This column provides an overview of the requirements for minimum documentation required to support the MDS responses. The column may also contain additional information that may aid the user in correctly providing supporting documentation for the MDS item.

All federal and state requirements must be met. Should state requirements be more stringent, they will supersede the federal requirements for the minimum documentation standards. It is the responsibility of the provider to be in compliance with both the federal and state requirements.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section B: Hearing, Speech, and Vision *(7-day look back)*		
B0100 Comatose (CPS)	*~Special Care High* *~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Active diagnosis of coma or persistent vegetative state documented by physician, physician assistant, nurse practitioner, or clinical nurse specialist. • ADLs must be consistent with diagnosis. • The focus of the person-centered care plan should be eliminating or minimizing complications and providing care consistent with resident health care goals. ***Does NOT include:*** • Resident in advanced stages of progressive neurologic disorders (i.e. Alzheimer's).
B0700 Makes Self Understood (CPS)	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) of the resident's verbal and/or non-verbal ability and degree of impairment to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language whether in speech, writing, sign language, or a combination. • The focus of the person-centered care plan should be to identify the best methods to facilitate communication for the resident and should identify the underlying cause or causes. ***Does include:*** • Reduced voice volume. • Difficulty in producing sounds. • Difficulty in finding the right word, making sentences, writing, and/or gesturing.
Section C: Cognitive Patterns *(7-day look back)*		
C0200 Repetition of Three Words (BIMS) **C0300 A,B,C** Temporal Orientation (BIMS) **C0400 A,B,C** Recall (BIMS)	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Validation of completion of interview items C0200, C0300A, B, C, C0400A, B, and C at Z0400 dated on or before the ARD and within the observation period. • The focus of the person-centered care plan should be to enhance future communication and assistance, direct nursing interventions to facilitate greater independence, monitor for abrupt changes in cognitive status, maintain a safe environment and provide safe discharge planning.
C0700 Short-Term Memory (CPS)	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) documenting an event or direction referencing a 5 minute time frame after it occurred validated by documenting the resident's response. • The focus of the person-centered care plan should be to assess for underlying related medical problems, evaluation of other problems with thinking, assess for additional nursing supports, prompting during daily activities, and additional support during recreational activities. ***Does include:*** • Example(s) documenting the lack of follow through on a direction given 5 minutes earlier.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section C: Cognitive Patterns (7-day look back)		
C1000 Cognitive Skills for Daily Decision Making (CPS)	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) of the resident's actual performance documenting the degree of compromised daily decision-making about everyday decisions for tasks or daily activities. • The focus of the person-centered care plan should be to assess for a more structured plan for daily activities and support in decisions about daily activities, encouragement to participate in structured activities, or assess for underlying delirium and medical evaluation. ***Does include:*** • Choosing clothing. • Knowing when to go to meals. • Using environmental cues to organize and plan (e.g. clocks, calendars). • Seeking information from others to plan the day. • Acknowledging need to use appropriate assistive equipment (i.e. walker). ***Does NOT include:*** • Resident's decision to exercise his/her right to decline treatment or recommendations by staff.
Section D: Mood (14-day look back)		
D0200A-I, Column 2 Resident Mood Interview (Symptom Frequency)	*~Special Care High* *~Special Care Low* *~Clinically Complex*	***Does require:*** • Validation of completion of interview items D0200A - I at Z0400 dated on or before the ARD and within the observation period. • Interventions addressing applicable moods must be documented. • The focus of the person-centered care plan should be identifying interventions (treatment, personal support, or environmental modifications) that could address symptoms.
D0500A-J, Column 2 Staff Assessment of Resident Mood (Symptom Frequency)	*~Special Care High* *~Special Care Low* *~Clinically Complex*	***Does require:*** • Example(s) that demonstrates the resident's mood specific to each applicable D0500A-J mood including interventions. • Daily documentation of frequency for each applicable mood occurrence. • The focus of the person-centered care plan should be to identify the underlying cause or causes and contributing factors and include interventions to address symptoms.
Section E: Behavior *(7-day look back)*		
E0100A Hallucinations	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) of the resident's perception of the presence of something that is not actually there. • When the cause is not reversible, the person-centered care plan should focus on management strategies to minimize the amount of disability and distress. ***Does include:*** • Auditory, visual, tactile, olfactory or gustatory false sensory perceptions that occur in the absence of any real stimuli.
E0100B Delusions	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) of a fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary. • When the cause is not reversible, the person-centered care plan should focus on management strategies to minimize the amount of disability and distress. ***Does NOT include:*** • A resident's expression of a false belief when the resident easily accepts a reasonable alternative explanation. • A belief that cannot be shown to be false or is impossible to determine if it is false.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section E: Behavior *(7-day look back)*		
E0200A (code 2 or 3) Physical Behavioral Symptoms *directed toward others*	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) of resident's physical behavioral symptoms directed toward others. • Daily documentation reflecting the frequency of 4 days to daily occurrence(s) for each applicable physical behavioral symptom directed towards others. • The focus of the person-centered care plan should address the treatment planning and interventions to reduce the frequency of truly problematic behaviors, evaluate impact of current plan, and compare subsequent assessments for determining response to interventions. ***Does include:*** • Hitting, kicking, pushing, scratching, grabbing, and abusing others sexually. ***Does NOT include:*** • An interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated.
E0200B (code 2 or 3) Verbal Behavioral Symptoms *directed toward others*	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) of resident's verbal behavioral symptoms directed toward others. • Daily documentation reflecting the frequency of 4 days to daily occurrence(s) for each applicable verbal behavioral symptom directed towards others. • The focus of the person-centered care plan should address the treatment planning and interventions to reduce the frequency of truly problematic behaviors, evaluate impact of current plan, and compare subsequent assessments for determining response to interventions. ***Does include:*** • Threatening others, screaming at others, cursing at others. ***Does NOT include:*** • An interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated.
E0200C (code 2 or 3) Other Behavioral Symptoms *not directed toward others*	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) of resident's other behavioral symptoms NOT directed toward others. • Daily documentation reflecting the frequency of 4 days to daily occurrence(s) for each applicable behavioral symptom not directed towards others. • The focus of the person-centered care plan should address the treatment planning and interventions to reduce the frequency of truly problematic behaviors, evaluate impact of current plan, and compare subsequent assessments for determining response to interventions. ***Does include:*** • Hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds. ***Does NOT include:*** • An interpretation of the behavior's meaning, cause or the assessor's judgment that the behavior can be explained or should be tolerated.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section E: Behavior *(7-day look back)*		
E0800 (code 2 or 3) Rejection of Care	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) of resident's rejection of care (e.g., blood work, taking medications, ADL assistance) that is necessary to achieve the resident's values, preferences or goals. • Daily documentation reflecting the frequency of 4 days to daily occurrence(s) for each applicable rejection of care occurrence. • The focus of the person-centered care plan should identify the resident's preferences and goals including approaches to achieve those goals and incorporate alternative interventions to accommodate the resident's preferences. ***Does include:*** • Behaviors that interrupt or interfere with the delivery or receipt of care including; verbally declining or statements of refusal or through physical behaviors that convey aversion to or result in avoidance of or interfere with the resident care. • Hindering the delivery of care by disrupting the usual routine or process by which care is given. • Exceeding the level of resources that is usually present for the provision of care. ***Does NOT include:*** • Behaviors that have already been addressed and determined to be consistent with resident's values, preferences or goals.
E0900 (code 2 or 3) Wandering	*~Behavioral Symptoms and Cognitive Performance*	***Does require:*** • Example(s) of resident's moving from place to place with or without a specified course or known direction. • Daily documentation reflecting the frequency of 4 days to daily occurrence(s) for each wandering occurrence. • The focus of the person-centered care plan should consider the impact of wandering on resident safety and disruption to others, focus on minimizing these issues, and determine the need for environmental modifications (door alarms, door barriers, etc.) that enhance resident safety if wandering places the resident at risk. ***Does NOT include:*** • Pacing within a constrained space. • Traveling via a planned course to another specific place (dining room or activity).

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section G: Functional Status *(7-day look back)*		
G0110A, Column 1&2 Bed Mobility **G0110B**, Column 1&2 Transfer **G0110I**, Column 1&2 Toilet Use **G0110H**, Column 1&2 Eating	*~Extensive Services* *~Rehabilitation* *~Special Care High* *~Special Care Low* *~Clinically Complex* *~Behavioral Symptoms and Cognitive Performance* *~Reduced Physical Function*	***Does require:*** • Documentation must reflect all episodes over each 24-hour period during the observation period while a resident. • Initials and dates to authenticate the ADL self-performance and support-provided including signatures and titles to authenticate initials per episode. • The ADL key for self-performance and support provided must include all the MDS key options and be equivalent to the intent and definition of the MDS key (key of "7" self-performance is optional). • The ADL key for self-performance and support provided must be understood by and readily available to staff. • ADL self-performance and support provided key definitions must be included in the electronic or hard copy ADL collection tool. • ADL descriptions must include all tasks and components related to the specific ADL activity. • If using narrative notes to support ADLs, each occurrence must include the specific ADL(s) and degree of self-performance and support provided. Wording must be equivalent to MDS key definitions for example "extensive-**weight-bearing** assist of one for transfers". • Facility to designate one ADL documentation tool to be used for the entire review when more than one tool is utilized. • ADL documentation must be maintained as part of the permanent original legal medical record and be readily accessible during the on-site review. • The focus of the person-centered care plan specific to the four late-loss ADLs should address strengths and weaknesses, possible reversible causes, and adverse side effects of medications or other treatments. Additionally, care plans should be based on an accurate assessment of the resident's self-performance and the amount and type of support being provided to the resident and include interventions focusing on maintaining and expanding self-involvement in ADLs. ***Does NOT include:*** • Individuals hired, compensated or not, by individuals outside the facility's management and administration. • Services provided other than by staff in the facility; such as family, hospice staff, nursing/CNA students and other visitors. • ADL self-performance and support provided key definitions posted outside the ADL collection tool (i.e. taped to computer or kiosk).

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section H: Bladder and Bowel *(7-day look back)*		
H0200C Current Urinary Toileting Program or Trial (Restorative Nursing)	*~Rehabilitation* *~Behavioral Symptoms and Cognitive Performance* *~Reduced Physical Function*	***Does require:*** • Documentation of a toileting program trial that includes an individualized, resident-centered toileting program of at least 3 days of toileting patterns with prompting to toilet and a documented response to the trial toileting program. • Following program trial and response, documentation of a current toileting program being used to manage urinary continence must include: 1) implementation of an individualized toileting program that was based on an assessment of the resident's unique voiding pattern; 2) documentation that the program was communicated to staff and resident (as appropriate) verbally and through a care plan, flow records, and a written report; and 3) documentation of resident's response to program by a licensed nurse during the observation period. • Systematic toileting program that is being managed 4 or more days of the 7-day look back period. • The focus of the person-centered care plan should include steps toward ensuring that the resident receives appropriate treatment and have interventions to restore as much bladder function as possible and modify as appropriate. ***Does include:*** • Program if only used by day (when documented that the resident does not want awakened at night). ***Does NOT include:*** • Less than 4 days of a systematic toileting program. • Simply tracking of urinary continence status. • Changing pads or wet garments. • Random assistance with toileting or hygiene.
H0500 Bowel Toileting Program (Restorative Nursing)	*~Rehabilitation* *~Behavioral Symptoms and Cognitive Performance* *~Reduced Physical Function*	***Does require:*** • Documentation of implementation of an individualized, resident-specific bowel toileting program based on an assessment of the resident's unique bowel pattern. • Documentation that the program was communicated to staff and resident (as appropriate) verbally and through a care plan, flow records, verbal and a written report. • Documentation of resident's response to the toileting program by a licensed nurse within the observation period. • The focus of the person-centered care plan should include steps toward ensuring that the resident receives appropriate treatment and have interventions to restore as much bowel function as possible and modify as appropriate. ***Does NOT include:*** • Simply tracking of bowel continence status. • Changing pads or soiled garments.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	***RUG-IV Categories Impacted***	***Minimum Documentation and Review Standards Required Within the Specified Observation Period***
Section I: Active Diagnoses *(7-day and 60-day look back)*		
Active Diagnosis Definition: A physician-documented diagnosis (or by an Optometrist, nurse practitioner, physician assistant, or clinical nurse specialist) **in the last 60 days** that has a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. ***Does require:*** • Physician (Optometrist**,** nurse practitioner, physician assistant, or clinical nurse specialist) documented diagnosis in the 60-day look-back period. • Documentation supporting active diagnosis in the 7-day look-back period. • Documentation related to necessary care, monitoring, interventions, symptoms, or risks relative to the diagnosis. • ADLs must be consistent with the diagnosis. • The focus of the person-centered care plan should identify how the active diagnosis has a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death and the interventions. ***Does include:*** • *Functional limitations* – loss of range of motion, contractures, muscle weakness, fatigue, decreased ability to perform ADLs, paresis or paralysis. • *Nursing monitoring* – clinical monitoring by a licensed nurse (e.g. serial blood pressure evaluations, medication management, etc.). ***Does NOT include:*** • Conditions that have been resolved and do not affect the resident's current status or do not drive the resident's plan of care within the 7-day look-back period; these would be considered inactive diagnoses**.**		
I2000 Pneumonia	~*Special Care High* ~*Clinically Complex*	See Active Diagnosis Definition. ***Does NOT include:*** • A hospital discharge note referencing pneumonia during hospitalization.
I2100 Septicemia	~*Special Care High*	See Active Diagnosis Definition. ***Does include:*** • Sepsis ***Does NOT include:*** • A hospital discharge note referencing septicemia during hospitalization.
I2900 Diabetes Mellitus (DM)	~*Special Care High*	See Active Diagnosis Definition. ***Does include:*** • Diabetic retinopathy. • Nephropathy. • Neuropathy.
I4400 Cerebral Palsy	~*Special Care Low*	See Active Diagnosis Definition.
I4900 Hemiplegia/ Hemiparesis	~*Clinically Complex*	See Active Diagnosis Definition. ***Does include:*** • Left or right sided paralysis. ***Does NOT include:*** • Left or right sided weakness.
I5100 Quadriplegia	~*Special Care High*	See Active Diagnosis Definition. ***Does require:*** • Physician documentation of an injury to the spinal cord that causes total paralysis of all four limbs (arms and legs) and is not the result of another condition. ***Does NOT include:*** • Functional quadriplegia. • Complete immobility due to severe physical disability or frailty that extends to all limbs.
I5200 Multiple Sclerosis (MS)	~*Special Care Low*	See Active Diagnosis Definition.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section I: Active Diagnoses *(7-day and 60-day look back)*		
I5300 Parkinson's Disease	*~Special Care Low*	See Active Diagnosis Definition. ***Does include:*** • Paralysis agitans. • Shaking palsy. ***Does NOT include:*** • Parkinsonism.
I6200 Asthma, Chronic Obstructive Pulmonary Disease (COPD) or Chronic Lung Disease	*~Special Care High*	See Active Diagnosis Definition. ***Does include:*** • Chronic bronchitis. • Restrictive lung diseases (such as asbestosis). • Emphysema. ***Does NOT include:*** • Obesity hypoventilation syndrome.
I6300 Respiratory Failure	*~Special Care Low*	See Active Diagnosis Definition.
Section J: Health Conditions *(7-day look back)*		
J1100C Shortness of Breath or Trouble Breathing When Lying Flat	*~Special Care High*	***Does require:*** • Documentation of the presence of or observation of shortness of breath or trouble breathing when lying flat during the observation period. Documentation might include signs and symptoms such as, but not limited to: 1) increased respiratory rate; 2) pursed lip breathing; 3) a prolonged expiratory phase; 4) audible respirations and gasping for air at rest; 5) interrupted speech pattern (only able to say a few words before taking a breath); and 6) use of shoulder and other accessory muscles to breath **OR** • Interventions to avoid shortness of breath while lying flat that are applied at all times or on an as needed basis must be documented daily when applicable. • The focus of the person-centered care plan should address underlying illness that may exacerbate symptoms of shortness of breath as well as symptomatic treatment for shortness of breath when it is not quickly reversible. ***Does NOT include:*** • General statements by the resident without actual observation or presence of symptoms of shortness of breath or interventions to alleviate shortness of breath.
J1550A Fever	*~Special Care High*	***Does require:*** • Consistent/documented route (rectal, oral, etc.) of temperature between the baseline and the elevated temperature. • Fever of 2.4 degrees F. above the baseline. • A baseline temperature established prior to the ARD. • Baseline must be updated annually. ***Does include:*** • A temperature of 100.4 degrees F. on admission.
J1550B Vomiting	*~Special Care High*	***Does require:*** • Documentation of regurgitation of stomach contents.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section K: Swallowing/Nutritional ***(*K0300 only; 30-day and 180-day look back)***		
***K0300** (code 1 or 2) Weight Loss	*~Special Care High*	***Does require:*** • Documentation of the resident's weight loss of 5% or more in last 30days or 10% or more in last 180days. • Percentage based on the actual weight. • Documentation supporting the expressed goal for the weight loss for code of "1", on physician-prescribed weight loss regimen. • The focus of the person-centered care plan should focus on possible causes of changed intake, changed caloric need, change in medication (e.g. diuretics), or changed fluid volume status. Weight loss should be care planned at the time of detection and not delayed until the next MDS assessment. ***Does include:*** • Mathematical rounding. • Planned or unplanned. • Weight loss via physician-prescribed weight loss regimen.
Section K: Swallowing/Nutritional ***(7-day look back)***		
K0510A Parenteral / IV Feeding Column 1-while not a resident Column 2-while a resident	*~Special Care High*	***Does require:*** • Documentation that reflects the need for additional fluid intake specifically addressing a nutrition and/or hydration need received by the resident either at the nursing facility, at the hospital as an outpatient or an inpatient. • The focus of the person-centered care plan should be to prevent dehydration by addressing risk factors, to maintain or restore fluid and electrolyte balance, and to address the underlying cause or causes of any current dehydration including periodic reevaluation of the appropriateness of the approach. ***Does include:*** • Introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous). • IV fluids or hyperalimentation, including TPN, administered continuously or intermittently. • IV at KVO (keep vein open). • IV fluids contained in IV piggyback. • Hypodermoclysis and sub-q ports in hydration therapy. • IV fluids administered for the purpose of "prevention" of dehydration if specifically documented for nutrition and/or hydration. *(Prevention of dehydration must be clinically indicated and supporting documentation for dehydration must be provided in the medical record.)* ***Does NOT include:*** • IV medications. • IV fluids used to reconstitute and/or dilute meds. • IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay. • IV fluids administered solely as flushes. • IV fluids administered in conjunction with chemotherapy or dialysis.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section K: Swallowing/Nutritional *(7-day look back)*		
K0510B Feeding Tube Column 1-while not a resident Column 2-while a resident	*~Special Care High* *~Special Care Low*	***Does require:*** • Documentation of administration for nutrition and/or hydration received by the resident either at the nursing facility, at the hospital as an outpatient or an inpatient. • The focus of the person-centered care plan should address the underlying cause(s) including any reversible issues and/or conditions that led to the use of a feeding tube and include a reevaluation during the quarter of the appropriateness of the feeding tube approach for nutrition and/or hydration. ***Does include:*** • NG tubes, gastrostomy tubes, J-tubes, PEG tubes. • Any type of tube that can deliver food/nutritional substances/fluids/ medications directly into the GI system.
K0710A3 Proportion of Total Calories the Resident Received Through Tube Feeding Column 3-during entire 7 days	*~Special Care High* *~Special Care Low*	***Does require:*** • Documentation to support the proportion of calories actually received for nutrition and/or hydration through tube feeding during the entire 7-day observation period. • The focus of the person-centered care plan should include monitoring the proportion of calories to ensure adequate nutrition and/or hydration during the quarter and reassess transition to increase oral intake if applicable. *Unless the resident is NPO documentation must demonstrate how the facility calculated the % of calorie intake the tube feeding provided and must include:* 1. Calories tube feeding provided each day within observation period. 2. Calories oral feeding provided each day within observation period. 3. Percent of total calories provided by tube feeding within the observation period.
K0710B3 Average Fluid Intake Per Day by Tube Feeding. Column 3-during entire 7 days	*~Special Care High* *~Special Care Low*	***Does require:*** • Documentation to support average fluid intake per day by tube feeding during the entire 7-day observation period. • The focus of the person-centered care plan should include monitoring the average fluid intake to ensure adequate hydration during the quarter and reassess transition to increase oral intake if applicable. *Documentation must demonstrate how the facility calculated the average fluid intake the tube feeding provided and must include:* 1. Adding the total amount of fluid received each day by tube feedings only. 2. Divide the week's total fluid intake by 7 to calculate the average of fluid intake per day (*Divide by 7 even if the resident did not receive IV fluids or tube feeding on each of the 7 days.)*

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section M: Skin Conditions (7-day look back)		
M0300B1 Stage 2 **M0300C1** Stage 3 **M0300D1** Stage 4 **M0300F1** Unstageable Due to Slough/Eschar	*~Special Care Low*	***Does require:*** • Description of pressure ulcer(s)/injury within the observation period must include but is not limited to; identification of wound as a pressure ulcer, location, and dimensions. • Documentation must include complete history of pressure ulcer(s)/injury when the reported stage is numerically higher than the current stage and description. • The focus of the person-centered care plan should include efforts to limit friction and/or shearing force on the skin and tissue, identify any other related causes and/or contributing risk factors, monitor the impact of interventions, evaluate effectiveness and modify interventions as appropriate. ***Does NOT include:*** • Pressure ulcers/injuries that are healed during the look-back period. • A pressure ulcer/injury surgically repaired with a flap or graft. • If pressure is NOT the primary cause. • Oral mucosal ulcers caused by pressure (report at L0200C). • Skin tears, tape burns, moisture associated skin damage, or excoriation.
M1030 Venous/Arterial Ulcers	*~Special Care Low*	***Does require:*** • Description of the venous/arterial ulcer must include but is not limited to; identification of the wound as a venous/arterial ulcer, location and dimensions. • The focus of the person-centered care plan should include efforts to identify any related causes and/or contributing risk factors and monitor the impact of the interventions to heal or close the venous and/or arterial ulcer. ***Does NOT include:*** • Pressure ulcers/injuries coded in M0210 through M0300.
M1040A Infection of the Foot	*~Special Care Low*	***Does require:*** • Documentation of signs and symptoms of infection of the foot. • The focus of the person-centered care plan should include efforts to identify any related causes and/or contributing risk factors and monitor the impact and effectiveness of the interventions to heal the infection. ***Does include:*** • Cellulitis. • Purulent drainage. ***Does NOT include:*** • Ankle problems. • Pressure ulcers/injuries coded in M0210-M0300.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section M: Skin Conditions (7-day look back)		
M1040B Diabetic Foot Ulcer	*~Special Care Low*	***Does require:*** • Description of diabetic foot ulcer must include but is not limited to identification of the wound as a diabetic foot ulcer, location and dimensions. • The focus of the person-centered care plan should include efforts to identify any related causes and/or contributing risk factors and monitor the impact and effectiveness of the interventions to heal or close the diabetic foot ulcer. ***Does include:*** • Ulcers caused by neuropathic and small blood vessel complications of diabetes. ***Does NOT include:*** • Ankle problems. • Pressure ulcers/injuries coded in M0210 through M0300. • Pressure ulcers/injuries that occur on the heel of a diabetic resident.
M1040C Other Open Lesion on the Foot, (e.g. cuts, fissures)	*~Special Care Low*	***Does require:*** • Description of open lesion must include but is not limited to location and dimensions. • Lesion must be open during observation period. • The focus of the person-centered care plan should include efforts to identify any related causes and/or contributing risk factors and monitor the impact and effectiveness of the interventions to heal or close the open lesion on the foot. ***Does NOT include:*** • Ankle problems. • Pressure ulcers/injuries coded in M0210-M0300.
M1040D Open Lesion Other Than Ulcers, Rashes, Cuts	*~Clinically Complex*	***Does require:*** • Description of open lesion must include but is not limited to location and dimensions. • Lesion must be open during observation period. • The focus of the person-centered care plan should include efforts to identify any related causes and/or contributing risk factors and monitor the impact and effectiveness of the interventions to heal or close the open lesion. ***Does include:*** • Open lesions that develop as a result of disease or condition and are not coded elsewhere on the MDS, such as wounds, boils, cysts, and vesicles. ***Does NOT include:*** • Pressure ulcers/injuries, venous or arterial ulcers, diabetic foot ulcers, or skin tears, cuts/lacerations, abrasions, or rashes.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section M: Skin Conditions *(7-day look back)*		
M1040E Surgical Wound	*~Clinically Complex*	***Does require:*** • Description of surgical wound must include but is not limited to identification of the wound as a surgical wound, location and appearance. • The focus of the person-centered care plan should include efforts to identify any related causes and/or contributing risk factors and monitor the impact and effectiveness of the interventions to heal or close the surgical wound. ***Does include:*** • Any healing or non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. • Pressure ulcers that are surgically repaired with grafts and flap procedures. ***Does NOT include:*** • Healed surgical sites and healed stomas. • Lacerations that require suturing or butterfly closure. • PICC sites, central line sites, peripheral IV sites. • Pressure ulcers/injuries that have been surgically debrided.
M1040F Burn	*~Clinically Complex*	***Does require:*** • Description of the second or third degree burn must include but is not limited to location and appearance. • The focus of the person-centered care plan should include efforts to identify any related causes and/or contributing risk factors and monitor the impact and effectiveness of the interventions to heal the burn. ***Does include:*** • Any stage of healing. • Skin and tissue injury caused by heat or chemicals. ***Does NOT include:*** • First-degree burns (changes in skin color only).
M1200A Pressure Reducing Device/*chair* **M1200B** Pressure Reducing Device/*bed*	*~Special Care Low*	***Does require:*** • Documentation substantiating use of equipment aimed at reducing pressure away from areas of high risk during the observation period. • A facility policy identifying use of pressure reducing/relieving/redistributing mattress on each resident bed will be considered sufficient documentation for the bed. • Mattress specifications if facility does not have a policy for use of pressure reducing/relieving/redistribution mattress on all resident beds. • The focus of the person-centered care plan should include intervention(s) including frequency and effectiveness of the pressure reducing device related to skin problems. ***Does include:*** • Foam, air, water, gel, or other cushioning. • Pressure relieving, reducing, redistributing devices. ***Does NOT include:*** • Egg crate cushions of any type. • Doughnut or ring devices.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section M: Skin Conditions *(7-day look back)*		
M1200C Turning/ Repositioning Program	*~Special Care Low*	***Does require:*** • Documentation substantiating utilization of a program with specific approaches for changing the resident's position and realigning the body. • Documentation of interventions and frequency of program. *(Program is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs)* • Evaluation by the licensed nurse describing the resident's response to the program within the observation period. • The focus of the person-centered care plan should include specific, individualized program intervention(s) including frequency and effectiveness of the turning and repositioning program related to skin problems.
M1200D Nutrition or Hydration Intervention to Manage Skin Problems	*~Special Care Low*	***Does require:*** • Confirmation or suspicion of nutritional deficiencies through a nutritional assessment. • Description of specific skin condition being prevented or treated. • Nutrition or hydration factors that are influencing the skin problem and/or wound healing. • The focus of the person-centered care plan should include interventions tailored to resident's needs, condition and prognosis related to skin problems. ***Does include:*** • Vitamins and/or supplements when administration is linked to a skin problem.
M1200E Pressure Ulcer/Injury Care	*~Special Care Low*	***Does require:*** • Documentation of intervention(s) for treating pressure ulcers/injuries coded at M0300B, C, D, and F. • The focus of the person-centered care plan should include assessments and outcomes related to interventions tailored to heal or close the pressure ulcer/injury. ***Does include:*** • Use of topical dressings. • Enzymatic, mechanical or surgical debridement. • Wound irrigations. • Negative pressure wound therapy (NPWT).
M1200F Surgical Wound Care	*~Clinically Complex*	***Does require:*** • Documentation of intervention for treating or protecting any type of surgical wound. • The focus of the person-centered care plan should include assessments and outcomes related to interventions tailored to heal or close the surgical wound. ***Does include:*** • Topical cleansing. • Wound irrigation. • Application of antimicrobial ointments. • Application of dressings of any type. • Suture/staple removal. • Warm soaks or heat application. • Pressure ulcers/injuries that require surgical intervention for closure (flap and/or graft coverage). ***Does NOT include:*** • Post-operative care following eye or oral surgery. • Surgical debridement of pressure ulcer/injury. • Observation only of the surgical wound.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section M: Skin Conditions *(7-day look back)*		
M1200G Application of Non-surgical Dressings Other Than to Feet	*~Special Care Low* *~Clinically Complex*	***Does require:*** • Documentation of application of non-surgical dressing (with or without topical medications) to the body other than to the feet. • The focus of the person-centered care plan should include assessments and outcomes of interventions tailored to resident's needs related to non-surgical dressings other than to feet. ***Does include:*** • Compression bandages. • Dry gauze dressings. • Dressings moistened with saline or other solutions. • Transparent dressings. • Hydrogel dressings. • Dressings with hydrocolloid or hydroactive particles. • Dressing application to the ankle. ***Does NOT include:*** • Non-surgical dressings for pressure ulcers/injuries other than to feet; use pressure ulcer/injury care (M1200E). • Band-Aids. • Wound closure strips.
M1200H Application of Ointments/ Medications Other Than to Feet	*~Special Care Low* *~Clinically Complex*	***Does require:*** • Documentation of application of ointments/medications (used to treat a skin condition) other than to feet. • The focus of the person-centered care plan should include assessments and outcomes of interventions tailored to resident's needs related to ointments/medications other than to feet. ***Does include:*** • Topical creams. • Powders. • Liquid sealants. • Cortisone. • Antifungal preparation. • Chemotherapeutic agents. ***Does NOT include:*** • Ointments/medications (e.g. chemical or enzymatic debridement) for pressure ulcers; use pressure ulcer/injury care (M1200E). • Ointments used to treat non-skin conditions (e.g. nitropaste for chest pain).
M1200I Applications of Dressings to Feet	*~Special Care Low*	***Does require:*** • Documentation of dressing changes to the feet (with or without topical medication). • Interventions to treat any foot wound or ulcer other than a pressure ulcer/injury. • The focus of the person-centered care plan should include assessments and outcomes of interventions tailored to resident's needs related to dressings to the feet. ***Does NOT include:*** • Dressings to pressure ulcers; use pressure ulcer/injury care (M1200E). • Dressing application to the ankle.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section N: Medications *(7-day look back)*		
N0350A Days of Insulin Injections	*~Special Care High*	***Does require:*** • Documentation must be consistent with physician orders and insulin administration records. • Documentation to include the number of days that insulin injections were received during the observation period. • The focus of the person-centered care plan should address the need for insulin injection(s) and monitor for adverse effects of injected insulin. ***Does include:*** • The number of days the resident actually required a subcutaneous injection to restart the subcutaneous insulin pump.
N0350B Days of Orders for Insulin	*~Special Care High*	***Does require:*** • Documentation must include the number of days that the insulin orders changed during the observation period. ***Does include:*** • Sliding scale order that is new, discontinued, or is the first sliding scale order. ***Does NOT include:*** • A different dose of insulin administered based on an existing sliding scale order.
Section O: Special Treatments, Procedures, and Programs *(14-day look back)*		
O0100 Special Treatments	*Informational Only*	***Does include:*** • Special treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. • Items "while a resident" ONLY. • The focus of the person-centered care plan should center on the specific interventions and the impact to ensure the continued appropriateness of the treatment, procedure, or program. ***Does NOT include:*** • Services provided solely in conjunction with a surgical procedure (pre- and post-operative) or diagnostic procedure.
O0100A Chemotherapy	*~Clinically Complex*	***Does require:*** • Documentation of administration of any type of chemotherapy agent (anticancer drug) given by any route for the sole purpose of cancer treatment. • The focus of the person-centered care plan should include the monitoring of side effects associated with chemotherapy. ***Does NOT include:*** • IV administered during chemotherapy. • IV medication administered during chemotherapy. • Blood transfusions administered during chemotherapy. • Hormonal and other agents administered to prevent the recurrence or slow the growth of cancer.
O0100B Radiation	*~Special Care Low*	***Does require:*** • Documentation of administration of radiation inside or outside of facility. • The focus of the person-centered care plan should include the monitoring of side effects associated with radiation therapy. ***Does include:*** • Intermittent radiation therapy. • Radiation administered via radiation implant.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section O: Special Treatments, Procedures, and Programs *(14-day look back)*		
O0100C Oxygen Therapy	*~Special Care Low* *~Clinically Complex*	***Does require:*** • Documentation of administration of oxygen continuously or intermittently via mask, cannula, etc. delivered to relieve hypoxia. • Related diagnosis that supports risk or evidence of hypoxia. • The focus of the person-centered care plan should monitor for the effectiveness to relieve hypoxia and ensure the continued appropriateness of oxygen therapy. ***Does include:*** • Resident places or removes his/her own oxygen mask, cannula. • Oxygen when used in BiPAP/CPAP. ***Does NOT include:*** • Hyperbaric oxygen for wound therapy.
O0100E Tracheostomy Care	*~Extensive Services*	***Does require:*** • Documentation of cleaning of tracheostomy and/or cannula cleansing. • The focus of the person-centered care plan should monitor for effectiveness and continued appropriateness of the tracheostomy care. ***Does include:*** • Changing a disposable cannula. • Resident performs his/her own tracheostomy care.
O0100F Ventilator or Respirator	*~Extensive Services*	***Does require:*** • Documentation of any type of electrically or pneumatically powered closed system mechanical ventilator support device. • The focus of the person-centered care plan should monitor for effectiveness and ensure the continued appropriateness of the ventilator/respirator. ***Does include:*** • Any resident being weaned off the ventilator or respirator during the observation period. • Any resident who was weaned from the respirator or ventilator in the last 14 days. ***Does NOT include:*** • Times when used as a substitute for BiPAP or CPAP.
O0100H IV Medications	*~Clinically Complex*	***Does require:*** • Documentation of the administration of any drug or biological by IV push, epidural pump, or drip through a central or peripheral port. • The focus of the person-centered care plan should monitor for effectiveness and reevaluate the appropriateness of the IV medications. ***Does include:*** • Epidural, intrathecal, and baclofen pumps. ***Does NOT include:*** • Flushes to keep an IV port patent. • IV fluids without medication. • Subcutaneous pumps. • IV medications administered during dialysis or chemotherapy. • Dextrose 50% and/or Lactated Ringers. • IV medication during ECT treatment.
O0100I Transfusions	*~Clinically Complex*	***Does require:*** • Documentation of the administration of blood or any blood products directly into the bloodstream. • The focus of the person-centered care plan should monitor for effectiveness and ensure the continued appropriateness of the transfusion while monitoring for side effects. ***Does NOT include:*** • Transfusions administered during dialysis or chemotherapy.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section O: Special Treatments, Procedures, and Programs *(14-day look back)*		
O0100J Dialysis	*~Special Care Low*	***Does require:*** • Documentation of the administration of peritoneal or renal dialysis that occurred inside or outside facility. • The focus of the person-centered care plan should monitor for effectiveness and possible side effects of dialysis. ***Does include:*** • Hemofiltration. • Slow Continuous Ultrafiltration (SCUF). • Continuous Arteriovenous Hemofiltration (CAVH). • Continuous Ambulatory Peritoneal Dialysis (CAPD). • Resident performing his/her own dialysis. ***Does NOT include:*** • IV, IV medication and blood transfusion administered during dialysis.
O0100M Isolation or Quarantine for Active Infectious Disease	*Informational Only*	***Code for "Single Room Isolation" only when all four of the following conditions are met:*** 1. Resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. 2. Precautions are over and above standard precautions. **Standard Precautions Include**: • Hand hygiene compliance • Glove use • Masks • Eye protection • Gowns 3. Resident is in a room alone because of active infection and cannot have a roommate regardless of whether the roommate has a similar active infection. 4. Must remain in room. All services must be brought to the resident.
O0100M Isolation or Quarantine for Active Infectious Disease	*~Extensive Services*	***Does require:*** • Documentation supporting active infectious disease, i.e., symptomatic and/or have a positive test and are in the contagious stage. • Documentation of need for transmission-based precautions and strict isolation alone in separate room. (See definition for "single room isolation" criteria.) • Documentation of highly transmissible or epidemiologically significant pathogens acquired by physical contact, airborne or droplet transmission. • **Documentation must include rationale describing why the infection must be contained in a single room isolation (cannot have a roommate) and why precautions must be over and above standard precautions.** • The focus of the person-centered care plan should define the necessity for isolation, interventions for the health and safety of the resident and staff, and address the resident's functional status, cognition, physical, and social abilities and improve quality of life. ***Does NOT include:*** • Standard precautions. • History of infectious disease. • Urinary tract infections. • Encapsulated pneumonia. • Wound infections. • Cohorting with roommate.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

Section O: Special Treatments, Procedures, and Programs Therapies (*7-day look back)*
(A) Speech-Language Pathology Services (SLP) (B) Occupational therapy (OT)
(C) Physical therapy (PT)

Licensed Therapy Requirements

Does require:

- Only skilled therapy provided while a resident in the facility.
- Therapy services are considered skilled when they are so inherently complex that they can be safely and effectively performed ONLY by, or under the supervision of, a qualified therapist.
- Services are directly and specifically related to an active written treatment plan signed by the physician.
- An evaluation must be completed prior to the start of therapy.
- Resident's individualized assessment of the clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are necessary for the performance of the services.
- Services are reasonable and necessary for condition.
- The focus of the person-centered care plan should define the necessity for, and the frequency and duration and effectiveness of each therapy modality and their respective services.

Does NOT include:

- Services provided at the request of the family that is not medically necessary shall not be counted in item O0400 even when performed by a therapist or assistant.
- Non-skilled services (facility election, maintenance treatments, supervision of CNAs) time.
- Nursing restorative services time.
- Therapy provided prior to admission.
- When services can be safely and effectively performed by supportive personnel, such as aides or nursing personnel, without the supervision of a licensed therapist, does NOT constitute skilled therapy.
- Services involving activities for the general good and welfare of the resident does NOT constitute skilled therapy.

In addition for Part A services does require:

- Resident's medical needs must indicate that "daily" therapy is required.
- A valid medical reason why various therapy modalities cannot be furnished on the same day.

In addition for Part A services, does NOT include:

- Arbitrarily staggering the timing of various therapy modalities through the week merely in order to have some type of therapy session occur each day.

Medicare Benefit Policy Manual; Chapter 8: 30.4.1.1 & 30.6

O0400 – Therapies (7-day look back)
(A) Speech-Language Pathology Services (SLP) (B) Occupational therapy (OT)
(C) Physical therapy (PT)

Minutes of Therapy Requirements

Does require:

- Only skilled therapy minutes reported on the MDS.
- Only skilled services after the initial evaluation reported on the MDS.
- Reimbursable (actual) therapy minutes (RTM) ONLY.
- Documentation of RTM for each specific mode of therapy.
- Documentation be differentiated between RTM minutes and billable minutes/units.
- Therapy minutes are reviewed based on payer type requirements.
- Physician order, treatment plan and assessment.
- RTM minutes with associated initials/signature(s) on a daily basis to support the total number of RTM minutes of actual therapy provided.
- Associated initials/signature(s) on a daily basis to support the total number of minutes each therapy modality was provided.

Does include:

- Therapist time spent on subsequent reevaluations conducted as part of the treatment process.
- Time required adjusting equipment or otherwise preparing for individualized therapy.
- Family education when the resident is present and is documented.
- Set-up time.
- Therapy services provided inside or outside the nursing facility.

Does NOT include:

- Therapist time spent on documentation or initial evaluation.
- Conversion of units to minutes or minutes to units.
- Rounding to the nearest 5th minute.
- Non-therapeutic rest periods.
- Treatment or portion of treatment that is not classified as skilled.
- SLP assistant time.
- Unattended e-stim minutes.
- Concurrent minutes reported for a resident under Part B.
- Group minutes for less than 4 residents under Part A.
- Therapy minutes while an inpatient at a hospital or rehabilitation center.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section O: Special Treatments, Procedures, and Programs *(7-day look back)*		
Therapy Days **O0400A4** Speech-Language Pathology and Audiology Services **O0400B4** Occupational Therapy **O0400C4** Physical Therapy	*~Rehabilitation*	***Does require:*** • Associated initials/signature(s) on a daily basis to support the total number of days each therapy modality was provided. • Treatment minimum of 15 direct minutes or more per day. • Documentation of therapy regimen start and end dates (as applicable).
O0400D2 Respiratory Therapy Days	*~Special Care High*	***Does require:*** • Physician order that includes a statement of treatment specific to the resident's needs. • Documentation of actual direct minutes on a daily/shift/occurrence basis. • Associated initials/signature(s) on a daily basis to support the total number of minutes of respiratory therapy provided. • The services be reasonable and necessary for treatment of the resident's condition. • Documentation that the respiratory nurse (licensed nurse) has been trained in the modalities provided either through formal nursing or specific training. • Respiratory evaluation during the observation period by a licensed nurse. • The focus of the person-centered care plan should include the necessity for, and the frequency and duration of the appropriateness of respiratory therapy. ***Does include:*** • Coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds and mechanical ventilation, etc. ***Does NOT include:*** • Treatment for less than 15 direct minutes per day. • Hand held medication dispensers.
End of Therapy (EOT)	*~Rehabilitation*	***Does require:*** • Submission of EOT dates prior to the specified cut-off date. • Documentation of therapy start and end dates.
O0420 Distinct Calendar Days of Therapy	*~Rehabilitation*	***Does require:*** • Documentation of the number of calendar days that the resident received Speech-Language Pathology and Audiology Services, Occupational Therapy, or Physical Therapy for at least 15 direct therapy minutes during the observation period. ***Does NOT include:*** • The count of more than one day when multiple therapy disciplines provide services on the same calendar day.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

MDS 3.0 Item Location and Item Description	*RUG-IV Categories Impacted*	*Minimum Documentation and Review Standards Required Within the Specified Observation Period*
Section O: Special Treatments, Procedures, and Programs *(7-day look back)*		
O0500A-J Restorative Nursing Program Days	*~Rehabilitation* *~Behavioral Symptoms and Cognitive Performance* *~Reduced Physical Function*	***Does require:*** • Documentation of actual direct minutes on a daily/shift/occurrence basis for each program provided within a 24-hour period. • Associated initials/signature(s) on a daily basis to support the total number of minutes of restorative nursing program(s) provided. • Each program must be individualized to the resident's needs, planned, monitored, evaluated, and documented. • Time must be provided separately for each restorative program. • Documentation must include the five criteria to meet the definition of a restorative nursing program: 1. Measurable objectives and interventions must be documented in the care plan and in the medical record; and 2. Evaluation of the program by a licensed nurse. (*For the case mix review, reassess progress, goals and duration/frequency of each program within the observation period*.); and 3. Staff trained in the proper techniques; and 4. Supervised by licensed nurse; and 5. No more than 4 residents per supervising helper or caregiver. • Documentation for splint or brace assistance must include an assessment of the skin and circulation under the device within the observation period. • The focus of the person-centered care plan should focus on achieving and maintaining optimal physical, mental, and psychological functioning and include measurable objectives and interventions. ***Does include:*** • An evaluation of the program written by the CNA and co-signed by a licensed nurse once the purpose and objectives have been established. ***Does NOT include:*** • Requirement for physician order. • Procedures or techniques carried out by or under the direction of qualified therapists. • Movement by a resident that is incidental to care. • Treatment for less than 15 direct minutes per day.
Section Z: Assessment Administration		
Z0400	Signature of Persons Completing the Assessment or Entry/Death Reporting	***Does require:*** • All staff who completed a section or portion of a section of the MDS. • MDS must include complete signature, title, section(s) and date the interview MDS items were collected or the coordination of the assessment information as required, attesting to the accuracy of the MDS responses.
Z0500	Signature of RN Assessment Coordinator Verifying Assessment Completion	***Does require:*** • A complete signature and date RN assessment coordinator certified assessment completion. • The actual date the MDS was completed, reviewed, and signed as complete by the RN Assessment Coordinator.
LOC and PASRR		
LOC	Nursing facility admission must meet the level of care criteria as defined in 405 IAC 1-3-1 (skilled level of care) and/or 405 IAC 1-3-2 (intermediate level of care).	***Does require:*** • The MDS to determine the resident continues to meet level of care criteria.

SUPPORTIVE DOCUMENTATION REQUIREMENTS

LOC and PASRR		
Level I	A screening used to identify individuals who may have a mental illness (MI), intellectual disability/developmental disability (ID/DD), mental illness/intellectual disability/developmental disability (MI/ID/DD), or related condition (RC). A Level I is required regardless of payer source prior to admission in a Medicaid certified nursing facility.	***Does require:*** • Level I forms be in the resident's medical record or readily available for all residents admitted to a Medicaid-certified nursing facility. • Level I screenings be updated to reflect the resident's current condition if there has been a significant change in condition. • Level I when a continued NF stay beyond the approval end date of a categorical determination or exemption, along with a LOC screen, in order to initiate the required onsite Level II (regardless of the resident's pay source) • Level I when admitted from out-of-state. • Level I due to a change in medication, diagnoses, etc. • Level I be updated when the Level I screen is no longer accurate even when the screen may not be associated with a Level II condition.
Level II	An assessment involving an in-depth clinical evaluation by a trained mental health professional to verify whether or not an individual has a serious mental illness and determines appropriateness of nursing facility placement.	***Does require:*** • Level II forms be in the resident's medical record or readily available as applicable: o Community Mental Health Center Level II forms (4 pages). o Bureau for Developmental Disabilities Services (BDDS) Level II Evaluation forms. o Inappropriate Referral form(s). o Ascend Summary of Findings Form for residents with a diagnosis of MI/IDD or IDD (effective 1/3/2017). ▪ Long Term Approval ▪ Time Limited Approval ▪ Denial o Level II recommendation documentation. o Yearly resident review (if required).

Office of Medicaid Policy and Planning Case Mix Review Policies and Procedures Posted at www.mslc.com/indiana. Click on "Case-Mix and Related Services"; click on "Resources" and select the "State Review Policies" folder It is the responsibility of the facility to read and understand the complete policies		
Medical Record Correction for the MDS Case Mix Review	*Effective July 1, 2015*	a) If an error is discovered in the supporting documentation **within 14 days of the ARD**, **but no later than the completion date of the MDS and before submission to the QIES ASAP system**, the documentation may be corrected using standard editing procedures. b) Any corrections made including but not limited to, the Activities of Daily Living (ADL) grid must have an associated note of explanation per occurrence correction. c) If a significant error is discovered in a record after submission to the QIES ASAP system, modification or inactivation procedures must be followed as directed in Chapter 5 of the RAI manual. d) A quarterly or summary note will not substitute for an occurrence correction for the case mix review. e) Improper or illegible corrections will not be accepted for the case mix review. f) All documentation, including corrections, must be part of the original legal medical record. g) Any and all MDS coding and interpretation questions shall be referred to the local State RAI Coordinator.
Electronic Health Records Review Policy	*Effective July 1, 2015*	a) The facility must provide a liaison to access medical records during the review process. b) The facility is responsible for ensuring data backup and security measures are in place. c) Access to EHR must not impede the review process.
Excessive Wait Time for Medical Records	*Effective July 1, 2015*	a) The facility must provide a liaison to obtain supporting documentation as requested within established time limits. b) Once the facility has been presented a list of medical records requested (approximately 8-12 residents), the facility must provide a minimum of two requested records within 15 minutes. c) The remaining requested medical records must be provided within 60 minutes.
Facility Request for Cancellation of Review	*Effective July 1, 2015*	a) Request for cancellation must be made in writing (i.e., fax, email) and include reason for request; if request is due to State Surveyors in facility on day of review, please include Team Leader's name with request. b) Each request is evaluated on a case-by-case basis. c) Two consecutive requests shall be referred to the OMPP for a decision.

Case Mix Review Protocol

POLICY DECISIONS FOR CASE MIX REVIEWS

- Delinquent MDS assessment definition
  - Any assessment with an assessment reference date (ARD) greater than 113 days from the previous ARD will be deemed delinquent and assigned a RUG code of BC1 and case mix index of 0.45
- Case mix review documentation requirements
  - Documentation requirements that define the supporting documentation necessary to verify an MDS RUG item
- Unsupported MDS assessment definition
  - When the case mix review results in a new RUG-IV classification
- Frequency of case mix reviews
  - As determined by OMPP
- Sample payer source selection
  - 90% Medicaid
  - 10% Other
- Primary sample size is the greater of:
  - 30% of the residents listed on the Review Roster Report or 25 assessments
- Expanded sample size (required if primary sample result exceeds the unsupported threshold) is the greater of:
  - 20% of the remaining residents listed on the Review Roster Report or 10 assessments
- Threshold defines when expanded review is required
  - Greater than 20% unsupported
- Frequency of End of Therapy (EOT) reviews
  - Conducted at each case mix review
- Sample payer source selection for EOT review
  - 100% Medicaid
- Validation improvement plan (VIP) is required when a facility review exceeds the threshold
- Late-loss Activities of Daily Living (ADL) documentation to reflect the 7-day/24 hours per day observation period while in the facility
- Follow-up case mix review process
  - Notification for follow-up case mix reviews is not provided

PRE-CASE MIX REVIEW PROTOCOL

- Facility notification will occur up to 72 hours prior to the scheduled on-site review
  - Notification by telephone
  - Confirmation sent by email
- Facility should make arrangements to provide a liaison to assist during the case mix review process for the purpose of accessing both electronic and paper medical records
- Private area to be provided free of any audio or video taping or surveillance

ON-SITE CASE MIX REVIEW PROTOCOL

- ❑ Entrance conference
  - o Facility Administrator or designee, MDS coordinator, Medical Records and any other staff of facility choice
  - o Facility designee to complete Facility Statistical Information Form
  - o Review process is explained
  - o Facility to identify liaison to assist with medical record review
  - o First resident request list provided
  - o Facility Administrator or designee and all other staff in attendance sign the entrance conference form
  - o Time allowed for questions
- ❑ Review process
  - o Electronic records access must be provided if applicable
    - Refer to the *Electronic Health Records Review Policy*
  - o Facility liaison will access medical records for resident list
  - o Facility liaison must be available to navigate facility electronic records
  - o A limited number of resident charts will be requested at one time to minimize chart removal from the resident chart location
  - o The liaison will be asked to locate all documentation the RN reviewer requires from the medical record
  - o All documentation to be considered for the review must be presented prior to the start of each day's exit conference
  - o Facility must provide supporting documentation as requested within established time limits
    - Refer to the *Excessive Wait Time for Medical Records Policy*
  - o Once brought to the review area, medical records cannot leave the area until released by the RN reviewer
  - o Suspected intentional alteration of or creation of clinical documentation after MDS assessments have been completed and transmitted or during the case mix review will be reported to OMPP and may be referred to the Medicaid Fraud Control Unit of the Indiana Attorney General's Office for investigation of possible fraud and could result in felony or misdemeanor criminal conviction. In addition, the state may exercise the right to complete an additional review.
- ❑ Exit conference
  - o Exit conference provided following the completion of each day of the review
  - o No supporting documentation will be considered for review after the start of each day's exit conference
  - o Facility Administrator or designee may invite any staff deemed appropriate to attend the exit conference
  - o Preliminary findings will be reported including the number of assessments reviewed and percent unsupported
  - o Facility Administrator or designee and all other staff in attendance sign the exit conference form
  - o Time allowed for questions

POST- CASE MIX REVIEW PROTOCOL

- ❑ Case Mix Review Findings Letter is posted to the web portal no later than 10-business days following the final exit conference date
- ❑ Informal Reconsideration Process
    - o Facility has 15-business days from the date of the posting of the case mix review findings letter to request an informal reconsideration
    - o Supporting documentation provided by the facility after the start of each exit conference shall not be considered for the informal reconsideration
    - o Myers & Stauffer response to the informal reconsideration no later than 10-business days following receipt of the request for an informal reconsideration
    - o Facility has 45 days after release of the Indiana Health Coverage Program (IHCP) rate by the rate-setting contractor to request a formal rate reconsideration

CORRECTIVE REMEDY

- ❑ At the close of the review all unsupported assessments will be reclassified into the RUG-IV classification based on review findings
- ❑ The direct care rate component will be recalculated
- ❑ Myers & Stauffer will notify facility of any retrospective rate adjustment
- ❑ Adjustment will impact all quarters where the assessment is displayed
- ❑ Adjustment will impact the administrative component by penalty of 15% for one quarter

WEB PORTAL

- o Facility Rosters are posted to the web portal located at: https://incasemixreports.mslc.com/
    - o Once logged in, the system presents the opening page which displays which facility rosters are available to access, view and download.
    - o The headers are listed below:
        - o Rosters
        - o Change Password
        - o Log Out
        - o Clicking on these headers allows the user to toggle between each screen.
    - o Refer to the *Web Portal User Guide*

WEB SITE

- o Current information always available under Long Term Care/Case Mix and Related Services/Resources at: www.mslc.com/indiana
    - o Case Mix in Indiana Newsletter
    - o Supportive Documentation Requirements
    - o State Review Policies
    - o End of Therapy Roster Resources
    - o RUG-IV 48-Grouper
    - o Time Weighted
    - o Calendar
    - o MDS 3.0
    - o Web Portal